BY THE COMPTROLLER GENERAL

Report To The Congress

OF THE UNITED STATES

More Can Be Done To Achieve Greater Efficiency In Contracting For Medicare Claims Processing

This is a comprehensive study of the claims processing system under Medicare. GAO found many opportunities for HEW to improve its administration and is recommending that the Congress and HEW take a number of actions.

Among other things, GAO is recommending that HEW: carefully evaluate ongoing experiments with competitive fixed-price contracts to assess their effect on benefit payments and services; conduct experiments aimed at evaluating the feasibility of merging parts A and B of Medicare under a single contractor and whether incentive contracts will work in Medicare; and take immediate action to reduce the number of contractors in the program by eliminating the less efficient performers.

HEW intends to ask the Congress for statutory authority to select Medicare contractors competitively. GAO believes there is insufficient information to recommend such a change at this time. It will take HEW a considerable amount of time to evaluate the experiments so the Congress may wish to consider providing HEW with contingency legislation which would become effective once HEW demonstrates that competitive fixed-price contracting is the most appropriate course of action.

HRD-79-76
JUNE 29, 1979

E R R A T A

To the recipients of the Comptroller General's report to the Congress entitled "More Can Be Done To Achieve Greater Efficiency In Contracting For Medicare Claims Processing" (HRD-79-76):

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

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To the President of the Senate and the
Speaker of the House of Representatives

This report discusses and recommends administrative and legislative changes that are needed to improve efficiency in the Medicare program.

We made our review pursuant to section 12 of the Medicare-Medicaid Anti-Fraud and Abuse Amendments (Public Law 95-142), enacted on October 25, 1977.

We are sending copies of this report to the Director, Office of Management and Budget; the Secretary of Health, Education, and Welfare; and the Chairman of the Railroad Retirement Board.

R. J. Kelly

ACTING Comptroller General
of the United States

COMPTROLLER GENERAL'S REPORT TO THE CONGRESS

MORE CAN BE DONE TO ACHIEVE GREATER EFFICIENCY IN CONTRACTING FOR MEDICARE CLAIMS PROCESSING

D I G E S T

Most benefits under Medicare are administered by HEW through contracts with private insurance companies such as Blue Cross and Blue Shield. Contractors called intermediaries pay bills for services provided by hospitals, nursing homes, and home health agencies (part A of Medicare). Contractors called carriers pay claims for the services provided by doctors and suppliers (part B). HEW's contracts have been cost reimbursable types, with neither a profit nor loss realized by the contractors. In fiscal year 1978 carriers and intermediaries were reimbursed $342.9 million and $199.1 million, respectively, for their administrative costs.

GAO was directed by the Congress to conduct a comprehensive study of the claims processing system under Medicare and to determine what modifications should be made to achieve more efficient claims administration. 1/

Specifically, GAO was asked to determine whether and to what extent more efficient claims administration could be achieved--

(1) by reducing the number of participating intermediaries and carriers;

(2) by making a single organization responsible for the processing of claims, under both part A and part B of Medicare in a particular geographic area;

(3) by providing for the performance of claims processing functions on the basis of a prospective fixed price;

1/Section 12 of the Medicare-Medicaid Anti-Fraud and Abuse Amendments (Public Law 95-142), enacted on October 25, 1977.

(4) by providing incentive payments for the most efficient organizations; or

(5) by other modifications in such structure and related procedures.

TOO MANY CARRIERS AND INTERMEDIARIES

There are too many carriers (46) and intermediaries (77) administering Medicare. Studies performed by several Medicare carriers and intermediaries indicated that savings of from 8 to 39 percent and from 5 to 16 percent, respectively, could be realized by consolidating carrier and intermediary workloads and distributing larger workloads to fewer contractors. Beyond savings achievable by economies of scale, a move to reduce the number of contractors would provide an opportunity to terminate the less efficient. (See pp. 22 to 33 and 40 to 47.)

COMBINING ADMINISTRATION OF PARTS A AND B--THEORETICALLY FEASIBLE BUT UNTESTED

Many organizations currently perform as both an intermediary and a carrier in Medicare. However, because of a wide variation in workload distributions it is rare that all Medicare administration is handled by the same contractor in a geographical area.

There are many similarities between the functions performed by intermediaries and carriers. Therefore, theoretically, combining parts A and B administration in a single territory should result in the improved coordination of program benefits for beneficiaries, the elimination of some duplicative functions and costs, and the reduction of additional overhead costs associated with having two or more companies instead of one. The available evidence suggests that the optimal advantages to be obtained in combining parts A and B would be achieved through an integrated claims processing system. There is no such system, however, currently being used to process parts A and B data in Medicare although,

according to several contractors, the capability does exist. (See pp. 54 to 61.)

COMPETITIVE FIXED-PRICE PROCUREMENT DESIRABLE--BUT ONLY LIMITED DATA AVAILABLE

A change from cost reimbursement contracting, would require a change in legislation. HEW has stated its intention to propose legislation authorizing the use of competitive fixed-price contracting 1/ in Medicare. To see if competitive fixed-price contracting is suitable for Medicare, GAO examined such contracting in DOD's Civilian Health and Medical Program of the Uniformed Services. It found that overall savings in administrative costs were about 20 percent--about $1.2 million for 20 States analyzed. (See pp. 69 to 73.)

Projected savings in three Medicare experiments with fixed-price contracts are even greater. GAO estimated administrative cost savings over the terms of the contracts of at least $32 million (about 32 percent). Other factors were involved, however, besides the change in contract type. (See p. 74.)

Effects, if any, on the quality of service provided and the control over program payments (which account for about 97 percent of total program costs) in Medicare are not yet known. Performance in DOD's health program has not been good, however. DOD officials believe that contractor performance under fixed-price contracts has been adequate at best, and in some cases poor.

Before such a broad change is made in Medicare, it should be determined whether performance and services will suffer during and after contractor changeover, and whether

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1/Competitive fixed-price contracting, as used in this report, refers to competitive negotiations and not to formal advertisement. (See footnote on p. 10.)

program payments will be adequately controlled. The experiments require further evaluation.

Specific performance standards have been used in the experimental contracts but not in cost contracts. GAO believes such standards should become an integral part of the cost reimbursement contracts, as well as in any change to fixed-price procurement. With the implementation of standards, HEW should establish a firm policy of contract termination for poor or marginally performing contractors.

INCENTIVE CONTRACTING--
AN UNTESTED APPROACH

HEW has not adequately experimented with incentive contracting in Medicare. Although an experiment was conducted in part B, it provided little insight into whether incentive contracts will work in the Medicare program. There have been no experiments with incentive contracting in part A. (See pp. 100 to 108.)

GAO believes HEW should experiment further with incentive contracting on either a cost or fixed-price basis.

OTHER MODIFICATIONS IN MEDICARE
ADMINISTRATIVE STRUCTURE

GAO reviewed two additional areas which impact on the first four mandated issues.

Separate contract with
Railroad Retirement Board
is uneconomical

GAO updated its previous findings and reviewed current claims processing operations at the Travelers Insurance Company, which serves as a national carrier for all Railroad Retirement Board part B beneficiaries. GAO estimated that an additional $43 million in administrative costs has been incurred from fiscal years 1970 through 1978 to maintain a

separate nationwide carrier to process part B claims for railroad retirement beneficiaries. (See p. 128.)

This has proven to be not the most efficient or economical arrangement. Claims for railroad retirement beneficiaries represent only about 3 percent of the total nationwide part B claims volume. Legislation to terminate this arrangement can result in an estimated yearly savings of about $6.6 million in administrative costs. (See pp. 122 to 126.)

Moreover, GAO found that the amounts allowed by Travelers as reasonable charges on actual Railroad Retirement Board claims were different in most cases from the amounts allowed by the area carriers in the same geographical areas--a situation inconsistent with Medicare regulations. (See pp. 129 to 135.)

Medicare/Medicaid crossover claims should be processed using an integrated system

GAO also reviewed the current claims processing systems for crossover claims--for which Medicare and Medicaid are jointly liable for the services rendered by a provider to a beneficiary.

Administrative costs and payment delays could be reduced if Medicare contractors used integrated systems instead of separate systems to process the Medicaid liability for Medicare coinsurance and deductible expenses on crossover claims. (See pp. 141 to 145.)

RECOMMENDATIONS TO THE SECRETARY OF HEW

The Secretary of HEW should direct the Administrator of the Health Care Financing Administration to:

--Evaluate the ongoing experimental fixed-price contracts to determine their advantages and disadvantages in Medicare.

--Incorporate performance standards in all Medicare contracts.

--Implement a firm policy of contract termination for poor or marginally performing contractors. (See p. 93.)

--Conduct experiments to evaluate the feasibility of merging parts A and B under a single contractor, and the effectiveness of requiring an integrated software system approach throughout the program. (See p. 67.)

--Conduct additional experiments, including cost and performance incentives, to evaluate whether incentive contracting will work successfully in the Medicare program. (See p. 112.)

The Secretary should immediately reduce the number of carriers and intermediaries participating in the Medicare program. To determine which contractors should be eliminated, the Secretary should direct the Administrator of the Health Care Financing Administration to determine the most efficient configuration of Medicare workloads and territories by

--identifying the carriers and intermediaries that are the most efficient with their existing workloads and

--identifying, through analyses of carriers' and intermediaries' costs, those carriers and intermediaries that can most efficiently handle larger workloads.

The Secretary should then terminate the contracts with the least efficient carriers and intermediaries, and as an interim step, while experimenting with competitive fixed-price and incentive contracting, award new contracts on a cost reimbursement basis. (See pp. 36 and 51.)

RECOMMENDATIONS TO THE CONGRESS

The Congress should:

--Enact legislation to terminate the authority of the Railroad Retirement Board to select a nationwide carrier for Railroad Retirement Board part B claims and to turn over responsibility for processing and paying of such claims to the area carriers paying part B claims for all other Medicare beneficiaries. (See p. 136.)

--Amend title XIX of the Social Security Act to require that the Medicaid liability for crossover claims be processed by the Medicare contractors using integrated data processing systems, unless the individual States can demonstrate to the Secretary of HEW that another arrangement is just as efficient and effective. (See p. 145.)

MATTERS FOR CONSIDERATION BY THE CONGRESS

HEW has stated its intention to propose legislation authorizing the use of competitive fixed-price contracting in the Medicare program.

GAO believes this would be premature because of the overall effect such changes could have on beneficiary and provider services, program payments, and other aspects of contractor performance.

GAO recognizes, however, that it may take HEW a considerable amount of time to fully evaluate the fixed-price experiments and to determine the effects of fixed-price contracting. Therefore, the Congress may wish to consider providing HEW with some contingency authority to expedite carrying out competitive fixed-price contracting should the experiments prove favorable to the Medicare program. GAO believes the contingency authority should take the form of authorizing

the Secretary of HEW to use competitive fixed-price contracting after HEW fully evaluates the experiments and demonstrates to the Congress' satisfaction that no measurable adverse effects will occur. (See p. 95.)

AGENCY COMMENTS

For the most part, HEW agreed with GAO's recommendations, and said that the recommendations are a major step in the right direction for improved Medicare administration.

HEW urged GAO to recommend that the Congress:

--Provide HEW with full authority to implement competitive fixed-price contracting in a systematic fashion.

--Eliminate the right of providers to nominate their own intermediary and the right of the adversely affected intermediaries to appeal and to obtain judicial review. HEW believes this right should be eliminated in order to consolidate and reduce the number of intermediaries. (See p. 188.)

GAO believes that there is insufficient information to recommend a legislative change to permit competitive fixed-price contracting in Medicare. Therefore, its suggestion that the Congress consider some form of contingency authority is more appropriate at this time.

GAO believes section 14 of Public Law 95-142 gives HEW the authority to consolidate and reduce the number of intermediaries in the interest of effective and efficient program administration.

The Railroad Retirement Board and the Travelers Insurance Company disagreed with

GAO's recommendation to terminate the authority of the Railroad Retirement Board to select a nationwide carrier to administer part B claims for railroad retirement beneficiaries. (See pp. 204 and 218.)

GAO believes its recommendation is sound. Furthermore, HEW agreed with this recommendation and said that administrative efficiencies can be realized by having the area carriers process these claims.

Contents

ABBREVIATIONS

ACER	Annual Contractor Evaluation Report
ASDC	Applied Systems Development Corporation
BCA	Blue Cross Association
BCN	Blue Cross of Northern California
BCS	Blue Cross of Southern California
BSM	Blue Shield of Massachusetts
CAC	Control Analysis Corporation
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
CIEP	Contractor Inspection and Evaluation Program
CPS	California Physicians' Service
DCO	Division of Contractor Operations

DDR	Division of Direct Reimbursement
DOD	Department of Defense
EDP	electronic data processing
EDS	Electronic Data Systems, Incorporated
EDSF	Electronic Data Systems Federal
EOMB	Explanation of Medicare Benefits
GHI	Group Health, Incorporated
HAS	Health Applications Systems, Incorporated
HCFA	Health Care Financing Administration
HEW	Department of Health, Education, and Welfare
HHA	home health agency
HIBAC	Health Insurance Benefits Advisory Council
Maine BC/BS	Maine Blue Cross and Blue Shield
MIO	Medi-Cal Intermediary Operation
MMA	Maine Medical Association
NH--VT BC/BS	New Hampshire--Vermont Blue Cross and Blue Shield
OCHAMPUS	Office for the Civilian Health and Medical Program of the Uniformed Services
OSI	Optimum Systems, Incorporated
RFP	request for proposal
RRB	Railroad Retirement Board
SAI	Systems Architects, Incorporated
SNF	skilled nursing facility
SSA	Social Security Administration

CHAPTER 1

INTRODUCTION

Private health insurance organizations--chiefly Blue Cross and Blue Shield plans and commercial insurance companies--are being used as intermediaries or fiscal agents under various Government health programs, such as the Medicare, Medicaid, and Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) programs. These organizations pay hospitals, physicians, and other health care providers for care rendered to beneficiaries, or they reimburse beneficiaries for health care charges paid directly by them. The intermediaries or fiscal agents usually assume no risk-taking or underwriting function; they are reimbursed in full by the Government for all proper payments made to health care providers or to beneficiaries, and for their necessary administrative expenses incurred in performing the work.

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.

Specifically, we were asked to determine whether and to what extent more efficient claims administration could be achieved by

--reducing the number of participating intermediaries and carriers,

--making a single organization responsible in particular areas for processing claims under part A (Hospital Insurance Benefits for the Aged and Disabled) and part B (Supplementary Medical Insurance Benefits for the Aged and Disabled) of Medicare,

--providing for the performance of claims processing functions based on a prospective fixed price,

--providing incentive payments to the most efficient organizations, or

--other modifications in such structure and related procedures.

We reviewed two areas for the last item which affect the first four mandated issues--we updated our previous findings and reviewed current claims processing operations at the Travelers Insurance Company (which serves as a national carrier for all Railroad Retirement Board part B beneficiaries) and reviewed the current claims processing systems used to process crossover claims. 1/ A description of the scope of our review is in chapter 11.

MEDICARE

Medicare is a Government program which pays much of the health care costs for eligible persons aged 65 or older. Medicare became effective on July 1, 1966. The Social Security Amendments of 1972 extended Medicare protection to (1) persons under age 65 who were entitled to social security or railroad retirement benefits because of a disability for at least 24 months and (2) insured individuals and members of their families under age 65 with chronic kidney disease. Medicare is administered by the Health Care Financing Administration (HCFA) 2/ of the Department of Health, Education, and Welfare (HEW). A component of HCFA--the Medicare Bureau--is further delegated administrative responsibility.

Medicare has two parts. Part A--Hospital Insurance Benefits for the Aged and Disabled--covers inpatient hospital services and post-hospital care in a skilled nursing facility or a patient's home. Part A is principally financed by taxes on earnings paid by employers, employees, and self-employed persons. For fiscal year 1967 (the first full year of Medicare) part A benefit payments were about $2.5 billion and covered about 19 million aged individuals. In fiscal year 1978 about 23.5 million aged individuals, 2.8 million disabled individuals, and 25,000 individuals with chronic kidney disease were eligible for part A benefits. Benefit payments for fiscal year 1978 amounted to $17.4 billion; about 95 percent was for inpatient hospital services.

Part B--Supplementary Medical Insurance Benefits for the Aged and Disabled--generally covers 80 percent of the

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1/Crossover claims are claims for which Medicare makes the primary payment for the service and Medicaid pays the Medicare coinsurance and deductible amounts.

2/Before the establishment of HCFA in March 1977, the program was administered by the then Bureau of Health Insurance of the Social Security Administration.

reasonable charges or costs for physician, outpatient hospital, home health, and other medical and health services subject to an annual $60 deductible. Enrollment in part B is voluntary. Part B is financed by beneficiaries' monthly premium payments and appropriations from the general revenue of the U.S. Treasury. In fiscal year 1978, about 23.3 million aged individuals, 2.5 million disabled individuals, and 23,000 individuals with chronic kidney disease were eligible for part B benefits. Benefit payments for part B for fiscal year 1967 amounted to about $644 million. Fiscal year 1978 payments were about $6.9 billion. About 73 percent were for physicians' services; about 16 percent were for outpatient hospital services.

HCFA administers part A and part B benefits furnished by institutional providers (e.g., hospitals, skilled nursing facilities, and home health agencies) with assistance from 77 intermediaries. These intermediaries pay health service providers usually on the basis of reasonable costs. Sixty-eight local Blue Cross organizations subcontract under the Blue Cross Association, which has a national prime contract. Eight commercial insurance companies and HCFA's Division of Direct Reimbursement are the remaining intermediaries. In fiscal year 1978 intermediaries spent about $199.1 million for administrative costs and processed about 36.6 million part A and part B bills. Because the vast majority of these payments involve part A benefits, unless otherwise specified we associate intermediaries with the administration of only part A in this report.

HCFA administers part B benefits furnished by non-institutional providers such as doctors, laboratories, and suppliers with the assistance of 46 carriers under prime contracts with the Government. Carriers perform many functions similar to intermediaries; however, their payments are usually on the basis of reasonable charges. Thirty-two of the carriers are Blue Shield plans, 13 are commercial insurance companies, and 1 is a State agency. In fiscal year 1978 carriers spent about $342.9 million in administrative costs and processed about 119.8 million claims.

MEDICAID

The Medicaid program, established by Title XIX of the Social Security Act, is a grant-in-aid program which became effective January 1, 1966. Under this program the Federal Government shares with the States the costs of providing medical assistance to certain individuals whose incomes and resources are insufficient to pay for health care.

Medicaid is designed to provide medical assistance to two groups of people. Generally, persons receiving public assistance under the Aid to Families with Dependent Children program and Supplemental Security Income for the Aged, Blind, and Disabled are eligible for Medicaid. These persons are referred to as the categorically needy. Aged, blind, or disabled persons or persons with dependent children who have too much money or resources to qualify for public assistance but not enough to meet the costs of necessary medical care may also be entitled to Medicaid benefits if the State chooses. These people are referred to as the medically needy.

State Medicaid programs are required by the Social Security Act to provide inpatient and outpatient hospital services, rural health clinic services, laboratory and X-ray services, skilled nursing facility services, physicians' services, home health care, family planning services, and early and periodic screening and treatment of eligible persons. Additional services specified by the Act may be included in its Medicaid program if a State so chooses.

The States may contract with private organizations to help administer their programs. The responsibilities assigned to the contractors (referred to as fiscal agents) vary, depending on the contractual arrangements. Some States administer the entire program through their State agencies.

In fiscal year 1978 about 22.8 million people received benefits in the 49 States and 4 jurisdictions with Medicaid programs. Depending on the per-capita income in each State, the Federal Government pays from 50 to 78 percent of the costs incurred by the States' Medicaid programs. During fiscal year 1978 Medicaid benefit payments totaled about $18.0 billion, of which the Federal Government funded about $10.1 billion. Administrative costs totaled another $1.0 billion, of which the Federal Government funded about $620 million.

CHAMPUS

The Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) provides financial assistance for medical care provided by civilian sources to dependents of active duty members, retirees and their dependents, and dependents of deceased members of the uniformed services.

The program is administered by the Office for the Civilian Health and Medical Program of the Uniformed Services (OCHAMPUS), which is located at Fitzsimons Army Medical Center near Denver, Colorado. OCHAMPUS is under the policy guidance and operational direction of the Assistant Secretary of Defense (Health Affairs).

OCHAMPUS contracts with fiscal agents to process and pay claims under the CHAMPUS program. These fiscal agents perform generally the same functions carriers and intermediaries perform under Medicare. In fiscal year 1978 CHAMPUS fiscal agents processed 3.7 million claims and incurred administrative costs of $21.5 million.

CHAPTER 2

BACKGROUND ON MEDICARE CONTRACTING

Title XVIII of the Social Security Act provided that HEW enter into cost reimbursement contracts with carriers and intermediaries which would result in neither a profit nor loss from carrying out Medicare activities. In essence, Federal procurement regulations regarding competitive bidding were waived.

The Medicare legislation and the accompanying committee reports reflected the congressional decision that program administration be carried out by contracting with private organizations that already serve as third-party payers of health care services and that perform in their private business many functions that they would perform for Medicare. Because these organizations had to make adjustments to their systems to accommodate Medicare's complex reasonable-charge determinations and strict Government reporting requirements for a new program, the selection of cost reimbursement contracts seemed appropriate.

Medicare legislation also intended that a system of local carriers and intermediaries be established that could respond immediately to circumstances where they were already operating and provide maximum personal services to the Medicare beneficiary. The law provided for institutional providers (such as hospitals) to nominate their intermediaries and gave these providers wide choice in their selection of intermediaries. It was the Congress' intent that a sufficient number of carriers would be selected on a regional or geographic basis to promote a competitive performance environment and permit comparisons of individual performance.

Although the congressional intent called for comparisons of contractor performance and costs followed by termination of poor performers, there has been limited action by HCFA in this area. Criticism of the cost contract and HCFA's failure to terminate poor performers is not new and has been discussed in several reports.

REPORT TO THE SENATE COMMITTEE ON FINANCE

The staff of the Senate Committee on Finance criticized the inefficent and costly performance of Medicare contractors in a 1970 report. 1/ The report cited the tremendous variance in the performance and costs per claim among the carriers and intermediaries, and it indicated that performance variations were so great that terminations were easily justifiable. The staff felt that the continual renewal of contracts for poorly performing contractors was against congressional intent; it felt that there had been no active policy of complete and indepth analysis followed by terminations of poor performers in favor of the better performers.

Although the report did not mention contracting alternatives for part A services, it did suggest that part B carriers might be compensated by other than a cost basis (such as incentive payments that would be tied to performance and unit costs per claim).

This criticism caused the enactment of section 222 of Public Law 92-603 in October 1972, which gave HEW the authority to experiment with incentive reimbursement arrangements and fixed-price contracts to determine whether such arrangements would induce the most effective, efficient, and economical performance.

THE PERKINS COMMITTEE REPORT

Alternatives for part B contracting were further discussed in the Perkins Committee report, issued June 21, 1974. The Advisory Committee on Medicare Administration, Contracting, and Subcontracting (the Perkins Committee), consisted of three members from outside the Government who were appointed by the Secretary of HEW. The Committee was to consider the most important issues in Medicare contract administration and recommend improvements.

Like the Senate Finance Committee report, the Perkins Committee noted the enormous variation in administrative costs among carriers. Numerous possible explanations were given to the Committee for the differences in unit costs; however, the Committee felt the majority of variance was

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1/"Medicare and Medicaid-Problems, Issues, and Alternatives," report of the Senate Committee on Finance staff, Feb. 9, 1970.

attributable to (1) the differences in efficiency among carriers and (2) the differences in accounting practices (particularly in accounting for the proportion of a carrier's costs allocated to its Medicare business). The Committee concluded that, even if the reason for it could not be determined, the cost variation was unacceptable.

The Perkins Committee recommendations involved devising methods that would substitute for direct competition in providing incentives to carriers. Methods included providing financial rewards, improved performance measurement, and a workable system for eliminating poor performers.

The report cited several advantages to multiple carrier participation in Medicare and the overall good job that carriers had done in implementing the program; it also stated that the advantages of private participation in Medicare administration disappear if each carrier is not given adequate incentive to do the most effective job possible.

Two factors in the system at that time were felt to work against an effective system. First, carriers were assigned territories on an exclusive basis, with no direct competition within assigned areas. Second, they were reimbursed on the basis of reported costs with, consequently, no financial incentive to minimize costs.

It appears that the Committee was reluctant to recommend wholesale competition because of the potential adverse effects of frequent carrier changes on services to the beneficiaries. However, the Committee did state that, for carriers that show significant deficiencies in cost or performance, the short-term problems of changeover should be outweighed by the long-range importance of not allowing territorial monopoly.

The Committee suggested the use of competitive fixed-rate procurement where a contract had been terminated. It also suggested negotiating fixed-rate contracts with other carriers.

HCFA STUDY OF MEDICARE AND MEDICAID CONTRACTING

In early 1978 the HCFA Administrator appointed a steering group of high-level HEW administrators to examine the methods in selecting, monitoring, and reimbursing contractors for the Medicare and Medicaid programs. The steering group's final report (issued Oct. 31, 1978) discussed contracting alternatives for parts A and B, and also addressed combining administration of parts A and B under a single contractor.

The report cited the need for cost reimbursement contracting early in the program to assure smooth implementation and provide an incentive to private contractors to participate with minimal risk. The cost contract also gave the Government flexibility in making program changes without opposition or a decrease in performance. However, the report stated that the cost contracts discourage efficiency in the program and the initial administrative structure which addressed original program needs may no longer be appropriate.

The recommended contract type was a fixed-price or fixed-rate contract, which would swing the risk of performance to the contractors and provide the contractors a potential for profits. It was felt that such a contract would promote greater efficiency, stimulate management, and decrease administrative costs. These types of contracts would lend themselves easily to competition. The report specifically recommended that

> "HCFA seek new legislation to permit a combined and fully integrated Part A and Part B structure for administration of the Medicare program. In combining the administration of Part A and Part B, the number of contractors should be reduced, the contractor areas should be defined on a geographic basis using States as the building block, the nomination process should be eliminated, the prime contract with the Blue Cross Association should be terminated, and the role of the Division of Direct Reimbursement should be limited to dealing only with Federal providers and special cases where the Government believes it is advantageous to efficient program administration. In addition, all contractors should be selected on a competitive basis and should not be limited to insuring organizations or to organizations currently serving as contractors. Contractors should be reimbursed on a fixed price or fixed rate basis rather than on a cost basis."

ALTERNATIVE CONTRACTING METHODS

Contracts generally are of two types--fixed price or cost. However, there are many variations within the two general types, depending on the amount of risk that the Government and the contractors are willing to incur. Any contracting method in Medicare other than reimbursing contractors

for their reasonable operating costs would require a change in legislation, unless it was done under HEW's experimental authority.

In addition to the various contract types there are two methods available for arriving at a contract price--formal advertisement or negotiation. Although formal advertising is the traditional mode of procurement by the Government and is generally preferred, procurement by negotiation has assumed an increasingly larger role in recent years. According to the Commission on Government Procurement, about 85 to 90 percent of the Federal Government's procurement dollars are awarded through negotiation.

A fundamental concept of Government procurement is that competition assures a fair and reasonable price. However, competition should not be equated with formal advertising since negotiation is also required to be competitive to the extent practical. Whenever competition is present and detailed specifications are available the preferred contract type is generally the firm fixed price.

HCFA has three ongoing experiments in Maine, Illinois, and upstate New York that are testing competitive fixed-price procurement 1/ in part B of Medicare. Only one experiment (Maine) is operational; the other two are in transition. Actual claims processing under these contracts will begin in mid-1979. In December 1978 HCFA completed a 2-year part B incentive contracting experiment with Blue Shield of Maryland. HCFA has also decided to experiment with a competitively awarded fixed-price contract for all part A services in Missouri. Proposals have been received and are being evaluated. The award of a contract is not scheduled before July 2, 1979.

1/HEW uses the term "competitive fixed-price procurement" when it refers to competitively negotiated contracts in the Medicare program. Technically, the term "competitive fixed-price procurement" encompasses both formal advertised contracts as well as negotiated competitive contracts. The negotiated competitive contract process does not have the rigid set of formalized procedural steps inherent with formal advertising, and factors other than the lowest price are used in making the contract award. To minimize the technical jargon, for the purposes of this report competitive fixed-price procurement refers to competitive negotiation, not to formal advertisement.

CHAPTER 3

SUMMARY OF FINDINGS AND CONCLUSIONS

Since the inception of Medicare, total benefit payments have skyrocketed--but increases in intermediary and carrier costs have been more moderate. For example, from 1968 to 1978 benefit payments have increased from about $5 billion to $24 billion, whereas total contractor administrative costs have increased from about $155 million to $542 million. In more current terms--from 1974 to 1980--benefit payments will have tripled, from $10.5 billion in 1974 to an estimated $32.8 billion (about 97 percent of total program costs) in 1980, but total contractor administrative costs will increase by about 88 percent, from $352 million in 1974 to an estimated $662 million in 1980. Further, in terms of volume and the unit costs of bills and claims processed, there has been a steady increase in the volume and a steady decrease in unit costs. Data for fiscal years 1974 and 1978 are summarized as follows:

	Part A		Part B	
	Volume	Cost per bill	Volume	Cost per bill
1974	22.0 million	$6.19	66.8 million	$3.24
1978	36.6 million	5.44	119.8 million	2.86

In May 1979 the Secretary of HEW expressed his desire to propose legislation giving HEW statutory authority for the selection of Medicare contractors on a competitive fixed-price basis, including the elimination of the providers' authority to nominate the part A intermediary of their choice. He indicated that this plan (which had been developed in 1978 by the HCFA steering group) has the potential for substantial administrative savings if fixed-price procurements are expanded throughout the country.

Although this proposal may well be the ultimate and most desirable goal for modifying the administrative structure of Medicare, we believe that there is insufficient information to make such a change at this time.

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

--careful and objective evaluation of recent 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) the feasibility of merging 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.

A summary of matters discussed in this report follows.

FIXED-PRICE PROCUREMENT IS DESIRABLE--
BUT ONLY LIMITED DATA ARE AVAILABLE (CHAPTER 7)

Although recent experiences with competitive fixed-price contracting in the CHAMPUS and Medicare programs have demonstrated that up to 30 percent of administrative costs can be saved with this contracting method, we are not prepared to recommend a broad legislative change from the existing contracting system in Medicare for the following reasons:

--Administrative costs in Medicare represent only about 3 percent of total program costs, and the effect of such fixed-price procurement on benefit payments has not been determined. Failure to assure adequate controls over benefit payments could more than offset savings in administrative costs.

--Performance in CHAMPUS has not been good, and many contracts have been terminated or not renewed--resulting in disruption of the program's administration and services.

When making needed changes in the contractor environment, the Secretary of HEW would be required to continue using cost reimbursement contracting. A change to fixed-price contracting would require a change in legislation. To determine if Medicare is suitable for competitive fixed-price contracting we examined the use of competitive fixed-price contracting in the CHAMPUS program and the three Medicare experiments.

We believe that procurement based on full and free competition is important to economical procurement by the Government, and the principle of equal opportunity to supply the needs of the Government is consistent with our free enterprise economy. The use of competitive procurement, where conditions are appropriate, should result in the most reasonable costs, prices, and profits in most cases.

Since 1976, the Department of Defense has converted all CHAMPUS contracts to competitively awarded contracts on a fixed-rate-per-claim basis. We analyzed 11 fixed-price contracts (covering 20 States) which had been in effect for 1 year. Overall savings in administrative costs were about 20 percent--about $1.2 million for the 20 States analyzed.

The projected savings in the three Medicare experiments are even greater. Based on the contract prices in each of the three procurements, we estimated administrative cost savings over the terms of the contracts of approximately $32 million (about 32 percent). However, there were a number of factors involved in these experiments besides the change in contract type that could account for part of the projected savings--such as the consolidation of territories, a reduction in the number of carriers, the elimination of medium- to high-cost carriers, and a change in carrier location to a different employment market.

Only limited data are available on the effects of competitive fixed-price procurement on contractor performance in Medicare. The effects, if any, on the quality of service provided and control over program payments (which account for about 97 percent of total program costs) are not yet known. Performance in CHAMPUS has not been good, however. Our review of CHAMPUS competitive procurement disclosed the following:

--OCHAMPUS officials believe that contractor performance to date under fixed-price contracts has been adequate at best, and in some cases poor.

--OCHAMPUS officials believe that some contractors submitted unrealistic price proposals and are losing money on the contracts.

--Contractors who obtained CHAMPUS contracts and had no prior experience generally had difficulty and left the program, or were terminated. Five contracts, involving 15 States, were terminated at the request of the contractor, OCHAMPUS, or by mutual agreement. In all cases, poor performance was indicated.

--CHAMPUS contracts are written for 1 year with two 1-year options. Three experienced CHAMPUS contractors requested that their options not be renewed.

--Changing contractors has disrupted services to beneficiaries and providers.

Before such a broad change is made in Medicare, it should be determined whether performance and services will suffer during and after contractor changeover; whether the Government is willing to accept the problems of contractor turnover in exchange for lower administrative costs; if past poor performers under cost contracts can significantly lower costs and improve performance under competitive procurement; whether program payments will be adequately controlled; and whether the selection process and contract design used in the experiments are sufficient for assuring a smooth procurement system. The experiments require further evaluation to address these issues.

We recognize that it may take HEW a considerable amount of time to fully evaluate the experiments and determine the effects of competitive fixed-price contracting. Therefore, the Congress may wish to consider providing HEW with some contingency authority to expedite the implementation of competitive fixed-price contracting should the experiments prove favorable to the Medicare program. We believe the contingency authority should take the form of authorizing the Secretary of HEW to use competitive fixed-price contracting after HEW fully evaluates the experiments and demonstrates to the Congress' satisfaction that no measurable adverse effects will occur.

ADDITIONAL EXPERIMENTS ARE NEEDED (CHAPTERS 6 AND 8)

Experimentation is needed to evaluate the feasibility of a single contractor processing parts A and B workloads using an integrated data processing system. Additional experiments are needed to evaluate whether incentive contracting will work successfully in the Medicare program.

Combining administration of parts A and B

Many organizations currently perform as both an intermediary and a carrier in Medicare. However, because of a wide variation in workload distributions it is rare where all parts A and B work is handled by the same contractor in a geographical area.

There are many similarities between the functions performed by intermediaries and carriers. Therefore, theoretically, combining administration of parts A and B in a single territory should improve the coordination of program benefits for beneficiaries, eliminate some duplicative functions and costs, and reduce additional overhead costs associated with having two or more companies instead of one.

However, the available evidence suggests that the optimal advantages to be obtained from combining parts A and B would be achieved through an integrated claims processing system.

Although only limited information was available on the cost effectiveness of such an integrated system in Medicare, the probable advantages include some savings in program payments from increased and more effective utilization review activities. Data from both parts can be readily exchanged, and decisions made under one part can be carried over to the other. More complete profiles on program benefits or medical services rendered can be developed for providers and beneficiaries, resulting in more informed decisions in utilization review. There is no such system, however, currently being used to process parts A and B data in Medicare although, according to several contractors, the capability does exist.

We simulated a relatively simple computer edit which matched the dates of service on beneficiaries' part A hospital billings with comparable data on the part B physician claims. The simulation identified several problems which we believe should be examined by HEW through a demonstration project, in order to obtain the maximum advantages of improved utilization review through an integrated claims processing system.

Incentive contracting

We also believe the Medicare program should experiment further with incentive contracting on either a cost or fixed-price basis. A system of incentives, designed to reward contractors for improved performance above satisfactory levels and to penalize contractors for performance below satisfactory levels, should improve efficiency in the Medicare program.

HCFA has not adequately experimented with incentive contracting. Although an experiment was conducted with Blue Shield of Maryland which was intended to test the desirability of incentive contracting in part B, we do not consider this a true incentive contract. It provided little insight into whether incentive contracts will work in the Medicare program. There have been no experiments with incentive contracting in part A.

INTERIM MEASURES ARE NEEDED--THERE ARE TOO MANY CARRIERS AND INTERMEDIARIES (CHAPTERS 4 AND 5)

There are immediate interim measures, however, which should be taken while the experiments are being carried out

and evaluated. One of these measures--the implementation of performance standards--has been needed in the Medicare program since its inception. Standards should become an integral part of the cost reimbursement contracts as well as in any change to competitive fixed-price contracts. HCFA plans to develop such standards by the end of 1980.

With the implementation of standards for parts A and B contractors, HCFA should establish a firm policy of contract termination for poor or marginally performing contractors. The Medicare Bureau has identified several contractors over the years--particularly in part B--as being "either chronic poor performers or becoming progressively worse without mitigating circumstances," yet little action has been taken to terminate their contracts. A system of strict contract monitoring and budgetary control, followed by a strong policy of contract termination for poor or marginal performers, can introduce many of the advantages of competition into the current Medicare environment and meet the intent of the Congress.

There are too many carriers and intermediaries administering the Medicare program. Cost studies by several Medicare carriers and intermediaries indicated that savings of from 8 to 39 percent and from 5 to 16 percent, respectively, could be realized by consolidating carrier and intermediary workloads and distributing larger workloads to fewer contractors. The savings are achieved primarily because of the large amount of fixed or semifixed costs that are part of each contractor's operations. The actual amount of these savings was not projected because of the number of alternatives available for distributing the workloads and territories.

The Secretary of HEW has recently been given the authority to change the part A administrative structure by assigning and reassigning providers to intermediaries. The authority to change the administrative structure has always been available under part B, yet, despite the Congress' intent regarding carrier selection and several subsequent reports addressing wide variations in carrier costs and performance, HEW has taken little action to change the carrier configuration.

SEPARATE CONTRACT WITH RAILROAD RETIREMENT BOARD IS UNECONOMICAL (CHAPTER 9)

We evaluated the role of the Travelers Insurance Company under its contract with the Railroad Retirement Board (RRB) as the nationwide carrier for part B claims from eligible railroad beneficiaries. We estimated that an additional $43 million in administrative costs has been incurred from

fiscal years 1970 through 1978 to maintain a separate nationwide carrier to process RRB part B claims. Travelers has improved the accuracy and timeliness of its claims processing activities and the beneficiaries appear satisfied with Travelers services.

Maintaining a separate carrier to pay RRB claims has not proven to be the most efficient nor most economical arrangement. Legislation to terminate this arrangement can result in estimated yearly savings of about $6.6 million in administrative costs--$5.4 million resulting from economies of scale present in the area carriers' larger claims processing operations and $1.2 million from eliminating costs resulting from misrouted RRB claims.

Also, because of the limited charge data available to the RRB carrier from the relatively small RRB claims volume, RRB customary and prevailing charges established for fiscal year 1979 vary from those established by the area carriers. We also found that the amounts allowed by Travelers as reasonable charges on actual RRB claims were different in most cases from the amounts allowed by area carriers in the same geographical areas. Although these differences tend to be offsetting, this situation is inconsistent with Medicare regulations which require that payments made by the RRB carrier should conform as closely as possible to the payments made for comparable services by the area carrier in the same locality.

MEDICARE/MEDICAID CROSSOVER CLAIMS SHOULD BE PROCESSED BY AN INTEGRATED SYSTEM (CHAPTER 10)

Administrative costs could be reduced if Medicare contractors also processed the Medicaid liability for Medicare coinsurance and deductible expenses of individuals eligible for both programs by using an integrated system. Provider dissatisfaction would also be lessened because the timeliness of payments would be enhanced. An integrated system eliminates the double processing of claims and thereby reduces costs and time delays when separate systems are used. We are proposing legislation to bring this about.

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The specific recommendations for needed changes in contracting for Medicare claims processing are included in the following chapters.

CHAPTER 4

THERE ARE TOO MANY CARRIERS FOR THE EFFICIENT ADMINISTRATION OF PART B

Cost studies performed by several Medicare carriers indicate that savings in administrative costs of 8 to 39 percent could be realized if the workloads and territories were consolidated under part B of Medicare. The actual savings would depend on the specific territories and the number of carriers consolidated. These savings can be realized by eliminating inefficient carriers and consolidating territories and workloads so that the remaining carriers can achieve greater efficiency. The fixed costs associated with carriers' operations are large, and these costs could be minimized if a number of carriers were eliminated from the program.

The Congress' intent regarding the number of carriers and their territorial responsibility was expressed in the Senate Committee on Finance report on the Medicare legislation (Report 404, 89th Congress, first session, p. 54):

> "* * * the Secretary shall, to the extent possible, enter into contracts with a sufficient number of carriers, selected on a regional or other geographical basis, to permit comparative analysis of their performance."

The intent was that all carriers would be evaluated and only the most economical and efficient carriers would remain in the program after a few years of operations. Despite this intent and several subsequent reports addressing wide variations in carrier costs and performance, the Department of Health, Education, and Welfare (HEW) has taken little action to change carrier configurations.

THERE ARE WIDE VARIATIONS IN THE SIZE OF WORKLOADS AND IN COSTS

There are 46 carriers in the part B program: 32 Blue Shield plans, 13 commercial insurance companies, and 1 State agency. Some commercial insurance companies are responsible for more than one geographical area. In most instances an entire State is assigned to a carrier.

Forty States are handled by a single contractor. Nine States are divided into two geographical areas (California, Florida, Illinois, 1/ Kansas, Maryland, Minnesota, Missouri, Virginia, and Wisconsin), with one part of the State generally assigned to a Blue Shield plan and the other part to a commercial insurance company. 2/ New York State is divided among five carriers (three Blue Shield plans, a commercial insurance company, and an independent health insurer). 3/

Carriers processed 119,812,605 claims at a cost of $342,869,864 for fiscal year 1978. The average workload per carrier was 2.5 million claims at an average cost of $7.3 million. The workload ranged from 99,086 claims in Wyoming (administered by the Equitable Life Insurance Company) to 9,928,593 for California Physicians' Service (Blue Shield of California), which serves northern California and handles the Medicare claims for welfare recipients for the entire State. The national unit cost for processing a claim was $2.86; the lowest unit cost was $1.80 at Blue Shield of Rhode Island and the highest unit cost was $4.50 at South Dakota Medical Service, Inc. (Blue Shield).

There is no significant correlation between workload size and high or low unit costs. The Medicare Bureau reports carrier administrative cost data in an arrayed manner by peer group (carriers with similar claims volume). According to Bureau statistics, 73 percent of the carriers in peer group I (claims volume averaging about 6.4 million claims annually) had unit costs in fiscal year 1978 at or below the national mean and an average unit cost of $2.79. At the other extreme are carriers in peer group IV (claims volume averaging about

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1/In July 1979 claims processing in the State will be done by only one carrier as a result of an experimental contract awarded in 1978.

2/Oklahoma is divided between two carriers--a State agency handles Medicare claims for welfare recipients and a commerical insurance company handles claims for all other beneficiaries.

3/Beginning in June 1979 claims processing in upstate New York (currently three carrier territories) will be done by one carrier as a result of an experimental contract awarded in November 1978.

500,000 claims)--these carriers all exceeded the national mean with an average unit cost of $3.63. It appears from these statistics that carriers with claims volume below 500,000 annually generally have the highest unit costs.

While these two peer group extremes seem to show some correlation, the other peer groups confuse the picture. Six of 13 carriers (46 percent) in peer group II (claims volume averaging about 2.4 million claims) had unit costs above the national mean. On the other hand, 64 percent of the carriers in peer group III (claims volume averaging about 1.2 million claims) had costs below the national mean.

A recent Bureau study defined an optimal claims volume to be about 6 million claims. Cost studies performed at our request and discussed below contradict this conclusion. All contractors participating in a study by us showed continued economies from increased workloads; this held true for several contractors with far more than 6 million claims.

ECONOMIES OF SCALE IN MEDICARE

Other organizations and individuals have studied whether economies of scale 1/ exist in Medicare. A study sponsored by the Social Security Administration's Office of Research and Statistics, completed in October 1975, studied the efficiency in providing health insurance both from the choice of optimal scale of operation and from cost minimization at whatever scale is chosen. The administrative cost structures of commercial health insurers and Blue Cross and Blue Shield plans were studied. The study centered on data from 1968 through 1971.

Economies of scale were found in the administration of commercial health insurance in a sample of 328 health insurers. However, no scale economies were found in a similar analysis of the Blue Cross and Blue Shield plans. This was attributed to the lack of cost-minimizing behavior on the part of the Blue Cross and Blue Shield's nonprofit organizational form.

1/Economies of scale, as used in this report, are the reduction in unit costs associated with increased volumes of workload. This occurs when total administrative costs do not increase proportionately with the workload. We do recognize, however, that factors other than volume increases (such as technological improvements) can account for some of the economies. The economy, as we have defined it, can result from elimination of excess capacity or other inefficiency existing at lower volumes of operation.

The Medicare Regional Processing Feasibility Study completed in October 1977 by Systems Architects, Inc. (SAI), also examined whether economies of scale existed in the Medicare processing environment. SAI analyzed total administrative costs per bill and claim for parts A and B to see whether unit costs decrease as bill and claims volumes increase.

In its analysis, which included multiple linear regressions 1/ of several variables against unit costs, neither bill volume nor claims volume demonstrated a statistically significant relationship with unit costs per bill or claim. SAI found no statistically significant evidence to support the hypothesis that economies of scale exist in the current Medicare processing environment.

Economies of scale do exist

The studies discussed above did not examine the historical growth of costs and volume, and the effects of such volume on each contractor individually. Rather, they studied the total contractor environment and attempted to see if a correlation existed between workload size and costs.

Economies of scale do exist in the current Medicare environment. As the volume of claims has grown rapidly over the last several years, the unit costs of processing these claims have decreased--total costs have not increased in proportion to volume. This has occurred despite the inflation the economy has experienced during these years.

Carriers have been able to reduce part B administrative unit costs by processing additional workloads without proportionate cost increases since at least 1974. Administrative costs and claims volume increased 12 percent and 16 percent a year, respectively, between fiscal years 1974 and 1978. The incremental 2/ unit cost was $2.39 during this period. (See the table on page 22 for an analysis by years of administrative costs, claims volumes, and incremental unit costs.)

1/A systematic way of statistically determining the relationships between several variables.

2/Incremental costs are the differences between total costs projected at increased volume levels. Incremental unit costs are the differences in costs divided by the difference in claims volume. The terms incremental costs, marginal costs, and differential costs are often used synonomously.

Incremental Costs For Processing Part B Claims--Fiscal Years 1975-78

Fiscal year	Administrative costs: Total costs	Administrative costs: Increase over previous year	Administrative costs: Percentage increase	Claim volume: Claim volume	Claim volume: Increase over previous year	Claim volume: Percentage increase	Unit costs	Incremental unit cost with inflation (note a)	Incremental unit cost without inflation (note b)
	(millions)			(millions)					
1975	$258.7	$42.7	19.8	80.6	13.8	20.6	$3.21	$3.10	$2.16
1976	290.2	31.5	12.2	92.4	11.8	14.6	3.14	2.67	1.36
1977	322.6	32.4	11.1	108.1	15.7	17.0	2.98	2.06	0.95
1978	342.9	20.3	6.3	119.8	11.7	10.8	2.86	1.73	0.08

a/The figures in this column were calculated as follows: The change in total costs between one fiscal year and the previous fiscal year was divided by the change in claim volumes between the same fiscal years.

b/The figures in this column were calculated the same as above except the previous fiscal years' costs were increased by 6 percent to allow for the estimated effects of inflation on overall cost increases.

The last column of the table shows the incremental unit cost, excluding a 6-percent annual allowance for inflation. This column attempts to differentiate between increased costs due to inflation and increased costs due only to claims volume increases. The incremental unit cost was $1.32 between fiscal years 1974 and 1978, excluding the 6-percent allowance for inflation. Although factors other than economies of scale (e.g., technological improvements) can reduce unit costs, we believe that the major factor is the carriers' ability to spread fixed costs over a larger volume.

Additional economies can be realized

There are 10 major part B contractor operations for which budgets are prepared and costs are reported. These operations and some of the activities included in each of the 10 categories are described in appendix III on page 185. The carriers are required to report the direct and indirect costs of each operation. Although the Bureau has general guidelines for allocating costs to the major operations, there is great diversity among carriers in their methods of allocating costs.

Since each carrier has an accounting system which normally satisfies its own business needs, there is no standard method for allocating costs to Medicare. Each carrier reports costs under the same operational headings, but each operation may not necessarily include identical functional costs. Costs may also vary, depending on changes in the number and complexities of claims.

Costs that fluctuate directly and proportionately with the volume of work are called variable costs. To the extent that some of a contractor's costs are fixed (costs that remain constant regardless of volume), then a change in claims volume will affect unit costs.

Many costs are not either completely fixed or completely variable; rather, they are referred to as semivariable costs (or semifixed costs). Semivariable costs vary with volume, but usually in steps. For example, the number of and/or the wages and salaries of supervisory personnel may remain constant for certain ranges of workload (behave like a fixed cost) and then increase or decrease as another range is reached.

Reducing the number of part B carriers would generally mean larger territories and workload for the remaining carriers. Understanding the variability of costs is essential for examining the effects of larger territories and workloads on existing contractors. If contractors can handle larger workloads and responsibility without a proportionate increase in total costs, they can achieve economies of scale. Theoretically, these contractors should continue to achieve economies of scale with increased volumes until additional claims cause a disproportionate increase in unit costs. The program thus benefits by assigning workloads and/or territories to achieve as much economy of scale as feasible (i.e., an optimal workload size).

Several carriers performed cost studies at our request to test our hypothesis that a reduction in the number of contractors should result in the elimination of some duplicative fixed costs as well as the spreading of fixed costs by the remaining contractors over larger workloads. Some carrier officials told us their fixed costs could be as high as 55 or 60 percent of their total costs. Examining the change in total costs projected at increased volume levels indicates the contractor's ability to handle additional work efficiently. This could result in significant economies being realized in the Medicare program.

The studies indicate that savings in administrative costs of from 8 to 39 percent could be realized by consolidating carrier workloads and territories. There are a number of alternatives available for distributing the workloads and territories, and the actual amount of savings would depend on the alternatives chosen.

The savings are achieved primarily because of the large amount of fixed or semifixed costs that are part of each carrier's operations. The specific operational areas where savings were estimated by each contractor varied, depending on (1) the assumptions followed in the analyses and (2) the cost allocation methods used by the carriers to allocate costs to the operations.

The areas generally showing the least variability to workload increases were computer usage; EDP systems and programming support; financial, accounting, and statistical; general and administrative; and service departments. These areas, generally along with claims review, also reflected the greatest potential economies.

Claims review is the largest single cost area of a carrier's operations and is very volume dependent. Although this area tends to have a smaller proportionate amount of fixed costs than many of the other areas, the actual dollar amount of the fixed costs is higher.

The projected savings are made up of two components. One component is the savings realized internally by the carriers spreading fixed costs over larger workloads (economies of scale). The other component is due to the relationship between the carriers' current unit costs and the average unit cost of other carriers in the State or region.

SAVINGS ARE REALIZABLE BY CONSOLIDATING THE CALIFORNIA CARRIERS

Two carriers serve California--the Occidental Life Insurance Company and California Physicians' Service (CPS). 1/ During fiscal year 1978 Occidental processed 4.8 million claims and CPS handled 9.9 million claims--the largest workload of any carrier in the part B program. The table below shows the claims processed and administrative costs for both contractors for fiscal years 1977 and 1978 and the budgeted amounts for fiscal year 1979.

1/CPS is a Blue Shield plan and is also referred to as Blue Shield of California.

	Fiscal year 1977			Fiscal year 1978			Fiscal year 1979 (budgeted)		
	Claims processed	Total costs	Unit costs	Claims processed	Total costs	Unit costs	Claims processed	Total costs	Unit costs
	(millions)			(millions)			(millions)		
CPS	9.1	$23.1	$2.53	9.9	$25.7	$2.59	10.9	$26.4	$2.42
Occidental	4.3	12.4	2.90	4.8	13.7	2.83	5.4	15.5	2.88
Total	13.4	$35.5	$2.65	14.7	$39.4	$2.67	16.3	$41.9	$2.57

Occidental and CPS officials estimated costs of Medicare administration if each operated as the single carrier in the State. Both contractors used budgeted estimates for fiscal year 1979 as the base for estimating consolidated claims processing costs in California. As indicated above, the approved budgets for fiscal year 1979 show a total workload of 16.3 million claims 1/ at an estimated cost of $41.9 million.

Both contractors projected savings from consolidating California operations, mainly because much of the fixed costs inherent in operating two companies would be eliminated or distributed over a larger volume of claims.

Although both contractors stated that their estimates did not reflect the lowest costs at which they could operate effectively, savings ranged from 11 percent to 20 percent of fiscal year 1979 costs. It is not practical to compare the contractors' estimates because of differing methodologies and assumptions followed in their analyses. However, both analyses present a clear picture of how economies can be realized through consolidation.

California Physicians' Service

CPS officials estimated it would cost about $37.5 million (a savings of about $4.4 million--11 percent) to process 16.3 million claims--this gives an average unit cost of $2.30 per claim compared with its approved budget of $26.4 million for 10.9 million claims ($2.42 per claim).

To arrive at the statewide claims volume, CPS used its and Occidental's projected claims volume as approved by the Medicare Bureau. CPS provided estimates showing the

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1/Occidental officials used a claims volume of 16.7 million for fiscal year 1979, as discussed on page 27.

administrative costs broken down into the 10 functional areas on the budget. Each of the areas was further broken down into labor and nonlabor categories. In addition, each department manager was contacted to identify all cost centers that would be affected by the claims volume increase and the effect of the increased volume on labor and nonlabor costs.

Throughout its analysis, CPS used the approach of calculating only the costs that were likely to be affected by the workload increase. The estimates of incremental costs were also developed by assuming that the present data processing system would be used which, according to carrier officials, has the capability to handle the additional workload.

Based on its analysis, we estimated that CPS could save about $1.9 million due to economies of scale if it processed all part B claims in the State. The additional $2.5 million in projected savings is due to CPS' current unit costs being lower than the statewide average. Claims volume for CPS in fiscal year 1979 would increase from 10.9 million to 16.3 million (about 50 percent); however, estimated costs would only increase by 42 percent. This reflects a unit cost for the added claims of only $2.07 per claim.

No savings were projected in computer usage. Since data processing costs under a subcontract with Electronic Data Systems Federal (EDSF) 1/ vary directly with the volume of claims processed, CPS treated these costs as pure variable costs; hence, a 50-percent increase in volume generates total costs which are 50-percent higher. Officials pointed out, however, that if a 50-percent increase in volume were actually realized, the EDP subcontract would be renegotiated and any savings passed on to Medicare.

CPS provided staffing estimates based on the current claims volume, as compared to the statewide claims volume. The schedule below shows the percentage increase in certain estimated staffing requirements for the 50-percent increase in volume.

1/EDSF is the major EDP subcontractor in the Medicare program. It provides computer facility management services and proprietary software packages to Medicare and Medicaid contractors. Also, EDSF was recently awarded a prime carrier contract for all of Illinois.

Functional area	Percentage increase
Claims review	41
Utilization and reasonable charge review	46
Beneficiary hearings and appeals	17
Data entry	27
Service departments	12
Financial, accounting, and statistical	22

CPS estimated that there would be no need for increased staffing in computer usage, EDP systems and programming support, professional relations, and general administrative areas. Total staffing was estimated to increase only 37 percent.

Occidental Life Insurance Company

Occidental used an estimated claims volume in California for fiscal year 1979 of 16.7 million claims--an increase of 209 percent over its existing workload. Despite this huge increase in workload, Occidental estimated that total costs would only increase by 120 percent--from $15.5 million to $34.2 million; a reduction in unit costs from $2.88 to $2.05 per claim.

The analysis centered primarily on an extrapolation of Occidental's current activities to the increased workload. As requested, Occidental examined the incremental costs associated with the increase. No consideration was given to the effect of possible technological improvements, systems changes, or organizational changes that could possibly result in further savings.

Occidental attributed most of the potential savings to its ability to combine similar functions and to maximize the spreading of fixed costs over a larger volume. This ability to spread fixed costs is most evident in the incremental costs associated with the increase. Occidental's estimates indicate an incremental unit cost of $1.65 per claim for the added claims.

Another factor, according to Occidental, which contributed to the low incremental unit cost was the type of claims it would be acquiring in a statewide consolidation. Occidental officials stated that the claims presently handled by CPS are significantly less labor intensive than the claims at Occidental and, as such, would be less costly to process.

Because the claim volume used by Occidental in its analysis was about 400,000 claims higher than the statewide budget, we reduced Occidental's total projected costs by $660,000 (assuming that each of the 400,000 claims were costed at the incremental cost of $1.65). The result was an estimated savings in California of $8.4 million--20 percent.

Occidental provided the projected effects on staffing requirements. While workload increased 209 percent, Occidental projected only a 95-percent increase in staffing--reflecting substantial economies of scale.

POTENTIAL SAVINGS IN NEW YORK STATE

There are too many carriers in New York State for efficient administration of the part B program. Cost studies indicate that savings of as much as 39 percent could be realized by consolidating carrier workloads. The amount of savings will depend on the efficiency of the remaining or new contractor(s) to handle increased volumes of claims.

Five carriers have operated in New York State since the Medicare program began. Blue Cross and Blue Shield of Greater New York (New York Blue Shield) is the largest carrier, with responsibility for New York City and surrounding counties, excluding Queens County which is serviced by Group Health Incorporated (GHI). The rest of the State is divided among Genessee Valley Medical Care, Inc. (Blue Shield of Rochester), Blue Shield of Western New York, Inc. (Blue Shield of Buffalo), and the Metropolitan Life Insurance Company. The table below shows the claims processed and administrative costs for all five contractors for fiscal years 1977 and 1978 and the budgeted amounts for fiscal year 1979.

	Fiscal year 1977			Fiscal year 1978			Fiscal year 1979 (budgeted)		
	Claims processed	Total costs	Unit costs	Claims processed	Total costs	Unit costs	Claims processed	Total costs	Unit costs
	(millions)			(millions)			(millions)		
New York	8.0	$23.8	$2.97	8.2	$25.9	$3.17	9.4	$29.1	$3.09
Metropolitan	1.5	4.6	3.03	1.7	4.5	2.70	1.5	4.6	2.99
GHI	1.1	3.0	2.91	1.0	3.3	3.29	1.1	3.6	3.18
Buffalo	.6	2.2	3.57	.6	2.5	3.71	.5	1.7	3.60
Rochester	.3	1.3	4.05	.4	1.3	3.50	.4	1.4	3.56
Total	11.5	$34.9	$3.04	11.9	$37.5	$3.15	12.9	$40.4	$3.12

To demonstrate the potential economies of consolidating the contractors in New York State, we selected three part B carriers for study--Blue Cross and Blue Shield of Greater New York, Group Health Incorporated, and the Metropolitan Life Insurance Company. Our study centered on the effects of increased workloads on these contractors. By demonstrating the potential for increased economies of scale, we believe the incremental costs shown at various workload levels provide useful data for projecting savings through consolidation.

Officials at the three carriers agreed to do cost studies for us that would indicate the effects on operations and costs from workload increases. Metropolitan and GHI based their analyses on additional workloads of 1 million, 4 million, 8 million, 12 million, and 16 million claims. New York Blue Shield's analysis was based on additional workloads of 1 million, 8 million, 12 million, and 18 million claims.

All three carriers indicated that they were able to acquire additional workloads at lower costs. Blue Shield's analysis, for example, showed economies realizable up to a projected volume level of at least 26 million claims--more than double the current volume in the entire State. The tables on page 30 show the workload and costs for the base year in the study (calendar year 1977), and the incremental costs estimated for each additional level of workload.

Additional considerations that were not included in the carriers' analyses would have to be made in a real consolidation of a territory such as New York State. For example, none of the carriers considered an increase in the actual size of the territory they presently serve. Therefore, any costs associated with increased travel requirements or possibly with suboffices throughout the State are not reflected in the estimates. Such costs would depend greatly on the requirements placed on a statewide contractor by the Medicare Bureau, particularly in the area of maintaining beneficiary services.

The range of incremental costs does indicate the estimated efficiency of these contractors with larger workloads. The declining unit costs for each carrier, as shown in the tables, clearly indicate the potential benefits from spreading large volumes over each carrier's fixed costs.

Metropolitan Life Insurance Company

Projected claims volume	Estimated costs Total	Estimated costs Unit	Incremental costs Total	Incremental costs Unit
1.6 million--base year	$ 4,497,189	$2.83		
2.6 million 1 million increase	5,982,362	2.31	$1,485,173	$1.49
5.6 million 3 million increase	11,513,829	2.06	5,531,467	1.84
9.6 million 4 million increase	18,852,510	1.97	7,338,681	1.83
13.6 million 4 million increase	26,017,821	1.91	7,165,311	1.79
17.6 million 4 million increase	33,131,263	1.88	7,113,442	1.78

Group Health Incorporated

Projected claims volume	Estimated costs Total	Estimated costs Unit	Incremental costs Total	Incremental costs Unit
1.0 million--base year	$ 3,137,058	$3.27		
2.0 million 1 million increase	5,743,245	2.93	$2,606,187	$2.61
5.0 million 3 million increase	12,861,708	2.59	7,118,463	2.37
9.0 million 4 million increase	21,854,898	2.44	8,993,190	2.25
13.0 million 4 million increase	30,874,812	2.38	9,019,914	2.25
17.0 million 4 million increase	39,759,432	2.34	8,884,620	2.22

Blue Cross/Blue Shield of Greater New York

Projected claims volume	Estimated costs Total	Estimated costs Unit	Incremental costs Total	Incremental costs Unit
8.3 million--base year	$24,517,710	$2.96		
9.3 million 1 million increase	27,119,751	2.93	$ 2,602,041	$2.60
16.3 million 7 million increase	42,797,468	2.63	15,677,717	2.24
20.3 million 4 million increase	53,338,913	2.63	10,541,445	2.64
26.3 million 6 million increase	66,445,106	2.53	13,106,193	2.18

Although we recognize there were certain limitations in the analyses' parameters, we projected the incremental costs to the statewide workload for each carrier over its fiscal year 1978 actual costs. In fiscal year 1978, the five carriers in New York State reported administrative costs of $37.5 million. If each carrier could handle the statewide workload of 11.9 million claims at the incremental costs indicated, savings from consolidation could amount to: Metropolitan--$14.6 million (39 percent), GHI--$9.0 million (24 percent), Blue Shield--$2.9 million (8 percent).

Blue Shield and GHI officials stated that their studies were based on the existing data processing systems. They pointed out that, if such a consolidation was actually planned, then their EDP systems would be redesigned and further savings would be realizable. Metropolitan, on the other hand, assumed that its processing system would be redesigned to handle the additional workload, beginning with the additional 1 million claims.

We believe the incremental costs indicated by the carriers are credible, and perhaps conservative. Metropolitan and GHI submitted proposals on the competitive fixed-price consolidation of upstate New York (see p. 182) and, using the Bureau's workload projections for the consolidated area, their proposals reflect unit costs of $1.80 and $1.61 per claim, respectively--both lower than the unit costs projected in the incremental cost analyses.

EXPANSION OF WORKLOAD AND TERRITORY IN HEW REGION VI COULD REDUCE COSTS

We asked officials at Blue Cross and Blue Shield of Texas (Texas Blue Shield) to estimate the effects on their operations and costs if they were to administer part B in the entire five-State area of Region VI. This would approximately double their geographical territory serviced and would increase their workload by almost 70 percent. The table below shows the claims processed and administrative costs for all carriers in the five States for fiscal years 1977 and 1978.

Carriers in Region VI	State	Fiscal year 1977 Claims processed	Fiscal year 1977 Total costs	Fiscal year 1977 Unit costs	Fiscal year 1978 Claims processed	Fiscal year 1978 Total costs	Fiscal year 1978 Unit costs
		(millions)			(millions)		
Arkansas Blue Shield	Arkansas	1.3	$ 3.7	$2.88	1.4	$ 3.7	$2.59
Pan American Life	Louisiana	1.1	3.5	3.08	1.2	3.8	3.23
Equitable Life	New Mexico	.4	1.2	3.06	.5	1.4	2.99
Aetna	Oklahoma	1.0	2.9	3.10	1.0	3.5	3.48
Oklahoma Dept. of Welfare	Oklahoma	.3	1.1	3.41	.3	1.4	4.08
Texas Blue Shield	Texas	5.9	16.2	2.72	6.4	18.1	2.83
Total		10.0	$28.6	$2.85	10.8	$31.9	$2.95

Texas Blue Shield officials agreed to cooperate but, instead of using the actual workload figures for the region, they based their cost estimates on simply doubling their workloads and the territory covered. Cost extrapolations were made by using the fiscal year 1979 budget as a base. They also chose to disregard the effect of changing the present EDP system or the new building presently being erected and planned for completion in 1981. In short, their estimates were based on "business as usual" with only those changes necessitated by the increased workload affected.

The estimates were developed by a panel of Texas Blue Shield's most knowledgeable management, finance, and operations personnel, starting with the approved budget and "brainstorming" the effects that doubling the volume of claims and their geographical territory would have on the several line items of cost set out in the budget, while maintaining the same level of service being provided to beneficiaries and providers.

Carrier officials estimated that, if they doubled their Medicare workloads, they could process part B claims for $2.28 per claim--compared with their 1979 budget of $2.73. Total costs increased 67 percent for a 100-percent increase in workload. However, individual cost elements within each budget line item increased at different rates.

Carrier officials assumed a doubling of workload rather than the actual budgeted regional volume of 12 million claims. As a result, the claims volume used in their analysis was 2.4 million claims higher than estimated for the region. Since their estimates reflected an incremental unit cost of $1.83,

we reduced their total costs by $1.83 for each of the 2.4 million claims.

This results in a potential savings of $3.1 million--10 percent from the total budgeted cost for Region VI. Since Blue Shield officials did not consider an incremental approach to the increased workload, we don't know whether the $1.83 would actually hold constant throughout each increment of the 7.2 million added claims. In theory it would not, possibly causing some variation from the $3.1 million projected savings. However, the $3.1 million is actually a conservative estimate in our opinion, because carrier officials did not consider a change in their EDP system which, according to Medicare Bureau and carrier officials, is greatly needed.

Blue Shield's analysis reflects internal economies of scale of about $4.3 million to handle the regional workload of 12 million claims. Total savings were only estimated to be $3.1 million, however, because its projected fiscal year 1979 budgeted unit costs were higher than the average costs in the region.

POSSIBLE SAVINGS PROJECTED BY OTHER CONTRACTORS

We solicited the views of most intermediaries and carriers on several aspects pertaining to a reduction in the number of contractors in the Medicare program. Several contractors were contacted directly, but most were notified by either the Blue Cross and Blue Shield Associations or the Health Insurance Association of America.

The Blue Cross and Blue Shield plans (called plans) generally conceded that, in theory at least, there should be economies realized by consolidating the workload. A larger claims volume would support a more sophisticated EDP system, would allow for a greater base for the distribution of ancillary services costs (which are relatively fixed), and would provide for increased efficiencies in organization, physical plant, and personnel resources.

Officials of EDSF identified basically the same advantages, pointing out that the purchase of specialized equipment to automate the handling of certain functions becomes cost effective with large volumes. They said that mail opening equipment, microfilm camera and viewers, microfilm developing equipment, mail stuffing equipment, online systems, and combined micrographics systems were such items.

Optimum workload levels not identified

Few contractors offered any opinion about the optimum workload size. It was generally believed that such a level could not be determined without modeling, which has not been done.

Several views were expressed as to the minimum workload arrangement that was believed to be beneficial. EDSF suggested there should be one carrier per large State and a combination of low-volume States to achieve a 5- to 6-million annual claims volume at minimum. Plan officials also generally believe that (1) State boundaries should be the minimum territory to be considered, (2) high-cost carriers should be consolidated, (3) small volume areas could be combined, and (4) territories should center around population densities.

The effect of consolidation on benefit costs and services

The plans responding generally believe that there are no apparent savings in benefit payments from consolidation and that costs for local relations with providers and beneficiaries would, in all likelihood, increase. They also emphasized that the needs of the beneficiary would become secondary in any massed carrier consolidation.

EDSF, on the other hand, cited two areas where consolidation and larger workloads could affect benefit costs. In a larger operation, EDSF pointed out the possibility of attracting more highly qualified medical specialists (physicians and nurses) that will apply fair and consistent medical policy to all claims. Secondly, data processing techniques utilizing large, high-speed computers and large data bases can be employed to screen claims with regard to utilization and medical necessity. EDSF added that these techniques would not be possible on smaller EDP systems and would not be cost effective with small volumes.

EFFORTS TO IDENTIFY THE LESS EFFICIENT PERFORMERS

Although the Bureau has had difficulty over the years with evaluating and comparing carrier performance, it has identified some carriers as being poor performers. Despite this identification HEW has taken little action to terminate or modify these carriers' participation in the program.

In a 1976 report, for example, the Bureau identified the 15 poorest performing carriers for the previous 3 fiscal years. Six of the 15 carriers were cited as being "either chronic poor performers or becoming progressively worse without mitigating circumstances." Despite this identification all 15 carriers are still in the program. One carrier had a portion of its territory taken away and another will lose its territory as a result of the experimental consolidation in upstate New York.

HCFA STUDY SAYS FEWER CONTRACTORS WOULD MEAN A REDUCTION IN ADMINISTRATIVE COSTS

In its report to the Administrator of HCFA dated October 31, 1978, the steering group consisting of HEW officials appointed to study the administration of the Medicare and Medicaid programs said:

> "It can be demonstrated that a reduction could be achieved in overall administrative cost by reducing the number of carriers, assuring that the workload of each is sufficient to achieve the economies of scale demonstrated by the larger Medicare carriers, and still maintain a high level of service to the beneficiary and professional communities."

The steering group presented two options for reducing the number of carriers: (1) establish one carrier per HEW region or (2) determine an optimum number based on workload statistics. The report discussed the advantages and disadvantages of each option and presented specific feasibility considerations.

The report recommended that carrier jurisdictions:

> "be redefined based on geographic and workload characteristics using State boundaries as a building block to allow for multistate or substate areas. Carrier territories would be of optimum size to allow for economies associated with large scale operations, thus reducing the number of carriers."

CONCLUSIONS

There are too many part B carriers for efficient administration of the Medicare program. Despite the intent of the Congress regarding carrier selection and several subsequent

reports addressing wide variations in carrier costs and performance, HEW has taken little action to change the carrier configuration.

The cost studies performed by several Medicare carriers indicate that savings in administrative costs ranging from about 8 to 39 percent could be realized by consolidating carrier territories and distributing larger workloads to fewer contractors. The actual amount of savings is difficult to estimate, particularly on a national basis, because of the number of alternatives available for distributing the workloads and territories.

The savings are achieved primarily because of the large amount of fixed or semifixed costs that are part of each carrier's operations. Although the studies did not identify the exact amount of such costs, it is apparent from the incremental cost projections that these costs are significant. The projections indicate, and some carrier officials have stated, that such fixed costs could be as high as 55 or 60 percent of a carrier's costs.

An accurate comparison of the cost projections among carriers could not be made, nor could we make an exact comparison to existing costs in the carriers' State or region because of the different assumptions followed by the carriers in their analyses. However, we believe the incremental costs indicated by the contractors for acquiring additional workloads provide a clear indication that a significant amount of fixed costs could be saved by reducing the number of carriers participating in the program.

The HCFA steering group recommended, and most contractors concur, that a single State should be the minimum territory for a carrier. We agree. There are several States with more than one carrier and this is not the most efficient way to administer the program.

RECOMMENDATIONS TO THE SECRETARY OF HEW

We recommend that the Secretary of HEW take immediate action to reduce the number of carriers participating in part B of the Medicare program. In order to determine which carriers should be eliminated from the program, we recommend that the Secretary direct the Administrator of HCFA to determine the most efficient configuration of Medicare part B workloads and territories by

--identifying the carriers that are the most efficient with their existing workloads and

--identifying, through analyses of carriers' costs, those carriers that can most efficiently handle larger workloads.

Once the most efficient configuration has been determined, the Secretary should (1) terminate the contracts with the least efficient carriers and (2) as an interim step, while experimenting with competitive fixed-price and incentive contracting (see chapters 7 and 8), award new contracts on a cost reimbursement basis.

AGENCY COMMENTS AND OUR EVALUATION

Commenting on our report, (see app. VI) HEW agreed with the intent of this recommendation, pointing out that it plans to take administrative actions in part B to reduce the number of contractors by eliminating poor performers and by consolidating contractors in specific areas. HEW plans to consider additional experiments that will provide for consolidation and result in increased efficiency.

However, HEW stated that experience has shown that whenever contractor territories are consolidated or poor performing contractors are terminated, the selection of a new contractor can be performed most equitably on a competitive basis. This appears to be a restatement of the Secretary's desire for authority to use competitive fixed-price contracting in Medicare. (See p. 11.)

We believe the selection of new contractors to take over the consolidated areas should be based on HEW's choice of the most efficient and effective contractors. These should be cost reimbursement contracts until a decision is made by the Congress on the use of fixed-price contracts in Medicare. (See ch. 7.)

CHAPTER 5

THERE ARE TOO MANY INTERMEDIARIES FOR THE EFFICIENT ADMINISTRATION OF PART A

There are too many intermediaries administering part A of the Medicare program. Cost studies performed by several Medicare intermediaries indicate that savings in administrative costs of 5 to 16 percent could be realized by redistributing the workload and by assigning territories to intermediaries so as to achieve as much economy of scale as possible. Large amounts of fixed costs are associated with each intermediary's operations, and a significant portion of these costs would be saved if a number of intermediaries were eliminated from the program.

The Secretary of HEW has the authority to change the intermediary configuration to improve efficiency. If such a change is made, most contractors believe it should be based on geographic territory, not on type of provider. Geographical assignment of intermediaries would allow for alignment with part B carrier territories, and should provide for more uniform application of policies and procedures to all providers within an area.

THERE ARE WIDE VARIATIONS IN THE SIZE OF WORKLOADS AND IN COSTS

As of December 29, 1978, the Medicare program part A had 77 intermediaries, of which 68 were subcontractors under a prime contract with the Blue Cross Association (BCA) and eight were prime contracts with commercial insurance companies. HCFA's Division of Direct Reimbursement (DDR) also services providers who elect to deal directly with the Government. These intermediaries serve from as few as 1 provider to as many as 1,000 or more. In one State there are 10 intermediaries serving groups of providers; in other instances 1 intermediary may service providers in many States.

The Medicare intermediaries service 7,079 hospitals, 5,170 skilled nursing facilities (SNFs), and 2,710 home health agencies (HHAs). The average for each of the three types of providers serviced by an intermediary is 92 hospitals, 67 SNFs, and 35 HHAs. The range by type of provider per intermediary is wide; for hospitals, from 4 at the Blue Cross plan in Watertown, New York, to 479 at Blue Cross of Texas; for SNFs, from 1 at several Blue Cross plans to 966 at Mutual of Omaha; and for HHAs, from 1 at Watertown to 374 at HCFA's Division of Direct Reimbursement.

These 77 intermediaries processed 36,587,443 bills at a cost of $199,084,963 for fiscal year 1978. The national unit cost for processing a bill was $5.44, with a low of $3.27 at Blue Cross of Western Pennsylvania and a high of $17.22 for the Travelers Insurance Company in California.

The significant variation in the number of providers serviced by the intermediaries occurred primarily because of the nomination process authorized by the original Medicare law, which allowed groups or associations of providers the right to choose a national, State, or other public or private agency or organization to serve as their Medicare fiscal intermediary. Provision was also made for providers to receive reimbursement directly from the Federal Government if they so desired.

Because of the nomination process, the Blue Cross Association was selected as fiscal intermediary by most of the hospitals and by substantial numbers of SNFs and HHAs. Those providers nominating BCA were originally serviced by 75 Blue Cross plans under a subcontract with BCA. The number of subcontracting Blue Cross plans has now been reduced to 68.

BCA was contractually responsible as of December 1978 for servicing approximately 90 percent of the hospitals (6,235), slightly more than 50 percent of SNFs (2,720), and 78 percent of the HHAs (2,104). Commercial insurance companies were servicing only about 9 percent of the hospitals (626), 46 percent of the SNFs (2,375), and 9 percent of the HHAs (232). DDR serviced 218 hospitals, 75 SNFs, and 374 HHAs.

Economies of scale difficult to determine

Using a reporting format similar to that used under part B, the Bureau reports administrative cost data for the Blue Cross plans in an arrayed manner by peer group (plans with similar bill volume). This proves meaningless, however, in any effort to examine the effects of bill volume on administrative cost. Not only is there a wide variation of unit costs within peer groups, but of the 14 plans listed in peer group IV (bill volume under 140,000), four had unit costs for fiscal year 1978 below the averages for the other three peer groups. At the other extreme, 4 of the 13 plans in peer group I (bill volume over 620,000) had unit costs higher than the average for peer group IV. So there seems to be little or no correlation between volume and cost when examining the total contractor environment.

There is a lack of meaningful data to examine the effects of volume on costs because of the mix of providers handled by each intermediary. Although it is generally recognized that bills from SNFs are much more difficult and costly to process than other types of bills (particularly hospital outpatient bills, which are the easiest to process), the costs of processing each type of bill are not reported. A contractor's high or low unit costs may result more from the type of bills it handles than from the volume it handles.

Economies can be realized

A reduction in the number of intermediaries would result in economies being realized generally for the same reasons as the last chapter. Less contractors means fewer companies being reimbursed for their corporate overhead and other savings from the elimination of duplicative costs (such as the costs of maintaining numerous EDP systems and other relatively fixed costs). The remaining contractors should achieve some economies of scale from the larger workload and spreading the workload over fixed and semifixed costs.

In the past, the Government could not require providers to use a particular intermediary, since doing so would violate the providers' rights under the nomination process. However, section 14 of Public Law 95-142 (enacted in October 1977) increased HEW's authority over the nomination process by amending section 1816 of the Social Security Act. The Secretary of HEW is now authorized to assign and reassign providers to available intermediaries and to use regional and national intermediaries for a single class of providers (e.g., home health agencies) when it is in the best interest of effective and efficient program administration. Before making such changes, however, the HEW Secretary is required to develop standards, criteria, and procedures to serve as a basis for determining what constitutes effective and efficient Medicare administration.

Cost studies performed by several intermediaries indicate that savings in administrative costs of from 5 to 16 percent could be realized by consolidating workloads and distributing larger workloads to fewer contractors. As was indicated by the cost studies under part B (see p. 24), the areas showing the least cost variability to workload increases were the computer areas; financial, accounting, and statistical; general and administrative; and service departments. Bill review showed a high variability to workload increases, but generally reflected a large amount of savings because it represents a large portion of an intermediary's operations.

SAVINGS ARE REALIZABLE BY REDUCING THE NUMBER OF INTERMEDIARIES IN CALIFORNIA

The costs of processing bills from providers in California have varied considerably. There are currently six intermediaries processing bills in California--Blue Cross of Northern California (BCN), Blue Cross of Southern California (BCS), Mutual of Omaha, Aetna Life Insurance Company, Kaiser Permanente, 1/ and HCFA's Division of Direct Reimbursement (DDR). Aetna has two processing sites--one in Marin County and the other in Los Angeles.

The workload in the State in fiscal year 1978 ranged from 47,000 bills at the Travelers Insurance Company 2/ to 1.6 million bills at BCS. Together, BCS and BCN process approximately 77 percent of the part A workload in the State.

Officials at BCN and BCS estimated the possible effects on Medicare administrative costs if each operated as the single intermediary in the State. Based on approved fiscal year 1979 budgets for all six intermediaries in the State, savings were estimated by BCN and BCS of $3.8 million (16 percent) and $1.2 million (5 percent), respectively. 3/ These savings are made up of two components. One component is the savings realized internally by the contractors being able to spread fixed costs over larger bill volumes. The other component is due to to the relationship between the contractors' current unit costs and the average unit cost of all intermediaries in the State.

1/Kaiser does not audit the providers it serves. This function is performed by DDR.

2/Beginning in July 1978, Travelers no longer serves as an intermediary in California.

3/In fiscal year 1979 Kaiser is expected to process about 64,000 bills. The costs of processing these bills were not included in the projected statewide costs by BCN or BCS. Therefore, any costs associated with these bills are not reflected in the estimated savings.

Both contractors used their budgets 1/ for fiscal year 1979 as the basic building block for arriving at the consolidated processing costs. The approved budgets 2/ show an approximate workload of 3.9 million bills at an estimated cost of $23.2 million.

Blue Cross of Northern California

BCN estimates it would cost about $19.4 million to process the 3.9 million bills in the State at an average cost of $5.00 per bill. BCN now has an approved budget of $6.8 million for 1.3 million bills--$5.40 per bill.

BCN assumed the current mix of bills and providers serviced in the State to make its projections. The administrative cost and staffing estimates were broken down into the functional areas (line items) on its budget. BCN assumed that there would only be one centralized processing site handling the entire State. However, provider relations, utilization review, and provider audit and reimbursement were expected to be decentralized.

Economies of scale were realized. Bill volume would increase from about 1.3 million to 3.9 million (about 206 percent) while costs were estimated to increase about 184 percent--from $6.8 million to $19.4 million. The greatest potential for internal economies of scale are in the areas of bill review, computer usage, EDP systems and programming support, financial and accounting, general and administrative, and service departments.

Personal service costs, which represent 72 percent of BCN's current costs, showed almost no economies from the expanded workload. BCN provided us with staffing estimates based on current workload, as compared to the statewide estimates by functional area. Staffing economies were only estimated in the computer functions and in the nonworkload-related areas. Total staffing was estimated to increase 197 percent to handle the added workload.

1/The intermediary budget form is similar to the carrier budget. It contains a few other line items pertinent to the part A program, such as medical review, provider reimbursement, and provider audit.

2/Mutual of Omaha and DDR did not break their 1979 budget down by State. Therefore, we estimated the approximate cost of processing their workload in California by using average processing costs in the State.

BCN projected a potential savings of $3.8 million (16 percent) over the current cost of several intermediaries operating in the State. Approximately $1.6 million was attributable to internal economies of scale and $2.2 million was apparently due to BCN having the lowest current unit cost in the State.

BCN also pointed out in its analysis that a decision regarding the consolidation or regionalization of part A should not be based solely on lower administrative costs but should consider all potential problems--including the effects on total program costs. They presented several opinions on the advantages and disadvantages of regionalization.

Among the advantages cited were: savings in administrative costs due to lower overhead with only having one intermediary, more consistent administration of medical review determinations, better utilization review tracking of the services a beneficiary receives, and bill processing and provider relations activities would be more consistently administered. Among the disadvantages cited were: the initial cost of developing a new system capable of handling the added workload, the autonomous and bureaucratic nature of large operations, the effect and costs of dismantling current intermediary operations, the initial disruption created by the change, and the potential problems if the sole intermediary developed trouble in its operations.

Blue Cross of Southern California

BCS reported basically the same reasons as BCN for economies in its operations due to consolidating the intermediary operations in California. The estimate from BCS tc handle the entire State was $22 million, compared to the existing costs of approximately $23.2 million for fiscal year 1979, a projected savings of only $1.2 million--5 percent. This compares with an approved budget for BCS of $11.1 million for 1.8 million bills ($6.23 per bill). The estimate reflects internal economies of scale of about $2.2 million. Because of BCS' currently high unit costs (compared to other intermediaries in the State), total savings were only estimated to be $1.2 million. BCS described the results of its analysis as follows:

"Our approximate cost estimates, based on current capabilities without enhancements, indicate that some savings in administrative costs may be anticipated by consolidating fiscal intermediaries, utilizing centralized claims processing (EDP and clerical) and consolidated (but decentralized) provider activity, including provider relations and provider audit."

BCS assumed the same provider mix and workload characteristics as did BCN. The increase in workload for BCS was 117 percent--compared to 206 percent for BCN. Although the actual dollar estimates and staffing figures differed because of the present size differences of the two companies, the relative effects were the same. BCS showed economies and diseconomies in generally the same areas as BCN. For example, BCS estimated a total staffing increase of 104 percent to handle the 117-percent increase in workload.

BCS officials presented generally the same views on consolidation of part A as did BCN. They also told us that their current bill mix was approximately 16 percent more difficult than BCN's bill mix. While this could account for their higher current unit cost, it should not have any effect on the differences between the contractors' statewide projections.

INCREASED WORKLOADS RESULT IN POTENTIAL ECONOMIES IN NEW YORK STATE

Part A providers in New York State are serviced by 10 intermediaries (7 Blue Cross plans, 2 commercial insurance companies, and DDR). In fiscal year 1978, these services cost at least $17 million and are estimated to be over $19.4 million in fiscal year 1979. These figures do not include the costs for DDR's and Aetna's portions of the workload, since their costs for New York are not separately identified.

Under this arrangement the Medicare program is paying the administrative overhead of 10 separate organizations, and it is not taking advantage of the economies of scale achievable by larger, more efficient organizations.

The table below shows the bill workload and administrative costs for all intermediaries in New York State, excluding DDR and Aetna, for fiscal years 1977 and 1978 and the budgeted amounts for fiscal year 1979.

Intermediary	Fiscal year 1977 Bills processed	Fiscal year 1977 Total costs	Fiscal year 1977 Unit costs	Fiscal year 1978 Bills processed	Fiscal year 1978 Total costs	Fiscal year 1978 Unit costs	Fiscal year 1979 (budgeted) Bills processed	Fiscal year 1979 (budgeted) Total costs	Fiscal year 1979 (budgeted) Unit costs
	(millions)			(millions)			(millions)		
Blue Cross Plans:									
New York	1.5	$ 7.5	$5.06	1.7	$ 8.8	$5.13	1.7	$10.1	$ 5.86
Buffalo	.3	1.4	5.13	.3	1.7	5.15	.4	1.9	5.09
Albany	.3	1.3	5.05	.3	1.5	5.05	.3	1.5	4.51
Syracuse	.2	1.1	4.72	.2	1.3	5.05	.3	1.4	5.13
Rochester	.2	.9	4.33	.2	1.0	4.30	.2	1.1	4.41
Utica	.2	.7	3.47	.2	.8	3.89	.2	.9	3.96
Jamestown	(a)	.1	4.44	Operations merged with Buffalo--5/78					
Watertown	(a)	.1	4.27	(a)	.1	4.02	(a)	.1	4.12
Travelers Insurance Co.	.2	1.7	8.39	.2	1.8	8.65	.2	2.4	10.60
Aetna Life Ins. Co.				Data not available					
DDR				Data not available					
Total	2.9	$14.8	$5.09	3.3	$17.0	$5.20	3.4	$19.4	$5.66

a/Less than 35,000 bills.

We selected two part A intermediaries for study--Blue Cross and Blue Shield of Greater New York (New York Blue Cross) and Blue Cross of Northeastern New York (Albany Blue Cross). The study centered on the effects of increased part A workloads on the contractors' operations.

However, because the studies assumed (1) no expansion of territory or increase in providers, (2) the same proportion of types of bills as handled presently by the individual plans, which was not typical of the entire State, and (3) projected savings as high as 55 percent, based on the statewide bill workload, we concluded that they did not represent what would happen in an actual consolidation of part A workloads, and they are not presented in the report. On the other hand, the studies did present useful information as to what functional areas in the intermediaries' operations showed the greatest potential for savings from workload increases. These areas were bill review; computer usage; EDP systems and programming support; service departments; financial, accounting, and statistical; and general and administrative. The savings were estimated because many of the cost centers in these areas have a large amount of fixed costs and would experience little or no increase as a result of added volume.

REGIONALIZATION OF THE INTERMEDIARY WORKLOAD IN HEW REGION VI COULD REDUCE COSTS

We asked officials at Blue Cross and Blue Shield of Texas (Texas Blue Cross) to estimate the effects on their operations and costs if they were to administer part A in the entire five-State area of HEW's Region VI. This would almost double their workload and geographical territory serviced.

There are eight intermediaries--five Blue Cross plans, two commercial insurers, and DDR--serving providers in the region. Information was not available on the workload and costs for DDR, Aetna, or Mutual of Omaha in the region, but the table below shows the number of bills processed and total administrative costs for the Blue Cross plans in each State for fiscal year 1978.

State	Bills processed	Total administrative cost
Texas	1,207,558	$ 6,939,835
Louisiana	477,570	2,468,571
Arkansas	315,662	1,628,884
Oklahoma	281,643	1,615,508
New Mexico	139,059	828,341
Total	2,421,492	$13,481,139

The fiscal year 1979 budgets approved for the five Blue Cross plans project a workload of 2.6 million bills at a cost of $13.8 million. The approved budget for Texas Blue Cross projects a workload of 1.3 million bills and a cost of $7.2 million. Using the 1979 budget as a base, Texas Blue Cross officials analyzed only those changes which would be necessitated by the increased workload. A panel of corporate managers reviewed each line item in the budget and the effects the workload has on each area.

Their estimates reflect that, if the part A workload were doubled, the part A unit cost would decrease from its current $5.43 to $4.62--reflecting an incremental unit cost of $3.81. Total costs were estimated to increase only 70 percent to handle the 100-percent workload increase. The result is a potential savings in the region of about $1.8 million (13 percent).

Bill review

Texas Blue Cross officials estimated an incremental cost of $.85 a bill in this area, compared to their present budget of $1.42 per bill. With the exception of provider audit and reimbursement, this is the highest single cost item and is very labor intensive.

Total costs were only estimated to increase 60 percent in this area. These projected savings primarily result because staff, particularly supervisors, would not increase proportionately with volume.

Medical review and utilization review

Costs for these areas are also estimated to only increase 60 percent. As was the case for utilization review under part B, officials estimated that the size of the samples needed for review in these areas would not increase in proportion to the workload. Therefore, significant economies were estimated.

Provider reimbursement and auditing

This function, which is unique to part A, is basically a variable cost, depending on the increase in providers serviced. Officials estimated only a slight savings in this area with larger workloads, reflecting that all levels of management would not increase proportionately with the added staff and space requirements.

Other line items

Blue Cross officials projected savings in other line items generally because labor costs for personnel services and general management are only slightly affected by changes in workload.

OTHER CONTRACTORS CITE ADVANTAGES TO THE GEOGRAPHICAL ASSIGNMENT OF PART A PROVIDERS

Many contractors presented views on the effects of a potential reduction in the number of Medicare intermediaries. Most of the comments were solicited by the Blue Cross Association from the subcontracting Blue Cross plans. (See p. 33.) The views primarily dealt with the effectiveness of the provider nomination process and how providers should be assigned to intermediaries.

Twenty-four Blue Cross plans commented on the current practice of providers choosing their intermediaries. Sixteen plans said providers should be given such an opportunity. Six plans suggested that assignment of all providers to a single intermediary within a given territory would be the best arrangement. Two plans were noncommittal.

Most plans felt that, if providers are to be assigned to intermediaries, it should be based on geographic territory. They did not believe it economical to split out providers by type due to the relatively small numbers of providers involved, other than hospitals, although it was pointed out that processing bills from only one type of provider might increase efficiency through specialization. Several advantages to territorial assignment were cited: (1) uniform application of rules and regulations to all providers within the area, (2) better, more consistent service to providers and beneficiaries, and (3) cost savings due to the elimination of duplicative functions in multi-intermediary States.

Mutual of Omaha officials stated that an intermediary can do a more effective job if it handles all types of providers. Assigning providers solely by type, in Mutual's opinion, would be a simplistic approach to the problems presented by SNFs and HHAs in particular. They stated that there were few problems in serving one type of provider that were not common to all three types. For purposes of effectiveness, they believe a minimum number of each type of provider should be served.

Mutual of Omaha officials pointed out that a reduction in the number of intermediaries could be accomplished simply by not renewing the agreements of inefficient contractors. The workload of inefficient contractors could be assigned by the Secretary of HEW to interested contractors which are performing efficiently and have indicated an interest in expanding their operations. Although they stated that some economy would be realized by a larger workload, they were not sure at what level maximum economies would be achieved.

The Blue Cross plans generally feel there would be economies realized from a consolidation of workload. There was no consensus as to the optimum workload volume, although some believed the optimal level should be based on factors such as beneficiary population, bill mix, or number of providers.

In commenting on our draft report, (see app. IX) the Blue Cross Association suggested that there are numerous

factors which can impact on the projected economies from consolidating contractors. The Association offered to work with HEW to identify and measure the probable effects of such factors.

We also received comments from Electronic Data Systems Federal (EDSF) in this area, although EDSF is not presently involved as either a prime contractor or subcontractor in the part A program. EDSF believes economies of scale can be achieved by consolidating the part A workload. It pointed out that volume within a geographic area was the key to achieving savings for both administrative and benefit dollars. The ability of a large operation to hire and cost justify medical specialists and utilize more sophisticated utilization review techniques, according to EDSF, can provide great potential for savings in benefit dollars. It stated that the development of these techniques is very costly and not justified by low workload volumes. The larger base of providers would also provide for a smaller proportionate amount of fixed overhead to maintain the provider audit function.

HCFA STUDY RECOMMENDS THE ELIMINATION OF THE PROVIDER NOMINATION PROCESS AND FEWER INTERMEDIARIES

In its report to the Administrator on October 31, 1978, the HCFA steering group (see p. 8) reported that the nomination process served a useful purpose in the timely implementation of the Medicare program. It pointed out, however, that the nomination process in some cases linked intermediaries to groups of providers and individual providers that may not have resulted in efficient and effective administration.

The steering group reported that the nomination process has restricted HEW's authority for determining intermediary jurisdictions. The report stated, in part:

> "The opportunity for providers to nominate and change intermediaries at any time causes the size and location of intermediary jurisdictions and workloads to fluctuate. Although such change has been minimal, it is costly to the Government since an intermediary needs to enlarge or scale down its operations to accommodate the change in workload. The nomination process also results in the overlapping of intermediary jurisdictions which can cause the inconsistent application of program policies to providers in the same geographic area.

"For example, Blue Cross, Aetna, Mutual of Omaha, Kaiser and Nationwide all perform an intermediary function to the providers in Ohio. The remote geographic dispersion of providers using the same intermediary sometimes results in ineffective communications between the parties and untimely delays in processing bills due to the long distances involved. This is a problem for multi-state intermediaries, particularly DDR which services providers in 45 States, the District of Columbia and Puerto Rico from its Baltimore, Maryland office."

The steering group considered four possible bases for reassigning providers: (1) geographical area, (2) class or type of provider, (3) workload characteristics, or (4) a combination of all three. The report discussed the advantages and disadvantages of each option and presented specific feasibility considerations. The group concluded that, if its proposal for combining parts A and B under a single contractor was not adopted, then intermediaries should handle specific geographic areas--not smaller than a State, but not larger than an HEW region. The steering group estimated that a configuration of intermediaries along State lines would reduce total administrative costs from 5 to 10 percent.

PENDING LEGISLATION AFFECTING INTERMEDIARY CONFIGURATIONS

In February 1979 a bill entitled "The Medicare Home Health Amendments of 1979" (S. 489) was introduced and co-sponsored by 17 Senators. Among the amendments is a provision which would require HEW to establish regional intermediaries for home health agencies. It was the view of the bill's sponsors that (1) there is great variation in the administrative and reimbursement practices among the various intermediaries with regard to home health providers, (2) there have been instances of fraud and abuse in this expanding new field, and (3) home health care is considered to be a minor portion of an intermediary's work.

Our May 1979 report 1/ to the Congress on Medicare's cost reimbursement procedures for home health care gives some support for these views, but we do not know the impact of this proposal on administrative costs.

1/"Home Health Care Services--Tighter Fiscal Controls Needed," HRD-79-17, May 15, 1979.

CONCLUSIONS

Administration of the part A program would be more efficient with less intermediaries. There are many intermediaries with relatively small workloads in certain States. For example, in New York State there are 10 intermediaries, in Ohio there are 9, and in Pennsylvania there are 7.

Many of the small intermediaries have low unit costs. For example, the Blue Cross plan in Watertown, New York, processed less than 35,000 bills in fiscal year 1978, yet had a unit cost of $4.02--$1.42 lower than the national average. This does not mean, however, that small, efficient intermediaries should not be consolidated.

The cost studies performed by several Medicare intermediaries indicate that savings in administrative costs of 5 to 16 percent could be realized by consolidating workloads and distributing larger workloads to fewer intermediaries. The incremental costs of handling the added workloads, at least for consolidating within a State, should be lower than the costs currently incurred by even the most efficient contractors. The actual amount of savings is difficult to estimate, particularly nationwide, because of the number of alternatives available for distributing the workloads and territories.

The consensus of opinion among the Medicare contractors and the HCFA steering group--which we support--is that there should be no more than one intermediary operating in a State. On the other hand, there is pending legislation which would require the establishment of regional intermediaries for home health agencies. We do not believe these opposing proposals are unreconcilable since both would involve the consolidation of workloads--the vast majority of which is generated by hospitals, and the legislation would have no effect on them.

RECOMMENDATIONS TO THE SECRETARY OF HEW

We recommend that the Secretary of HEW take immediate action to reduce the number of intermediaries participating in part A of the Medicare program. To determine which intermediaries should be eliminated from the program, under the authority provided by section 14 of Public Law 95-142, we recommend that the Secretary direct the Administrator of HCFA to determine the most efficient configuration of Medicare part A workloads and territories by

--identifying the intermediaries that are the most efficient with their existing workloads and

--identifying, through analyses of intermediaries' costs, those intermediaries that can most efficiently handle larger workloads.

Once the most efficient configuration has been determined, the Secretary should (1) terminate the contracts with the least efficient intermediaries and (2) as an interim step, while experimenting with competitive fixed-price and incentive contracting (see chs. 7 and 8), award new contracts on a cost reimbursement basis.

AGENCY COMMENTS AND OUR EVALUATION

HEW agreed with the intent of this recommendation, pointing out that it plans to take administrative actions to reduce the number of contractors by eliminating poor performers and by consolidating contractors in specific areas. HEW plans to consider additional experiments that will provide for consolidation and result in increased efficiency.

As was the case with part B, HEW stated that the selection of new contractors could be performed most equitably on a competitive basis. HEW also stated that its actions in part A are constrained by the provider nomination process. The Secretary stated:

> "* * * in particular, the statutory provisions defining the provider nomination process and the appeal rights of intermediaries restrict HEW's ability to select the most cost-effective contractors in a timely fashion. To solve this problem, I recommend that the Congress remove providers' statutory authority to nominate the intermediary of their choice. This action would eliminate the potential for conflict of interest which now exists in allowing providers to select the organization which controls and monitors their own reimbursement."

HEW's concerns in this regard may prove to be valid; however, at the present time we have no basis for concluding that section 14 of Public Law 95-142 is not administerable. As discussed beginning on page 40 of this report, section 14 of Public Law 95-142 gives the Secretary the authority to make the recommended changes in the interest of effective and efficient program administration. However, the lack of performance standards and criteria has hampered HEW's ability to compare intermediaries' performance. Section 14 required

the Secretary to develop such standards and criteria by October 1, 1978, and to apply them in making determinations relating to the renewal or termination of agreements with intermediaries, the assignment or reassignment of providers, and the designation of regional or national intermediaries. According to HEW, the new methodology for part A is in the field test stage and is expected to be implemented over the next 6 to 12 months.

Our review of the drafts of the new methodology indicate that, through a sophisticated point system assigned to the standards and criteria, HEW will be able to rank intermediaries in terms of overall performance. In our view the ability to rank intermediaries should enable HEW to use its existing authority under section 14 to terminate the least-efficient intermediaries.

CHAPTER 6

NEED TO EXPERIMENT WITH HAVING A SINGLE CONTRACTOR PROCESS ALL OF THE MEDICARE WORKLOAD IN A TERRITORY

The previous two chapters discuss actions needed by the Secretary of HEW to reduce the number of carriers and intermediaries in the Medicare program. Additional experimentation is needed to evaluate the feasibility of a single contractor processing parts A and B workloads using an integrated data processing system.

Many organizations currently perform as both an intermediary and a carrier under Medicare. However, because of the workload distributions in part B and the provider nomination process in part A, it is rare where all parts A and B work is handled by the same contractor in a geographical area. Also, there is no integrated EDP software system currently being used to process parts A and B data in Medicare, although there is some sharing of facilities and hardware. The capability does exist, however, according to several contractors, to integrate the processing with a single system.

There are many similarities among the functions performed by intermediaries and carriers. Therefore, theoretically, combining parts A and B administration in a territory could improve the coordination of program benefits for beneficiaries, eliminate some duplicative functions and costs, and reduce the additional overhead costs associated with having two or more companies instead of one.

There may also be some savings in program payments from increased and more effective utilization review activities facilitated by sharing parts A and B data. We contacted officials of the Medicare Bureau and several contractors to determine if any studies had been done to support the hypothesis that having more data available from the combined processing of parts A and B workloads would result in increased utilization review and better control of program payments. No such studies were identified; however, information from the Medicaid program in California indicates that savings from increased utilization review can be realized with a merged institutional (e.g., hospital bills) and noninstitutional (e.g., physician claims) data processing system.

IMPROVED COORDINATION OF BENEFITS AND LOWER ADMINISTRATIVE COSTS

We did not attempt to estimate the possible costs of a combined parts A and B operation in a territory. There should be some economies realized, however, by less management costs and overhead functions from having one company versus two or more. Not only have previous studies pointed this out, but comments received from many Medicare contractors and HCFA officials also support this view.

Additional advantages could stem from having a single contact point for beneficiaries and providers concerning all aspects of Medicare benefits. Coordination with Medicaid eligibility and program benefits would also be made easier. Although a single contractor could still maintain separate parts A and B processing departments, it is likely that many functions would be combined.

Indiana Blue Cross and Blue Shield, for example, handles most of the part A workload in Indiana, all of the part B workload, and is fiscal agent for Indiana's Medicaid program. Many functions are combined in the company: in addition to a single corporate executive staff, there is only one program integrity department, one professional relations department, one correspondence department, and one data processing department. There is no integrated data processing system, however. Contractor officials pointed out that information can be exchanged on all aspects of the company's business; this results in savings from eliminating duplicative functions and provides better service to the provider and beneficiary community.

ADVANTAGES IN USING THE SAME FACILITY TO PERFORM PARTS A AND B DATA PROCESSING

In the regional processing feasibility study conducted by Systems Architects Incorporated (SAI), several Medicare and contractor officials were interviewed to determine the potential effect of combining parts A and B EDP operations. As might be expected, those organizations currently processing parts A and B data showed a great deal of interest in developing an integrated software package to support both parts. Those organizations handling only part A or only part B showed very little interest.

SAI studied the relationships of parts A and B data elements, compared EDP functional requirements, and analyzed the potential impact of combining parts A and B EDP operations.

SAI identified 22 data elements (e.g., beneficiary name, sex, service date) that are used in parts A and B processing. Ten of these elements are identical in both parts.

These 10 elements comprise approximately 137 (61 percent) of the characters involved in the processing. SAI concluded in its October 1977 report that significant savings in administrative costs could result if parts A and B files were shared.

SAI identified 13 processing functions (e.g., utilization control, claim/bill receipt, correspondence) required in parts A and B. Eleven of the functions were common to both parts. They noted, for example, that parts A and B documents could be received in the same mail room without significantly altering its operations. SAI also noted that data entry of both bill and claim data can be performed under the same general level of supervision and with the same equipment.

The advantages reported by SAI in using the same facility to perform parts A and B electronic data processing were one set of hardware, file sharing of data, better fraud and abuse detection, and reduced data processing administration. SAI concluded that no existing system was available to process parts A and B data in the Medicare program, and recommended that "The Medicare Bureau should create an internal task force to document requirements for combining Parts A and B into a single data base for Electronic Data Processing purposes." As of March 31, 1979, this had not been done.

ADVANTAGES FROM INTEGRATED PROCESSING IN CALIFORNIA'S MEDICAID PROGRAM

The Medicaid program in California (Medi-Cal) is administered by three fiscal agents. 1/ The two Blue Cross plans--Blue Cross of Northern California and Blue Cross of Southern California--process institutional claims, and California Physicians' Service (CPS) processes noninstitutional claims. The three organizations operated independently before

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1/In August 1978 the State awarded a contract to the Computer Sciences Corporation to administer the Medicaid program in California. The contract is for a 5-1/2 year period, but full implementation and transfer of responsibility from the existing contractors is not expected to be completed before March 1980.

1972. The three agents joined in November 1972 to process institutional and noninstitutional claims under the Medi-Cal Intermediary Operation (MIO).

According to MIO officials, the MIO system uses a single data processing system and has resulted in savings in administrative costs and improved control over benefit payments through better utilization review techniques. CPS officials described the advantages as follows:

> "The obvious advantages come from having a more complete picture of the medical services rendered the patient. One of the most useful tools in utilization review, under the California Medi-Cal program, is the patient profile. This document provides a complete medical history of all drugs, inpatient and outpatient services for a recipient over the last eighteen months. With such a complete history, assessment of current service can be made with precision not possible in any other environment.
>
> "Combined operations also allow for computer editing to assure that services are not duplicated in the inpatient and ambulatory setting, that contraindicated services have not been provided, and that the institutional and professional provider are not both billing for the same service. Separate operations allow for certain screens in these areas, but combined operations would permit more extensive editing."

Electronic Data Systems Federal (EDSF) is the data processing subcontractor for MIO. The MIO system is capable of processing all claims submitted by institutional and noninstitutional providers. The system's centralized history files are used simultaneously by the three companies to process claims; each processing location can use all aspects of the system for claims under its jurisdiction. MIO processed about 32.7 million claims during 1977 consisting of 14.5 million physician claims, 15.1 million drug claims, and 3.1 million institutional claims.

The MIO system checks institutional inpatient claims against outpatient claims and vice versa to reduce possible duplicate service billings from providers; this prepayment edit is due to the combined institutional and professional history in MIO. First, the computer notes the beneficiary's

identification number and type of current claim (a current claim is one which is being reviewed for possible payment). Then the computer checks through the claims history file to determine whether any claims for the same type of service were previously paid. If it identifies claims with the same dates of service and beneficiary identification number, the claims are suspended for further review.

Contractor officials were not able to measure the deterrent effect of this edit on provider behavior. However, CPS officials stated that the MIO system suspended 31,970 claims at CPS as a result of this edit during 1977. These suspended claims caused 12,704 items on these claims to be either cut back or denied. The total dollars saved by this edit in 1977 was $401,252; CPS estimated the cost of handling the suspended claims was less than $10,000. Examples of some of the duplicate situations detected by this edit and their potential applicability to Medicare are:

--Physician bills part B carrier for diagnostic lab tests and the hospital duplicates these services upon admission (both on the same day) and bills under part A.

--Tests sent to an outside lab during hospitalization are billed to the part B carrier causing duplicates against inpatient billings.

--Chest X-rays performed in the physician's office are repeated on hospital admission. Physician bills part B carrier, hospital bills under part A.

--Some hospitals are not equipped to perform radiology services and send patients to radiology facilities or call in portable X-ray providers. The radiology providers bill the hospital and/or the part B carrier, while the hospital bills under part A.

The savings resulting from the duplicate billing edit used in the California MIO system appear worthwhile and, if Medicare could realize similar savings, an integrated system would appear advantageous. We do not know, however, how many companies are presently capable of using an integrated software system nor what the costs might be to develop, convert, and implement such a system for Medicare.

Also, there are essential differences between Medicaid and Medicare in how the programs are structured administratively which could make a comparable arrangement more difficult and disruptive under Medicare. In California, for example, providers--whether located in the State or not--that serve a California beneficiary with a Medi-Cal identification card--bill the California MIO System. Under Medicare, however, claims for a California beneficiary who receives services from a doctor or provider in another State would be paid by the part B carrier and most likely the part A intermediary in the other State.

To make Medicare comparable to MIO would require converting Medicare's administrative structure to a situation where a single contractor has jurisdiction over specific beneficiaries--irrespective of where the services are rendered--which could be disruptive and result in many unforeseen problems.

The development of more complete profiles on providers and beneficiaries is possible with a combined parts A and B processing system. CPS officials, who use such profiles with MIO, say the savings from the profiles may be the most important reason to integrate parts A and B in Medicare. They were not able to furnish us statistics on the use of such profiles, however. They pointed out that the advantages are derived from analyses of specific cases and peer group comparisons, and statistics on the cost effectiveness of the analyses are not kept.

EDSF develops the profiles in the MIO system and refers to their use as a "retrospective analysis of medical services." The system can generate several different profiles, detailed histories, and exception reports on a regular basis, all encompassing the total medical care rendered (which would include parts A and B type data). A systematic monitoring capability is then provided to enhance the utilization review function. Additionally, certain treatment models, peer group comparisons, and detailed histories or profiles can be produced as needed.

EDSF officials said the use of retrospective analysis of medical services under a combined parts A and B processing system would improve utilization review and result in substantial savings in program payments. A systems manual prepared by EDSF in 1976 described the benefits of retrospective analysis:

"Retrospective analysis provides information necessary for effecting benefit controls through retrospective settlements, establishing and maintaining medical policy edits imposed prior to payment, and projecting the effects of coverage changes. Instances of program abuse are more efficiently identified on a retrospective basis since they comprise but a small percentage of the total provider and patient populations. Defined areas of abuse can then be monitored on an ongoing basis to insure against any recurrence.

"Perhaps the greatest area of concern in recent months is that of 'quality of care'. In this case the emphasis is to insure that care is provided at, or above, a level consistent with the minimum standards of a community. The intent is not to standardize care but simply to insure that care received meets or exceeds minimum standards. This emphasis has prompted a generalization of the scope of analysis to that of appropriateness of care which includes both quality of care and utilization. The system presented herein has been developed specifically in response to these current requirements with consideration for projected applications. To this end, the EDSF Retrospective Analysis of Medical Services represents a state of the art product which can be an invaluable tool in the development of a comprehensive retrospective analysis program."

A further use of shared data, according to CPS officials, is when hospital stays are reduced or denied for reimbursement in Medicaid. When this happens, the physician charges for the disallowed days are also denied. For example, if a hospital stay was for 20 days and a review of the stay determined that the last 5 days were not medically necessary, then these days would be denied for reimbursement. In such a situation in California under the MIO system, all physician charges for the last 5 days would also be denied. Similar savings could be realized in Medicare, according to CPS officials, with an integrated system.

Prudential Insurance Company officials also cited the advantage of carrying over decisions on part A hospital stays to the part B side. However, they believed this points out

the need for good cooperation between the part A intermediary and part B carrier. It does not, in their opinion, have to be done with an integrated claims processing system. They compared their experience as part B carrier in New Jersey to their experience in Georgia. They pointed out that utilization review efforts are enhanced in New Jersey, where they have good cooperation with the local Blue Cross plan; however, they pointed out that there was little cooperation in Georgia between the part A intermediaries and the part B carrier.

We agree that cooperation between part A and part B contractors could achieve some of the advantages of shared program data. However, having one contractor with responsibility for both parts, particularly in the same territory, would facilitate the utilization review effort because there would be no need to go to other contractors to obtain needed data.

MATCHING PART B PHYSICIAN CHARGES FOR INHOSPITAL SERVICES WITH PART A BILLS COULD RESULT IN LARGE NUMBERS OF UNWARRANTED EXCEPTIONS

The matching of claims history performed in the MIO system is an effort to identify duplicate billings; claims are suspended for review when identical or similar claims are identified. This is done by computer on a prepayment basis, but it could also be performed on a post-payment basis.

One of the most elementary edits for an integrated parts A and B claims processing system would be to match dates of services on beneficiaries' part B physician claims for inpatient hospital services with comparable data on part A hospital billings. Such a match could identify situations where claimed inhospital services were not rendered.

Our simulation of this edit or match on a post-payment basis in a New York county and in Texas resulted in a surprisingly large number of non-matches or exceptions which, when investigated, proved to be valid claims. A similar study was performed in three States by the HEW Audit Agency. Because of the relatively high incidence of such exceptions on an elementary computer edit, we believe that more sophisticated edits featuring the matching of parts A and B claim data could result in similar unforeseen problems. Therefore, to better assure the smooth transition to a combined parts A and B contracting mode and to refine an integrated claims processing system, we believe that HEW should undertake a demonstration project in a designated area or areas of the country.

Computer match in New York identified no incorrectly paid claims

Claims for inpatient hospital services rendered by physicians with offices in Queens County, New York, were compared with bills from hospitals located in the same county. We matched claims listing service dates of January 1 through April 30, 1978, with hospital bills with service dates during the same period and found that 14,564 records did not indicate a corresponding hospital stay.

From these 14,564 non-matches we selected 202 claims for review and determined that approximately 42 percent did not match because the intermediary had not yet received the hospital bill and 30 percent did not match because the physician performed the service in a hospital not in Queens County. Another 23 percent of the claims were valid; they were shown as non-matches because of coding errors by the contractors, physicians, and the hospitals, or because the patient was confined in a hospital but did not have part A coverage. The remaining 5 percent of the claims were determined to be correct but were identified as being a non-match because the service dates on the claim overlapped the consecutive hospital stay. For example, if a hospital billed separately for the period January 4 to February 10, 1978, and February 11 to February 16, 1978, and the physician charged for services from January 30 to February 16, 1978, the claim was identified as a non-match.

No incorrect claims found in Texas

Using computer-assisted techniques, claims for inpatient hospital services rendered by physicians with offices in Texas were compared with bills from Texas hospitals. Claims processed during the period January 1 through April 30, 1978, were matched with hospital bills processed from May 1, 1977, through April 30, 1978.

Initially 506,811 claims for inhospital services were identified as not having a corresponding hospital stay. However, the large number of non-matches was caused partly because our match did not include any Mutual of Omaha billing records. Mutual of Omaha is one of the four intermediaries in Texas; the other three are Aetna Life and Casualty, HCFA's Division of Direct Reimbursement (DDR), and Blue Cross and Blue Shield of Texas (Texas Blue Cross). We estimated that

approximately 55 percent of the non-matches--about 279,000 claims--resulted from not using Mutual of Omaha billing records. None of our sample claims were for services provided in Aetna or DDR hospitals.

From the universe of 506,811 records we selected 198 claims for detailed review. We found that the claimed services were rendered and billed only once to Medicare.

Seventy-nine percent of the claims were identified as non-matches either because the services were performed in a hospital in which Mutual of Omaha was the intermediary or because Texas Blue Cross had not received the hospital bill at the time of our computer match. Another 10 percent of the claims were valid but were "kicked out" because of coding errors by the carrier, intermediaries, hospitals, and physicians. Hospital personnel verified that the services were performed on the claimed service dates for the remaining 11 percent. We were unable to determine, however, why the intermediaries did not have this information on their records.

A refinement of the matching techniques by either us or the contractors on a regular basis could reduce the number of potentially incorrect or fraudulent claims for review. This was true in the New York analysis as well. 1/ Nevertheless, the surprisingly high incidence of exceptions in our simulation of a relatively simple edit involving only beneficiaries and dates of service indicate that, in order to obtain the maximum advantages of improved utilization review through an integrated claims processing system as envisioned by the advocates of combining parts A and B, answers would be needed to such questions as:

--What modifications would be required to Medicare's inpatient hospital billing form to facilitate the types of cost-effective edits made by the MIO system in California?

1/If we had done our match about 8 months after the service dates on the claims, and if the names and addresses of the hospitals had been on the claim forms and kept on file by the contractors, we could have reduced our universe of non-matches in New York by about 11,900 records. We still would have had about 2,600 non-matches to review.

--What arrangements would be made for out-of-area coverage furnished by physicians located in one State that provide services in a hospital located in another?

HEW studies indicate match is not cost effective

The HEW Audit Agency conducted two reviews--called "Project Emptybed"--to determine the incidences of physicians being paid by Medicare and Medicaid for inpatient hospital services when the patient was not in the hospital. In one review, it concluded that this type of abuse was restricted to a small number of physicians and that, it would not be cost beneficial to continue work in this area. In the other review it found no instance of physician abuse.

In a review conducted in Connecticut and Washington, the Audit Agency reported on June 30, 1978, that, although certain aberrant practices were being followed by physicians with Medicaid billings for inpatient hospital services, the dollar amounts were insignificant. The agency estimated that the maximum recovery for abuse by physicians in Connecticut would be approximately $47,000 and about $20,000 in the State of Washington. However, in order to achieve these savings, extensive effort would be required by the Audit Agency and State Medicaid personnel. They concluded the cost of such an effort would greatly exceed the dollars recoverable.

In a review conducted in Colorado, the Audit Agency reported on October 31, 1978, that it initially identified 8,168 physician inpatient hospital services that were paid by Medicare for which there was no corresponding hospital bill. They selected a sample of 44 services and found, after reviewing various documents, data showing why the corresponding hospital bills had not been paid and concluded that there were no indications of abuse or fraud.

HCFA STUDY RECOMMENDS A COMBINED AND FULLY INTEGRATED PARTS A AND B STRUCTURE

The steering group studying Medicare contracting recommended that the administration of Medicare parts A and B be combined into a totally integrated structure along functional lines. According to the group, combining the administration of parts A and B under a single contractor based

on configurations of State boundaries would offer several advantages:

--Decrease the number of Medicare contractors and thereby reduce total administrative costs. The report said cost savings would be realized by eliminating duplicative hardware systems, software systems, physical plants, and administrative structures. Additional cost savings were projected through better utilization review and control of program payments resulting from the establishment of single beneficiary data bases.

--Provide better coordination and flow of information on program activity and improve the exchange of data with Professional Standards Review Organizations, Medicaid, and other agencies. The report cited the provision for a closer examination of the interrelationship between providers in a geographic area through common ownership or arrangements for services. Further, more uniform and consistent application of program policies and procedures with respect to the provider and beneficiary community was suggested. Lastly, it was suggested that a basis for future integration with the Medicaid program would be provided.

--Improve the relationship of the Medicare program to its beneficiaries. By providing a single contact point, it was estimated that beneficiary confusion with having to deal with separate organizations for hospital benefits and doctors' bills would be lessened. More effective communication and service was also expected.

--Enhance the capability to accommodate and implement future legislative changes.

--More equitable distribution of work and maximized potential for cost savings through the economies of large-scale operations which would result from combined workloads.

CONCLUSIONS

Combining parts A and B administration under a single contractor in a geographical area should benefit the Medicare program. Additional advantages should be realized if the

processing of parts A and B workloads was performed on centralized computer facilities with integrated EDP software systems.

There should be less cost for management personnel and other overhead functions with a merged organization. Although a single contractor could still maintain separate parts A and B departments, it is likely that many functions would be combined. Beneficiaries and providers in a territory would only have one organization to contact concerning all aspects of Medicare benefits. Coordination with the Medicaid program in States would also be made easier, particularly if Medicare territories were along State boundaries.

The MIO system in California, which matches institutional bills (similar to part A of Medicare) under Medicaid with noninstitutional claims (like part B), and vice versa, indicates the extent that duplicate billings might be detected by an integrated processing system under Medicare. An edit performed by the California Physicians' Service looking for duplicate billings among institutional and noninstitutional providers saved $401,252 in unnecessary billings in 1977 at a cost of less than $10,000.

Utilization review efforts could be further improved by combining parts A and B under a single contractor. Data from both parts can be readily exchanged, and policy decisions can be applied uniformly to both parts. More complete profiles of program benefits and medical services can be developed for providers and beneficiaries, resulting in more informed decisions in utilization review. CPS and EDSF officials cite this capability as a great potential benefit to Medicare. However, information was not available to show the cost effectiveness of such a capability.

Our experience with matching data from part A bills and part B claims identified several problems which need to be overcome before such matching could be undertaken on a regular basis. The match was limited in that it was only one approach to utilization review. However, some of the problems that could affect the successfulness of merged operations in Medicare were the different timing of submission of parts A and B claims, mistakes in filling out the appropriate forms, errors in entering the data into the computer, and territorial problems where the part A bill or part B claim may come under separate jurisdictions. If

any of these problems are encountered with one part or under both parts, this could lead to increased, and, in many cases, unnecessary work in utilization review.

RECOMMENDATIONS TO THE SECRETARY OF HEW

Combining the administration of parts A and B of Medicare under a single contractor in a territory appears workable and may result in savings in administrative costs and benefit payments. However, because of the limited data available concerning such a merger and the potential problems that could develop, we recommend that the Secretary of HEW conduct experiments to evaluate the feasibility of merging parts A and B under a single contractor, and the effectiveness of requiring an integrated software system approach throughout the program.

AGENCY COMMENTS

HEW agreed with this recommendation and is developing a plan for additional experiments in the next few months which will include combining the administration of parts A and B under a single contractor.

CHAPTER 7

COMPETITIVE FIXED-PRICE PROCUREMENT-- CAN IT WORK FOR MEDICARE?

Recent experience with competitive fixed-price contracting in the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) and in Medicare have demonstrated that savings of as much as 30 percent in administrative costs are attainable with this contracting method. To use competitive fixed-price contracting in the Medicare program, other than through experiments, the Congress would have to provide HEW with the necessary authorizing legislation, and HEW intends to ask the Congress to consider such legislation.

Based on our review we are not prepared to recommend a broad legislative change from the existing contracting system for the following reasons:

--Administrative costs in Medicare represent only about 3 percent of total program costs, and the effect of such fixed-price procurement on benefit payments has not been determined. Failure to assure adequate controls over benefit payments could more than offset savings in administrative costs.

--Performance in CHAMPUS has not been good, and many contracts have been terminated or not renewed, resulting in disruption to program administration and services.

Before a broad change to competitive fixed-price contracting is legislatively authorized for Medicare, we believe that HEW's experiments require further evaluation. HEW should determine whether performance and beneficiary and provider services will suffer during and after contractor changeover, whether the Government is willing to accept the problems of contractor turnover in exchange for lower administrative costs, if past poor performers under cost contracts can significantly lower costs and improve performance under competitive procurement, whether program payments (which account for 97 percent of total program costs) will be adequately controlled, and whether the selection process and contract design used in the experiments are sufficient to guarantee a smooth procurement system.

We recognize that it may take HEW a considerable amount of time to fully evaluate the experiments and determine the effects of fixed-price contracting. Therefore, we are suggesting that the Congress may wish to consider providing HEW with some contingency authority to expedite the implementation of competitive fixed-price contracting should the experiments prove favorable to the Medicare program. We believe the contingency authority should take the form of authorizing the Secretary of HEW to use competitive fixed-price contracting after HEW fully evaluates the experiments and demonstrates to the Congress' satisfaction that no measurable adverse effects will occur.

FIXED-PRICE PROCUREMENT IS DESIRABLE-- BUT ONLY LIMITED DATA ARE AVAILABLE ON MEDICARE

In theory, a competitive fixed-price contract assures the least cost to the Government and places maximum risk on the contractor. Because the contractor assumes full responsibility for all costs over the fixed price, there is incentive for effective cost control. There has been increased interest from the Congress in recent years to use this type of contracting for procurement of administrative services in Federal health care programs such as CHAMPUS and Medicare.

CHAMPUS provides financial assistance for medical care provided by civilian sources to dependents of active-duty members and military retirees and their dependents. CHAMPUS has converted to competitive fixed-price contracting after a long history of operating in a cost-reimbursable environment. In addition, the Medicare Bureau's experimental contracting program is placing emphasis on this type contract. Three of the four experiments to date have used this approach for procurement of Medicare part B administrative services.

Competitive bids 1/ in the three Medicare experiments are estimated to save the Government approximately $32 million--or 32 percent in administrative costs over the multiyear

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1/As discussed on p. 10, "competitive fixed-price contracts," as used in this report, mean negotiated contracts. Since in awarding negotiated competitive contracts factors other than price are considered, the use of the terms "bid" or "bidders" should not be construed as being synonymous with awards on the basis of price only.

contract periods. 1/ The limited experience of the first competitive experimental contract in Maine also indicates that, once initial conversion problems are worked out, a satisfactory level of performance can be maintained.

The Medicare contractors, however, are concerned about whether competitive procurement is in the best interest of program efficiency and quality service to the beneficiary--the ultimate objective of the program. Much of this concern has arisen from the problems that CHAMPUS encountered in competitive bidding.

While many of the benefits and disadvantages of competitive fixed-price procurement will only be demonstrated by the experimental program, our review of competitive contracting in CHAMPUS and Medicare has indicated several issues which should be considered before an unrestricted competitive procurement system is legislatively authorized for Medicare.

THE CHAMPUS EXPERIENCE IN FIXED-PRICE CONTRACTING--CAN MEDICARE LEARN FROM IT?

Although CHAMPUS is a much smaller program than Medicare, the type of contractors and the administrative structure of the programs are similar. 2/ Because of these similarities, we reviewed the CHAMPUS contract conversion to identify problems that Medicare might face. We were unable to measure the complete effect of changing from cost reimbursement to competitive fixed-price contracts because of many other program changes which took place during the conversion of contract types and the lack of a detailed performance measurement system that could provide a before-and-after analysis. However, we did identify some problems that Medicare is likely to encounter if it enters a competitive environment.

1/In commenting on our report (see app. VI) HEW estimated that the administrative cost savings for the three experiments would be about $55 million. HEW estimated the savings based on current claims processing unit costs whereas our estimate factored in the historical downward trend in unit costs, which we believe is more realistic and is consistent with other computations in the report.

2/CHAMPUS is dissimilar to part A of Medicare in that it does not have the provider nomination and the phenomenon of having as many as 10 contractors operating in a single State.

Conversion to fixed-price contracts

Like Medicare, the CHAMPUS program has contracted with fiscal agents to process and pay claims. Before 1976 the administrative structures of both programs were similar because CHAMPUS also divided the program into hospital and physician components, and it contracted separately for administrative services with Blue Cross and Blue Shield plans, private insurance companies, and State medical societies. All CHAMPUS contracts with fiscal agents were on a cost reimbursable basis, and the program received much the same criticism as Medicare (i.e., it was regarded as having an administrative structure that was not the most economical and efficient).

In 1975, the Department of Defense (DOD) decided that competitive fixed-price contracting was warranted for three major reasons

--very high and variable administrative costs,

--poor contractor performance, and

--a long DOD policy of competitive contracting and congressional pressure.

DOD began converting all CHAMPUS contracts to competitively bid contracts on a fixed-rate-per-claim basis. Contracts were also awarded for combined physician and hospital components and for larger geographical areas.

In February 1976, DOD awarded the first competitively bid fixed-price contract to Health Applications Systems, Inc., (HAS) for the processing of all claims from California, Arizona, Nevada, New Mexico, and Texas. HAS took over an area that had previously been serviced by seven individual contractors and represented about one-third of the total CHAMPUS volume. HAS bid a maximum of $3.26 per claim, compared to an average of $5.81 actual cost per claim for the former fiscal agents.

The contract was terminated in November 1976 because of poor performance. DOD awarded interim emergency cost reimbursable contracts to two of the former fiscal agents to take over the HAS backlog and process claims until a new contract could be arranged.

HAS had built up a backlog of over 230,000 claims, which was over three times the average backlog of the former fiscal

agents. An April 1978 report 1/ by the Surveys and Investigations Staff of the House Appropriations Committee stated that, as a result of the delays in HAS claims processing, many providers as well as beneficiaries had numerous claims awaiting payment for several months. In addition, it cost the Government $1.9 million to get the HAS backlog cleared, which was $1.3 million more than it would have cost if HAS had met its commitments.

The Director of OCHAMPUS felt that the first contract failed because of the contractor and not because it was a fixed-price contract. As a result, all CHAMPUS contracts were converted to a competitive fixed-rate basis by April 1978.

Administrative costs are declining

Competitive procurement has lowered administrative costs to OCHAMPUS. We analyzed 11 fixed-price CHAMPUS contracts (covering 20 States) which had been in effect for 1 year. Our analysis showed that there was an apparent savings of about $1.2 million (20 percent) due to the reduced unit costs and a secondary savings of $860,000 not anticipated by OCHAMPUS due to a large reduction in claims volume. Overall savings in administrative costs were about 35 percent--$2.06 million for the 20 States analyzed.

The average unit cost for the 11 contracts reviewed dropped from $6.65 to $5.14 after fixed-price contracting was implemented--a difference of $1.51 per claim (about 22 percent). In 5 of the 11 cases the savings represented a reduction of over 30 percent.

While part of the decrease in unit costs may be attributed to economies of scale incurred by combining geographical areas, OCHAMPUS offered the following additional reasons:

--Contractors have instituted more management controls under fixed-price contracting in order to remain within the bid amount.

--Less overhead costs are being allocated to CHAMPUS than previously as contractors are underwriting part of the cost in order to be competitive in Government programs as part of their long-range planning for national health insurance.

1/"A report to the Committee on Appropriations, U.S. House of Representatives on the Management of the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)," by the Surveys and Investigations Staff, April 1978.

--There had been little cost surveillance by OCHAMPUS, so in the past excess costs were dumped on the CHAMPUS program.

--Some contractors submitted unrealistic price proposals and are losing money on the contracts.

Our review of CHAMPUS competitive procurement indicated the following:

--As of August 1978, the number of CHAMPUS contractors declined from over 100 to 12.

--OCHAMPUS officials believe that contractor performance to date under fixed-price contracts has been adequate at best, and in some cases poor. However, performance evaluations under cost contracts were so cursory that it is impossible to accurately measure the effect resulting from a contract change.

--Contractors who obtained CHAMPUS contracts and had no prior experience generally had difficulty and left the program or were terminated. Five contracts involving 15 States were terminated at the request of the contractor, OCHAMPUS, or by mutual agreement. Poor performance was indicated in all cases.

--CHAMPUS contracts are written for 1 year with two 1-year options. Three experienced CHAMPUS contractors requested that their options not be renewed.

--Changing contractors has disrupted services to beneficiaries and providers.

--CHAMPUS program officials are unable to quantify the success or failure of the move to fixed-price contracting other than as it relates to administrative costs.

--CHAMPUS is undergoing almost constant change. OCHAMPUS had issued 59 administrative instructions as of May 25, 1978, some of which resulted in requests for additional payments. One instruction may cost $100,000 to implement. Each change that costs money requires negotiation of a change order to the contract.

All of the above are not necessarily problems inherent in competitive fixed-price procurement. Changing contractors

under any contract type may disrupt services. Also, selection of inexperienced or unqualified contractors and the lack of a sufficient performance measurement system may be more of a problem in the operation of a procurement system than in the contract type itself.

Our review of the CHAMPUS fixed-price experience and the comments attributable to others concerning CHAMPUS centered on the performance of CHAMPUS contractors during fiscal years 1977 and 1978. OCHAMPUS has awarded new contracts since our review, and we have not evaluated these contracts.

MEDICARE'S EXPERIMENTAL PROGRAM

The Medicare Bureau has three ongoing experiments in part B that are testing competitive fixed-price procurement--in Maine, Illinois, and upstate New York. Only one experiment (Maine) is operational; the other two are in transition. Each experiment has placed high risk on the contractor by providing for minimal price adjustment and monetary penalties for deficient performance. Each experiment has attracted several bidders. A description of the experiments, including criteria for selecting the areas and the evaluation of proposals, is in appendix II.

Blue Shield of Massachusetts (BSM) began processing claims in Maine in December 1977, after winning the first experimental fixed-price contract. The Bureau projected savings from this contract of approximately $341,400. Contract awards in the Illinois and upstate New York experiments were to Electronic Data System Federal (EDSF) and Blue Shield of Western New York (Buffalo Blue Shield), respectively.

We estimated the contract with EDSF would save approximately $20.6 million over the costs that might have been otherwise incurred by the two incumbent carriers--the Health Care Service Corporation (Chicago Blue Shield) and the Continental Casualty Insurance Company (Continental)--over the 5-year contract period. The 4-year contract with Buffalo Blue Shield was estimated to save approximately $10.8 million over the costs of the incumbents in upstate New York--Metropolitan Life Insurance Company, Genesee Valley Medical Care (Rochester Blue Shield), and Buffalo Blue Shield.

Total estimated savings from the three experiments are about $32 million, or 32 percent of administrative costs. While these savings are clearly a result of the competitive bids, they were based on the expected costs of replaced

medium- to high-cost carriers. Thus, the extent of savings in other areas would depend largely on the size of the workload and the efficiency of the existing contractors in those areas. Also, there were a number of other factors involved in these experiments, besides the change in contract types, that could account for part of the projected savings; such as consolidation of territories, reduction in number of carriers, and change in carrier location to a different employment market.

In designing the experiments, the Medicare Bureau included a provision that we believe will help in evaluating the experiments. Although competitive fixed-price contracts are usually not subject to an audit of actual costs, a provision to allow an audit was included in the contracts. In addition, contractors with experimental contracts are required to submit a yearly statement of costs incurred. This will provide the Medicare Bureau the opportunity to compare actual costs and performance data for the experiments with those of present contractors.

PERFORMANCE--WILL IT SUFFER UNDER FIXED-PRICE CONTRACTING?

A common concern of many Medicare carriers and intermediaries is that, although competitive fixed-price contracting will reduce administrative costs, such savings may be offset if a contractor decreases its effort in controlling actual benefit costs (which account for about 97 percent of total program costs). They also point out that provider and beneficiary services will be given less attention and become secondary to the contractor's goal of maximizing profits or minimizing losses.

OCHAMPUS officials concede that performance under fixed-price contracting has not been good, and in several cases even poor. However, concurrent with the conversion to competitive contracting, CHAMPUS performance reviews were changed from a cursory review to an indepth evaluation and monitoring program. In essence, OCHAMPUS did not have an adequate knowledge of performance under cost contracts in order to compare performance.

The report by the House Surveys and Investigations Staff (see p. 71) made the following comments regarding performance under the CHAMPUS fixed-price contracts:

"--An ineptly planned and executed Department of Defense (DOD) experiment in competitive procurement of fiscal intermediary services

failed miserably and left one-third of the program in shambles, with the full costs of recovery yet to be tallied.

"--OCHAMPUS conversion to fixed-price contracting was replete with mistakes in planning and source selection, resulting in award of contracts to offerors who were not able to process claims satisfactorily."

Although California Physicians' Service, Mutual of Omaha, and Wisconsin Physicians' Service all bid less for processing CHAMPUS claims under fixed-price contracting than their costs had been under cost reimbursement contracting, officials from each contractor said that they had not cut provider relations, beneficiary relations, or other services to do so.

We were not able to measure this, however, because the only CHAMPUS performance standard that requires reporting is claims processing time. One contractor official told us it would be easy to reduce utilization review levels in order to cut costs because there is no standard for detecting a reduction. This could result in unnecessarily high benefit payments.

The Medicare Bureau implemented a more sophisticated performance monitoring system in the experiments than it has for its cost contracts. Acceptable contractor performance under the cost reimbursable contracts has never been defined by specific standards--most contractor evaluations are based on a system of goals established by each Bureau regional office, and most of the regional office evaluation systems are based, to a large extent, on the judgment of the Bureau representatives who work onsite at the contractors' facilities. The official appraisal of a contractor's performance is the Annual Contractor Evaluation Report (ACER). The report is written each fiscal year and assesses seven areas of performance in terms of satisfactory, adequate but needs improvement, and unsatisfactory.

Because of the fixed-price nature of the experiments and the inherent concern that this type of contract would lead to a reduction in service, the Bureau devised a monitoring plan to quantify performance as much as possible and allow for the assessment of liquidated damages in case of performance deficiencies.

The monitoring plan, for the Maine experiment as well as Illinois and New York, imposed a two-faceted system of quality control on the contractor. The first system used

five performance standards based on quantified workload data, some of which had been previously collected by the Bureau. The second system is based on continuous reviews and determinations of the contractor's compliance with all pertinent operational instructions in six areas (such as coverage and utilization safeguards and beneficiary and provider services). Although this system is very similar to that used in preparing ACERs, the Bureau tried to provide the contractor with a detailed plan of the functional standards to be used and provided for a grading system that would more objectively define performance and, overall, provide a better indication of deficient areas that require management attention.

In addition, all the experimental contracts include provisions for monetary penalties for deficient performance. The penalties are to be assessed for any standards missed in a 3-month period. The amount of penalties can range from $10,570 per standard in Maine to $52,250 per standard in Illinois.

Performance in Maine

The Medicare Bureau plans to evaluate the Maine experiment in terms of quality of service, certain financial aspects of the contract, and changes in relationships between the Bureau and BSM and between components of the Bureau itself. However, as of June 1, 1979, no formal evaluation of the experiment had begun.

We analyzed the available data and found the early results favorable. After an initial period of generally unacceptable performance, BSM's performance in Maine exceeded the standards and is considered highly satisfactory for those areas where comparable data are kept on other carriers. 1/

In discussing performance in Maine with BSM officials and why performance is better in some areas than it is under BSM's cost contract in Massachusetts, the Vice President of Government Programs stated that the comparison of performance in Maine with areas under cost contracts is unfair. He attributed the level of performance in Maine to the fact that the Bureau defined acceptable carrier performance through established standards and pointed out that cost contracts do not have such standards. He believes that the stiff performance penalties used in the Maine contract are not necessary

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1/Ratings used by the Bureau's Boston Regional Office to evaluate all carriers in the region are unsatisfactory, marginal, satisfactory, highly satisfactory, and exceptional.

and added that the Bureau could get a similar level of performance under cost contracts by implementing similar standards and a strong policy of contract termination for poor performers.

BSM met all functional standards for the quarter ending June 30, 1978, and five of the seven standards for the quarter ending September 30, 1978. BSM's performance in coverage and utilization safeguards and in program integrity was rated unsatisfactory. The monitoring plan for the Maine contract provides a grace period for each standard, during which performance levels can be raised to satisfactory and penalties avoided. As of March 1, 1979, BSM had not yet been retested within the grace period.

The principal indicator of whether performance will suffer under fixed-price contracting would appear to be whether BSM continues to meet standards that are more sophisticated and applied more frequently than in the cost reimbursement environment. BSM officials have stated that the company is losing money on the Maine contract. Financial reports submitted by BSM show costs incurred of $1,659,477 through September 30, 1978. BSM has received $1,585,500 in payments through the same date--a deficit of $73,977, based on the unaudited statements. Approximately $200,000 of the costs incurred are onetime conversion and implementation costs, so BSM may be able to make a profit on the contract during the last 2 years. The point that bears watching, however, is whether the level of performance provided by BSM will change if it continues to incur a loss.

Illinois and New York performance may be more indicative

The Maine experiment may not represent what might happen under fixed-price competitive procurement in Medicare. Bureau officials agree with this. It is a relatively small area, and it was taken over by an experienced carrier already processing a much larger workload. Illinois and New York are much bigger areas; in addition, Illinois claims will be processed by a new prime contractor, and New York claims by a carrier that will be absorbing a claims volume five times larger than its present workload.

CONTRACTOR TURNOVER MAY AFFECT THE SUCCESS OF COMPETITIVE PROCUREMENT

Competitive fixed-price procurement can result in periodic changes in contractors. Although contractors can change under any system, this is more likely in a pure competitive environment. The Medicare contractor community is

concerned about the effect of periodic contractor changes on the relationships with beneficiaries and providers, and the continuity of Medicare policy interpretation.

Many contractors feel program policy is not definitive in many areas and that it requires individual interpretation. Further, when contractors change, policy interpretations may vary from previous contractors, the amounts reimbursed to the providers and beneficiaries may change, and problems may result. As a new contractor takes over there are startup problems that may result in a period of lower performance and service, and this could weaken the program's credibility and stability.

These concerns were cited by the steering group in its October 1978 report to the Administrator of HCFA. It also pointed out that, in the transfer of carrier jurisdictions, it may take a year after the new contractor begins before the beneficiary population and medical community adjust to the transfer. Each carrier has unique systems and procedures to handle local conditions, and conversion from one system to a completely different system is a major problem to be overcome by the incoming carrier.

There have been provider complaints concerning differences in reimbursement levels between incoming and outgoing contractors in the CHAMPUS and Medicare conversions. These differences in reimbursement can be caused by problems in physician profile conversions, changing procedure coding systems, and the degree to which contractors vary in applying program guidelines and requirements for establishing medical necessity.

Contractors' transitions are a problem

The Medicare program, like CHAMPUS, may be unique from many other types of Government procurement in that the Government does not stop dealing with one contractor for a specific product and easily begin dealing with another. Also, Medicare's eligibility requirements, utilization controls, and reasonable-charge determinations require the development of large amounts of history and individual profiles as well as the maintenance of correspondence for provider and beneficiary inquiries. Because carriers are assigned geographical areas, they become the sole source of this data, which must be transferred to the incoming carrier. This must be done on a timely basis and with minimal interruption to providers and beneficiaries.

CHAMPUS contractors cited transition problems with obtaining provider files, a lack of guidance from OCHAMPUS, and large backlogs of claims from the previous contractor. Two contractors felt that the problems were caused by OCHAMPUS not allowing sufficient time for changing contracts--OCHAMPUS tries to allow 60 days for a contractor to take over a new territory; however, one contractor commented to us that it takes at least 90 to 100 days just to convert a former contractor's data to its own system. We found that some of the contracts OCHAMPUS had awarded did not even allow 60 days (the Kentucky/Indiana contract, which was to begin August 15, 1978, was awarded to Blue Cross of Southwest Virginia on July 18, 1978).

Transition of the Medicare part B contract in Maine, however, appears to have gone well. The contract allowed for a 5-month period to facilitate the transfer of carrier functions, and during this period representatives of the Union Mutual Life Insurance Company (the former carrier), 1/ BSM, and the Medicare Bureau met numerous times to discuss the status of various tasks that needed to be completed. In addition, before actual operation numerous efforts were made to minimize beneficiary and provider confusion during the change. BSM held a series of orientation meetings with the medical community throughout the State and contacted various agencies representing the elderly. The Medicare Bureau conducted a mass mailing of a carrier change notice to beneficiaries. Social Security district offices also assisted in arranging for publicity of the transition to local media.

A major consideration throughout the transition was the ability of Union Mutual and BSM to keep the level of pending claims at a low level, both at Union Mutual and in BSM's Massachusetts part B program. A large backlog in either program could affect how much service levels would suffer during the changeover. In CHAMPUS, some prior contractors passed on large backlogs of claims, many of which were the most difficult to process. Mutual of Omaha inherited about 60,000 claims when it took over responsibility for claims in Texas from Health Application Systems, Inc. It took about 4 months to clear the backlog, caused Mutual of Omaha to experience a large backlog in other States, and affected services in those areas.

Union Mutual did not have any problem maintaining operations because the company had an economic security plan where employees were guaranteed a job or full pay if a department

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1/As discussed in appendix II, Union Mutual voluntarily terminated its contract as Medicare part B carrier in Maine.

proposal was rated higher than another bidder with a superior performance record. There was not a significant difference in price. Its technical proposal was rated excellent because it far exceeded the minimum RFP requirements by comprehensively describing a new system to assure accountability at all levels of claims processing and payment. After being awarded the contract, the bidder found that, in trying to process claims properly with the new system, its administrative costs exceeded its estimates; it experienced difficulty in processing claims in a timely manner. By mutual agreement, the contract was not renewed after 1 year, and a new contractor was selected.

STANDARDS ARE NEEDED IN ALL TYPES OF CONTRACTING

Standards or goals for contractor performance have been needed in the Medicare program since its inception. Although many statistical indicators have been used to measure carrier and intermediary performance, these indicators have not been incorporated into a system which defines overall performance or compares it to other contractors.

Standards, along with penalty provisions for failing to meet such standards, have been incorporated into the fixed-price contracts, and they appear to be working. (See p. 76.) We believe such standards should become an integral part of the cost reimbursement contracts, as well as in any change to fixed-price procurement. The standards should represent clearly defined program objectives or goals for contractor performance.

HCFA plans to develop such standards for carriers and intermediaries by the end of 1980. The proposed system would establish standards as well as a methodology for determining acceptable performance in Medicare. With the implementation of standards for parts A and B contractors, HCFA should establish a firm policy of contract termination for poor or marginally performing contractors. A system of strict contract monitoring and budgetary control, followed by a strong policy of contract termination for poor or marginal performers, can introduce many of the advantages of competition into the current Medicare environment and meet the intent of the Congress.

determinations are broad and leave many decisions up to the ixdividual contractors. Thus, a change in payments can result because of different, yet technically correct, methodologies followed by the two contractors in computing reimbursement amounts. Differences could also result from variations in physician profile data, as well as different procedure coding systems.

Under CHAMPUS, the California Physicians' Service (CPS) found that a previous CHAMPUS contractor had been paying claims in three States with incorrect profiles and, when CPS began payments using correct profiles, payments for many procedures were reduced. CPS officials stated that they received many complaints from both providers and beneficiaries who received reduced payments. A similar payment problem occurred in Florida and Puerto Rico when CPS took over those territories. The previous contractor did not always pay in accordance with program regulations, and CPS ended up disallowing benefits which the previous contractor had allowed.

Wisconsin Physicians' Service also found several instances where the previous CHAMPUS contractor was paying claims by using its regular business profiles. When Wisconsin Physicians' Service began paying claims properly it received many complaints.

Similar problems arose in the Maine experiment. BSM officials feel that the difference in payment levels from those of the previous contractor appear to be caused principally by BSM more fully applying program guidelines and requiring the establishment of medical necessity for some procedures to a greater extent than did the previous contractor.

The Medicare Bureau pointed out other potential reasons for differences in payment in addition to BSM correcting questionable payment practices of Union Mutual. Different payment levels could be attributed to high numbers of clerical errors by BSM, as was reflected in the quality assurance statistics for the first few months of changeover. The increased use of automated pricing and utilization review by BSM can also result in different payments, as less human error or judgment is involved.

Medicare Bureau officials feel that, despite these problems, physicians are being serviced well by BSM. Claims are being paid correctly and on a timely basis. The MMA Executive Director feels that, excluding the first few months of operation when claims were lost or paid slowly, BSM is providing good service in Maine. In his opinion, after the

initial period of adjustment the number of physicians' complaints regarding BSM is at a level comparable to or even lower than the number of complaints that the MMA received at any time regarding Union Mutual. The Executive Director added that he would not like to see a carrier change every 3 to 5 years, despite the acceptance of BSM.

Difference in services

Union Mutual performed certain services for physicians in Maine which BSM did not want to continue. For example, physicians were provided with preprinted forms with their name and number. Union Mutual also provided physicians with an extra copy of the Explanation of Medicare Benefits (EOMB). The extra EOMB was used to file for Medicaid benefits with the State or to file for supplemental insurance benefits from Maine Blue Cross and Blue Shield.

The costs of these services, although not required, were paid by the Medicare program. Since these services are not required, nor were they requested to be provided by the request for proposals (RFP), BSM did not plan to continue them. Physicians complained about this reduction in services. The problem was partially resolved by BSM entering into agreements with both the State and Maine Blue Cross and Blue Shield for the exchange of certain information on the EOMB. However, now the State and Maine Blue Cross and Blue Shield must reimburse BSM for this data.

New York and Illinois--the potential for bigger problems

By the Bureau's own admission the transition in Maine was relatively easy compared to the potential problems that may occur in the New York and Illinois experiments. The Maine experiment involved only one incumbent carrier who withdrew voluntarily and had a relatively small area. Special steps were also taken to minimize the potential adverse effects of the experiment.

One primary concern is procedure coding and terminology. Procedure coding and terminology systems are used by carriers and health insurance companies to provide physicians and third-party payors with a common language to accurately describe the type of service provided and to serve as a base for coverage and payment determination. Not only do the systems vary, but the compatibility among carriers using the same basic system may vary, depending on the extent to which a carrier modifies a system for its internal use.

The Maine experiment can illustrate the potential problems with differences in procedure coding and terminology systems. In its technical proposal to the Medicare Bureau, BSM planned to change the coding system by Union Mutual to the system that BSM used in its Medicare program in Massachusetts to maximize the interchange of clerical systems between the two programs. Because the carriers used different coding systems, maintenance of the Union Mutual system would require BSM to have a separate clerical staff to handle several functions for each system.

BSM encountered numerous problems with attempting to convert the coding system. If the conversion was made, Maine physicians would have payment determinations made on different profile data, and the resulting payments could be either more or less than previously received. Also, physicians and their staffs would have to adjust to the new terminology and codes.

These problems caused the Medicare Bureau to require that BSM maintain the coding system used by Union Mutual. With minor exceptions the exact system was kept in place.

In the Illinois and New York experiments, however, the Medicare Bureau has required the successful bidder to implement a single coding system; none of the incumbent carriers involved are using the same system. Present plans call for each of the successful bidders to implement the coding system of the carrier that had serviced the first area to become operational (begin claims processing) under the staggered conversion plans. 1/ This will require a change in the coding system for at least three areas--one in Illinois and two in New York.

THE CONTRACTOR SELECTION PROCESS: ARE THE BEST CONTRACTORS BEING SELECTED?

The selection process used by the Medicare Bureau in awarding contracts under the experimental program was not originally planned as part of our review. Our intention was to address the issue of whether or not Medicare administrative services should be procured on other than a cost basis. In addition, in ruling on a bid protest regarding the Maine experiment, we recognized that the selection of a

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1/As explained in appendix II, claims processing in the consolidated territories does not begin at the same time--it is staggered over several months.

particular method for proposal evaluation is within the broad discretion of the procuring agency. It is only required that the method provide a rational basis for source selection and that the evaluation itself be conducted in good faith and in accordance with the announced evaluation criteria.

The process used in the experimental program evaluates contractor proposals in three areas--technical, experience, and price. The RFP details the factors to be used in evaluation and the predetermined weights to be assigned to each factor.

Point awards for technical and experience are made basically the same way. Each proposal is evaluated separately and each bidder can receive maximum points if the experience and technical aspects of the proposal so warrant. There is no sliding scale of points based on relative standing.

Scoring in the technical and experience categories has been close. In the Maine experiment, the range of total scores for technical and experience was 83 points. In the Illinois and New York experiments, the range of total points for these categories was 48 and 87, respectively.

Point awards in the price category, however, are computed differently and result in a much greater range. For scoring purposes, the lowest offer receives the full point value for price. For example, in the New York experiment 1/ price had a weight factor of 50 percent, so the low bidder automatically received 500 of the possible 1,000 total points. Each higher bid then received points based on its ratio to the low bidder:

1/Offers were submitted by Buffalo Blue Shield, Continental, Group Health Incorporated (GHI), Metropolitan, Occidental Life Insurance Company, and Prudential Insurance Company.

Price Evaluation in the New York Experiment

Bidder	Total offer (note a)	Ratio to lowest offer	Assignable points	Points assigned
Buffalo	$20,296,150	100.00	500.0	500.00
GHI	21,358,800	95.02	500.0	475.10
Continental	22,320,000	90.93	500.0	454.65
Occidental	23,790,000	85.31	500.0	426.55
Metropolitan	23,871,000	85.02	500.0	425.10
Prudential	29,377,000	69.09	500.0	345.45

a/These are the final offers submitted. Previous offers were submitted by some of the contractors before the Medicare Bureau requested a "best and final offer."

As a result of the scoring for price, Buffalo Blue Shield, which ranked fourth out of the six carriers in total points for experience and technical, was able to finish first:

	Points available	Buffalo	Continental	Metropolitan	GHI	Occidental	Prudential
Technical	150	133.31	137.01	136.89	124.26	130.46	132.00
Experience	350	275.65	304.63	311.99	238.01	265.59	313.00
Price	500	500.00	454.65	425.10	475.10	426.55	345.45
Grand total	1,000	908.96	896.29	873.98	837.37	822.60	790.55

A similar situation arose in the Illinois experiment. EDSF's point total after technical and experience evaluations was fourth of the five competitors, trailing both of the incumbent carriers and Prudential. In the price competition EDSF obtained the maximum of 450 points, 45 to 215 points higher than any of the competitors.

It appears that, as long as price receives such a high weighting factor and if the same method is followed to distribute the points for price, the low bidder will probably win the contract. The technical and experience factors do not significantly differentiate carriers in terms of scoring.

There is no problem with such a heavy emphasis on price if all the bidders are equally qualified. Our concern is whether the deficiencies noted by the Bureau's evaluation teams in awarding lower points in the technical and experience categories will have an adverse impact on the program

if such bidders win on the basis of lower bids. As previously noted, administrative costs only represent 3 percent of total program costs, and this could be easily overshadowed by increased benefit payments or poor service to the beneficiaries.

Our concern over the selection process arises basically from the Medicare Bureau's own considerations in selecting geographical areas for both the Illinois and New York experiments. A consideration in both experiments was the poor or marginal performance of incumbent carriers.

In several internal documents discussing potential experiments, the Medicare Bureau stated that one factor in choosing the Illinois experiment was the past performance of Chicago Blue Shield and Continental. Continental was considered to be a below-average performer, while Chicago Blue Shield was close to average.

Performance was a primary consideration in the New York experiment. In discussing the criteria for the experiment the Medicare Bureau noted that both Buffalo Blue Shield and Rochester Blue Shield had been considered among the Bureau's worst performing carriers for several years. The Bureau also rated Metropolitan's overall performance as below average. The following represents factors for each carrier considered by the Bureau when it was selecting upstate New York as an experimental area:

Buffalo Blue Shield

--Poor claims processing in 1975 and 1976.

--Poor ACER ratings in 1975, 1976, and 1977. In its ACERs, unsatisfactory ratings were received for claims processing and EDP operations in 1975, provider and beneficiary services in 1976, and carrier management in 1977. Also, during the 3-year period several adequate but needs improvement ratings were received.

Metropolitan

--Poor claims processing timeliness in 1975 and 1976.

--ACER ratings of adequate but needs improvement in claims processing and EDP operations for 3 consecutive years.

Rochester Blue Shield

--Poor claims processing timeliness for 3 years.

--A high percentage of errors in the quality assurance program.

--Numerous unsatisfactory ratings in ACER categories for 3 years.

In view of the previous evaluations and opinions of these contractors' performance and the stated criteria for selecting the experimental sites, we have serious reservations about the Bureau's selection process; particularly considering that Buffalo Blue Shield won the New York procurement and that Continental, Chicago Blue Shield, and Metropolitan all submitted bids on at least one experiment and were very competitive.

One reason marginal performers are able to receive competitive scores in proposal evaluations is that the ACERs are used in awarding points for experience. The ACERs are very subjective and do not adequately distinguish levels of performance among carriers because there are only 3 different ratings given--satisfactory, adequate but needs improvement, or unsatisfactory. Thus, a poor performer can score relatively close to others in experience. Price then becomes the major determinant. Bureau officials from the Division of Contractor Operations (DCO) agree that the ACER is subjective, but claim it is the best system the Bureau has, and it will continue to be used in future procurements to evaluate experience.

They added that there are no plans to predetermine who is qualified to bid on experimental contracts, and that all contractors are qualified to bid. Although the evaluation of proposals does consider past experience, the Medicare Bureau feels that past performance does not indicate what carriers will do under the experimental contracts. Bureau officials stated that excellent technical proposals were received from all bidders and that carriers had no incentive under cost contracts to improve performance, but competitive procurement will provide that incentive.

A similar position was taken by CHAMPUS and resulted in problems, as reported by the House Surveys and Investigations Staff. In one instance, for example, a bidder with a record of marginal performance as a CHAMPUS fiscal intermediary was awarded a fixed-price contract because its technical

proposal was rated higher than another bidder with a superior performance record. There was not a significant difference in price. Its technical proposal was rated excellent because it far exceeded the minimum RFP requirements by comprehensively describing a new system to assure accountability at all levels of claims processing and payment. After being awarded the contract, the bidder found that, in trying to process claims properly with the new system, its administrative costs exceeded its estimates; it experienced difficulty in processing claims in a timely manner. By mutual agreement, the contract was not renewed after 1 year, and a new contractor was selected.

STANDARDS ARE NEEDED IN ALL TYPES OF CONTRACTING

Standards or goals for contractor performance have been needed in the Medicare program since its inception. Although many statistical indicators have been used to measure carrier and intermediary performance, these indicators have not been incorporated into a system which defines overall performance or compares it to other contractors.

Standards, along with penalty provisions for failing to meet such standards, have been incorporated into the fixed-price contracts, and they appear to be working. (See p. 76.) We believe such standards should become an integral part of the cost reimbursement contracts, as well as in any change to fixed-price procurement. The standards should represent clearly defined program objectives or goals for contractor performance.

HCFA plans to develop such standards for carriers and intermediaries by the end of 1980. The proposed system would establish standards as well as a methodology for determining acceptable performance in Medicare. With the implementation of standards for parts A and B contractors, HCFA should establish a firm policy of contract termination for poor or marginally performing contractors. A system of strict contract monitoring and budgetary control, followed by a strong policy of contract termination for poor or marginal performers, can introduce many of the advantages of competition into the current Medicare environment and meet the intent of the Congress.

MEDICARE CONTRACTORS ANTICIPATE PROBLEMS WITH COMPETITIVE FIXED-PRICE PROCUREMENT

We obtained the views of many Medicare contractors concerning competitive fixed-price contracting.

The Blue Cross and Blue Shield Associations are opposed to competitive fixed-price procurement in Medicare. The individual Blue Cross and Blue Shield plans generally believe that:

--Competitive fixed-price procurement in Medicare would result in a substantial reduction in quality and the level of service provided.

--The emphasis on cost effectiveness will reduce administrative costs, but will have a detrimental effect on the beneficiaries and possibly increase benefit payments.

--Cost reimbursement contracting along with strict governmental budget controls takes on fixed-price characteristics, but allows for program innovation, system enhancements, and the highest quality of service.

Comments submitted on behalf of the 12 commercial Medicare carriers and intermediaries who are members of the Health Insurance Association of America (see app. X) also expressed concern about the use of competitive fixed-price contracting in Medicare. They do not believe that the contract award prices for the Illinois and New York experiments can be achieved without serious consequences in terms of benefit costs and/or beneficiary services. Further, they stated

> "It is ironic that HCFA continues to pursue the fixed-price method of contracting for Medicare administration, the same method that has been commonly used in Medicaid and CHAMPUS for a number of years, despite the problems encountered by those programs."

Every contractor that addressed the issue of fixed-price contracting in commenting on our report agreed with our conclusions that the experiments require further evaluation to determine their impact on the Medicare program. The Blue Cross Association added that

"In order to obtain a credible base of further information as to the effects of this procurement technique, existing experiments should be carefully and openly evaluated. The evaluating organization should be impartial and objective."

HCFA STUDY RECOMMENDS THAT ALL CONTRACTORS BE SELECTED ON A COMPETITIVE FIXED-PRICE OR FIXED-RATE BASIS

In its report to the Administrator, the HCFA steering group recommended that Medicare contractors be selected on a competitive fixed-price or fixed-rate basis and not be limited to insuring organizations or organizations currently serving as Medicare contractors.

HCFA's rationale for competition

The steering group said competition "would stimulate potential contractors to increase the efficiency of their operation and thus reduce costs in order to submit the lowest possible bid to win the contract." They also believed that competing for contracts periodically would eliminate complacency and encourage improved performance. Such a process, according to the group, would provide an opportunity to terminate marginal contractors who have been performing at lower levels. The steering group stated:

"It is recognized that periodic competition will lead to a change in contractor in many cases. This change may cause inconvenience to providers and beneficiaries who will have to become acquainted with the new organization. In addition, it will require funding for start up and phase out of contractors. Employees of existing contractors may be impacted. Nevertheless, on balance, the Steering Group believes that the benefits resulting from competition outweigh these disadvantages and recommends that periodic competition be required."

Fixed-price or fixed-rate basis

The steering group also said that fixed-price and fixed-rate contracts lend themselves easily to open competition, and the contracts would encourage firms with the competence and capabilities to compete. The group recognized that program costs could increase under a fixed-price arrangement since contractors would have the incentive to process claims quickly and with minimal expenditure of resources. They did not believe this would occur, however, because

"(1) contractor functions will be clearly and specifically detailed in the contracts, (2) the contracts will be carefully and closely monitored and, (3) an intensive quality assurance program with sufficient performance standards will be implemented to insure good performance and service by the contractor."

CONCLUSIONS

Recent experience with competitive fixed-price contracting in Medicare has resulted in estimated savings of $32 million, or 32 percent in administrative costs over the 3- to 5-year contract periods. These savings were based on the expected costs over the contract periods of the existing medium- to high-cost carriers in the experimental areas. The extent of savings in other areas would depend largely on the size of the workload and the efficiency of the existing contractors in those areas.

We analyzed 11 fixed-price CHAMPUS contracts (covering 20 States) which had been in effect for 1 year. Our results showed an apparent savings of about 20 percent in administrative costs due to competitive bidding as well as the consolidation of geographical areas. Performance under the CHAMPUS fixed-price contracts has not been good, however, and many contracts have been terminated or not renewed, resulting in disruption of program administration and services.

The limited Medicare experience in Maine indicates that good performance can be maintained under fixed-price contracting after a startup period where in all probability service will suffer. However, it is not clear whether this is the result of performance penalties or the more definitive standards developed for the experiments. Specific performance standards are not in place for cost contracts.

We believe such standards should become an integral part of the cost reimbursement contracts, as well as in any change to fixed-price procurement. The standards should represent clearly defined program objectives or goals for contractor performance. HCFA plans to develop such standards for carriers and intermediaries by the end of 1980 and to incorporate such standards into the contracts.

With the implementation of standards for parts A and B contractors, HCFA should establish a firm policy of contract termination for poor or marginally performing contractors. A system of strict contract monitoring and budgetary control,

followed by a strong policy of contract termination for poor or marginal performers, can introduce many of the advantages of competition into the current Medicare environment and meet the intent of the Congress.

We believe that a competitive procurement system shows promise for Medicare. However, there is only limited data available from the experiments in Medicare. The Maine experiment involved one carrier area and was a relatively easy transition. The New York and Illinois experiments involve much larger areas and there is greater potential for problems to develop.

Before a broad change to competitive fixed-price contracting is legislatively authorized for Medicare, we believe the experiments require further evaluation. It should be determined whether performance and beneficiary and provider services will suffer during and after contractor changeover, whether the Government is willing to accept the problems of contractor turnover in exchange for lower administrative costs, if past poor performers under cost contracts can significantly lower costs and improve performance under competitive procurement, whether program payments (which account for 97 percent of total program costs) will be adequately controlled, and whether the selection process and contract design used in the experiments are sufficient to guarantee a smooth procurement system.

RECOMMENDATIONS TO THE SECRETARY OF HEW

We recommend that the Secretary of HEW direct the Administrator of HCFA to:

--Evaluate the ongoing experimental contracts to determine the advantages and disadvantages of such contracts in Medicare. Particular emphasis should be placed on the effects of competitive procurements on total program costs and on beneficiary and provider services.

--Incorporate performance standards in all Medicare contracts.

--Implement a firm policy of contract termination for poor or marginally performing contractors. An effective budgetary system and the threat of contract termination can introduce many of the advantages of competition into the current Medicare environment.

AGENCY COMMENTS AND OUR EVALUATION

HEW agreed with our recommendation to evaluate the experimental contracts to determine their advantages and disadvantages. HEW stated that each experiment has a detailed evaluation plan to accumulate meaningful and comprehensive statistics and documentation. The evaluation, according to HEW, also provides a means to study the administrative costs of the contractors and program expenditures.

HEW also agreed with our recommendation to incorporate performance standards in all part A and part B contracts, although it pointed out that there will be some differences between standards under the fixed-price contracts and standards under the cost contracts. According to HEW, implementation of standards in part A is expected to take place over the next 6 to 12 months, whereas standards for part B are not expected to be completed until 1980.

HEW agreed only with the intent of our recommendation concerning terminating the contracts of poor or marginally performing contractors. As formal performance standards for carriers and intermediaries are developed and published, HEW stated that its policy for termination of poor performers will be strengthened. However, HEW believes a more flexible approach must be followed which involves working with poor performers and allowing opportunity for improvement. HEW estimates it saved approximately $30 million during fiscal years 1976-78 by working with marginally or poorly performing contractors and improving their performance.

We believe that HEW's comments are responsive to our recommendations except for terminating poor or marginally performing contractors. As discussed in this report, HEW has failed to meet the Congress' intent of terminating inefficient contractors. We agree that improving the efficiency of high-cost contractors can result in savings to the program. However, we believe that HEW should, in addition to helping improve the efficiency of poor performers, implement a firm termination policy. In our view such action would

- --result in additional savings in administrative costs and
- --more fully comply with the Congress' intent that only the most economical and efficient contractors would remain in the program.

HEW also stated that "the CHAMPUS experience is not representative of the Medicare workloads nor the advance preparation and pre-set evaluation plan established by HCFA before the awarding of fixed-price contracts." HEW further stated that "Medicare conducts on-going monitoring activity for its contractors so that problems, if any, are identified and resolved early."

We acknowledge that the CHAMPUS program is much smaller than Medicare and that HCFA has a more comprehensive contractor evaluation program than OCHAMPUS had prior to changing to fixed-price contracts. However, many of the problems identified with the CHAMPUS experience could also affect Medicare, such as contractor turnover, inexperienced contractors having difficulties, and experienced contractors deciding not to participate. Further, at the time we began this study CHAMPUS was the only federally financed health insurance program with experience converting from cost reimbursement to fixed-price contracts.

MATTERS FOR CONSIDERATION BY THE CONGRESS

To use competitive fixed-price contracting in the Medicare program, other than through experiments, the Congress would have to provide HEW with authorizing legislation. The limited data available from the Medicare experiments indicate that administrative cost savings will result from such a change, but in our opinion there is not enough information on the other aspects of contractor performance to conclude that fixed-price contracting will work efficiently and effectively in Medicare. The Secretary of HEW has stated his intent to propose legislation authorizing the use of competitive fixed-price contracting in the Medicare program. We believe it would be premature to authorize the use of such contracting at the present time because HEW has not fully assessed the overall effect such changes could have on beneficiary and provider services, program payments, and other aspects of contractor performance.

We recognize that it may take HEW a considerable amount of time to fully evaluate the experiments and determine the effects of competitive fixed-price contracting. Therefore, the Congress may wish to consider providing HEW with some contingency authority to expedite the implementation of competitive fixed-price contracting should the experiments prove favorable to the Medicare program. We believe the contingency authority should take the form of authorizing the Secretary of HEW to use competitive fixed-price contracting after HEW fully evaluates the experiments and demonstrates that no measurable adverse effects will occur.

If the Congress decides that providing HEW with contingency authority is desirable, then it

--should require the Secretary of HEW to submit a plan to the Congress for implementing fixed-price contracting before the Secretary can use such authority;

--may wish to consider including a provision which would provide that after HEW's implementation plan is submitted to the Congress it would automatically take effect after a specified period of time; and

--should eliminate the provider nomination process, because it would not be appropriate for institutional providers to prevent otherwise qualified organizations from competing for Federal contracts on a fixed-price basis.

In commenting on our report, the Secretary of HEW urged us to recommend that the Congress provide HEW with full authority to implement fixed-price contracting in a systematic fashion over several years. He stated that HEW's experience to date clearly demonstrates the advantages of this approach.

The one advantage of competitive fixed-price contracting that has been demonstrated is the reduced administrative cost incurred to process Medicare claims. However, as pointed out above, HEW has not assessed the overall effect of such a change on program payments which account for about 97 percent of the Medicare costs. In our opinion, HEW has not had sufficient experience to determine whether the potential disadvantages will outweigh the advantages to the Medicare program. In fact, as of June 1, 1979, no formal evaluation of the experiments had even begun.

CHAPTER 8

INCENTIVE CONTRACTING IS A GOOD CONCEPT-- BUT IT REMAINS UNTESTED IN THE MEDICARE PROGRAM

Although there have been no incentive contracts in Medicare under the conventional definition of the term, there have been two contracts (or subcontracts) containing provisions designed to reward or penalize contractors for meeting or not meeting targeted unit costs or performance standards. However, both instances provided little insight as to how incentive contracting will work under Medicare.

With clearly defined performance standards and an objective system for evaluating contractor performance, incentive contracting should improve the administration of the Medicare program. Current contractors are interested in this type of contracting, and the Medicare Bureau is refining its criteria for evaluating performance and is working on standards for intermediary and carrier performance.

HCFA should conduct additional experiments to test the results of incentive contracting in Medicare. Careful attention must be given to designing proper incentives--contractors should not be rewarded for satisfactory performance levels that should have been achieved without incentives.

TYPES OF INCENTIVES-- COST AND PERFORMANCE

There are two incentives which could be applied to the Medicare program--cost incentives and performance incentives. A contract containing a cost incentive and sharing arrangement basically provides for a bilateral sharing of cost savings or losses by the contractor and the Government. A performance incentive involves the Government paying a predetermined sum to the contractor for performance in excess of basic contractual requirements. Conversely, when performance is below the targeted performance level, the Government may, depending on the contract's structure, accept performance and reduce the payments under a negative incentive provision set forth in the contract. Contracts may contain both cost and performance incentives.

The inclusion of cost and performance incentives in the same contract could achieve two important results for the Medicare program. First, it would state specific goals or

objectives the Medicare Bureau wants accomplished and, second, it establishes the contractor's profit in direct relationship to the contractor's costs and the combined level of performance in all areas.

INCENTIVE CONTRACTS-- COST OR FIXED-PRICE BASIS

Incentive contracts are awarded either on a fixed-price or cost reimbursable basis. The two most commonly used incentive type contracts are fixed-price incentive and cost-plus-incentive fee.

Fixed-price incentive

A fixed-price incentive contract is characterized by an adjustment formula in the contract which relates to the efficiency of the contractor. A target cost, a target profit, a price ceiling, and a formula by which the contractor will benefit or be penalized for underruns or overruns in its actual costs are all established at the outset of the contract. The final price is based on the total allowable costs actually incurred in performing the contract, with the contractor's target profit increasing or decreasing under the formula according to whether the actual costs are less or more, respectively, than the target cost. Costs in excess of the ceiling price are borne entirely by the contractor.

The fixed-price incentive contract may also include performance incentives in addition to cost incentives. These would be designed to provide to the contractor, in advance, a calculable incentive for better performance and a penalty for poor performance. The performance incentives must be tied directly to measurable performance criteria. These performance criteria are established in the contract and are used to either reward or penalize the contractor for its performance.

Cost-plus-incentive fee

This type of contract is similar to the fixed-price incentive contract, except there is no ceiling price. There is a target cost, target fee, a minimum and a maximum fee, and a fee adjustment formula. The variation in fee depends on the extent that total allowable costs exceed or are less than target costs. This provides the contractor an incentive to manage the contract effectively.

Performance incentives can also be included in a cost-plus-incentive-fee contract. The performance incentives must be tied directly to measurable performance criteria.

INCENTIVE CONTRACTING APPEARS WORKABLE IN MEDICARE

Incentive contracting appears workable in the Medicare program. The appropriate use of incentive-type contracts generally requires the following conditions:

1. There should be a reasonably definite understanding between the Government and the contractor as to the scope of the contract, methods of performance, the probable success in achieving desired goals, and the degree to which the contractor will subcontract the work. Such an understanding is necessary in order to establish realistic targets that will serve as the basis for applying incentive provisions.

2. Reliable cost estimates reasonably free of contingencies should be available for both the prime contractor's and the subcontractor's portions of the contract, or those elements not subject to close pricing should be excluded from the target fee computation and profit-sharing arrangements.

3. There should be adequate cost accounting systems for prime contractors and subcontractors subject to incentive formula adjustments.

4. The contract work should normally require a sufficiently long performance time to give the contractor an opportunity to reduce contract costs.

These conditions exist in the Medicare program. The program has 12 years of past experience with basically the same contractors. There should be sufficient cost information available to set realistic goals and assure adequate protection and benefit to the Government.

Cost reimbursement contracts have been used in the Medicare program since its inception. A cost-plus-incentive fee contract is a variation of a cost reimbursable contract. As discussed in chapter 2, cost reimbursement contracts are not only provided for by the Medicare law, but are generally appropriate for use where sufficient information is not available to negotiate fair and reasonable firm-fixed prices, or the work cannot be described with sufficient specificity to adequately describe what is to be done.

The degree of technical and cost uncertainties should be the primary criteria for a choice between a fixed-price incentive contract and a cost-plus-incentive fee. A fixed-price incentive contract should be selected when there is a reasonable expectation of technical success within stated measurable limits. However, fixed-price incentive contracts should not be used when cost or pricing information and performance specifications, adequate for negotiation of firm targets and firm ceiling prices, are not available at the time of initial contract negotiation.

Although the use of fixed-price incentive contracts may be successful in inducing contractors to control and reduce their costs, the use of such contracts does not necessarily assure adequate protection or benefit to the Government. When negotiated target costs are not forecast with reasonable accuracy, cost underruns may be due to the initial overestimates of costs and not to the efficiency of the contractor.

In such cases the additional profits paid to contractors under the profit-sharing arrangement are in the nature of windfalls rather than earned profits. Therefore, fixed-price incentive contracts should be used only when the target costs can be estimated with reasonable accuracy and are free of significant contingencies. It is intended under this type of contract that the contractor receive additional profit for increased efficiency rather than for contingencies that do not materialize or for overestimated target prices.

To effectively improve performance, HCFA must be able to establish clear-cut performance standards and be able to effectively monitor contract performance to judge whether the standards were met.

MEDICARE'S EXPERIENCE WITH INCENTIVE CONTRACTING

The Medicare Bureau, under the authority provided by section 222 of Public Law 92-603, can use incentive contracts on an experimental basis. The Advisory Committee on Medicare Administration, Contracting, and Subcontracting (the Perkins Committee) recommended in 1974 that the Bureau give top priority to formulating an incentive reimbursement plan for contractors. Although the Bureau did negotiate a fixed-rate-per-claim experimental contract with Blue Shield of Maryland in 1977, the contract provided little incentive to either reduce costs or improve performance, and provided little insight into whether incentive contracts will work in the Medicare program.

The Bureau considered this an incentive contract because, if the contractor's actual administrative cost per claim was less than the negotiated rate per claim, the difference could be retained by the contractor. The results of the experiment, however, are inconclusive as to the appropriateness of incentive contracting in the Medicare program. Further experimentation is needed.

The contract was not a true incentive contract; a targeted total cost and incentive formula were not negotiated. Also, at the time the contract was negotiated, Blue Shield of Maryland's total operating costs had stabilized, and its unit costs were in a downward trend. The contractor's risks for the 2-year contract were minimal because the reimbursement rate for the first year of the contract was set too high and did not reflect Blue Shield's current operating costs, which were considerably lower than the rate negotiated. As a result, Blue Shield profited from the contract despite its operating costs increasing 12.8 percent over the previous year.

Bureau's efforts to solicit interest in incentive contracting

In July 1976 the Medicare Bureau issued a letter to Medicare carriers in an attempt to solicit interest in incentive contracting. The letter stated that the Bureau was considering a 2-year experimental project involving a fixed-rate-per-claim contract for administrative services.

It was the Bureau's intention to test whether (1) an incentive contract encourages the carrier's management to become more efficient, thereby reducing its actual cost of operation while maintaining the quality of work performed and (2) this type of contract is an appropriate method of contracting for part B carrier services.

The incentive for a participating carrier was that, when the actual administrative cost per claim is less than the effective fixed rate per claim, the difference could be retained. It would also place the carrier at risk if the actual administrative cost per claim exceeds the fixed rate. The solicitation letter stated that, in the second year, the fixed rate per claim would be limited to the lower of either the actual rate or the negotiated rate for the first year of the experimental contract, plus adjustments for inflation and productivity increases.

To assure that performance did not deteriorate under a fixed-rate-per-claim contract, the Bureau proposed implementing a two-faceted measurement system. The first facet used performance standards based on quantitative workload data. The second facet was based on the Bureau's present functional standards as reported in the Annual Contractor Evaluation Report (ACER). If the contractor missed a quantitative standard, a portion of the contractor's earnings would be denied at the end of the year.

Sixteen carriers responded favorably to the Bureau's general solicitation by submitting a letter of intent to sign a negotiated fixed-rate-per-claim contract. From this list, the Medicare Bureau selected six carriers to submit a 2-year proposal for processing claims. All proposals were to include suggested ways (management innovations) in which the existing Medicare process could be streamlined and made less costly.

The six carriers selected for negotiations were:

--Blue Shield of Maryland.

--Connecticut General Life Insurance Company.

--Blue Cross and Blue Shield of Texas.

--Wisconsin Physicians' Service (Blue Shield).

--Blue Shield of Rhode Island.

--Blue Shield of Western New York (Buffalo Blue Shield).

All carriers except Blue Shield of Maryland eventually withdrew or were terminated from negotiations. The primary reasons for ending negotiations were the carriers' concerns about degrees of risk associated with the fixed-rate contract and major operating changes or problems encountered by the carriers. Some cited the fixed-rate ceiling for the second year as the cause of the high risk.

Contract with Blue Shield of Maryland

The experimental contract with Blue Shield of Maryland became effective January 1, 1977, and ran through December 31, 1978. A separate fixed rate per claim was negotiated for each year. For calendar year 1977 the negotiated rate was $3.33

per claim based on a projected volume of 1,102,100 claims. As shown in the following table the rate of reimbursement depended upon the actual number of claims processed.

Number of claims processed	Reimbursement rate per claim	Total reimbursement (000 omitted)
1,212,310	$3.22	$3,904
1,190,268	3.24	3,856
1,168,226	3.26	3,808
1,146,184	3.28	3,759
1,124,142	3.31	3,721
1,102,100	3.33	3,671
1,080,058	3.34	3,607
1,058,016	3.36	3,556
1,035,974	3.38	3,503
1,013,932	3.41	3,459
991,870	3.44	3,412

Blue Shield of Maryland was reimbursed $3.313 per claim, because the actual number of claims processed was 1,120,715.

In calendar year 1978, a rate of $3.06 was negotiated on a projected claims volume of 1,245,000. This rate was later increased to $3.12 per claim to cover the increased costs for a postage rate increase, the requirement to provide toll-free telephone service, and additional expenses incurred in maintaining the part B Model System. 1/ The final payment per claim again was dependent on the actual number of claims processed. It could vary between $3.22 2/ per claim if the claims volume was 1,120,500, down to $3.02 2/ per claim if the claims volume was 1,369,500.

The Bureau imposed performance standards. Blue Shield was required to meet 10 quantifiable standards and 7 non-quantifiable (functional) standards. A penalty would be imposed if Blue Shield failed to meet a quantifiable standard. The Bureau established a different weighting factor for each

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1/An EDP claims processing system developed in 1968 and made available to all Medicare carriers. (See p. 171.)

2/Has been adjusted to reflect the $.06 increase for postage, toll-free telephone service, and additional Model System expenses.

quantifiable standard to determine the amount of penalty. No penalties were included for failure to meet a functional standard, except that the contract could be terminated.

Results of the first year--1977

Blue Shield of Maryland reported costs of $3,418,132 to process 1,120,715 part B claims during calendar year 1977. The actual cost per claim was about $3.05. The Medicare Bureau reimbursed Blue Shield at a per-claim rate of $3.313 ($3,712,928). This resulted in Blue Shield earning $294,796 above its actual costs. Blue Shield, however, lost 7 percent of its earnings ($20,635) because it did not meet one of the quantifiable standards. Blue Shield retained, therefore, $274,161 in earnings.

Blue Shield profited from the contract despite total operating costs increasing by about $400,000--12.8 percent over calendar year 1976. The earnings were retained because the negotiated rate per claim of $3.33 was about $0.16 more than Blue Shield was experiencing at the time of negotiations.

The claims volume increased from 977,088 in 1976, to 1,120,715 in 1977 (14.7 percent). The claims volume increase was greater than the total increase in costs. This resulted in the unit cost dropping from $3.10 for calendar year 1976 to $3.05 for 1977, although total costs increased by about $400,000.

The carrier met all but one of the quantitative standards--frequency of payment record errors. This failure resulted in Blue Shield losing 7 percent of its earnings. Overall performance remained about the same, but the carrier's unit cost is still higher than the national average for part B carriers. The ACER for the first year reported that Blue Shield met five of the seven functional standards. The two remaining standards were rated adequate but needed improvement. No dollar penalty was assessed for failing to meet a functional standard.

In the fixed-rate proposal, Blue Shield of Maryland submitted 42 management innovations for consideration by the Medicare Bureau. The Bureau approved nine of these innovations on an experimental basis in an effort to reduce claims costs. Most of the remaining innovations were disapproved because they were not in accordance with Medicare regulations or general instructions.

Blue Shield implemented three of the nine proposed innovations during 1977. Two of the changes were implemented because the Medicare Bureau made such changes for all carriers. The third was the development of an online claims history. This system change was to reduce the number of history printouts requested and to decrease duplicate claims by providing better explanations of benefits. Blue Shield officials stated that none of the implemented management innovations resulted in any significant cost savings.

Results of the first 9 months of 1978

Blue Shield reported costs during the first 9 months of 1978 of $2,916,354 to process 919,574 claims--a unit cost of $3.17 per claim--and claimed a loss of about $47,000. Blue Shield was being reimbursed at a rate of $3.12 per claim.

Performance standards remained the same for the second year, but evaluations have been made for only the first 6 months of 1978. The carrier met all the quantifiable standards during this period. During the first 3 months the carrier failed to meet two of the nonquantifiable standards, but was rated satisfactory in all seven areas for the next 3 months.

Blue Shield did not implement any management innovations during 1978. Carrier officials stated that most of their cost-saving innovations were put in place prior to the experiment, and that it would take program changes to further reduce costs.

Blue Shield's costs were in a downward trend

During November 1974 Blue Shield switched to the part B Model System. Between 1974 and 1976, as the following table indicates, Blue Shield's unit cost dropped sharply; even total administrative costs dropped slightly.

Calendar year	Total administrative costs	Number of processed claims	Unit cost
1974	$3,125,192	713,426	$4.38
1975	3,159,939	842,079	3.75
1976	3,029,739	977,088	3.10

The Bureau's Philadelphia Regional Office was aware of these declining costs. The Program Officer cautioned the Bureau's Program Experimental Branch about Blue Shield's participation in the experimental program. The Program Officer warned that the full cost reductions of Blue Shield's switch to the part B Model System had not yet been realized. In a memorandum to the Experimental Branch dated August 5, 1976, the Program Officer stated:

> "Since November 1974 when the carrier went on the Model B System, performance standards based on quantitative workload data and unit cost per claim has improved steadily. If a fixed price were to be negotiated at this time, while unit cost is still in a downward trend, the Bureau could find itself locked into a cost figure higher than would be the case if the Regional Office continued to impress on the carrier the importance of adhering to a rigorous cost containment program including budgetary control."

This warning was apparently ignored, however. The Medicare Bureau began negotiations with Blue Shield in December 1976 to determine a reimbursement rate per claim for 1977. At the conclusion of the negotiations in January 1977, a target rate of $3.33 per claim was agreed to. The target rate was based on Blue Shield's costs for the 12-month period July 1975 through June 1976. Blue Shield's actual cost per claim was $3.29 during this period. The target rate was increased from $3.29 to $3.33 to allow for costs related to a required change in the data processing system.

The target rate agreed to by the Bureau did not reflect Blue Shield's more recent operating costs. Blue Shield of Maryland had operated at $3.17 for fiscal year 1976 and $3.10 for calendar 1976. Information about the lower costs, particularly the fiscal year costs, was available when the Bureau began negotiations.

The Medicare Bureau's cost analysis was not adequate. The result was a fixed rate per claim which was set too high because it was not based on Blue Shield's current actual performance. Maryland only had to operate at the same unit cost level for fiscal year 1976, and it would earn 16 cents per claim ($3.33-$3.17). Blue Shield's unit costs had sharply dropped the prior 3 years.

Performance standards

The Medicare Bureau developed two systems of quality control to assure that performance was sustained during the contract period. The first system used quantifiable standards to measure the carrier's performance. The second system used nonquantifiable or functional standards which are reported in the Annual Contractor Evaluation Report (ACER).

Blue Shield was required to meet 10 quantifiable standards. The basis for each standard was one statistical deviation below average performance levels for fiscal year 1976. The Bureau was, therefore, making no attempt to improve performance under the experimental contract. In fact, the standards were relatively low in some cases. We obtained the national average for 6 of the 10 performance standards and found that 3 of the standards were set considerably lower than the national average. A penalty was to be imposed if Blue Shield failed to meet a standard. The Bureau established a different penalty percentage for each standard, depending on the importance of each standard to the Medicare program.

As previously discussed, Blue Shield failed a standard for frequency of payment errors during 1977 and lost 7 percent of its earnings. While the remaining nine standards were met, performance did not improve over fiscal year 1976--it remained about the same. All 10 standards were met through the first 6 months of 1978.

Functional standards

The Bureau established standards for seven functional areas covered by the ACER. Blue Shield was required to obtain a satisfactory rating for each of the seven areas--claims processing, coverage and utilization safeguards, program reimbursement, EDP operations, beneficiary services and professional relations, fiscal management, and carrier management.

Blue Shield failed to meet two of the seven functional standards. Program reimbursement was rated "adequate but needs improvement" for the entire year. Coverage and utilization safeguards were rated satisfactory for the first 9 months of 1977, but slipped into a rating of "adequate but needs improvement" for the last 3 months in 1977. At the end of 1977, Blue Shield was not meeting two functional standards--coverage

and utilization safeguards and program reimbursement. There was no dollar penalty assessed for missing the functional standards, although the contract could be terminated if the carrier failed to correct the deficiencies.

The ACER is a slow and cumbersome method for assessing performance. The ACER covering Blue Shield's performance for 1977 was not issued until December 1978--12 months after the reporting period and the last month of the experimental contract.

COST GUARANTEE UNDER CARRIER SUBCONTRACT NOT FULLY EFFECTIVE

Contract incentives in the form of guarantees of total claim processing costs appear difficult to administer, particularly if such guarantees involve comparisons of cost and/or performance with other contractors.

In September 1972 the Medicare Bureau approved a 6-year data processing and facilities management subcontract between Electronic Data System Federal (EDSF) and the Nationwide Mutual Insurance Company--the carrier processing part B claims in Ohio and West Virginia.

Because the proposed subcontract price was from 2 to 3 times higher than those proposed by two other offerors, the proposals were subject to extensive evaluation by the carrier and the Bureau, and negotiations between EDSF, Nationwide, and the Bureau. The evaluations were in terms of total carrier costs that would be incurred under the various proposals, and they narrowed the difference between the proposals. Nevertheless, the Bureau was unwilling to accept Nationwide's recommendation that EDSF be awarded the subcontract because of the difference between the projected costs under EDSF's proposal and the low bid.

To overcome the Bureau's objections, EDSF offered to guarantee the total carrier costs per claim of $2.40 as projected in its proposal by the end of the first full year after entering into the subcontract. This offer led to further negotiations which culminated in final subcontract guarantees based on a complicated formula which featured comparisons of Nationwide's costs with the total unit costs incurred by other carriers not using the EDSF system. The first full year of the guarantee began January 1, 1974.

For calendar year 1974 the Nationwide cost per claim was $2.72, whereas the guaranteed cost as computed by the Bureau in 1977 was $2.37. Considering the volume of claims processed, this resulted in a difference of $1,136,740.

EDSF disputed the application of the guarantee as computed by the Bureau, however, because (1) the alleged failure of HEW to establish a formal evaluation system made the guarantee provision inoperable and (2) one of the other carriers included in the computation was not performing services substantially comparable to those provided by Nationwide. As of March 1979 the dispute was in the appeals process and was not resolved. 1/

Without commenting on the merit of the dispute, it appears clear that, had EDSF's initial offer to guarantee its proposed estimate of $2.40 a claim been the basis for the guarantee, the basic source of dispute--comparability of carrier performance--would have been avoided.

Therefore, although comparisons of contract performance are an important management function, we believe that, under Medicare, incentive contracts which involve comparisons with the costs and/or performance of other contractors should be avoided.

CONTRACTORS SHOW AN INTEREST IN INCENTIVE CONTRACTING

Contractors have expressed interest in incentive contracting. This was evident in responses to the Bureau's general solicitation as well as comments submitted to the Perkin's Committee during its review of Medicare contracting and subcontracting in 1973. Comments received from Medicare contractors during this study suggested that incentive contracting was an acceptable concept.

The main problems identified by the contractors are the lack of a realistic set of performance standards and a better system for comparative performance reporting. Contractors believe a system of rewards and penalties is appropriate, and see benefits for the program and themselves.

1/This dispute would be academic for the following years because Nationwide's total cost per claim dropped to a level below $2.40, which was lower than any amounts at which the guaranteed cost could be computed.

Commenting on the experimental fixed-price procurement in Maine, the National Association of Blue Shield Plans, in a letter to the Administrator of HCFA dated September 21, 1977, stated that the performance assessment mechanism in the RFP for Maine acted "entirely as a negative form of incentive while neglecting to obtain superior performance." It referred to the penalties assessable in Maine if performance fell below certain standards. The only incentive was to meet the acceptable standards, not necessarily go above them. It expressed the belief that an "incentive structure could be improved by providing a sliding scale of both penalties and rewards for performance below and above the specified norms."

Contractors believe incentives are workable in the existing cost reimbursement environment, if the Bureau would develop the necessary contract performance standards and evaluative systems that have been sought for years. As discussed on page 89, the Bureau is working toward this objective.

Representatives from the commercial carriers submitted a proposed cost-plus-incentive fee contract to the Bureau in 1978. The proposed contract differs from the standard cost contract because it proposes that contractors could earn an incentive fee in addition to their incurred costs. The incentive fee would be based on 3 percent of the negotiated target costs. From this amount, the contractor would have added or subtracted an amount equal to 20 percent of the actual costs below or over the target. Any performance penalties would also be subtracted.

Contractors would be required to meet six proposed performance standards. For each standard failed, a penalty assessment of 10 percent of the target incentive fee would be made. However, no penalty would be assessed unless more than two quarterly measures have been failed within a 12-month period.

The contract is one version of a negotiated incentive contract and is an alternative to the standard cost contract. It does provide a contractor with a profit incentive and clear-cut performance standards. However, as proposed, the contract is heavily weighted on the side of the contractor.

The contract does propose standards to be met, but they are less stringent than the ones currently used in the experimental contracts. Moreover, a standard must be missed for more than two quarters and the assessed penalties cannot be any greater than the target incentive fee. As far as performance standards are concerned, under this contract the Government would apparently be paying more for what contractors are now required to do.

CONCLUSIONS

The Medicare program could operate effectively with incentive contracts on either a cost or fixed-price basis. Incentive contracts fall in between the firm fixed-price contract and cost contracts regarding the degree of cost responsibility incurred by the contractor. Under the firm fixed-price contract the contractor assumes full cost responsibility. Under a cost contract, the Government assumes the full cost liability. Incentive contracts provide for varying degrees of contractor cost responsibility.

The Medicare program has not adequately experimented with incentive contracting. Although the Medicare Bureau considers the experimental contract with Blue Shield of Maryland an incentive contract, it provided little insight into whether incentive contracts will work in the Medicare program.

The experiment will result in Blue Shield of Maryland earning over $200,000 from the contract. The Government did not benefit from the experiment because Blue Shield's unit costs were in a downward trend at the time of negotiations and an unreasonably high fixed rate per claim was negotiated for the first year of the contract.

Incentive contracts should contain performance, as well as cost incentives. The incentives, however, should not reward contractors for meeting standards that should have been met to reach satisfactory performance levels. Before the contracts can be negotiated effectively and benefits can be realized, the Bureau must develop clear-cut performance standards and refine its measurement criteria. Contract incentives which involve comparisons with other contractors should be avoided.

RECOMMENDATION TO THE SECRETARY OF HEW

We recommend that the Secretary of HEW direct the Administrator of HCFA to conduct additional experiments to evaluate whether incentive contracting will work successfully in the Medicare program. The experiments should include cost and performance incentives.

AGENCY COMMENTS

HEW concurred with this recommendation and stated that HCFA will consider and pursue additional contracting experiments, particularly where cost savings seem likely.

CHAPTER 9

COSTS CAN BE REDUCED BY ELIMINATING THE RAILROAD RETIREMENT BOARD'S CONTRACTING AUTHORITY

The existing arrangement under which a carrier makes benefit payments nationwide for Railroad Retirement Board (RRB) beneficiaries is neither efficient nor economical. Maintaining a separate carrier for RRB beneficiaries since fiscal year 1970 has cost the Federal Government as much as $43 million in additional administrative costs. Termination of this arrangement could result in annual administrative cost savings of at least $6.6 million. Moreover, although the RRB carrier has improved the accuracy and timeliness of its claims processing activities, the carrier does not make payments which conform to the payments made for comparable services by the area carrier in the same locality.

OUR 1971 REPORT ON THE NEED FOR CONSOLIDATING RRB CLAIMS PROCESSING ACTIVITIES

In January 1971, we issued a report on the opportunity to reduce Medicare program costs by consolidating the claims processing activities of the Social Security Administration (SSA) and RRB. 1/

There were 50 separate area carriers under contract with SSA at that time to process part B claims. Each carrier had a designated geographical service area where it made benefit payments to all eligible beneficiaries, except for eligible railroad workers and annuitants of RRB. RRB, under a delegation of authority from SSA, contracted with the Travelers Insurance Company to perform this function for about 810,000 of the total 18.9 million people eligible for part B benefits.

Because of their prior experience with Travelers and because they would continue to contact Travelers regarding complementary insurance benefits not covered by Medicare, railroad union and management officials, in December 1965 and in January and February 1966, recommended to HEW that

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1/"Opportunity to Reduce Medicare Costs By Consolidating Claims Processing Activities," B-164031(4), Jan. 21, 1971.

Travelers be selected as the nationwide part B carrier for railroad workers and RRB annuitants. These railroad officials stated that it would be more feasible for their members to deal with one carrier because such an arrangement would result in greater efficiency and more timely benefit payments. In February 1966 officials of railroad management and labor organizations pointed out to the Undersecretary of HEW that about 166,000 RRB-related beneficiaries who would be eligible for Medicare had health insurance with Travelers.

Accordingly, the selection of Travelers in July 1966 as the nationwide RRB carrier was made primarily for the convenience of about 22 percent of the 761,000 railroad workers and annuitants who were eligible for Medicare, or about 1 percent of the total 17.6 million beneficiaries who had enrolled under part B of the Medicare program. Further, of the 810,000 railroad workers and RRB annuitants who were eligible for part B benefits as of January 1, 1969, only about 125,000, about 15 percent, had complementary coverage with Travelers.

Our 1971 report showed that, due to the relatively small number of railroad workers and annuitants eligible for Medicare part B benefits and because some Travelers administrative functions appeared to duplicate area carriers, an opportunity existed to reduce administrative costs and to increase program efficiency and effectiveness by using the existing area carriers to make benefit payments to all eligible beneficiaries. Our 1971 conclusions were based on the following findings:

1. Travelers could not determine if physicians' charges to RRB beneficiaries were reasonable because it did not have enough data on physicians' fees for services provided only to RRB beneficiaries to determine customary charges for individual physicians. 1/ We estimated that this resulted in payments of approximately $2.9 million more than the area carriers would have made if they had processed and paid claims for eligible RRB beneficiaries.

2. The use of a separate carrier to process claims for RRB beneficiaries resulted in approximately $2.8 million more a year in administrative costs than would have been incurred if the RRB claims were processed by the area carriers.

1/A customary charge is the charge the physician usually bills most of his patients for the same service.

3. The use of area carriers would eliminate the duplication of effort and costs resulting from RRB claims being sent to the area carriers in error, where they have to be forwarded to the Travelers' field offices.

Our 1971 report recommended the withdrawal of the contracting authority from RRB, and recommended that the area carriers--who made payments for all other Medicare beneficiaries--be directed to make the payments for eligible RRB beneficiaries.

HEW advised us in 1971 that it was not prepared to accept these recommendations. HEW acknowledged that the relatively small number of RRB claims posed a serious obstacle to the development of adequate RRB reasonable charge data and that the arrangement with Travelers as the sole carrier for RRB claims presented administrative problems. However, HEW was reluctant to take unilateral action to revise the delegation of authority to RRB.

HEW also stated that, because Travelers was processing RRB claims nationwide, it would provide an excellent opportunity to conduct an experiment using fee limitations to establish maximum allowable physicians' charges on a State-by-State basis. However, officials at Travelers, RRB, and the Medicare Bureau told us during our current 1978 review that no such experiment had been conducted.

As part of the Social Security Amendments of 1972, the Congress gave RRB legislative authority to contract with a carrier (or carriers) to process and pay part B Medicare claims for eligible RRB beneficiaries in accordance with such regulations as the Secretary of HEW might prescribe.

This provision originated in the House and, in its deliberations on the bill, the Senate deleted it "in the interest of program efficiency, economy, and consistency of administration in an area." However, the conferees agreed to the House proposal.

CHANGES MADE IN TRAVELERS RRB OPERATIONS SINCE 1970

Before 1970, Travelers processed RRB part B claims at about 125 field offices throughout the United States. In 1970 Travelers reduced the number of RRB claims processing locations to 62; we estimated in our earlier report that this

would save $352,000 annually in administrative costs. Travelers began a further consolidation of claims processing activities in 1975. It also began making major changes in its RRB claims processing system.

Conversion to a regional online processing system

In 1975 RRB reviewed and approved proposals by Travelers to convert to an online regional claims processing system. The consolidation was to reduce claims processing costs and improve quality. Between September 1976 and March 1978 Travelers consolidated the RRB claims processing activities from 62 field offices to 5 regional claims processing centers. 1/

The regional centers have a system which provides direct access to the Travelers' computer center in Hartford, Connecticut, and provides an online claims processing capability through Cathode Ray Tube terminals. The five regional claims processing centers spend all of their time on RRB claims processing and beneficiary and provider services. To facilitate assisting RRB beneficiaries and providers with filing RRB claims, the centers are equipped with toll-free telephone lines for their multi-State service areas.

RRB and Travelers officials stated that converting to the regional online claims processing system would

--lower Travelers administrative costs,

--improve claims processing quality by reducing clerical and payment errors,

--maintain or improve claims processing time,

--facilitate monitoring and control of claims processing operations and more fully utilize EDP capabilities, and

--maintain or improve services to beneficiaries.

1/Regional claims processing centers are located in Augusta, Georgia; Albany, New York; Salt Lake City, Utah; Lansing, Illinois; and Garland, Texas.

RRB beneficiaries and providers are generally satisfied with the regional online system

We developed questionnaires to obtain beneficiary and provider views to determine if RRB beneficiaries and providers were satisfied with claims processing services provided by the Travelers RRB regional online system. Questionnaires were sent to 377 RRB beneficiaries and 403 providers who had submitted claims selected for the Travelers' nationwide quality assurance sample during the week of June 25, 1978. Travelers officials agreed that the method used to choose questionnaire recipients would provide a representative nationwide cross section of RRB beneficiaries and providers.

Usable questionnaire responses were received from 307 RRB beneficiaries (81 percent of those selected) and 289 providers (72 percent of those selected). Most respondents were satisfied with the Travelers claims processing services. About 78 percent (239) of the RRB beneficiaries and 65 percent (189) of the providers indicated they were satisfied with the services provided by Travelers.

Beneficiary and Provider Evaluation of Travelers RRB Claims Processing Services

Level of satisfaction with Travelers	Respondent group			
	Beneficiaries		Providers	
	Number	Percent	Number	Percent
Satisfied	239	77.9	189	65.4
Dissatisfied	26	8.5	24	8.3
Not sure	19	6.2	12	4.2
No answer	23	7.5	44	15.2
No basis to judge	-	-	20	6.9
Total	307	100.0	289	100.0

About 23 percent of the RRB beneficiaries and 45 percent of the providers who responded to the questionnaires indicated that they had contacted Travelers for claim assistance by phone, letter, or walking into an office. Of those who did contact Travelers, most indicated they received the assistance they needed by writing or telephoning.

About half the providers expressing an opinion concerning the effects of the conversion to a regional online system said that the conversion has improved the timeliness of RRB claims processing. Providers believe that regionalization has led to faster receipt of payments and some improvement in the amount of time required to get a response to an inquiry or to resolve a disputed claim.

We believe that RRB beneficiary and provider questionnaire results indicate that the use of regional processing centers with toll-free lines can provide satisfactory service to Medicare beneficiaries. Questionnaire results also indicate that the Travelers conversion to a regional online system has improved the timeliness of RRB claims processing.

Improved accuracy and timeliness of RRB claims processing reflected in Bureau statistics

Carrier quality assurance program results published by the Medicare Bureau indicate that the Travelers conversion to a regional online system has improved processing quality. Data show a decrease in the number of claims processing errors since Travelers converted from a largely manual RRB claims processing system with many processing locations to the more computerized online system with only five processing centers.

The Bureau's quality assurance program provides for a systematic review of a sample of claims drawn from the claims processed to completion by the carrier during a given reporting period. The review identifies various types of processing errors in the carrier's operations. Errors are then examined further to determine if they resulted in actual payment errors or in errors that affected the deductible amount. The results of the review are reported in a carrier quality assurance report designed to provide a basis for evaluating carrier performance.

Data in the Bureau's reports for the periods July 1976 to June 1977 and July 1977 to June 1978 indicate that conversion to an online regional processing system has improved the accuracy of RRB claims processing.

In commenting on our report (see app. VIII and XI), Travelers and RRB both stated that the report did not consider the effect of Travelers claims processing on benefit dollars. The statistic they used to judge processing

quality was the payment-deductible error rate 1/ which in fiscal year 1978 was 1.46 percent for RRB compared to a national average of 2.1 percent. The difference of 0.64 percent, when applied to total submitted charges for railroad beneficiaries, indicates, according to RRB and Travelers, that area carriers would make more incorrect benefit payments than Travelers for the RRB claims. 2/ We believe this statistic can be used in assessing a carrier's processing quality, although other evaluations would have to be made to judge the overall effect of a carrier's operations on benefit payments.

In addition to reducing errors, the online regional processing system has allowed Travelers to achieve an average RRB claims processing time which has been consistently better

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1/Calculated by dividing the estimate for dollars paid in error and/or incorrect amount charged to the deductible plus any applicable penalty amount by the submitted charges associated with the carrier's adjudicated claims.

2/RRB stated that Travelers payment-deductible error rate "resulted in savings in benefit payments approximating $2 million." This is incorrect, as the overall error rate is made up of both overpayments and underpayments. For example, for fiscal year 1978 Travelers RRB overpayments were estimated to be about 57 percent of the total incorrect RRB payments and underpayments were about 43 percent. Nationwide, overpayments accounted for about 54 percent of the total estimated incorrect payments and underpayments were about 46 percent.

than the national average. A comparison of Travelers RRB claims processing time to the national average for the period July 1977 to September 1978 can be found in the following table:

Period	Claims processed: Travelers RRB	Claims processed: All carriers (note a)	Average processing time: Travelers RRB (note b)	Average processing time: National average all carriers (note a)
			(days)	
7/77-9/77	746,426	25,984,559	8.9	12.7
10/77-12/77	766,039	26,506,608	7.6	12.1
1/78-3/78	867,671	29,089,312	8.6	14.6
4/78-6/78	859,950	29,848,467	8.1	12.6
7/78-9/78	850,953	29,076,517	7.9	12.4

a/Includes Travelers RRB workload.

b/Does not include time for misrouted claims, which represent about 31 percent of the RRB workload.

Travelers regional online system has contained escalating RRB claims processing costs

From fiscal year 1970 through 1974 the Travelers RRB unit cost per claim rose from $3.23 to $3.52--an increase from 7 cents above to 29 cents above the national average unit cost per claim for all part B carriers.

Travelers officials told us this increase in claims processing costs took place largely because RRB claims processing prior to conversion to a regional online system was a labor intensive, primarily manual, operation. They stated that inflation in wages and a relatively small RRB claims volume was pushing up the RRB unit cost per claim. Travelers completed the conversion to an online regional claims processing system in 1978. The total nonrecurring cost of the conversion was about $4.8 million.

The RRB unit cost per claim continued to rise while the conversion to the new system was taking place. From fiscal year 1975 through fiscal year 1977 the RRB unit cost per

claim rose from $3.72 to $4.56 (excluding conversion costs)--from 53 cents above to $1.61 above the adjusted 1/ national average unit cost per claim for all part B carriers.

Travelers and RRB officials recognized that the RRB unit cost per claim continued to be high during the conversion period. They told us that they expected processing costs to escalate but believed a substantial reduction in RRB processing costs as a result of the conversion would begin to be realized in fiscal years 1979 and 1980.

Travelers officials told us that claims processing costs were high in fiscal years 1975 through 1977 because regional claims processing centers were being staffed and phased in while the old field office processing locations were maintained. Field office processing locations were phased out gradually as the regional processing centers came online to avoid the development of a claims backlog and to prevent deteriorated claims processing services.

Travelers officials expected that the conversion would reduce claims processing costs by decreasing the number of personnel needed to process claims through more automated claims processing procedures. They also expected to realize improved data processing costs through system enhancements and fuller utilization of electronic data processing capabilities.

Travelers completed the conversion to an online system during March 1978. The 1978 RRB unit cost per claim, excluding conversion costs, was $3.90--$1.06 above the adjusted national average unit cost per claim of $2.84. Travelers estimates its 1979 unit cost will drop to about $3.20, 32 cents less than the RRB unit cost per claim for fiscal year 1974, the fiscal year before the conversion began.

Travelers officials told us they believe the RRB unit cost per claim will be reduced further. However, they were unable to estimate how much more of a reduction could be expected over the next 5 years.

1/Adjusted to include costs related to the development and maintenance of the Model B System, and to exclude nonrecurring costs.

We believe the Travelers conversion to a regional online system has been effective in containing escalating RRB claims processing costs.

AREA CARRIERS COULD PROCESS THE RRB WORKLOAD AT SUBSTANTIAL SAVINGS

The cost to Medicare of maintaining a separate RRB carrier and of financing the conversion to a regional system has not been economical. As much as $43 million in administrative costs could have been saved between fiscal years 1970 and 1978 if the area carriers had processed RRB claims. Additional savings of at least $6.6 million in fiscal year 1979 and in all future years can be realized. The $6.6 million is made up of two components--an estimated $5.4 million can be saved by using area carriers to process RRB claims and $1.2 million by eliminating misrouted claims.

Administrative costs could be saved by using area carriers to process RRB claims

During fiscal year 1978, Travelers incurred administrative costs of about $14 million to process about 3.5 million RRB part B claims--about 3 percent of the total nationwide Medicare part B claims volume. Travelers estimates that the fiscal year 1979 RRB claims volume will be about 3.8 million claims. During fiscal year 1978, the area carriers incurred administrative costs of $328.7 million to process about 116.3 million part B claims. We believe that it would be feasible and less costly to give the area carriers responsibility for processing RRB claims because the number of RRB claims processed by Travelers in any State is relatively small compared with the number of claims processed by each area carrier.

Based on estimates furnished by 14 area carriers, we estimate that the consolidation of RRB claims processing on a nationwide basis could decrease the overall administrative cost of the Medicare program by about $5.4 million in fiscal year 1979. These savings would result from the economies of scale present in the larger claims processing operations of the area carriers. Cost savings of a similar magnitude would be realized in future years.

The proportion of total Medicare part B claims in individual States processed by the Travelers RRB claims processing

offices is very small. In a single low-volume State such as Colorado the area carrier will process about 1.4 million regular part B Medicare claims; in a large-volume State such as California the two area carriers will process about 16 million regular part B claims. Based on estimates furnished by Travelers we project that RRB beneficiaries will file about 80,000 claims in Colorado and about 406,000 claims in California in fiscal year 1979. These claims represent only about 5.7 percent of the claims volume the area carrier will process in Colorado and 2.5 percent of the volume the two carriers will process in California.

Area carriers estimate savings through consolidation of RRB claims processing

Using economies of scale present in the larger claims processing operations of the area carriers could reduce the costs of processing RRB claims. To determine how much could be saved, we asked 14 area carriers in 13 States to estimate the incremental costs that each would incur in fiscal year 1979 if they were to assume responsibility for processing RRB claims in their service areas.

Based on claims volume data provided by Travelers, we estimated that RRB beneficiaries would submit about 2.1 million claims in this 13-State area. These claims represented about 53 percent of the total estimated fiscal year 1979 RRB claims volume for Travelers nationwide. The 14 area carriers estimated they would require approximately $3.7 million in additional administrative funds to process the 2.1 million RRB claims.

Travelers estimated that it would incur about $12.3 million in administrative costs to process the 3.8 million RRB claims in 1979. Based on estimates provided by area carriers, we believe that all 1979 RRB claims could be processed by area carriers for about $6.9 million--about $5.4 million less than the administrative costs Travelers expects to incur.

The 14 carriers in our study had an average fiscal year 1979 unit cost approved by the Medicare Bureau of $2.66 per claim--about 54 cents per claim less than the $3.20 unit cost approved by RRB for Travelers. Their average estimated incremental unit cost for processing the RRB claims was $1.76--$1.44 per claim less than Travelers. We believe that the 90-cent reduction from the average unit cost for processing regular part B claims is attributable to fixed costs within the area carriers' approved 1979 budgets, which would not increase directly with claims volume.

As one carrier reported, "The foregoing costing information ties closely to our current activity level in which 1/3 of our forecasted cost for FY 79 tends to be fixed and the remaining 2/3 appears to vary with the workload." Most of the area carriers contacted identified budget areas that would not increase with claims volume.

Each of the carriers contacted estimated the additional personnel they would need to process the RRB claims in their service areas. Based on the data submitted by these area carriers, we estimate that nationwide all the area carriers would need about 271 people to process the fiscal year 1979 RRB claims volume; this is about 232 people less than Travelers has estimated it will need. This reduction in personnel needs, along with other identified costs which do not change due to claims volume increases, are the major factors in the incremental cost savings.

The following table presents the area carriers' estimates of additional costs necessary to process RRB claims.

Carrier	Estimated RRB claims	Estimated additional expense
1	129,705	$ 250,000
2	276,257	500,271
3	103,284	151,400
4	58,553	120,370
5	242,167	510,729
6	51,898	13,619
7	141,699	221,445
8	215,521	397,700
9	220,641	222,400
10	117,793	205,373
11	103,998	294,000
12	240,600	457,139
13	94,437	152,174
14	80,331	161,246
Total	2,076,884	$3,657,866

In commenting on our report, Travelers stated (1) it did not agree with the incremental costs we used as a basis to estimate savings to the program, and (2) our conclusion regarding economies of scale was distorted because only large carriers were surveyed.

While it is true that the carriers we selected were among the program's largest in terms of part B workload, we believe the economy of scale theory is still valid. The estimated effect on any carrier's operations from processing RRB claims is relatively the same no matter how large the carrier--it would generally represent less than a 5-percent increase in volume. Most carriers have an increase in volume of at least 10 percent from one year to the next and, as we pointed out in chapter 4, the average incremental cost for these increases is less than the average incremental cost used in our RRB projections. In addition, 12 of the 14 carriers we selected were in the two largest carrier peer groups. (See p. 19.) Along with the other carriers in the two peer groups, these carriers would process over 80 percent of the RRB workload, leaving less than 20 percent to be processed by the smaller carriers. 1/

Misrouted claims cause serious problems

In addition to savings in administrative costs resulting from economies of scale if the area carriers processed RRB part B claims, additional savings could be realized by eliminating misrouted claims. The area carriers receive and, in many instances, process up to the point of payment a relatively high percentage of RRB claims. These misrouted RRB claims could cost the Medicare program as much as $1.2 million in fiscal year 1979.

A misrouted claim is a request for payment of an RRB part B claim that has been sent by either an RRB beneficiary or a provider of medical services to an area carrier instead of to Travelers. These claims are generally identified either before processing by the area carrier or are processed completely but with no reimbursement check issued. In either case, costs are incurred to identify, handle, and redirect misrouted claims to Travelers.

To determine how serious a problem misrouted claims pose for the area carriers, we requested that the 14 carriers surveyed for incremental cost data provide us with data on

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1/Some of the smaller carriers already have lower unit costs than Travelers' costs for processing RRB claims. Blue Shield of Rhode Island, for example, had an overall unit cost for fiscal year 1978 of $1.80 per claim.

the number of misrouted claims they received and the costs they incurred in identifying and redirecting these claims to Travelers.

Eleven of the 14 area carriers participating in the study reported that they handled 398,861 misrouted RRB claims at a cost of approximately $385,344 in fiscal year 1977, or about $1.00 per claim. The other three carriers did not have misrouted claim data available. The 398,861 misrouted claims represented about 31 percent of the total RRB claims processed by Travelers in the 11 States serviced by these carriers. If the area carriers' experience with misrouted claims is typical of what all area carriers experience nationwide, about 964,228 RRB claims were misrouted in fiscal year 1977.

The 14 carriers estimated that in fiscal year 1979 they will incur about $658,251 in costs resulting from misrouted RRB beneficiary claims. About 53 percent of the Travelers total RRB claims volume in fiscal year 1977 originated in the States serviced by these carriers. Assuming these costs represent the costs incurred in the remaining States and that the claims distribution has not changed, we estimate that about $1.2 million in administrative costs as a result of misrouted RRB beneficiary claims could be incurred nationwide in fiscal year 1979.

In addition to increased administrative costs, the carriers identified the following problems resulting from misrouted claims:

--Increased time from submission of a claim to receipt of payment.

--Increased inquiries regarding the status of a claim or the amount paid.

--Increased possibility of duplicative payments and necessary efforts to recoup such monies.

--Confusion among providers as to where a claim should be sent.

--Increased need for inservice training of carrier personnel on how to identify and handle transfer claims.

One carrier that handled an estimated 29,340 misrouted railroad claims in fiscal year 1977 stated that an additional problem occurs for the individual carrier faced with a relatively large number of RRB transfer claims, because the carrier is given no credit for the cost of processing them in statistical reports issued by the Bureau. The carrier believed that the cost of misrouted claims was even greater than could be documented for studies such as ours.

Travelers recognizes that misrouted claims are a problem

Travelers officials stated that they are aware of the misrouted claims problem. In their opinion, the primary cause of misrouted claims has been with providers of service who routinely send all claims to the area carrier.

In an effort to correct the problem, Travelers has distributed preaddressed yellow claim forms; the area carriers use a white form. Travelers has also put notices in area carrier newsletters, advising providers to sort and file claims correctly. However, Travelers officials believe that, because of the unique situation of having a nationwide carrier for a single beneficiary group, some providers would always misroute claims. This is supported by our study and by our beneficiary and provider questionnaires.

At least 25 percent of the providers who responded to our questionnaire indicated that they routinely submitted RRB claims to either their area carrier or to a Travelers Insurance Company office other than an RRB Medicare claims processing office. A number of respondents to our beneficiary questionnaire stated that they were unable to get providers to submit their claims correctly even after repeatedly notifying them that RRB claims must go to Travelers. This situation could result in a long delay between submission of a claim and subsequent reimbursement.

Although Travelers has attempted to deal with misrouted claims, the problem still exists. We believe misrouted claims result from the unique situation of having a single nationwide carrier for all RRB beneficiaries. If the existing area carriers paid RRB part B claims, the misrouted claims problem would be minimized, and about $1.2 million in administrative costs could be saved.

In commenting on our report, Travelers and RRB both stated that a contemplated change in Medicare instructions should alleviate the problem of misrouted claims. In April 1979 the Medicare Bureau stated that it was considering a change to its carriers' manual which will further emphasize to area carriers the importance of identifying and transferring misrouted claims at the beginning of the claims process.

We do not agree that this change will alleviate the problems with misrouted claims. The identification techniques are not new and the problem has existed since the beginning of the program. Our 1971 report also highlighted the problem with misrouted claims.

Estimated $43 million cost to maintain a separate RRB carrier since 1970

To determine what the cost has been to maintain a separate RRB carrier since fiscal year 1970, we compared the unit cost per claim experienced by Travelers for fiscal years 1970 through 1978 to an incremental unit cost for all part B carriers. Since the area carriers participating in our study estimated an incremental unit cost to handle the RRB workload of approximately 66 percent of their present unit cost, we used this same ratio for each previous year.

For example, in fiscal year 1970 the national average unit cost was $3.16. We assumed that the area carriers could have processed the RRB claims at an incremental unit cost in 1970 of $2.09 (66 percent of $3.16). If the area carriers had begun processing RRB claims in 1970, we estimate that about $43.0 million in administrative costs could have been saved by the end of fiscal year 1978.

As shown in the following table, the estimated $43.0 million includes about $4.8 million expended to convert Travelers to a regional online system. The estimates do not include any costs for misrouted claims during this period.

Costs Associated with Continuing a Separate
National Carrier for RRB Part B Medicare
FYs 1970-1978

Fiscal year	Claims processed	RRB unit cost	National average unit cost	Area carriers' estimated incremental unit cost	Difference in unit cost over RRB	Total administrative cost difference
1970	1,515,876	$3.23	$3.16	$2.09	$1.14	$ 1,728,099
1971	1,721,160	3.20	3.28	2.16	1.04	1,790,006
1972	1,932,500	3.12	3.18	2.10	1.02	1,971,150
1973	2,034,174	3.45	3.23	2.13	1.32	2,685,110
1974	2,330,694	3.52	3.23	2.13	1.39	3,239,665
1975	2,633,398	b/3.72	3.19	2.11	1.61	4,239,771
1976	2,848,121	b/3.97	3.11	2.05	1.92	5,468,392
TQ (note a)	705,614	b/4.45	3.13	2.07	2.38	1,679,361
1977	3,147,987	b/4.56	2.95	1.95	2.61	8,216,246
1978	3,544,070	b/3.90	2.84	1.87	2.03	7,194,462
		Total administrative cost difference				38,212,262
		Cost of converting to a regional online system				4,785,705
		Total cost to Government				$42,997,967

a/Transitional quarter.

b/Does not include nonrecurring costs of converting to a regional online processing system.

DIFFERENT REIMBURSEMENT DETERMINATIONS FOR RRB BENEFICIARIES

Travelers develops reasonable-charge screens for payment of RRB claims in a similar manner to that of the area carriers. However, Travelers has only limited charge data available with which to develop customary and prevailing charges. As a result, the 1979 customary and prevailing charges developed by Travelers to determine reimbursement amounts for RRB beneficiaries vary about half the time from those developed by the area carriers. Although in the aggregate these variances tend to offset one another, they do result in differences between Travelers RRB claims payments and area carrier claims payments for the same service provided by the same physician.

Reasonable-charge determinations

The reasonable charge is the basis of payment for part B health services furnished by providers of health care, such as physicians, medical groups, and independent laboratories under Medicare part B. The reasonable charge for a specific service in the absence of unusual medical complications or circumstances is defined as the lowest of

(a) the provider's customary charge for that service,

(b) the prevailing charge made for similar services in the locality, or

(c) the actual charge of the provider rendering the service.

Carriers are required to develop extensive profiles of all charge data from providers in the program. The profiles are used to calculate customary charges for each provider and prevailing charges for each procedure. These customary and prevailing charges are then used to develop reasonable charge screens by applying the criteria listed above.

Carriers are required to update their customary and prevailing reasonable-charge screens for implementation on July 1 of each year. The screens are based on physician and provider charges submitted during the prior calendar year. The screens are in effect from July 1 through June 30 of the next year. For example, July 1, 1978, through June 30, 1979, would be referred to as fee screen year 1979.

The Medicare Carriers Manual, which contains operating instructions for all carriers, states that for developing 1979 reasonable-charge screens carriers should use three charges as the minimum number of charges for the same service to establish a customary charge for that service. The manual also states that the carrier should establish four customary charges as the minimum number to calculate the prevailing charge for a service in a locality or in a carrier service area. Provisions were made by the Bureau in the manual for situations when the carrier might not be able to meet this criteria.

Reasonable-charge screen requirements for 1979 were less stringent than the requirements for 1978, when carriers were required by the Bureau to develop a customary charge using four charges and to develop a prevailing charge using five customary charges.

Travelers has insufficent screen data

Medicare Bureau officials told us that Travelers has only about 3 percent of the data that area carriers have to develop customary and prevailing charges for their service areas. They believed that the lack of reasonable charge data would result in Travelers making different payments to providers submitting claims for RRB Medicare beneficiaries than area carriers would have made on the same claims.

RRB granted Travelers exceptions to the manual's minimum requirements for establishing both 1978 and 1979 reasonable-charge screens. Under these exceptions, the minimum number of charges authorized by RRB to establish a customary charge was one performance of a service and three customaries to establish a prevailing charge.

Travelers requested these exceptions because it processed too small a percentage of Medicare part B claims in any area to meet the manual's requirements. A Travelers official stated that if Travelers had followed the Bureau's requirements over half of its charge data could not have been used in developing its 1978 and 1979 profiles. In approving the exceptions for 1979, RRB stated that it would evaluate the effect of the manual's parameter requirements on Travelers RRB screens and consider using the correct parameters for the 1980 update.

At the time of our review RRB had not studied whether Travelers 1979 reasonable-charge screens were comparable to area carriers' screens.

Travelers customary and prevailing charges vary about half the time from area carriers

To determine if the prevailing and customary charges established for fee screen year 1979 by Travelers were comparable to area carrier screens, we compared a randomly selected sample of customary and prevailing charges for 10 common medical and surgical procedures in 10 States. We selected 10 medical/surgical procedures which, according to the Bureau's statistics, represented about 67.6 percent of all procedures performed nationwide in fiscal year 1977. The procedures also represented high-cost and low-cost services.

To assure that our sample was taken in geographical areas where a significant portion of railroad claims originate, we selected the 10 States listed below. About 53.8 percent of Travelers RRB claims processed in fiscal year 1977 originated in these States.

States selected	Percentage of total Travelers RRB claims volume
Virginia (and portions of Maryland)	2.5
Florida	4.9
California	10.4
Ohio	4.8
Minnesota	3.2
Illinois	5.7
Missouri	4.1
Texas	6.1
New York	6.6
Pennsylvania	5.5
Total	53.8

In these States for the 10 procedures, Travelers had established customary charges for about 158,600 provider/procedure combinations. We selected a random sample of providers for each procedure. We then determined the Travelers RRB prevailing charge for each selected provider/procedure combination and requested that the 21 area carriers in the 10 States surveyed provide us with their established customary and prevailing charges for the provider/procedure combinations in their service areas. The area carriers provided us with customary and prevailing charges for 2,206 provider/procedure combinations.

We found that, for the 2,206 customary charges, 679 (31 percent) were different from those established by the area carriers. Analysis of prevailing charges for the same 2,206 provider/procedure combinations showed that 1,473 (67 percent) were different from the area carrier prevailings.

We were able to project the results of our samples for 9 of the 10 procedures. For the nine procedures in the States sampled, we are 95-percent confident that, of the 157,468 providers for which Travelers had established 1979

customary charges, 34,609 to 54,480 of these customaries would be different from those established by the area carriers. We are also 95-percent confident that from 96,837 to 116,217 prevailing charges out of the 157,468 provider/procedure combinations would differ from those established by the area carriers.

Differences in charge screens result in different reasonable-charge determinations

We analyzed the customary and prevailing charges for each of the 2,206 provider/procedure combinations in our sample to determine which charge was lower. This was done for Travelers and the area carriers. We assumed that whichever was lower (customary or prevailing) would form the reasonable-charge basis for payment.

Comparison showed that out of 2,206 combinations the area carriers' reasonable-charge basis was different from Travelers 1,094 times--higher 669 times and lower 425 times. In other words, about half the area carriers' and Travelers' reasonable charge bases were different.

When the area carrier basis was lower for the 10 procedures, the dollar differences ranged from 7 percent lower for one procedure (transurethral electrosection of the prostate) to as much as 22 percent lower for another (urinalysis). These differences could result in significantly different allowances by Travelers and the area carriers on claims submitted by the same physician for the same service.

When the area carrier basis was higher for the 10 procedures, the dollar differences ranged from 9 percent higher for extraction of a lens to 34 percent higher for dilation of the urethra.

Travelers paid amounts usually different from area carriers

To determine the effect of the differences between Travelers RRB and area carriers' fee screen year 1979 reasonable-charge screens, we compared a sample of actual RRB claims paid by Travelers to what the area carriers would have paid on the same claims. The claims sample consisted of the 377 claims included in the Travelers RRB quality assurance sample for the week of September 11, 1978.

The Medicare Bureau's quality assurance sample is a statistically representative sample of the nationwide claim base taken weekly. Travelers officials agreed that the use of a quality assurance sample would provide us with a representative sample of the RRB claims they process.

Included in the 377 claims selected for sampling were 55 claims which could not be used because the claims were resubmissions, incomplete, or poorly reproduced. We sent the remaining 322 claims to 42 area carriers in 42 States for pricing, using 1979 reasonable-charge profiles. The area carriers were able to price 287 of the 322 claims. They were unable to price 35 claims due to insufficient information. The final sample analyzed consisted of 287 claims with submitted charges of about $90,000.

Medicare regulations require that the payments by the RRB carrier should conform as closely as possible to the payments made for comparable services in the same locality by area carriers. Of the 287 actual RRB part B claims we compared, however, the area carriers would have paid a different amount on 233 of the claims--higher on 122 claims and lower on 111 claims. Area carriers would have, therefore, paid a different amount on over 80 percent of the claims sampled.

Of the $90,000 in claims submitted, the area carriers would have paid about $56,273; Travelers paid about $56,408. The area carriers would have paid about $3,920 more than Travelers on the 122 claims where their determinations were higher. Of the 111 claims where the area carriers' determinations were lower, they would have paid about $4,055 less than Travelers. The net difference between higher and lower payments resulted in the area carriers determining that they would have paid about $135 less.

We believe the primary cause of the variation between the Travelers RRB and area carrier determinations on part B claims are the differences previously discussed between the Travelers RRB and area carrier 1979 customary and prevailing charges. Because of these differences, Travelers and the area carriers do not arrive at comparable reasonable-charge determinations.

The area carriers paid about 97 percent of all part B Medicare claims in fiscal year 1978. Because area carriers have more extensive data bases for making reasonable-charge determinations, we believe the determinations made by them

are more accurate than those made by Travelers. Furthermore, we believe these differences in reasonable-charge determinations result in Travelers paying more to some RRB beneficiaries than the area carriers would pay if they processed the claims, while other beneficiaries receive less than they would receive under the same circumstances. This results in inequitable treatment of many beneficiaries under the Medicare program.

CONCLUSIONS

We believe that the existing arrangement under which a carrier makes benefit payments nationwide for a relatively small group of RRB beneficiaries is neither efficient nor economical.

The Travelers conversion to a regional online claims processing system has improved the accuracy and timeliness of its claims processing system, and beneficiaries appear satisfied with Travelers' services. To some extent the conversion has also been effective in controlling claims processing costs and may allow Travelers to process RRB claims at a cost near the national average unit cost per claim over the next several years.

The estimated $43 million in administrative costs incurred from fiscal years 1970 through 1978 to maintain a separate nationwide carrier to process RRB part B claims has not been prudent. Maintaining a separate carrier to pay RRB claims has not, in our opinion, proven to be the most efficient or most economical arrangement. Termination of this arrangement could result in an estimated savings of about $6.6 million in administrative costs in fiscal year 1979--$5.4 million resulting from economies of scale present in the area carriers' larger claims processing operations and $1.2 million from eliminating costs resulting from misrouted RRB claims. Savings of at least these amounts should be realized in future years.

Because of the limited charge data available to the RRB carrier from the relatively small RRB claims volume, RRB customary and prevailing charges established for 1979 vary about half the time from those established by the area carriers. Moreover, we found that the amounts allowed by Travelers as reasonable charges on actual RRB claims were different in most cases from the amounts allowed by the area carriers in the same geographical areas. Although these differences tend to offset one another in terms of total

benefit payments, this situation is inconsistent with Medicare regulations, which require that payments made by the RRB carrier should conform as closely as possible to the payments made for comparable services by the area carrier in the same locality.

RECOMMENDATION TO THE CONGRESS

We recommend that the Congress enact legislation to terminate the authority of the Railroad Retirement Board to select a nationwide RRB carrier and to turn over responsibility for processing and paying RRB beneficiary claims to the area carriers paying part B claims for all other Medicare beneficiaries.

TRAVELERS, RRB, AND HEW COMMENTS

Travelers and RRB both disagreed with our recommendation in separate letters dated May 15, 1979. The full text of their comments are in appendixes VIII and XI. We have incorporated the major concerns of Travelers and RRB in the text of this chapter. (See pp. 118, 124, and 128.)

We believe that maintaining a separate carrier to pay RRB claims has not proven to be the most efficient or the most economical arrangement for the Government. Furthermore, HEW agreed with the recommendation and said that administrative efficiencies can be realized by having the area carriers process RRB beneficiary claims. HEW also agreed that the change would permit more accurate and effective application of the prevailing charges in the localities.

CHAPTER 10

SAVINGS IN THE ADMINISTRATION OF MEDICARE-MEDICAID CROSSOVER CLAIMS

Administrative costs could be reduced if Medicare contractors processed Medicaid's liability for Medicare coinsurance and deductible expenses of individuals eligible for both programs by using integrated systems. Provider dissatisfaction with the States' Medicaid programs would also be lessened because timeliness of payments would be enhanced. An integrated system eliminates the double processing of claims, and thereby reduces costs and time delays when separate systems are used.

MEDICARE COST-SHARING PROVISIONS

Medicare beneficiaries are responsible for paying a portion of the cost for most covered hospital and medical services. Generally, the portion paid by beneficiaries represents coinsurance and deductible amounts.

Under part A of Medicare, hospital insurance benefits are structured around a benefit period or "spell of illness." A benefit period begins when a beneficiary is admitted to a hospital and ends when the beneficiary has been out of a hospital or skilled nursing facility for 60 consecutive days. A beneficiary can have as many benefit periods as needed.

Medicare provides coverage for inpatient hospital care up to 90 days in each benefit period. For the first 60 days during a benefit period, Medicare pays for virtually all covered services, 1/ except for a deductible which is generally related to the cost of a day of inpatient care and is charged to the beneficiary. 2/ Medicare pays for all covered services from the 61st to the 90th day of inpatient hospital care in a benefit period, except for a daily coinsurance amount paid by the beneficiary. The coinsurance equals one-fourth of the deductible amount. Since January 1968 Medicare has also covered an additional 60 reserve days of inpatient hospital care. These can be used as elected

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1/The beneficiary pays for the first three pints of blood furnished in a calendar year.

2/For calendar year 1979 the inpatient hospital care deductible is $160.

by the beneficiary, but they can be used only once. Daily coinsurance for the reserve days is one-half of the deductible amount.

Medicare provides coverage for post-hospital care in a skilled nursing facility up to 100 days in each benefit period. Medicare pays for all covered services for the first 20 days. For the next 80 days the patient must pay a daily coinsurance charge based on one-eighth of the inpatient deductible. For home health care, Medicare part A pays for up to 100 home visits in each benefit period, provided that such visits are used within a year from the beneficiary's most recent discharge from a hospital or skilled nursing facility. The beneficiary does not pay a coinsurance charge for home health visits.

Under part B the beneficiary is usually responsible for paying the first $60 for covered medical services in each calendar year (the deductible). Medicare pays 80 percent of the reasonable charges for covered services in excess of the $60 deductible in each year, and the beneficiary is responsible for the remaining 20 percent (coinsurance).

MEDICARE COINSURANCE AND DEDUCTIBLE EXPENSES COVERED BY STATE MEDICAID PROGRAMS

Under the Medicaid program, payments for services are set forth in individual State plans. States are required by the Social Security Act to reimburse inpatient hospital services on the basis of reasonable cost following the reimbursement practices of Medicare, unless they have approval from the Secretary of HEW to use an alternative method--States are not required to use the Medicare method of payment for all other services, but the State Medicaid reimbursement may not exceed the amount payable under Medicare.

State Medicaid programs supplement Medicare coverage for the nearly 4 million people eligible for both programs. All States have assumed some liability for the Medicare coinsurance and deductible expenses of these people. This shared liability for Medicare services provided to individuals with dual entitlement generates crossover claims (claims for which Medicare and Medicaid are jointly liable for the services rendered by a provider to a beneficiary). Medicare makes

the primary payment for the service; the State Medicaid expenditure is limited to the coinsurance and deductible amounts. Crossover claims can involve either Medicare part A bills or part B claims.

Although all State Medicaid programs have assumed some liability for Medicare coinsurance and deductible expenses, they differ in the coverage and payment of crossover claims. Some States

--reimburse deductible expenses only,

--reimburse expenses only if the beneficiary is categorically needy (cash welfare recipients),

--reimburse expenses according to their Medicaid upper reimbursement limits, or

--reimburse expenses according to Medicare's determination of reasonable charges or costs.

These differences exist because States are not required to reimburse providers for Medicare coinsurance and deductible amounts or to reimburse providers based on Medicare's reimbursement determinations.

Coverage under part A

Inpatient hospital care deductible expense represents nearly all (over 87 percent in 1977) of the cost-sharing amounts beneficiaries are responsible for paying under part A. State Medicaid programs were originally required to pay all part A deductible expenses for individuals eligible for both programs. The Congress intended

> "* * * that hospitalization be readily available to needy persons and that the necessity of their paying deductibles shall not be a hardship on them or a factor which may prevent their receiving the hospitalization they need."

This requirement was removed when the Social Security Amendments of 1967 were enacted. All State Medicaid programs, however, have continued to pay deductible expenses for individuals eligible for both programs.

Coinsurance expenses for inpatient hospital care and skilled nursing facility services accounted for the remaining 13 percent of part A cost-sharing expenses in 1977. Nearly all State Medicaid programs pay the coinsurance expenses of individuals with dual entitlement, although they are not required to do so; only four States do not pay all part A coinsurance expenses. Florida, South Dakota, and West Virginia do not pay inpatient hospital care coinsurance expenses. Mississippi does not pay any part A coinsurance expense.

Coverage under part B

Under current Medicaid legislation States may pay part or all of any part B coinsurance and deductible expenses, even if the service is not covered by the State's program for other Medicaid recipients. Most States have chosen to pay the full coinsurance and deductible expenses for all part B services. Thirteen States--Alabama, Alaska, Louisiana, Maryland, Mississippi, Missouri, Montana, New Mexico, New York, Rhode Island, South Dakota, Virginia, and Wyoming--have chosen to pay these expenses only if the service is covered by the State's Medicaid program. Chiropractic and podiatric services are examples of Medicare services not covered by some State programs.

Seven States may pay only part of the part B coinsurance and deductible expenses. Six of these States--Florida (for physician services only), Illinois, Nevada, Oregon, Pennsylvania, and Rhode Island--apply their Medicaid program's upper reimbursement limits to the total amount paid to providers by both programs. Because these limits cannot exceed Medicare's allowed charge, providers may receive full, partial, or no reimbursement for part B coinsurance and deductible expenses:

Provider's submitted charge	$115
Medicare allowed charge	$100
Medicare pays	80
Coinsurance	$ 20

If a State's upper limit was	Then the State would pay
$100	$20
85	5
80	-
75	-

Maine pays physicians 90 percent of the coinsurance and deductible expenses.

We estimated the additional costs if Florida had paid physicians the full coinsurance and deductible amounts in 1977. Total expenditures would have increased approximately $6.6 million (about 3 percent of total Medicaid payments in the State). The Federal Government's share of this amount would have been $3.8 million. We were unable to make similar estimates for the other States because information regarding the amount paid for coinsurance and deductible expenses was not available.

PRESENT METHODS USED BY STATES TO OBTAIN CROSSOVER CLAIM INFORMATION

Most States receive documentation of Medicare's payment determination before processing its Medicaid portion of a crossover claim. These States, or their fiscal agents, obtain this information from the provider or from the Medicare carrier or intermediary. Minnesota (for part A providers), Michigan, and New York require providers to file a separate claim to collect coinsurance and deductible amounts, but do not require documentation of Medicare's payment determination. There are increased possibilities of fraud in these States, since the State cannot verify what Medicare has paid on the claim.

The following table shows the number of States which have or have not established a data exchange agreement with the Medicare contractors.

	Part A	Part B
No data exchange	21	16
Data exchange	29	34

In less than half the States, providers must first file a claim with Medicare and then file a separate claim with the State to collect the Medicare coinsurance and deductible amounts. Generally, providers attach a copy of the explanation of Medicare benefits or remittance advice to support their claim. This method of obtaining crossover claims

--increases providers' costs because they must file two claims;

--delays Medicaid's payment to providers because providers cannot submit a claim until they have been reimbursed by Medicare, and States must process the claim again; and

--increases administrative costs to States with automated claims processing systems because the data must be entered manually.

Providers in most States usually do not have to file a second claim to be reimbursed for Medicare coinsurance and deductible amounts. These States, or their fiscal agents, receive crossover claim information directly from the Medicare contractors under a data exchange agreement. The Medicare contractors provide a hard copy or magnetic tape (a form of automated exchange) of the information. States pay the Medicare contractor from 15 to 33 cents for each crossover claim provided by hard copy and from nothing to 65 cents for each crossover claim provided by magnetic tape.

Providers in States that process crossover claims with magnetic tape should receive Medicaid's reimbursement faster than providers in States without data exchange agreements. Institutional providers in Oklahoma must file a separate claim with the State to collect coinsurance and deductible amounts. We selected a sample of part A crossover claims processed in August and September 1978. An estimated 39 days (including nonwork days) elapsed between Medicare's payment and the State's payment to providers. Oklahoma required 15 days to process and pay the claim. The remaining time, 24 days, represents the time taken by providers to submit their claim to the State.

States using an automated data exchange (e.g., magnetic tape) to input crossover claims can reduce their administrative costs. Pennsylvania is implementing an automated data exchange agreement with the part B carrier. A State official estimated that the State will reduce data entry costs by 25 cents a claim. Additional savings should be realized because fewer claims will be suspended for errors during processing.

NEED FOR AN INTEGRATED SYSTEM FOR PROCESSING AND PAYING CROSSOVER CLAIMS

Generally, independent Medicare and Medicaid processing systems are used to process and pay Medicare and Medicaid

liabilities for crossover claims, even in States which use an automated data exchange between the two programs. This approach creates duplicative effort (e.g., separate processing, checks, and payment information) and delays payments to providers. Integrating the processing and payment of crossover claims with the Medicare processing system can reduce administrative costs by eliminating the duplicative effort and can reduce the delays in paying providers. These additional costs and time delays occur even when an automated data exchange is used between the two programs.

Under an integrated system for processing and paying crossover claims, providers would submit only one claim to receive payment from both programs. The State would provide the Medicare contractor with the necessary Medicaid eligibility information. Generally, States provide their fiscal agent with weekly updates. Providers would show a beneficiary's Medicaid eligibility data on the claim form.

This method of identifying crossover claims is used in most States having a data exchange agreement with the Medicare contractor. The Medicare contractor would process the claim for Medicare and Medicaid liability in a concurrent operation. One check and a consolidated explanation of benefits would be issued for both programs. The Medicare contractor would maintain records for each Medicaid payment processed and would provide the State with periodic reports. HCFA could bill the State for administrative costs and coinsurance and deductible expenses or deduct these amounts from the State's Medicaid grant.

Medicare contractors in 16 States also process the Medicaid liability for crossover claims, but most have not developed an integrated processing and payment system--crossover claims are processed first for Medicare liability and are then transferred to a Medicaid system for processing. Unlike the case for part A providers, Oklahoma has developed a totally integrated system for physicians' services. Part B providers can submit a claim to the Oklahoma Department of Institutions, Social and Rehabilitative Services--the State Medicaid agency and Medicare part B carrier--and receive a single check and explanation of benefits for both programs. New Hampshire-Vermont Health Service--the Medicaid fiscal agent and Medicare parts A and B contractor in Vermont--processes Medicare and Medicaid liability for crossover claims in a concurrent operation but issues one check for each program. The checks are mailed together, so further integration would probably yield little savings.

An integrated system for crossover claims can reduce administrative costs. In California, one Medicare part B carrier, the California Physicians' Service, also served as the State's fiscal agent for noninstitutional claims. The carrier estimated that it saved the State $5.2 million in 1977 (93 cents a claim) by using a magnetic tape data exchange of crossover claim information instead of having providers submit a separate claim. Using data supplied by the carrier, we estimated that California could have saved an additional $448,000 in 1977 had the claims been processed by using an integrated system.

In Massachusetts, the Medicare part B carrier--Blue Shield of Massachusetts--processes the Medicaid liability for part B crossover claims. The carrier uses an automated data exchange between its Medicare and Medicaid operations. Using data supplied by the carrier, we estimated that the State could have saved $103,000 in fiscal year 1978 if the claims had been processed by using an integrated system. Savings would occur with postage, checks, forms, and by not generating a magnetic tape for the data exchange.

Montana's Medicaid fiscal agent processes part B crossover claims from hard claim copies received from the Medicare part B carrier. A State official said that nearly all of the money paid ($1.44 per claim) to the fiscal agent could be saved if an integrated system were used.

In 1976, when it proposed an integrated system for processing crossover claims in Vermont, the Medicare/Medicaid contractor estimated a savings of $30,000-$40,000 on a volume of 60,000 claims.

An integrated system can improve the timeliness of payments to providers because providers submit only one claim and because Medicare and Medicaid liabilities are processed concurrently. This approach could eliminate delays in a system where providers must wait for Medicare's determination, file a second claim with the State, and wait for the State's payment. Delays in an automated data exchange system could also be eliminated. These delays include the time required to transfer the magnetic tape between programs and to process and pay the claim. When the Medicare contractor is not the State's fiscal agent, crossover claim information is usually forwarded weekly.

We selected a random sample of part B crossover claims processed by Blue Shield of Massachusetts in August 1978 to

determine an average processing time. As stated previously, the contractor uses an automated data exchange between its Medicare and Medicaid operations. However, the data must be rearranged before entry into the Medicaid system.

We found that nearly 10 days elapsed between the time Medicaid received the crossover tape from Medicare and the date of entry into the Medicaid system. The claims were processed in only 3 days. The State took an additional 7 days to sign and mail the checks.

In contrast, in Texas the State's fiscal agent receives a magnetic tape of part A and part B crossover claim information daily from the Medicare contractor. The fiscal agent then processes and pays the coinsurance and deductible expenses in an average of 2.7 days.

CONCLUSIONS

Crossover claims should be processed by Medicare contractors by an integrated system. This approach would reduce administrative costs to the Federal Government and to the State Medicaid programs. Provider dissatisfaction with the States' Medicaid programs should be lessened because payment delays and paperwork would be reduced. An integrated system would also reduce fraud possibilities in those States which do not require documentation of Medicare's payment determination.

RECOMMENDATION TO THE CONGRESS

We recommend that the Congress amend Title XIX of the Social Security Act to require that the Medicaid liability for crossover claims be processed by the Medicare contractors by using integrated data processing systems unless the individual States can demonstrate to the Secretary of HEW that another arrangement is just as efficient and effective.

AGENCY AND OTHER COMMENTS

HEW concurred in the desirability of having a single processor of cross-over claims and stated that HCFA has plans underway to experiment with this approach.

The Blue Cross Association, in its comments on the report, also supports this recommendation. The recommendation received further endorsement from the 12 commercial carriers and intermediaries who are presently members of the Medicare Administration Committee of the Health Insurance Association of America.

CHAPTER 11

SCOPE OF REVIEW

Due to the broad issues mandated by section 12 of Public Law 95-142, the scope of this review was quite extensive. It consisted of several concurrent studies of various aspects of CHAMPUS', Medicaid's, and primarily Medicare's contracting activities.

Work was performed at the Medicare Bureau's central office in Baltimore, Maryland, and regional offices in Massachusetts, New York, California, Texas, and Pennsylvania. Work was also performed at the Blue Cross and Blue Shield Associations in Chicago, Illinois, and individual Blue Cross and/or Blue Shield plans in Dallas, Texas; San Francisco, California; Los Angeles, California; Oakland, California; Boston, Massachusetts; Baltimore, Maryland; New York, New York; and Albany, New York. The commercial insurance companies where work was done were the Travelers Insurance Company in Hartford, Connecticut; Occidental Life Insurance Company in Los Angeles, California; and Metropolitan Life Insurance Company and Group Health Incorporated in New York, New York. Several other contractors were visited or contacted throughout the country concerning various aspects of the studies.

To determine the effects on the Medicare program of fewer carriers and intermediaries, we reviewed the effects an increased workload would have on administrative costs at 11 Medicare contractors located in California, Texas, and New York. In each State a different approach was used: (a) California contractors estimated their costs assuming only a single contractor had responsibility for the State, (b) Texas contractors estimated their costs to approximately double their workload and the geographic area serviced, and (c) New York contractors estimated costs at several different volume increments. We also interviewed contractor officials and reviewed supporting data used in their cost estimates.

To assess the feasibility of combining parts A and B of Medicare under a single contractor we obtained information from the Medicaid program's experience in California where bills from institutional and noninstitutional providers are processed using an integrated system. We also simulated a relatively simple utilization review edit by using data from parts A and B.

The work included using computer-assisted techniques to identify and sample hospital bills and claims for physicians' inpatient hospital services. We reviewed supporting documentation at selected carriers, intermediaries, and hospitals in New York and Texas.

We reviewed certain aspects of the Health Care Financing Administration's experimental contracting program, including the competitively awarded contracts in Maine, Illinois, and New York; and the negotiated fixed-rate incentive experiment with Blue Shield of Maryland.

We also reviewed the CHAMPUS program's use of competitive procurement at the Office for the Civilian Health and Medical Program of the Uniformed Services in Denver, Colorado; the Office of the Assistant Secretary of Defense for Health Affairs in Washington, D.C.; and at three contractors' offices.

We reviewed applicable regulations, agency reports, correspondence, contracts, and other documents; compiled statistics; and interviewed responsible agency officials of both the Medicare and CHAMPUS programs. We also reviewed various Department of Defense and other Government documents and previous reports by us pertaining to incentive contracting.

We evaluated the role of the Travelers Insurance Company under its contract with the Railroad Retirement Board (RRB) as the nationwide carrier for part B claims from eligible railroad beneficiaries. We reviewed records, reports, and other data at Travelers home office in Hartford, Connecticut, and at the RRB in Chicago, Illinois. We also visited a Travelers regional claims processing center in Lansing, Illinois.

We contacted 14 carriers in 13 States to obtain estimates of incremental costs for processing RRB claims and data on the numbers and costs of misrouted RRB claims. We also contacted 21 carriers in 11 States to compare area carriers' and Travelers RRB reasonable-charge determinations, and 42 carriers in 42 States to compare actual claims payments made by Travelers to what area carriers would have paid. We also conducted questionnaire surveys of RRB beneficiaries and providers to obtain their views on the claims processing services provided by Travelers.

To evaluate the advantages of having Medicare contractors process and pay the Medicaid liability for crossover

claims using an integrated system, we interviewed representatives of each State Medicaid program to ascertain the existing systems used to process these claims and the extent of coverage provided by the States' Medicaid programs. We calculated and compared the processing time for crossover claims in Massachusetts (where an automated data exchange is used) and in Oklahoma (where institutional providers resubmit a separate claim to the State). We obtained estimates of additional cost savings if an integrated system instead of automated data exchange was used in California and Massachusetts.

In order to provide a historical perspective on contractor selection and performance and the use of data processing in Medicare, we reviewed the legislative history of the program and various Bureau documents pertaining to these issues.

APPENDIX I

A HISTORICAL PERSPECTIVE OF MEDICARE CONTRACTING--LEGISLATIVE BACKGROUND, CONTRACTOR SELECTION, PERFORMANCE EVALUATION, AND USE OF DATA PROCESSING

The Congress intended that a sufficient number of contractors would be involved in Medicare administration to permit comparative analysis of individual performance. Medicare law required intermediary and carrier performance to be consistent with effective and efficient administration. Even though the Medicare Bureau has revised and improved its program of contractor evaluation a number of times over the years, it was 1976 before the Bureau began to develop the necessary standards to effectively determine the acceptability of contractors' performance and to identify and support actions to eliminate poor performers.

Public Law 95-142, enacted on October 25, 1977, provided a stimulant to the Bureau's efforts by requiring the development of standards, criteria, and procedures for part A intermediaries to serve as a basis for determining what constitutes effective and efficient administration. The first intermediary evaluation period for using the new standards and criteria is expected to cover the period October 1, 1979, through September 30, 1980. Similar standards, criteria, and procedures are being developed for the part B carriers.

The early Medicare experience demonstrated that the contractors' largely manual claims review processes were not adaptable to the Medicare claims volumes. This lack of adequate processing systems contributed in part to the poor performance of some of the contractors at that time. This led to the development of automated systems, including the development of a model B system for carriers and two model A systems for intermediaries.

LEGISLATIVE BACKGROUND

According to history, the designers of social security left health insurance out of their 1935 legislation for fear that physician opposition would jeopardize the entire program. It was another 30 years before efforts were successful in putting it back in. The Medicare program was the result of there efforts, and its provisions reflected two major compromises believed necessary for enactment.

First, Medicare provided health insurance only to the elderly, reflecting the belief that the appeal of helping this segment of the population would overcome physician opposition to Federal health insurance. Second, Medicare law explicitly provided that the Federal insurance program would not interfere with the practice of medicine or the structure of the medical care industry. Further assurance of a hands-off policy was included, guaranteeing elderly persons the freedom to obtain health services of their choice as well as the option to obtain other forms of health insurance.

Controversy occurred long before the legislation was passed on the issue of who should administer Medicare. A panel of consultants, affiliated with the National Academy of Public Administration and under a broad contract with the Social Security Administration (SSA), 1/ commented on this controversy in its 1973 report. 2/ The private sector (providers, health insurers, and prepayment plan officials) vigorously opposed Government health insurance legislation. SSA had been strongly in favor of a Government-operated program that included direct payment to providers. By the early 1960s the rationale for using the private sector began to emerge as a significant issue.

The elements of the rationale as seen by the above panel of consultants were:

(1) The Government could not deal effectively with providers (especially physicians). The providers would not participate if they were required to deal directly with the Government.

(2) An inplace administrative system (health insurance companies and prepayment and group health plans) exists which can and should be used to implement a national program.

1/Before the establishment of the Health Care Financing Administration (HCFA) in March 1977, the program was administered by the Bureau of Health Insurance of the Social Security Administration.

2/"Final Report of the Medicare Project Panel," National Academy of Public Administration, Washington, D.C., June 30, 1973.

(3) The Government could not be flexible enough to deal with local conditions.

(4) To obtain the necessary political support to pass any legislation, the health insurance industry would have to play a role in the program.

The Congress intended that private organizations already engaged as third-party payers for health care services would administer the program. Implicit in this decision was the assumption that such private organizations would provide an effective approach to administration and obtain more cooperation from providers of care than would the Federal Government.

The Congress intended for the Secretary of Health, Education, and Welfare to have overall responsibility for program administration but that the Secretary would provide a considerable role for the participation of private organizations in the day-to-day administration. As a result, intermediaries (part A) and carriers (part B) perform the bulk of the day-to-day work of the program, which includes administrative responsibility for receiving and reviewing bills from providers and making payments. Intermediaries deal with institutional providers such as hospitals, skilled nursing facilities, and home health agencies for part A as well as hospital outpatient services and home health services under part B. Carriers deal with others (such as physicians) who furnish services under part B.

The committee reports accompanying the Medicare legislation indicated that these intermediaries and carriers were expected to perform for Medicare a variety of functions and operations which the Congress assumed were performed in their normal business. However, in many respects, particularly in the carriers' administration of part B, this did not prove to be the case. The early Medicare experience demonstrated that most carriers' largely manual claims review processes were not adaptable to the Medicare claims volumes and that carriers would need to develop or utilize EDP systems capabilities.

Private insurers, group health plans, and voluntary medical insurance plans were thought to have great experience in reimbursing providers of service. It was the intent of the committees that, in framing regulations, SSA would take full advantage of the experience of such private organizations in order that the rates of payment to hospitals may be fair to the institutions, to the hospital insurance trust fund contributors, and to other patients.

The Medicare law provided for the establishment of a Health Insurance Benefits Advisory Council (HIBAC) to advise the Secretary on general administrative policy matters and on the formulation of Medicare regulations. HIBAC consisted of 19 members, which included representatives from the general public, medical profession, hospitals, and health organizations. The group was instrumental in achieving a political consensus for Medicare acceptance and implementation. Because members were chosen as individuals and they were not officially responsible to the interest groups with which they were affiliated, they had the flexibility to reject or mediate special interest demands.

SELECTION OF INTERMEDIARIES

Intermediary selection for the hospital insurance plan (part A) is specified in the Social Security Act. Section 1816 of the act provides for a nomination process. Groups or associations of providers may nominate an agency or organization to serve as an intermediary between themselves and the Government or they may elect to deal directly with the Government. The law allows the Secretary to enter into an agreement with a nominated organization only if it would be consistent with effective and efficient administration. A member of an association may elect to receive payment from an intermediary other than the one nominated by its association or may elect to deal directly with the Government.

Nomination process

SSA believed a mechanism was needed to afford providers an opportunity to express their choice of intermediary. SSA developed procedures for nominating intermediaries and communicated them to providers in November 1965. The procedures provided that: (1) nominations must be by associations or groups, (2) nominations on behalf of hospitals and home health agencies (HHAs) were to be made before January 1, 1966, to permit sufficient lead time for intermediaries to be selected and to make necessary arrangements for the program to be operational by July 1, 1966, (3) nominations on behalf of skilled nursing facilities (SNFs) were to be made before July 1, 1966, because coverage of SNF services began January 1, 1967, (4) nomination letters were to fully identify the organization being nominated and include basic information about the size and composition of the group or association membership to facilitate evaluating the scope of the nomination, and (5) nominations would not be binding on all members of a group or association.

Selection criteria

For a nominated organization to be selected, SSA first determined that selection would be consistent with effective and efficient administration. SSA considered such factors as the nominated organization's size, experience, capability for paying bills, the number of providers, and the patient capacity of the groups making the nomination. Selection of intermediaries was restricted to organizations with a potential workload of over 10,000 bills. SSA's selection goal was to build a manageable network of providers tied to an efficient intermediary operation while preserving the rights and prerogatives of providers.

The Blue Cross Association (BCA) was approved to serve in all States except Hawaii and Nevada. Because nominations for commercial organizations were few and widely scattered, additional criteria were used in their selection. Where a commercial organization had a significant number of nominations in a State, this factor weighed heavily, as it reflected provider preference in the State. Also considered were the resources and capacities of the organization to assume the responsibilities for the program. Three factors were used as indications of an organization's capabilities to serve as an intermediary: (1) designation as a part B carrier in the particular State, (2) the location of its home office, and (3) the extent of the organization's own health insurance business in a particular State.

All intermediaries previously approved to serve hospitals and home health agencies were approved to serve skilled nursing facilities on the same geographic basis. One organization, the Hamilton Life Insurance Company, was not selected to serve hospitals and HHAs but received sufficient nominations for selection to serve as an intermediary for SNFs in New York State.

Configuration of intermediaries

Due to the nomination process there is a wide variation in the number of providers and States serviced by intermediaries. As of December 29, 1978, the part A program had 77 intermediaries, of which 68 were subcontractors under the BCA prime contract and 8 were commercial insurance companies. In addition, HCFA's Division of Direct Reimbursement services providers who elect to deal directly with the Government.

Blue Cross subcontractors service providers in 48 States, plus Puerto Rico and the District of Columbia. Aetna Life and Casualty services providers in 39 States; Mutual of Omaha Insurance Company services providers in 34 States and the District of Columbia. The other commercial intermediaries service providers in from one to four States each. (The map in app. V shows the States serviced by the intermediaries and the approximate number of providers they service. See p. 187.)

The following chart presents the number of providers by category for each intermediary as of December 29, 1978:

	Number of providers		
	Hospitals	SNFs	HHAs
Blue Cross Association	6,235	2,720	2,104
Aetna Life and Casualty	288	683	95
The Travelers Insurance Co.	58	493	1
Mutual of Omaha Insurance Co.	163	966	57
Kaiser Foundation Health Plan, Inc.	26	2	3
Hawaii Medical Services Association	28	27	7
The Prudential Insurance Co. of America	38	86	30
Nationwide Mutual Insurance Co.	8	117	34
Cooperativa de Seguros De Vida de Puerto Rico	17	1	5
Health Care Financing Administration	218	75	374
Total	7,079	5,170	2,710

As a result of the nomination process, BCA was selected as fiscal intermediary by the bulk of the hospitals and by substantial numbers of skilled nursing facilities and home health agencies seeking participaton in the program.

BCA prime contract

Initially the American Hospital Association, with the approval of its member hospitals, nominated BCA to serve as its intermediary. Because neither providers nor administrative agencies had prior experience in such a massive health program, it appeared to SSA that utilization of a prime contract with BCA would help obtain acceptance of the program. The Blue Cross plans around the country, under a subcontract

with BCA, perform the actual functions required of an intermediary. Originally, 75 Blue Cross plans serviced providers under a subcontract with BCA. By August 1978 the number of subcontracting Blue Cross plans had been reduced to 68. There have been a number of basic changes over the years in Medicare administration which have affected the role of BCA.

In a move toward decentralization, which started in 1970, the Medicare Bureau delegated authority and shifted responsibilities to the Medicare regional offices, thereby providing the framework for direct relations between the regions and the individual Blue Cross plans for budgeting and monitoring their performance. In view of this shift to decentralization, which was aimed primarily at achieving more effective program administration, BCA's level of activity has been reduced significantly over recent years. However, BCA continues to be the legally designated intermediary.

Under its prime contract, BCA is responsible for providing support and oversight of the subcontracting plan's activities. BCA also maintains a telecommunications system for communicating information on beneficiary eligibility, status of deductible, and utilization of days of care.

BCA's role is primarily a link between the Health Care Financing Administration (HCFA) and the Blue Cross plans that perform the intermediary functions.

SELECTION OF CARRIERS

The Secretary may contract directly with a carrier. However, the organization must be able to perform its obligations efficiently and effectively and meet requirements as to financial responsibility, legal authority, and certain other matters. It was the Congress' intent that a sufficient number of carriers would be selected on a regional or geographic basis to permit comparative analysis of individual performance. The Secretary's initial selection of Medicare carriers was made from what the Medicare Bureau considered to be the best qualified of the 141 organizations that submitted proposals stating their qualifications for and interest in providing carrier services.

Several organizations submitting proposals did not meet the minimum criteria contained in a pamphlet distributed to

potential carriers in November 1965. In considering the proposals received in each State the Bureau compared such factors as

--the extent of group insurance coverage for each of the potential carriers,

--the percent of the private health insurance market controlled by each potential carrier,

--the extent to which each potential carrier determined reasonable charges in its private business for individual physician services, and

--the size and flexibility of each organization.

A major consideration was the capacity of the organization to absorb the additional heavy workload for the Medicare program. When it appeared the added workload would be much greater than the organization's existing business and represented only a small portion of the national workload, the Bureau considered combining several States under one carrier. However, in some cases it appeared desirable to depart from this selection criteria where the insuring organization had unusual strengths. In assessing the organization's administrative capability, the Medicare Bureau considered such factors as computer capability, research and statistical capability, client relations, professional relations, general management competence, and operating efficiency.

Configuration of carriers

There is a wide variation in the geographic areas assigned to carriers in the part B program. (The map in app. IV depicts the geographic areas serviced by the individual carriers.) The 46 carriers currently administering the program include 32 Blue Shield plans, 13 commercial insurance companies, and 1 State agency. Several of the commercial companies are responsible for more than one geographic area. Aetna Life Insurance Company services Oregon, Nevada, Arizona, Alaska, Hawaii, Guam, and Samoa, and shares Oklahoma with the Department of Public Welfare. Four other companies service two to four States.

In most instances, however, a State constitutes the entire area assigned to a carrier. Nine States are divided

into two geographic areas, with one part of the State generally assigned to a Blue Shield plan and the other part to a commercial insurance company. New York State is serviced by five carriers (three Blue Shield plans, a commercial insurance company, and an independent health insurer).

HISTORY OF MEDICARE PROGRAM COSTS

The Medicare program has expanded considerably over the years. In terms of workload the part A bill volume has more than doubled since fiscal year 1968; the part B claims volume has more than tripled. Contractors' costs for parts A and B have more than tripled. But the real jump has been in the amount of benefits paid under the two parts. Part B benefit payments have more than quadrupled--from $1.3 billion to $5.4 billion since fiscal year 1968. Part A benefits were five times as great in 1978 as fiscal year 1968--an increase from $3.7 billion to $18.7 billion. The following table shows these changes by fiscal year from 1968 to 1978:

	Intermediaries			Carriers		
Fiscal year	Administrative costs	Bills processed	Benefits paid	Administrativ costs	Claims processed	Benefits paid
	(millions)					
1978	$199.1	36.6	$18,702	$342.9	119.8	$5,437
1977	189.7	33.5	16,126	322.6	108.1	4,635
TQ (note a)	42.6	7.6	3,480	75.3	23.9	985
1976	164.8	28.9	12,855	290.2	92.4	3,659
1975	151.8	25.7	10,712	258.7	80.6	3,071
1974	136.2	22.0	8,090	216.1	66.8	2,430
1973	121.2	18.7	6,822	188.5	58.0	2,084
1972	110.1	17.4	6,288	171.8	54.1	1,958
1971	99.9	16.4	5,587	159.9	48.8	1,775
1970	99.4	15.7	5,017	138.1	43.6	1,652
1969	75.8	15.4	4,638	118.4	38.8	1,510
1968	55.4	14.5	3,727	99.4	33.9	1,319

a/Transitional quarter.

EVOLUTION OF PERFORMANCE EVALUATION AND CONTRACTOR MONITORING

Much of SSA's early efforts in contract monitoring involved resolving problems and defining needed contractor capabilities. Although the Congress intended for SSA to make comparative evaluations of contractor performance, the necessary standards to do so had not been developed. The early evaluation attempts by central office review teams, while enabling the agency to learn the operations of carriers and intermediaries, resulted in general descriptions of contractor operations rather than indepth evaluative reports. Several years after the Medicare program began, responsibility for contractor evaluations was shifted to the regional offices and representatives located onsite at contractors' offices, which allowed for more indepth qualitative reviews.

Concern over variations in contractor performances and costs has been discussed in several reports and congressional hearings since the program's inception. The Bureau has been developing programs to evaluate and compare contractor performance for years. Despite these efforts and the identification of some carriers and intermediaries as being poor performers, HEW has taken little action to terminate or modify these contractors' participation in the program.

Efforts to evaluate contractor performance

The Medicare law authorizes the Secretary of HEW to terminate contracts with carriers and intermediaries if such contracts are inconsistent with efficient administration of the program. Under part B, the Congress intended that a sufficient number of carriers would be selected on a regional or geographic basis to permit a comparative analysis of individual performance.

Initially, SSA lacked the experience and benchmarks necessary for quantitative evaluation and comparisons of performance. As the program got underway, SSA began establishing the quantitative measures needed for a basic data base, but initially reported on only a few measures of contractor performance. SSA directed much of its early efforts to solving gearing-up problems and defining capabilities needed in contractor operations. In the early days, the

regional office role was to establish and define working relationships with contractors and to visit each contractor monthly to discuss and attempt to resolve problems. SSA used feedback from the regional office visits as input in preparing for contractor performance reviews.

The Medicare Bureau's central office was responsible for the Contractor Performance Review Program, which became operational in early 1967. Central office personnel expected to make onsite reviews of each contractor about every 2 years. An SSA staff paper defined the purposes of these reviews:

> "To obtain a detailed picture of the respective intermediary and carrier operations.
>
> "To help determine whether the contracting organization is performing its responsibilities efficiently and effectively and to assure that it is following the regulations and instructions issued by the Government.
>
> "To perform the review in such a manner as to facilitate comparative analyses of contracting third-party organizations.
>
> "To make recommendations for improvement in intermediary and carrier operations.
>
> "To obtain and communicate to various Government components specific information concerning the contracting organization's operation which could be helpful in implementing or recommending administrative and program improvements."

A four- or five-member team, including one regional office person, was usually assigned to the review. The review team devoted 3 to 5 days onsite at the intermediary or carrier to observe and analyze operating procedures, examine records, interview personnel at all levels, and make an indepth inquiry into a number of areas. These areas included organization; staffing; space and equipment; claims processing; and public, professional, and provider relationships.

The initial reports from these reviews were extensive, detailed, and highly descriptive. Later, the reports became exception type reports that discussed only deficiencies in a contractor's operations. Although the onsite review process

enabled the agency to gain valuable knowledge of carrier and intermediary operations, the resulting reports did not contain a comparison of the contractor's performance against either a standard of efficient and effective administration or another contractor's performance.

After the Bureau gained some experience in evaluating contractor operations, it attempted to establish basic requirements for common contractor functions. The Bureau issued instructions for part B carriers containing basic requirements in such areas as utilization safeguards, reasonable-charge development, and claims control requirements. The Bureau developed tests to validate how effectively carriers applied the instructions. The first such tests were designed to check overall claims processing performance.

Concurrent with developing basic requirements, the Bureau was formulating reports to evaluate performance. One of these contained measurements in seven areas: (1) weeks' work on hand, (2) percent of claims pending over 30 days, (3) payment record return rates, (4) percent of rejects to total query replies, (5) claims processed per staff year, (6) personal service costs per claim processed, and (7) other costs per claim processed. With this quarterly report, carrier performance was first compared to a common measure--national average performance.

Periodic status reports on intermediary performance prepared from program (part A) data described the progress and cost of auditing provider cost reports. Monthly workload reports prepared from program data displayed patterns of intermediary performance in the bill processing area. Additional agency efforts included the initiation of a study to develop a better way of evaluating contractors.

A few years after the Medicare program began, the Bureau expanded regional office staffing to play a larger part in evaluating contractors and administering Medicare. As part of this change, the Bureau established the position of resident representative.

In 1970 the Bureau placed a representative onsite at the majority of intermediaries' and carriers' offices. The site representative's role was to gain better and more timely insight into the quality of contractor operations and to provide assistance to Medicare contractors in identifying and resolving program problems. Because of their day-to-day monitoring and oversight of individual contractor operations,

the resident representatives were able to provide a more complete picture of a contractor's operations. Their reports, when combined with existing quantitative information, allowed for a more indepth qualitative review than was previously possible.

The Contractor Performance Review Program was replaced in 1972 by the Contractor Inspection and Evaluation Program (CIEP), which was conducted on a regional level. The product of the CIEP program is the Annual Contractor Evaluation Report (ACER). ACER reports on contractor strengths as well as weaknesses. The areas evaluated in ACERs include bill/claims processing, provider/program reimbursement, utilization review, beneficiary services, administrative management, and fiscal management. Performance in each area is rated as "satisfactory," "adequate,but needs improvement," or "unsatisfactory." The basic evaluations addressed were to assure that contractors complied with general program requirements and to measure their quantifiable performance against the national average.

A concept of inhouse quality control for part B carriers developed shortly after the shift to decentralization of responsibility to regional offices. The Bureau issued instructions to carriers for formulating and implementing comprehensive programs of self evaluations. The purpose of the quality control programs was to check on the accuracy, quality, and effectiveness of carriers' Medicare operations. The instructions described the aspects of claims processing to be covered and outlined the information to be maintained.

The results, however, varied among contractors because (1) sampling techniques were not standardized, (2) claims processing difficulty varied, (3) dollar amounts of submitted charges were not accounted for, and (4) uniform review and data recording procedures were not employed. As a result, the quality control programs were of limited use for comparing carrier performance.

A staff paper prepared by the Bureau in 1973 described a proposed part B carrier evaluation system. It explained that, since November 1971, special work groups comprised of contractor and agency representatives had met to explore ways in which evaluation methods previously used by the Bureau could be improved and to develop new methods. Efforts were on the development of a system for part B, although the paper said that "planning with respect to an improved system for evaluation for part A intermediaries is also going forward."

A major Bureau concern was that the evaluations be equitable. A number of variables influence the performance of different contractors unequally. For example, the size of geographic area or the population serviced, the prevailing salary differentials, and differences in difficulty or mix of claims or bills processed may vary among contractors. The proposed system was to account for significant variables which are outside contractors' control.

The proposed part B carrier evaluation system included three elements (cost, timeliness, and quality) for determining a carrier's performance. The Bureau planned to use regression analysis to identify and eliminate the effect of noncontrollable variables on performance scores.

In part B, unit cost per processed claim is the standard unit for measuring the cost of contractor operations. The staff paper stated that factors had been developed "to adjust observed performance to discount the impact of the noncontrollable environmental and workload variables on performance scores," and that the Bureau planned to incorporate these adjustments in a 1973 cost report. It was pointed out that further regression analyses were being made to determine appropriate adjustment factors for part A costs. Although this plan was proposed in 1973, as of March 1979 the administrative cost reports for carriers and intermediaries contain no such adjustments.

A new reporting system was developed to identify the claims processing time because the Bureau did not consider previous indicators sufficient for measuring timeliness. The new reporting system provided for the number and percentages of claims processed in specific time categories--15 days, 30 days, 60 days, and 90 days. Similar data are reported for the number of claims pending.

In the area of quality, an end-of-line (post-payment) sample claims review system was developed. The end-of-line sample claims review became operational in July 1976 and is intended to provide uniform performance data to permit comprehensive and accurate comparisons of carrier quality in processing claims. The previous measures used to indicate the quality of processed claims were believed to be only partial indicators at best. The Medicare Bureau considers the new system to be a major improvement in carrier performance evaluations. Under the new system, quality is measured by determining the monetary amount of carrier overallowances, underallowances, and the incidence of specific types of processing errors.

Past use of terminations, nonrenewals, and reductions in service areas

Since the inception of Medicare the Medicare Bureau has taken little action to terminate or nonrenew agreements with carriers and intermediaries. Agreements for three intermediaries were not renewed due to inadequate performance. Two carrier agreements were terminated due to inadequate conformance to program requirements. The service areas of three carriers and one intermediary were reduced to obtain a better balance of workloads and to provide improved services to the public. Agreements for two carriers and four intermediaries were terminated by mutual agreement. HCFA officials identified the following carriers and intermediaries who left the program and indicated the reasons for separation:

Intermediary Agreements Terminated

Hamilton Life Insurance Company of New York--Agreement terminated by mutual consent (5-31-68).

Community Health Association (Highland Park, Michigan)--Agreement terminated by mutual consent (6-30-69).

New York State Department of Health--Agreement terminated by mutual consent (10-31-69).

Cooperativa de Salud de Puerto Rico--Agreement terminated by mutual consent (12-31-69). The contractor was replaced by Cooperativa de Seguros de Vida de Puerto Rico.

Intermediary Agreements Not Renewed

Blue Cross of Puerto Rico--Agreement not renewed due to inadequate conformance to program requirements (6-30-72). The contractor was replaced by Florida Blue Cross.

Group Hospital Service (Tulsa, Oklahoma)--Agreement not renewed beyond 6-30-73. Returned to program on 7-1-75.

Inter-County Hospitalization Plan, Inc.--Agreement not renewed due to inadequate performance in the audit/reimbursement area (6-30-75).

Illinois Hospital and Health Services Inc. (Rockford)--Agreement not renewed beyond 4-30-77 due to performance deficiencies.

Reductions In Service Areas of Intermediaries

The Travelers Insurance Company--Of the 21 States in which Travelers served as intermediary, it has withdrawn from 18 States located in five regions effective 10-1-78. In so doing, it transferred jurisdiction of 480 providers (40 percent of its workload) and will only continue to serve hospitals and SNFs. The purpose of the change was to achieve greater economies and efficiencies through a more concentrated workload environment.

Carrier Agreements Terminated

Nebraska State Department of Public Welfare--Agreement terminated by mutual consent (5-5-67). The contractor was replaced by Mutual of Omaha.

Pilot Life Insurance Company--Agreement terminated by mutual consent (6-30-69). The contractor was replaced by the Prudential Insurance Company of America.

John Hancock Mutual Life Insurance Company--Agreement terminated due to inadequate conformance to program requirements (4-5-70). The contractor was replaced by The Prudential Insurance Company of America.

Medical Mutual of Cleveland, Inc.--Agreement terminated due to inadequate conformance to program requirements (6-30-71). The contractor was replaced by Nationwide Mutual Insurance Company.

Carrier Agreements Not Renewed

Union Mutual Life Insurance Company--Agreement for State of Maine not renewed beyond 9-30-77. The contractor withdrew voluntarily and was replaced by Blue Shield of Massachusetts.

Reductions In Service Areas Of Carriers

California Physicians' Service--Jurisdiction for seven counties was transferred to Occidental Life Insurance Co. (12-31-69). The purpose for the change was to bring about a greater balance of workloads between the two Medicare carriers in California and to provide improved service to beneficiaries, physicians, and other health care suppliers.

Illinois Medical Service--Jurisdiction for four counties was transferred to The Continental Casualty Company (6-30-71). The purpose for the change was to bring about a greater balance of workloads between the two Medicare carriers in Illinois and to provide improved services to the public.

Blue Shield of Florida, Inc.--Jurisdiction for two counties was transferred to Group Health, Inc. (6-30-75). The purpose for the change was to ameliorate the effects of a substantial increase in workload and program administration problems.

The law provides that the Secretary may terminate an agreement with a fiscal intermediary if, after reasonable notice and opportunity for hearing, he finds that (1) the agency or organization has failed substantially to carry out the agreement or (2) the continuation of some or all of the functions provided for in the agreement is disadvantageous or is inconsistent with the efficient administration of part A. Likewise, a carrier's contract can be terminated if the carrier failed to substantially carry out the contract or did so in a manner inconsistent with the efficient administration of part B.

In February 1970 the staff of the Senate Committee on Finance reported on problems in the administration of Medicare. 1/ The report concluded that:

> "* * * the Congressional intent has not been carried out in at least two respects. First, there has been no active policy of complete and indepth comparison of carrier performance followed by decisions to weed out the poorer carriers in favor of those who are efficient and economical. As indicated, variations in performance are so great as to make at least some terminations easily justified. Second, the performance of some carriers has been so poor that there is little question that their performance was 'inconsistent with the efficient and effective administration' of the supplementary medical insurance program."

* * * * *

1/"Medicare and Medicaid-Problems, Issues and Alternatives," report of the Senate Committee on Finance Staff, Feb. 9, 1970.

"What appears needed are fewer carriers and a benefits and administrative structure lending itself to genuine competition for the job of medicare agent."

Problems with contractors' performances and costs have been addressed in several studies over the years. The Subcommittee on Intergovernmental Relations, House Committee on Government Operations, held several hearings over a 3-year period (1970-1972) on the administrative organization and operation of the Medicare program and on the use of data processing. Additionally, staff of the Subcommittee studied the performance of Medicare contractors and subcontractors for several years with particular emphasis on poor performers.

The Advisory Committee on Medicare Administration, Contracting, and Subcontracting was formed in February 1973 to advise the HEW Secretary and the SSA Commissioner on broad organizational and operational matters, contract formulation, and reimbursement principles applicable to Medicare contracts and subcontracts. The Committee became known as the Perkins Committee, named for the Committee chairman. The Committee's report in June 1974 to the Secretary and Commissioner identified many of the same concerns that the staff of the Senate Finance Committee and the House Subcommittee on Intergovernmental Relations identified.

The Medicare Bureau has been developing programs to identify poor performers for both parts A and B for a long time. Although the Bureau has had difficulty over the years with evaluating and comparing contractor performance, it has identified some carriers and intermediaries as being poor performers. Despite this identification, HEW has taken little action to terminate or modify these contractors' participation in the program.

For example, in a 1976 report the Bureau identified the 15 poorest performing carriers for the previous 3 fiscal years. Six of the 15 carriers were cited as being "either chronic poor performers or becoming progressively worse without mitigating circumstances." Despite this identification all 15 carriers are still in the program. One carrier had a portion of its territory taken away and another will lose its territory as a result of the experimental consolidation in upstate New York.

Control Analysis Corporation reported methodology for comparison of Medicare contractor performance

The Perkins Committee considered SSA's system for evaluating carrier performance in Medicare to be inadequate and recommended (1) placing the highest priority on developing more refined criteria and (2) contracting with an independent organization to accelerate the development of the performance criteria. In September 1976 SSA contracted with the Control Analysis Corporation (CAC) to study Medicare contractor performance measures and standards. CAC's task was to determine the extent that factors outside the control of the contractors affect their cost and performance, to adjust for such factors, and to develop a meaningful method of making comparisons among contractors.

CAC limited its examination to measures of contractor performance in three areas--administrative cost, timeliness of claims payment, and accuracy of claims payment. This limitation fails to recognize crucial aspects of operational quality in certain areas (e.g., utilization safeguards, provider and beneficiary relations, etc). Specific measures for these areas have not been developed.

CAC's basic task was to explain differences in contractor cost and performance in terms of factors such as claims mix and claims volume, which vary from contractor to contractor and are outside the contractor's control. CAC surveyed existing methodologies and attitudes concerning performance measures. The survey involved interviewing both agency and contractor personnel as well as reading published reports and analyses. CAC also sent a questionnaire to each contractor and each regional office to further solicit opinions on appropriate performance measures and noncontrollable factors. The raw data used in their analysis were based on data compiled for the period July 1975 through June 1976.

CAC completed its final evaluation of Medicare contractor performance in April 1977. CAC cautioned that, while its report demonstrated the general feasibility of a methodology for making comparisons of performance among contractors, additional refinement in modeling and in data collection is desirable for implementation. CAC emphasized the need for continual monitoring to identify the need to change factors as the program or operating environments change.

Status of the development of performance evaluation

One of the provisions of Public Law 95-142 required the Secretary to publish in regulation by October 1, 1978, standards, criteria, and procedures for evaluating part A intermediary performance. The Medicare Bureau also has plans to establish such standards, criteria, and procedures for evaluating part B carrier performance. As previously discussed on page 161, the Bureau had proposed such plans in 1973, including addressing the problem of properly evaluating uncontrollable factors which affect individual contractors and which affect statistical compilations and analyses.

In March 1978 the Medicare Bureau circulated to all regional Medicare directors a paper outlining a general methodology for evaluating contractor performance and determining acceptable levels of performance under the Medicare program. The general methodology could apply to either intermediaries or carriers. The proposal outlined the elements of a system for determining (1) acceptable levels of contractor performance (standards) in terms of specifically defined program and functional requirements and (2) the operational performance elements of speed, cost, and accuracy of claims and cost report settlement processing.

The proposed methodology is a two-step process. The first step involves an assessment of specifically defined program and/or functional requirements for contractors. If a contractor fails these, his overall performance would be unacceptable. Contractors meeting these program standards would then be assessed for speed, cost, and quality of claims and cost report processing. Contractors would be made aware of their current level of performance and would be able to take remedial actions. Unacceptable performance could be grounds for adverse action--such as reassigning providers or territories, offering a short-term agreement, or termination.

As of March 1, 1979, the Medicare Bureau had developed a draft of newly developed statistical standards for evaluating part A intermediary performance. Once they are approved by the Secretary, they will be published in the regulations. There are 16 standards, which consist of measures of timeliness, cost, and quality of the intermediary's or perspective intermediary's performance.

These standards, together with specific performance criteria, are to be applied whenever the Secretary enters into, renews, or terminates an agreement with an organization to serve as an intermediary; or whenever the Secretary assigns or reassigns a provider or providers, or designates an intermediary to serve a class of providers. The standards are to be used to evaluate intermediary performance in three major areas--unit cost of processing, timeliness of processing, and timeliness in settling provider cost reports. Intermediaries' performance will be monitored by regional office staff on a continuous basis, but the intermediaries will be evaluated annually to determine if they meet the specific standards and criteria. The first evaluation period is expected to cover the period October 1, 1979, through September 30, 1980.

EVOLUTION OF DATA PROCESSING SYSTEMS IN MEDICARE

The early Medicare experience demonstrated that the largely manual claims processing systems used by most contractors in their own business were inadequate for handling the increasing claims volume in the Medicare program. Lack of adequate processing systems contributed in part to the poor performance of some of the contractors at that time. This led to the development of automated systems, including development of a model B system for carriers and two model A systems for intermediaries.

Mostly manual inhouse systems at beginning of the program were inadequate for increasing claims volume

It was anticipated that intermediaries and carriers would be able to do the day-to-day operational work of the Medicare program as they were accustomed to doing in their normal business. As the Medicare program got underway and the number of bills and claims increased, problems were encountered by both intermediaries and carriers in adjusting their processing systems to the volume generated by Medicare. The huge volume of individual claims made the problem more acute under part B than part A.

The need for more automated processing systems for part A was considerably less urgent than for part B because of the lower bill volume and because intermediaries' existing systems, whether manual or automated, could more readily

be adapted to Medicare needs. Even so, work was initiated in 1969 on two part A model systems for automated data processing of bills, one designed for use by the Blue Cross plans and the other for use by the commercials. With one exception, all intermediaries are either using one of the part A model systems or using inhouse systems.

In contrast to the readily adaptable systems of most intermediaries, the largely manual claims review processes used by most carriers were not adaptable to the part B Medicare claims volume, the complex Medicare determinations, and the strict accounting required for a Government program. It was evident that carriers needed more sophisticated processing capabilities to handle this increased volume and to reduce the serious backlogs that were occurring. Some of the carriers were able to upgrade their existing capabilities or to develop new electronic data processing (EDP) systems. Some carriers concluded that outside firms could perform the EDP function more effectively and elected to subcontract for EDP operations.

One of the first EDP subcontractors to enter the Medicare market was Electronic Data Systems, Inc. (EDS). Because EDS had been used for systems modification and expansion related to its non-Medicare business, Texas Blue Shield turned to EDS for help on its Medicare data processing. EDS began with a limited computer process in 1966, and by 1969, through its wholly-owned subsidiary, Electronic Data Systems Federal (EDSF), offered systems design and processing for all phases of a carrier's business, rather than for just Medicare. This capability had particular appeal to many Blue Shield plans that were finding it increasingly difficult to meet the demands of Medicare's volume and complex claims processing. In addition, EDS was the only subcontractor to offer a systems facilities management subcontract for a carrier's total business needs. This service relieved the carrier, not only of the responsibility for systems development but also of the actual operation of the EDP process with which some had had considerable difficulty.

In 1967 and 1968 Applied Systems Development Corporation (ASDC) developed and installed a claims processing system under subcontract to Rhode Island Blue Cross and Blue Shield. The ASDC system covered both parts A and B of Medicare as well as the carrier's regular business. During the early years of Medicare, ASDC installed similar systems for three other carriers. All of the ASDC installations, however, were operated by the carriers on an inhouse basis.

In 1966 and 1967, McDonnell Douglas Automation, Inc. (McAuto) performed EDP Medicare claims processing services for Colorado Medical Service. By 1973 McAuto had also developed an online Medicare system 1/ to be used by carriers on an inhouse basis. In addition to McAuto and EDSF, four other EDP firms (University Computing Co., Data Inc., Systems Resources Inc., and Computer Systems Inc.) had subcontracts with Medicare carriers by 1973.

Development of Model B System

In addition to the above EDP systems available to carriers, the Medicare Bureau sponsored development of the Model B System, which was designed and put into operation by 1969. The Bureau believed that, if the best features of all systems used by carriers could be combined in a model system and made available to all carriers, duplication of effort could be avoided and systems development and maintenance costs could be reduced. The development of the Model B System was initiated in response to a request for assistance from Pilot Life Insurance Company. After a review at Pilot Life and five other carriers, the Bureau agreed to provide a systems team to assist with the design and installation of the system. Pilot Life also engaged McAuto for contractor assistance. The system was designed and ready to install on June 30, 1969. The new system was operational only briefly at Pilot Life before Prudential Life Insurance Company replaced Pilot Life as the carrier in North Carolina.

Subsequently, the new system was installed with a number of other carriers (20 as of September 1978). McAuto continued to operate as the systems maintenance contractor under a contract with the Bureau for several years. In 1971 the Bureau decided to develop an online version of the Model B as a cooperative effort with Group Health, Incorporated without private contractor assistance. The online Model B System was first installed at Alabama Blue Shield in 1972. By 1973 the Bureau had built up a branch of about 70 people for the maintenance, enhancement, training, programming, and carrier assistance of the Model B System. Consequently, no outside support for the Model B System was necessary.

1/Provides direct access to the computer.

Competition for data processing subcontracts

The staff of the House Subcommittee on Intergovernmental Relations studied the awarding of data processing subcontracts in Medicare for several years. The staff's efforts centered primarily on the degree of competition among EDP subcontractors and the circumstances surrounding the approval of certain systems. These issues were also addressed by the Perkins Committee.

At the time of the Perkins Committee report (June 21, 1974), there were 47 carriers having agreements with the Secretary to process part B Medicare claims in assigned geographic areas. Of the 47, 16 employed EDP subcontractors, and the remaining 31 operated their EDP systems inhouse. The number of carriers employing EDP subcontractors had increased from 7 carriers in 1970 to a peak of 18 in 1973 before dropping down to 16 in 1974. During calendar year 1973, EDP subcontractors processed about 48 percent of all part B claims. The following chart shows the share of Medicare part B claims workload processed by EDP subcontractors for fiscal years 1973 and 1978.

Name of subcontractor	Number of subcontracts with contractor		Percent of carrier claims (part B) processed by subcontractor		Percent of subcontracted workload processed by subcontractor	
	FY 1973	FY 1978	FY 1973	FY 1978	FY 1973	FY 1978
Electronic Data Systems Federal	12	9	41.3	26.1	86.0	82.2
McDonnell-Douglas	3	-	4.0	-	8.3	-
Data, Inc.	1	1	0.2	0.2	0.5	0.6
Systems Resources, Inc.	1	1	0.8	0.3	1.7	1.0
University Computing	1	-	1.7	-	3.6	-
Optimum Systems, Inc.	-	2	-	2.7	-	8.5
Management Data Communications, Corp.	-	3	-	2.5	-	7.7
Total	18	16	48.0	31.8	100.0	100.0

A carrier which does not wish to operate an inhouse EDP system has few alternatives since there are few competing subcontractors. The following chart presents the number of carriers using each of the major EDP systems in operation for fiscal years 1974 and 1978.

System	Number of carriers using systems FY 1974	FY 1978
SSA Model B System	14	20
EDSF System	11	13
ASDC System	3	3
Independently developed	22	11
Total	50	47

In February 1978 the Secretary of Health, Education, and Welfare requested HEW's Office of General Counsel to study the competition for Medicare data processing contracts. The Office of General Counsel's April 1978 response contained the following conclusions:

> "Although there is no present danger of monopoly in the data processing field, the Department has taken and should continue to take steps to avoid such a danger.
>
> "To the extent a problem exists, it is primarily one of overseeing individual procurements rather than intervening in the market for data processing services.
>
> "* * * the Medicare Bureau has regularized procedures designed to ensure effective competition for data processing contracts in the Medicare program.
>
> "The federal government * * * has the strongest interest in assuring continuing fair and open competition for data processing contracts. The interest of Medicare carriers and the States is limited generally to individual procurements."

The study noted that it is unlikely that any changes in the status quo will occur in the short run due to a recent change in Medicare policy. Medicare intermediaries and carriers were notified in September 1977 that

"* * * requests for alterations in their claims processing systems for new software, upgrading of existing software, or change to a facilities management subcontract would be denied unless the change is cost effective and the nonrecurring implementation costs can be recovered in administrative cost reductions within a one year period. Since few, if any contractors will be able to meet this requirement, the policy effectively freezes the current situation."

Termination of Government role in the maintenance and enhancement of Model B System

The Perkins Committee made two recommendations in its report dealing with the Federal Government's role in the maintenance and enhancement of the Model B System. The Perkins Committee recommended that the Medicare Bureau withdraw from the maintenance responsibility for the Model B System. According to the Committee the Bureau should announce a policy to end Government maintenance support in two stages: (1) transfer of operational responsibility for interim maintenance to a private contractor and (2) ultimate termination of the maintenance contract when there is assurance of adequate competition. As an interim measure the Perkins Committee recommended that the decisionmaking process on the award of EDP subcontracts be separated from the Bureau for as long as it continues to maintain and enhance the Model B System.

In response to the Committee's recommendations, the Medicare Bureau offered three options to those carriers who were relying on Bureau maintenance: (1) perform systems maintenance on an inhouse basis using their own staff, (2) subcontract for systems maintenance via competitive procurement, or (3) continue to rely on the Medicare Bureau for maintenance support.

The Medicare Bureau concluded that the marketplace has improved since the Perkins Committee report in June 1974. Although McAuto withdrew from competition, another contractor, Optimum Systems Incorporated (OSI), entered the market. OSI has its own proprietary data processing system and has been awarded a facilities management contract from Connecticut General. In addition, OSI replaced the incumbent EDSF in Arkansas through a competitive process. Even with the withdrawal of McAuto from the competition for Medicare business,

the Bureau's assessment is that the facilities management marketplace is more competitive now than it was in June 1974, and there is at present an assurance of adequate competition for the carriers' data processing workloads.

The Bureau conducted a study in 1977 to determine if it was more expensive for the carriers to perform the maintenance of the Model B System than it was for the part B branch. The study's recommendation was to withdraw from maintenance of the Model B System. To ease the transition of this responsibility to the carriers and to assure effective program administration, it was further recommended that the phasedown be over a period of 18 months or shorter, based on carrier performance. HCFA announced total withdrawal from maintenance of the Model B System effective June 1979.

Possible regional or national data processing centers

The Perkins Committee recommended that the Government contract for an independent feasibility study to determine the costs and benefits of developing regional or national EDP centers. Although the Committee received no evidence that would substantiate or refute the proposition that savings would result from regional centers, they believed that this possible future course of action should be fully investigated. However, as the Committee noted, the EDSF approach is basically a regional system and, to a lesser degree, so are McAuto, Aetna, Travelers, and Prudential data processing operations. Thus, some organizations appear to have found merit in a regional approach.

The Medicare Bureau awarded a contract in June 1976 to Systems Architects, Inc., (SAI) to conduct such a feasibility study. SAI completed its study on October 31, 1977. The study was to survey current claims processing systems and ascertain the feasibility and cost effectiveness of consolidating workload by utilizing regional centers for Medicare processing.

SAI concluded in its report that "Regional Processing Centers are not feasible and not recommended at this time." Its conclusion was based on the Bureau's "lack of long-range EDP policies, EDP planning standards, management control of EDP resources, and EDP performance standards." However,

the report says that "from an EDP state-of-art viewpoint Regional Processing is feasible and viable." SAI even states that "regionalization is a desirable goal if the Government wishes to gain better control of systems development, planning, and performance evaluation." Although SAI presented a proposed methodology and constraints that should be considered in making a final decision to go to regional processing, according to Bureau officials the study did not pursue the depth necessary for making such a decision.

APPENDIX II

A CAPSULE LOOK AT MEDICARE'S COMPETITIVE FIXED-PRICE EXPERIMENTS

The Medicare program has three ongoing experiments in part B that are testing competitive fixed-price procurement--in Maine, Illinois, and upstate New York. Claims processing under the experiment in Maine began December 1, 1977. The other experiments are in transition from the previous contractors to the new contractors.

THE MAINE EXPERIMENT

The initial experiment arose when Union Mutual Life Insurance Company decided to terminate its contract as the Medicare part B carrier for Maine. Union Mutual's decision was based on its desire to concentrate its resources in its private lines of business. Union Mutual was unhappy with its administrative costs compared to other part B carriers, and felt that without incentives the Medicare program offered little potential for making money. Maine provided an excellent opportunity for an experiment because Union Mutual withdrew voluntarily and had one of the smallest carrier workloads, with 542,495 claims processed in fiscal year 1977.

The request for proposal (RFP) for the experimental contract was issued on March 18, 1977. Bidders were requested to submit a total firm fixed price for all carrier services for a 39-month period, consisting of a 5-month transition period beginning July 1, 1977, and 34 months of claims processing beginning December 1, 1977.

The RFP stated that there would be renegotiation of the fixed price only if legislative changes or other action substantially changed the scope of work. While the Medicare Bureau recognized that this could result in contractors including contingency factors in bids, resulting in higher prices, they believed it was preferable to have contractors absorb the cost of minor administrative or procedural changes.

The RFP provided that the bidder was responsible for estimating claims volume during the contract period and that there would not be any price adjustment for volume. The Medicare Bureau was concerned that the claims count is susceptible to manipulation by the contractor by inducing more frequent claim filings from physicians or beneficiaries.

Contractor selection

The Medicare Bureau developed a detailed plan for contractor selection in which each proposal was evaluated on the basis of company experience, the quality of the technical proposal, and price. Weights were assigned to these factors: company experience--30 percent, technical proposal--30 percent, and price--40 percent. Five organizations submitted proposals. They were Aetna Life Insurance Company, Prudential Insurance Company, Blue Shield of Massachusetts (BSM), Maine Blue Cross and Blue Shield (Maine BC/BS), and New Hampshire-Vermont Blue Cross and Blue Shield (NH-VT BC/BS). Although New Hampshire-Vermont Blue Cross and Blue Shield was the low bidder by a substantial margin, Blue Shield of Massachusetts placed first overall in the scoring:

Bidder	Total (note a)	Point difference from winning bidder
BSM	863.21	-
NH-VT BC/BS	848.81	14.40
Prudential	815.83	47.38
Maine BC/BS	782.90	80.31
Aetna	645.03	218.18

a/Total points available--1,000.

The winning margin for Blue Shield of Massachusetts was gained by the experience factor.

Price proposal

When the bids were received in May 1977, the Medicare Bureau evaluated them in terms of national average unit costs and Union Mutual's unit cost experience, and found them to be very favorable. Union Mutual's unit costs for fiscal years 1976 and 1975 had been $3.74 and $3.58, respectively, while national average unit costs had been $3.19 and $3.11 for the same period. The following table shows the Medicare Bureau's estimate of unit price per bid for the Maine contract, based on a Bureau projection of the claims volume for the entire contract period.

Bidder	Total price	Estimated unit price for contract
NH-VT BC/BS	$4,737,498	$2.59
BSM	5,285,000	2.88
Prudential	5,450,000	2.98
Maine BC/BS	5,660,700	3.09
Aetna	8,496,100	4.46

To compare total prices, the Bureau used an estimated total price of $5,626,400, based on estimated claims volume multiplied by the national average unit cost of $3.00 per claim. This estimate shows a savings from the competitive bidding:

Bidder	Total price	Estimated savings
Prudential	$5,450,000	$176,400
BSM	5,285,000	341,400
NH-VT BC/BS	4,737,498	888,902

As stated above, this analysis is based on the Bureau's volume projection. Contractors are responsible for estimating claims volume; however, they are not required to include their projection in the proposals. Any variance between Bureau and contractor volume projections would cause price comparisons to be inaccurate. For example, if a contractor estimated that claims volume was greater than the Bureau projection, then what is shown as estimated unit price would be overstated.

Conversion costs

In addition to the firm fixed price to be paid to BSM, the Government incurred additional costs in the replacement of Union Mutual. Approximately $17,000 was spent for a notice sent to 140,000 Medicare beneficiaries in Maine informing them of the change. This covered the cost of printing and mailing. Present plans call for a similar notice to be sent to beneficiaries in Illinois and New York.

Union Mutual has billed the Medicare Bureau for approximately $175,000 in termination costs. Approximately $25,000 of this amount has been paid for services related to completing carrier duties after BSM took over. The remaining $150,000 constitutes billing by Union Mutual for payments made to employees under an economic security plan where employees were guaranteed full salary for up to 2 years if their jobs were lost due to a department closing. As of

March 1, 1979, the Medicare Bureau has not made a decision on whether these costs will be paid in full.

THE ILLINOIS EXPERIMENT

The Medicare Bureau's second experiment with competitive fixed-price procurement was initiated in Illinois in early 1978. Medicare part B beneficiaries in Illinois had been serviced by the Health Care Service Corporation (Chicago Blue Shield) in Cook County and the Continental Casualty Insurance Company (Continental) in the remaining counties. In this experiment the Medicare Bureau solicited a fixed-price proposal to serve the entire State. Total fiscal year 1978 part B claims volume for Illinois was 3,591,672; 1,890,828 claims were processed by Chicago Blue Shield, the remaining 1,700,844 were processed by Continental.

Among the primary reasons cited by the Medicare Bureau for selecting Illinois as an experimental area were (1) the competitive process should produce a contractor that can operate at substantially lower administrative costs than either Continental or Chicago Blue Shield and contribute to the fiscal year 1979 budget objective of reducing operating costs through the use of fixed-price contracting, (2) concern over having two carriers service Illinois with both operating out of Chicago, and (3) by combining the workload of both incumbent carriers, the effects of increased workload could be tested. Another factor in the decision was that the Bureau considered Continental to be marginal in performance and Chicago Blue Shield close to average.

The RFP called for a total firm fixed price to include all carrier services to be performed in Illinois over the term of the contract--July 1, 1978, through September 30, 1983. Actual claims processing was to begin April 1, 1979, in Cook County, and July 1, 1979, for the remainder of the State. The period between July 1, 1978, and the start of claims processing was allowed as a transition period in which the successful bidder would work with the Medicare Bureau and the incumbent carriers to assure a smooth change.

As in the Maine experiment, the RFP called for a total fixed price independent of claims volume. The only adjustments to be considered are increases or decreases in postage or Social Security taxes announced after the bids were received, and major legislative changes that affect the carrier's workload. Changes in postage and Social Security were not allowed in the Maine contract.

Contractor selection

The Medicare Bureau received proposals from five organizations--Chicago Blue Shield, the General American Life Insurance Company, Electronic Data Systems Federal (EDSF), Continental, and the Prudential Insurance Company. Four offerors were existing Medicare carriers, and the fifth, EDSF, was an EDP subcontractor to several carriers.

The award factors used in the evaluation were the same as in the Maine experiment, with a variation in weights: technical (20 percent), experience (35 percent), and price (45 percent). Point awards were made in the same way as the Maine experiment, with the following results:

Bidder	Total (note a)	Point difference from winning bidder
EDSF	905.27	-
Chicago Blue Shield	887.28	17.99
Continental	846.50	68.77
Prudential	728.54	176.73
General American	684.87	220.40

a/Total points available--1,000.

EDSF, which finished fourth in the technical category and third in experience, won, based on a 45-point advantage in the price category. Prudential, the high scorer in both technical and experience categories, finished low in the overall scoring as a result of receiving the lowest point award for price.

Price

The price proposals were evaluated by the Medicare Bureau, based on current national average cost experience and the inclusion of implementation and conversion costs.

The following table shows the total bid price and the effective unit cost per bid based on the Medicare Bureau's projected claims volume.

Bidder	Total price	Effective unit cost
EDSF	$41,800,000	$2.03
Chicago Blue Shield	46,505,000	2.25
Continental	49,006,000	2.38
General American	79,981,400	3.87
Prudential	81,490,600	3.94

Chicago Blue Shield and Continental incurred costs of $3.48 and $3.02 a claim, respectively, in fiscal year 1978.

Again, it is difficult to make any specific conclusions about the price proposals because we do not know what volume levels were used by the contractors in making their estimates. However, in terms of total fixed price, it appears that substantial savings will occur. For example, in fiscal year 1978 the total administrative costs incurred by Continental and Chicago Blue Shield were $5,129,660 and $6,584,483, respectively. Based on the fiscal year 1978 costs and the assumption that there would be a 6-percent increase in total costs on a yearly basis, the cost to the Government if Chicago Blue Shield and Continental had been retained would be an estimated $62.4 million for the operational period covered by the experimental contract. This would result in an approximate savings of $20.6 million, minus whatever termination costs are paid to the incumbents.

THE UPSTATE NEW YORK EXPERIMENT

A contract was awarded to Blue Shield of Western New York (Buffalo Blue Shield) on November 1, 1978, in the latest of the Medicare part B experiments. This experiment consolidated three carrier territories in upstate New York into one new geographical territory. The contract was offered through a fixed-price competitive process.

The area is presently serviced by Buffalo Blue Shield, Genessee Valley Medical Care (Rochester Blue Shield), and Metropolitan Life Insurance Company. The total part B claims volume for the carrier areas in fiscal year 1978 was 2,692,181, with individual carrier workloads and cost per claim as follows:

Carrier	Claims volume	Cost per claim
Metropolitan	1,663,679	$2.70
Buffalo	663,466	3.71
Rochester	365,036	3.50

The considerations given by the Medicare Bureau in designing this experiment were: (1) potential savings in administrative costs that could be achieved by replacing cost reimbursement contractors with a single contractor selected through competition, (2) reducing the total number of part B carriers in the interest of better program administration, (3) eliminating poor performing contractors as their territories are combined, (4) keeping realignment within the current HEW regional structure, and (5) working toward a long-term goal of a more competitive environment.

The New York contract is for a 47-month period; transition began on November 1, 1978. Actual claims processing under the fixed-price contract will begin on June 1, 1979, in the area Buffalo Blue Shield presently services, with the remaining two areas being absorbed at 2-month intervals until the territory is fully operational on October 1, 1979. Processing will continue through September 30, 1982.

Similar to the Illinois contract, there will be price adjustments only in case of major legislative changes or changes in postage or Social Security taxes announced after the price proposals were submitted.

Contractor selection

Proposals for the New York experiment were received from six organizations presently operating as Medicare carriers, including two of the three incumbents. They were Buffalo Blue Shield, Continental, Group Health Incorporated (GHI), and Metropolitan, Prudential, and the Occidental Life Insurance Company.

The award factors were similar to those used in the first two experiments; however, adjustments were again made in the weights for technical (15 percent), experience (35 percent), and price (50 percent). The evaluation of proposals resulted in these point awards:

Bidder	Points (note a)	Point difference from winning bidder
Buffalo	908.96	-
Continental	896.29	12.67
Metropolitan	873.98	34.98
GHI	837.37	71.59
Occidental	822.60	86.36
Prudential	790.55	118.41

a/Total points available--1,000.

Buffalo Blue Shield, which finished third in scoring in the technical category and fourth in experience, was able to overcome the other carriers with its 45-point winning margin in the price category.

Price

This experiment received the most response so far in terms of the number of bidders and the competitiveness of price. The following table shows the actual bids and the effective unit price per claim based on the Bureau's projected claims volume of 13,270,000.

Bidder	Total price	Effective unit cost
Buffalo	$20,296,150	$1.53
GHI	21,358,800	1.61
Continental	22,320,000	1.68
Occidental	23,790,000	1.79
Metropolitan	23,871,000	1.80
Prudential	29,377,000	2.22

In terms of total price, the successful bid saved an estimated $10.8 million if total administrative costs for each incumbent carrier are used. Based on the fiscal year 1978 costs and assuming a 6-percent increase in costs for each year, the incumbents would have incurred approximately $31.1 million in costs over the contract's operational period.

TEN MAJOR CARRIER OPERATIONS

1. Claims review: Includes all activities related to (1) claims control and screening, (2) claims development and correspondence, (3) routine review and coding of claims, (4) routine quality control techniques, and (5) services furnished to the Medicare Bureau's onsite representatives.

2. Utilization and reasonable charge review: Includes all activities by medical or para-medical employees or outside consultants related to (1) the review of claims for over- or under-utilization and/or reasonable charge fees for services rendered and (2) certain program integrity procedures.

3. Beneficiary hearings and appeals: Includes all activities related to formalized hearings and appeals procedures regarding beneficiaries' and physicians' dissatisfaction with the carrier's initial claim determination.

4. Data entry: Includes all activities relating to entering data into the computer system.

5. Computer usage: Includes all activities relating to the actual operation of the computer system, including facility management subcontracts where costs for other functions are not separately identified.

6. EDP systems and programming support: Includes all activities related to all systems and programming personnel only as it is associated with the routine operation of the EDP system.

7. Professional relations: Includes discussions and liaison activities with the physician and provider community.

8. Service departments: Includes activities relating to personnel, storeroom management, purchasing, mailroom, printing, duplicating, and switchboard operations.

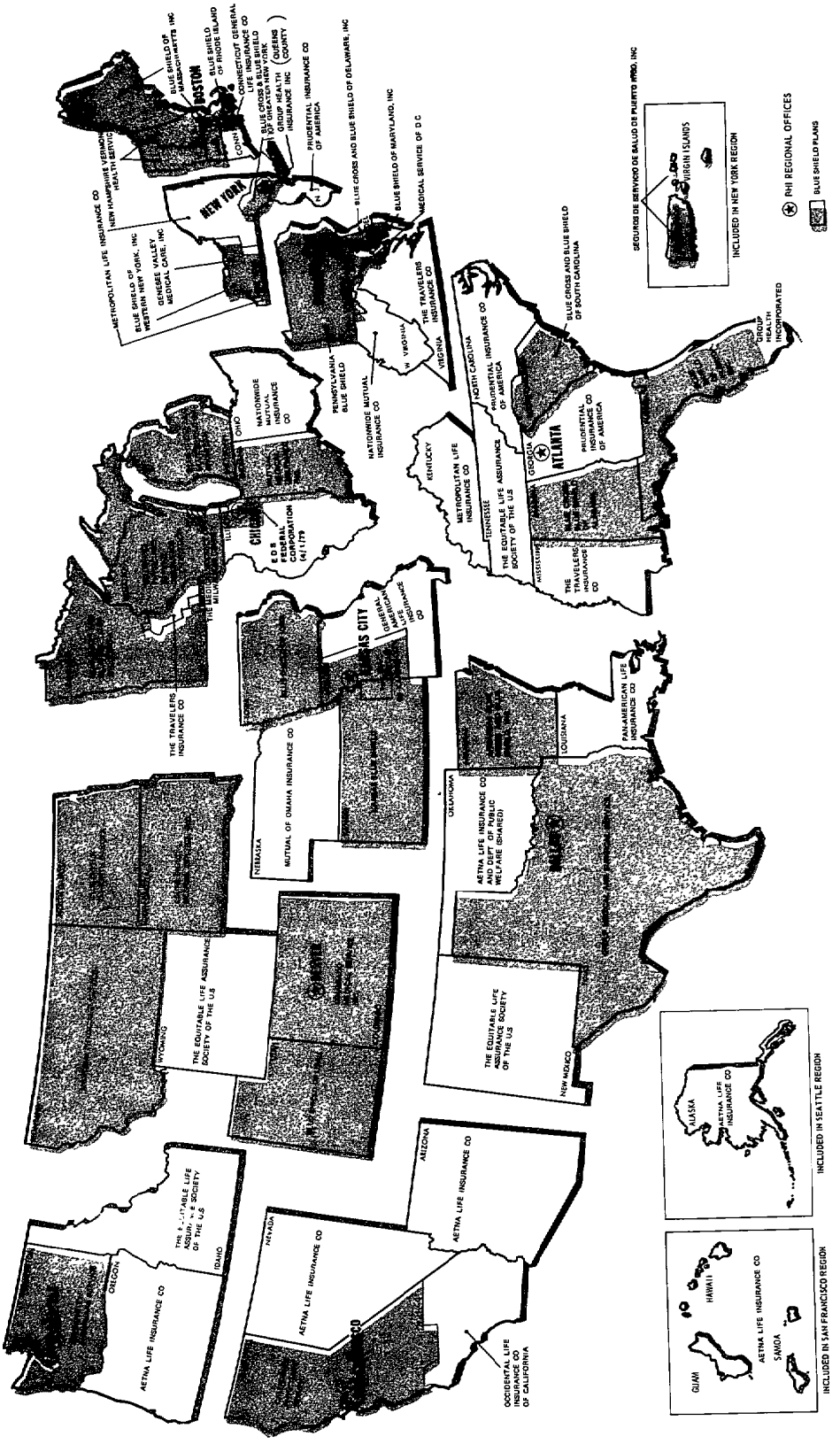
9. Financial, accounting, and statistical: Includes activities relating to (1) accounting for and control of benefit disbursements, (2) budget preparation, (3) internal audits, and (4) general accounting and recordkeeping.

10. General and administrative: Includes the total cost allocated to Medicare for general corporate legal activities and individuals responsible for overall corporate or Medicare matters.

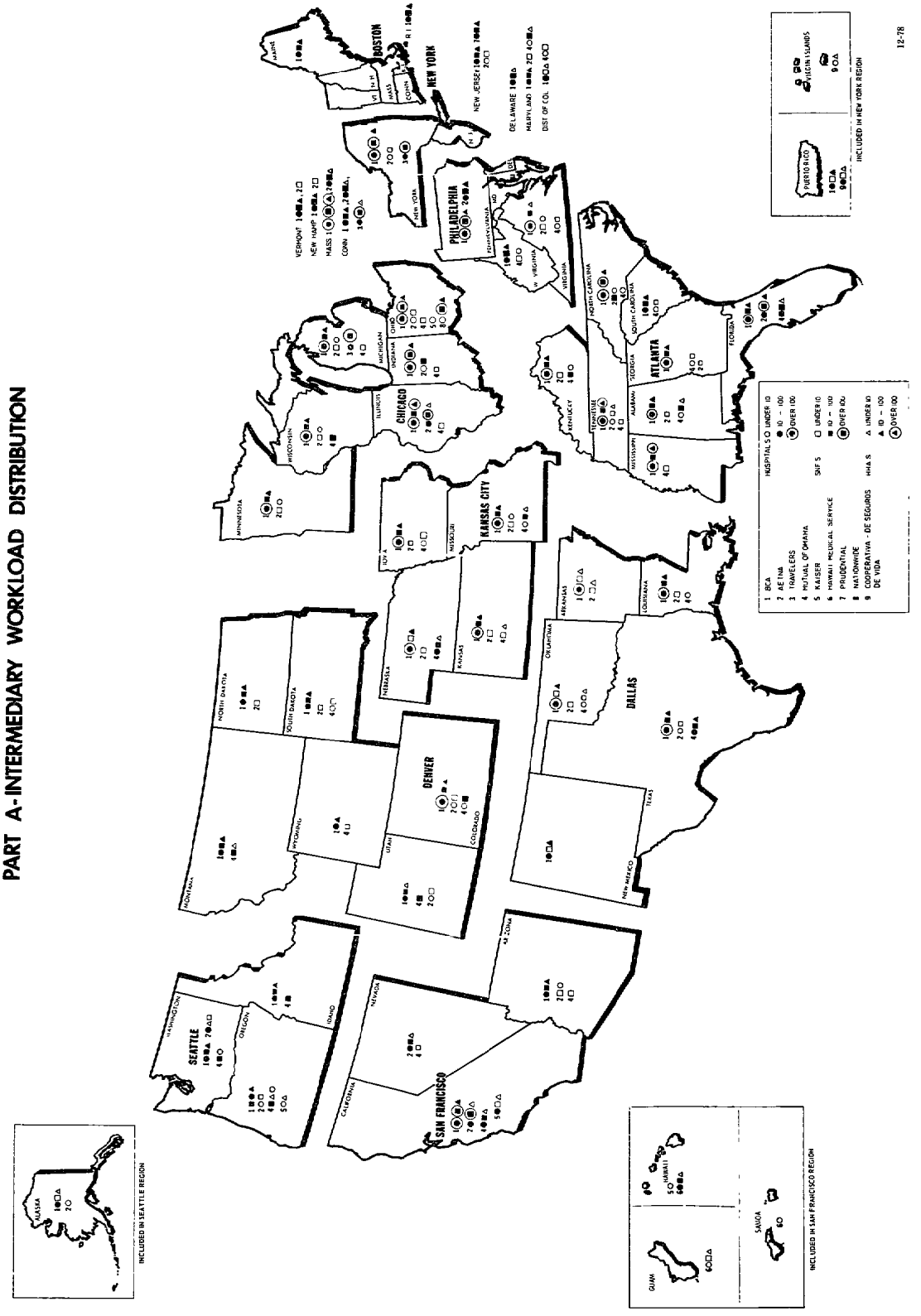
APPENDIX IV

HEALTH CARE FINANCING ADMINISTRATION

'MEDICARE' PART B CARRIERS



APPENDIX V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THE SECRETARY OF HEALTH, EDUCATION, AND WELFARE
WASHINGTON, D C 20201

MAY 7 1979

The Honorable Elmer Staats
Comptroller General of the
United States
Washington, D.C. 20548

Dear Elmer:

I appreciate the opportunity to comment on your proposed report to the Congress entitled, "Changes Needed in Contracting for Medicare Administrative Services."

Your draft report is a comprehensive assessment of the way in which Medicare is administered and of ways to strengthen this program. In many ways it supports legislative and administrative actions which are already being taken or which are currently being planned by the Department. Your review also specifically supports the conclusions and recommendations of the "Medicare and Medicaid Contracting" report issued last fall to the Administrator of the Health Care Financing Administration (HCFA) by a special Departmental Steering Group.

The report clearly illustrates the desirability of using fixed-price procurements for Medicare contractors and of consolidating the number of contractors by geographic area. Our experience to date clearly demonstrates the advantages of this approach. In our current experimental fixed-price contracts for Part B carriers in Maine, Illinois, and Western New York, we project administrative cost savings totaling some $55 million over the term of those contracts. Substantial additional administrative savings should be made as fixed-price procurements are expanded to other areas of the country.

I also support the report's conclusion that fixed-price contracting should be widely adopted only when acceptable qualitative and quantitative controls over performance exist. This is essential to ensure that Medicare beneficiaries and providers receive high quality services and the benefit payments to which they are entitled. We continue to improve our understanding of potential problems associated with awarding fixed-price contracts and to refine the qualitative and quantitative standards necessary for them to be implemented effectively. I am thus confident that we can administer fixed-price contracts widely.

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As you are aware, legislation will be required to achieve changes in our current Medicare contracting procedure. We are now preparing proposals for Congressional consideration. We are preparing some legislative proposals which were not included in the GAO report, because we believe they are also needed to improve Medicare contracting.

While I support the report's legislative proposal to provide HEW with standby authority to pursue fixed-price contracting for Medicare contractors, I believe that this proposal does not go far enough. The proposed legislation should provide HEW with full authority to implement fixed-price contracting in a systematic fashion over several years. This is necessary because it would be administratively difficult to require prior Congressional approval before additional fixed-price contracts could be extended.

Several other legislative constraints make it difficult for HEW to reduce and consolidate the number of intermediaries in Part A of Medicare. These should be addressed now as well. In particular, the statutory provisions defining the provider nomination process and the appeal rights of intermediaries restrict HEW's ability to select the most cost-effective contractors in a timely fashion. To solve this problem, I recommend that the Congress remove providers' statutory authority to nominate the intermediary of their choice. This action would eliminate the potential for conflict of interest which now exists in allowing providers to select the organization which controls and monitors their own reimbursement.

The general conclusions and specific findings in the report will be most helpful to HCFA in its efforts to secure improved Medicare administration. More detailed comments on the General Accounting Office's recommendations are provided in the enclosed statement of the Department's proposed actions.

Sincerely,

for Joseph A. Califano, Jr.

Enclosure

Comments of the Department of Health, Education, and Welfare on the General Accounting Office Draft Report Entitled, "Changes Needed in Contracting for Medicare Administrative Services"

Overview

The GAO report substantially supports the findings and recommendations in the report on "Medicare and Medicaid Contracting" issued in October 1978 by a Departmental Steering Group to the Administrator of the Health Care Financing Administration (HCFA). Based on that report the Department is now pursuing a strategy to seek legislative changes to strengthen the potential for improved administration in Medicare, to conduct additional experiments including a combined Part A and Part B contractor in a particular geographical area and to achieve through administrative action a reduction in the number of contractors, subject to the constraints of present law.

In this report, GAO concludes that it is desirable to move in the direction of fixed price contracting but only after there are demonstrated assurances by HEW that there will be no adverse effect on program benefit payments.

GAO cites the CHAMPUS experience and several instances in that program which argue for a more cautious approach under Medicare. We believe GAO should note in its report that the CHAMPUS experience is not representative of the Medicare workloads involved nor the advance preparation and pre-set evaluation plan established by HCFA before the awarding of fixed price contracts. Additionally, Medicare conducts on-going monitoring activity for its contractors so that problems, if any, are identified and resolved early.

GAO also supports the reduction in the number of intermediaries and carriers, experimentation with a combined Part A and Part B contractor in a geographical area and additional experimentation with incentive contracting techniques.

We endorse and support the several recommendations made by GAO, and believe they are a major step in the right direction. However, we would urge that GAO consider modifying its legislative proposal for moving to fixed price contracting to provide the Secretary with full authority to make such changes rather than "stand-by authority" as presently stated.

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We also recommend that GAO support amendments to section 1816 of title XVIII of the Social Security Act to eliminate the constraints in that section of the Act which inhibit effective action by the Secretary. More specifically we refer to the right of providers to nominate their own intermediary and the right of the adversely affected intermediaries to appeal and to obtain judicial review if the Secretary makes a determination to consolidate and reduce the number of intermediaries.

Dramatic administrative savings can be achieved by moving to fixed price contracting on a national basis. The administrative savings from the three fixed price experiments in Maine, Illinois and Western New York are projected to total $55,000,000 over the term of those contracts. The total savings for fix-priced contracts were calculated by multiplying the anticipated workload to be processed by the contractor during each fiscal year by the unit cost claimed by the cost reimbursement contractor during the last year of its operation. From this amount, calculated on an annual basis we subtracted the fixed price payments (excluding the implementation and termination costs). The net differences for each year were totaled to arrive at the total savings. Further, we believe that HCFA has established in the Medicare program a very comprehensive system of monitoring contractor performance and program payments which provides an adequate safeguard against any adverse impact on program benefit payments.

Change would be phased in over a period of years. Full authority to the Secretary could be conditioned to provide to the Congress appropriate reports on the results of experiments and on the safeguards that would be applied to the fixed price contracts and to provide his specific plans for phasing in fixed price contracting over a period of years.

We also believe that reduction and consolidation in the number of contractors is desirable and agree with GAO that this can lead to improved efficiencies and more effective oversight of program payments. We welcome GAO's support for such change. However, over the next few years administrative action to achieve these changes will be difficult and cumbersome at best in the cost contract environment. GAO's support in recommending changes in section 1816 of the Act would therefore be most helpful.

independence in making settlements of program reimbursement. Under the existing procedure, i.e., the nomination process, the providers have the opportunity to select organizations which will control and monitor their own payments. This is a classic conflict situation.

The fixed price contract itself also contains many features that are intended to assure quality performance and which have proven successful. Performance standards contained in the contract are used to assess the quality of contractor performance. If it is determined that a contractor has failed to perform the work in accordance with a standard or within the timeframes specified in the contract, liquidated damages are assessed. This places a financial incentive on the contractor to meet the performance standards established.

The fixed price contract also contains termination provisions that further act as a deterrent to poor performance by a contractor. If a contractor's performance is inadequate or unacceptable, the contractor may be terminated by default. In addition, a standard provision concerning termination for convenience of the Government is contained in the fixed price contracts.

Our experience has shown that a fixed price contract experiment can be implemented without a diminution in the continuity of quality of beneficiary services and provider-professional relations. The extremely successful changeover to a new contractor in the State of Maine was largely attributable to HCFA efforts to coordinate the implementation of the experiment to assure a smooth process. Additional actions were taken to facilitate the transition in Maine which assured a continued quality of service especially in the area of beneficiary relations. This transitional approach in Maine will be repeated as new experiments are implemented.

With our knowledge and experience gained in Maine, we conducted an experiment in Illinois where large workloads were involved. HCFA was able to successfully transfer all carrier functions from the former contractor to the new contractor in an orderly and efficient manner.

It should also be noted that in order for HCFA to perform fixed price contracting on a broader scale, the provider nomination process must be changed. Fixed price competitive contracting is contrary to the nomination process and GAO should so state in its report.

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Recommendations to the Secretary of HEW

GAO recommends that the Secretary of HEW direct the Administrator of the Health Care Financing Administration to:

Recommendation # 1: Evaluate the ongoing experimental contracts to determine the advantages and disadvantages with such contracts in Medicare. Particular emphasis should be placed on the effects of such procurements on total program costs and on beneficiary provider services.

Comment: We concur. We believe that one of the most important aspects of the competitive fixed price contract experiments is the evaluation of each experiment to determine its effect on both program costs and quality of services. Accordingly, we have developed a plan to accumulate meaningful and comprehensive statistics and documentation by which to evaluate the experiments. The detailed evaluation plan to analyze the results of the experiments is part of every experiment. This evaluation plan extends beyond the actual contract period.

In addition, a system of performance monitoring and evaluation has been devised to assure the quality of a contractor's performance. This performance monitoring plan involves a two-faceted system of quality control. The first system measures workload related performance based on quantitative data concerning such factors as claims processing timeliness and claims processing accuracy. The second system involves continuous reviews and determinations regarding a contractor's functional performance in such areas as coverage and utilization safeguards, program reimbursement and program integrity.

The evaluation of competitive fixed price contracts also provides a means to study the administrative costs of the contractors and program expenditures. Since all of the contractors are subject to the same reporting requirements, including verification by Government audit, a good basis of comparison has been established for purposes of such evaluation. These reporting requirements encompass such areas as management, workload, financial and program expenditures.

Our experience to date indicates that the Medicare program is benefiting from this contracting arrangement. All of the experimental procurements have resulted in substantial costs savings accruing to the Government.

We have found that while costs have decreased under fixed price contracts, the selection and contracting process permits a high level of quality of performance to be maintained. Another advantage of fixed price contracting in Part A is that there will not be the same ties between the providers and the contractors that exist today under the nomination process. This should give the contractor a greater degree of

Our basic system of evaluation is to identify and give notice to poor performers, provide them with an opportunity to correct deficiencies and if they fail, take corrective action. The corrective action may be termination, reduction in the territory, or in the number of providers served through interdicts on new nominations, or other adjustments in the availability of an intermediary. The nomination process in section 1816 of the Act and the amendments to that section by P.L. 95-142 (section 14) granting appeal rights and access to judicial review make it difficult to implement a firm policy of termination of poor performers in Part A.

As we devleop and publish formal performance standards for Part A intermediaries and Part B carriers our policy for termination of poor performers in Part A and Part B will be strengthened. However, we believe that a flexible approach such as we presently utilize, must be followed, which involves due notice, opportunity for improvement, and where there is failure, utilization of different corrective options depending on the specific situation and program impact.

We have achieved significant improvements under our present system of identifying poor performance and setting targets for improvements as a condition for retaining their Medicare contracts. In 1976 we focussed on a group of Part B contractors that were marginally or poorly performing and set specific goals which would have to be met for the contractors to continue in the program. Substantial improvements were made by these contractors, and HCFA estimates that as a result of these efforts, the combined savings to the program during FY 1976, FY 1977, and FY 1978 was approximately $30 million dollars.

Recommendation #4: Conduct experiments to demonstrate the feasibility of merging Parts A and B under a single contractor, and the effectiveness of requiring an integrated software system approach throughout the program.

Comment: We concur. HCFA is developing a plan for additional experiments including combining Part A and Part B under a single contractor. HCFA staff are now engaged in defining the issues and actions that must be addressed in framing a Request for Proposal (RFP) for an experimental fixed price contract that would merge Part A and Part Part B program administration under a single contractor in a specific area. It is now planned that the first such RFP will urge prospective offerors to submit fixed price bids that call for an integrated EDP software system. We expect this effort will be instituted in the next few months.

HCFA is also considering variations on the basic concept of incentive contract experiments which call for a single contractor to perform all Medicare fiscal intermediary and carrier functions in an area on a

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Recommendation #2: Incorporate Performance Standards in All Part A and Part B Medicare Contracts.

Comment: We concur. HCFA is now in the process of developing a new contractor perofrmance evaluation methodology for Part A intermediaries and Part B carriers. The new methodology sets forth at the beginning of the evaluation period (1) statistical performance standards of cost, timeliness, and quality, and (2) objective program criteria on Medicare requirements. We expect the new methodology to be more effective than the current one in realizing significant further improvements in the efficiency and effectiveness of Medicare administration. Contractors will have objective standards and criteria up front that they must strive to achieve.

The new methodology for Part A is currently in the field test stage and we expect to be implementing it over the next 6 to 12 months. We anticipate publishing regulations for Part A standards this year. The Part B standards will be published in regulation form early in 1980 and implementation will follow. These performance standards will be applicable to all Part A and Part B contractors on cost contracts.

Specific standards are already contained in the fixed price contracts which have been awarded under our experimental authority. There will be some differences between standards under the fixed price contract and the cost contract e.g., one standard for cost contracts is average cost per claim processed whereas in a fixed price contract the cost is fixed by price based on competitive bids. Further, liquidated money damages are assessed against a fixed price contractor for failure to meet specific performance standards and goals. During a transition phase where both fixed price and cost contracts exist there will be some variation, however, the basic qualitative standards and performance requirements must be essentially the same.

Recommendation #3: Implement a firm policy of contract termination for poor or marginal performing contractors. An effective budgetary system and the threat of contract termination can introduce many of the advantages of competition into the cost reimbursable environment.

Comment: We concur with the intent of this recommendation. Over the years our contractual controls over the cost contract budget process and the development of our performance assessment system has been considerably strengthened. Our direction has been to reduce the number of Medicare contractors by eliminating the poorest performers and we have achieved limited success through appropriate corrective actions applied to each particular situation.

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Recommendation #5: Conduct additional experiments to determine if incentive contracting will work successfully in the Medicare program. The experiments should include cost and performance incentives .

Comment: We concur with recommendation. HCFA will consider additional contracting experiments and pursue those which seem to have merit, particularly where cost savings seem likely. In addition to the combined Part A and Part B alternatives discussed previously, possible additional experiments include the following:

-- Use of multi-State contractors. We plan to let a fixed price contract which would combine all fiscal intermediary and carrier responsibilities in two or more States under one contract. We believe efficiencies will result because of economies of scale in claims processing and reduced overhead. It should also provide for more uniform program administration and control over utilization.

-- Recompeting a Fixed Price Contract. We will be considering recompeting a fixed price contract experiment. This would test the continuing benefits of an existing fixed price relationship.

-- Separate Contracts for the Provider Audit and Reimbursement Functions Only. Such an experimental contract would open Medicare contracting to many competent accounting firms used to dealing with health care institutional auditing. It would allow comparison with the results obtained when fiscal intermediaries perform these functions in addition to claims processing.

-- Cost-Plus Incentive Fee Contracts. We would enter into such contracts only if a model were developed whereby the contractor might be placed in a true risk environment, i.e., where there were provisions which made it equally possible for the contractor to sustain a loss or to benefit from incentive provisions allowing retention of earnings. To date the contractors have not supported any such contract model.

fixed price basis. One type calls for this single contractor to perform all the Part A and Part B claims processing functions on a fixed price basis, while the usual fiscal intermediary provider audit and reimbursement responsibility would be left on a cost contract basis. Another incentive contract experiment concept being evaluated calls for one contractor to process all Part A and Part B claims on a fixed price basis. An entirely separate contract would then be let by the Secretary on either a cost or fixed price basis for the performance of the provider audit and reimbursement functions. It is thought such an alternative contract proposal would serve to bring a wider cross section of companies into the bidding.

It should be stressed that, until the nomination procedure changed legislatively, combined Part A/Part B Medicare contracts will be possible only under program experimentation provisions of present law as was pointed out in the HCFA study mentioned on pages 8991 of GAO's report. Therefore, we urge GAO to recommend to the Congress the recission of the provider nomination process.

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We concur with GAO that reducing the number of contractors will provide for a more efficient contractor configuration, with more uniform application of program requirements and a better base to contain program costs. We must add however, that these very positive results will only occur through changes to Section 1816 of the Act.

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A fixed rate experiment was conducted in Maryland, and its price results were not as dramatic as the fixed price approach. Additionally, the commercial contractors favor a cost plus incentive type contract where there is no risk of loss contractors. Both of these approaches can be tested in the future with significant revisions to negotiate a more favorable posture for HCFA and shifting some degree of costs risks to contractors.

Recommendation #6 : Take immediate action to reduce the number of carriers and intermediaries participating in the Medicare program.

Comment: We concur with the intent of this recommendation. HCFA has long recognized the problems associated with excessive number of contractors. In spite of the legal constraints (the nomination process and cost-contracting requirements) action has been taken.

Under the experimental provisions, we plan to consider additional experiments that will provide for consolidation and which will result in an increase in efficiency in the area to be served. A major part of the thrust of future experiments will be reduction in the number of carriers and intermediaries.

We also plan to take administrative actions in both Part A and Part B to reduce the number of contractors by elimination of poor performers and by consolidation of contractors in specific areas. Our actions in Part A are, however, constrained by the terms of the law. The process of provider nomination of its intermediary must be considered in any termination or nonrenewal effort under the cost contracts. Although intermediary availability can be limited, the nomination process prevails. Reduction of intermediaries must be considered in that light.

In addition, whenever contractor territories are consolidated or poor performing contractors are terminated, we must select a new contractor to take over the territory. Our experience has shown that this selection process can be performed most equitably on a competitive basis. We do not see how we could compete only the incremental load as suggested in the draft report under a cost contract.

RECOMMENDATIONS TO THE CONGRESS

GAO recommends that the Congress:

Recommendation: Provide HEW with standby authority to use fixed-price procurement of carrier and intermediary services in the Medicare program, subject to the approval of the cognizant legislative committees, if the evaluation of existing experiments demonstrate acceptable contractor performance and no measurable adverse impact on the program benefit costs.

Comment: This is the principal recommendation of the GAO report. It would provide the Secretary of HEW with the authority to implement fixed-price contracting. This change, however, would require the approval of the cognizant legislative committees for each new contract, provided the performance of contractors under existing experiments demonstrate there is no adverse impact on program benefit payments. This recommendation is welcomed as it is a strong endorsement of the direction in which HEW is moving.

However, we would urge that GAO consider modifying this legislative proposal to provide the Secretary of HEW with full authority to proceed to make the change to fixed price contracting on a phased basis. It would be inappropriate and unconstitional for the Secretary to take action if he were required to seek the approval of the cognizant legislative committees before executing each new contract. Full authority could be conditioned by setting forth requirements that the Secretary provide appropriate reports to the cognizant legislative committees on the safeguards and controls to be applied, the results of the experimental activity and his specific plans for phasing in fixed-price contracts over a period of years.

It also should, be noted that HCFA has already established in the Medicare program a comprehensive system for monitoring contractor performance and program benefit payments. This system incorporates detailed reporting of various program data and indices of contractor performance, an extensive program of onsite inspection and review of an ongoing basis by regional staff, and the application of a broad range of functional standards and qualitative controls. Further, formal performance standards in both Part A and Part B will be issued and implemented in 1979 and 1980.

With the monitoring system presently in place and with the experience gained and improvements made in the three experimental procurements to date, we believe an effective framework of safeguards and controls has been established. The qualitative and quantitative standards applied to the experimental contracts have been refined and strengthened with each procurement and there is considerable pressure on the fixed-price contractors to meet these standards for if they do not, they will suffer monetary damages.

Recommendation: Enact legislation to terminate the authority of the Railroad Retirement Board to select a nationwide RRB carrier and to turn over responsibility for processing and paying of RRB beneficiary claims to the area carriers

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paying Part B claims for all other Medicare beneficiaries.

Comment: We concur in this recommendation and agree that administrative efficiencies can be realized by having the local carrier process the claims of RRB eligibles who are entitled to Medicare benefits. The change whould also permit more accurate and effective application of the prevailing charges in the locality and of the utilization screens and profile analysis for the providers in the locality. Time has not permitted consultation with the Railroad Retirement Board on this recommendation.

Recommendation: Amend title XIX of the Social Security Act to require that Medicaid liability for cross-over claims be processed by the Medicare contractors using integrated data processing systems unless the individual States can demonstrate that another arrangement is just as efficient and effective.

Comment: We concur in the desirability of a single processor because it would lead to administrative efficiencies, improve service to providers and eliminate duplicative processing. In fact, HCFA has plans underway to experiment with this approach to handling cross-over claims.

ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, D. C. 20301

HEALTH AFFAIRS

17 MAY 1979

Mr. Gregory J. Ahart
Director
Human Resources Division
General Accounting Office
Washington, D.C. 20548

Dear Mr. Ahart:

This is in reply to your letter of April 5, 1979 to the Secretary of Defense, regarding Chapter 7 of your draft report on "Changes Needed in Contracting for Medicare Administration Services" (OSD Case #5143) (Code 106150).

We agree with the overall thrust of your report, i.e., that competitive, fixed-price procurements offer significant promise for cost savings. OCHAMPUS has experienced significant growing pains in implementing competitive, fixed-price procurements. We agree also that, regardless of the type of contracting, there is no substitute for a well-designed, quality procurement process. This starts with a thorough, but realistic statement of work that has built-in measurable performance standards. It includes fair, balanced evaluation and award criteria. In this regard, OCHAMPUS strongly agrees to award contracts. The contractor's ability to deliver services and products in an efficient, quality manner should be the paramount concern when awarding OCHAMPUS and Medicare-type contracts.

Also, OCHAMPUS has recently found that pre-award surveys are a highly effective tool to ensure that a quality contractor is selected. Once awarded, a capable performance evaluation process must exist to ensure contract compliance. OCHAMPUS has recently redesigned and strengthened its performance evaluation capability. This is proving to be a valuable asset in upgrading contractor performance.

Regarding contractor transitions, more emphasis throughout the Nation's health care system needs to be given to uniform coding and nomenclature for medical services, providers, facilities, etc.

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Your report should be helpful. Thank you for the opportunity to comment.

Sincerely,

Vernon McKenzie
Principal Deputy Assistant Secretary

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UNITED STATES OF AMERICA
RAILROAD RETIREMENT BOARD
844 RUSH STREET
CHICAGO, ILLINOIS 60611

MAY 15 1979

Mr. Gregory J. Ahart
Director
Human Resources Division
U.S. General Accounting Office
Washington, D.C. 20548

Dear Mr. Ahart:

We appreciate this opportunity to comment on Chapter 9 (Opportunity to Reduce Costs by Eliminating the Railroad Retirement Board's Contracting Authority) of the draft of a proposed report prepared by the staff of the U.S. General Accounting Office regarding "Changes Needed in Contracting for Medicare Administrative Services."

The Board opposes the recommendation that its legislative authority to select a nationwide carrier to handle Part B Medicare claims for railroad retirement beneficiaries should be terminated. Further, the Board disagrees with the conclusion that the existing arrangement for payment of Part B Medicare claims is neither efficient nor effective.

The Board is vitally concerned in administering a Medicare program that is cost effective and provides a satisfactory level of service to qualified railroad retirement beneficiaries. Various items mentioned in this chapter of the report have been discussed on numerous occasions since the inception of the Medicare program in 1966. However, the Board firmly believes in the basic concept that Medicare insurance claims be handled on a uniform basis and that the Board should retain legislative authority to select any carrier best suited to serve the needs of railroad retirement beneficiaries.

In order to present our position on the arrangement with The Travelers Insurance Company, we feel it is necessary to review some of the important considerations that led to this arrangement. In 1966, authority to select an intermediary to process Part B Medicare claims for qualified railroad retirement beneficiaries was

delegated to the Board by the Secretary of Health, Education and Welfare. In 1972, this arrangement was formalized by legislation enacted by Congress and approved by the President. The delegated authority or the legislation did not specify one carrier.

The theory behind the original delegation was the uniqueness of the railroad retirement system, a centralized, federally-administered social insurance program for a single industry. The concept of a special national carrier naturally evolved from this origin. Throughout its 44-year history, the railroad retirement system has been based on a series of collective bargaining agreements negotiated by representatives of railroad labor and railroad management. Both parties supported the idea of a separate railroad Medicare carrier in 1966, and they continue to fully support this concept. Any abandonment of this arrangement would in effect nullify the collective bargaining process.

The arrangement of having one carrier process Medicare Part B claims is not restricted to the railroad industry. The same situation exists for members of the United Mine Workers Union. The State of Oklahoma's Rehabilitation Service is a carrier for another select group of beneficiaries; one carrier in California processes claims for individuals entitled to both Medicare and Medicaid and the processing of Rural Health Clinic claims is also restricted to select carriers.

One of the major goals in the Board's arrangement for one single national carrier was to provide our beneficiaries with the best possible level of service, without regard to where they reside. We believe our beneficiaries are receiving a uniformly high level of service.

The report reaches the conclusion that the existing arrangement under which The Travelers Insurance Company makes Medicare medical insurance (Part B) payments for qualified railroad retirement beneficiaries on a nationwide basis is neither efficient nor effective. It recommends that Congress enact legislation (1) to terminate the existing legislative authority of the Railroad Retirement Board to contract with Medicare Part B carriers, and (2) to turn over the responsibility for processing and paying Medicare Part B claims of railroad retirement beneficiaries to area carriers paying Part B claims for all other Medicare beneficiaries. The conclusion is based on an estimated savings in administrative costs for fiscal year 1979 and future years as well as a disparity of payments between The Travelers and area carriers.

The carriers used for comparison purposes were not identified, and we cannot verify the statistics used in the comparisons or assess the performance of these carriers. Therefore, our comments are restricted to providing additional information or considerations.

The draft report presented a table which disclosed that for the period July 1, 1977, through September 30, 1978, The Travelers average processing time ranged from 7.6 to 8.9 days while the national average of all carriers ranged from 12.1 to 14.6 days. What price can one assess on timeliness? It is intangible and can only be appreciated by those who depend on prompt reimbursement for their Medicare claims in order to exist, especially in times of high inflation. There is nothing in the report to show that the high level of uniform service would continue if the national carrier concept was abandoned.

The report also made reference to The Travelers above average quality in the railroad Medicare claims processing operations. However, we believe a further explanation is warranted. There are 62 carriers paying Part B Medicare claims. One method that is used to assess their performance is through the Quality Assurance Program. The Health Care Financing Administration, Medicare Bureau, exercises direct supervision of this program. The Travelers had a 91 percent accuracy rate for processing claims during the period July 1977 through June 1978, and for the same period had a very respectable payment/deductible error rate of 1.5.

The report states that, by not having a separate Railroad Retirement Board carrier, as much as $43 million in administrative costs could have been saved in the interval beginning with fiscal year 1970 and ending with fiscal year 1978, and that an additional $6.6 million could be saved in fiscal year 1979. However, no consideration is given to the program dollars that are saved by high quality claims processing which prevents benefit payment errors. The Travelers' performance regarding their payment/deductible error rate resulted in savings in benefit payments approximating $2 million. Therefore, the report's estimated savings in administrative costs could be offset by increased benefit payments if area carriers were given the responsibility for processing railroad Medicare claims.

It is very difficult to comment on that portion of the report that concerns itself with estimated savings through consolidation. As previously stated, the surveyed carriers were not identified, and we are unable to determine the quality of their performance. The table contained in the report shows the estimated additional costs for these carriers to process railroad claims. The added cost ranges from a low of $0.26 to a high of $2.82 per claim. Because of the wide range of difference, we question the objectivity of the carriers in furnishing the data. Also, we question whether the estimates include costs incurred for providing beneficiary service such as toll-free telephone service and walk-in facilities.

The report also presented the results of a survey that was conducted to determine whether beneficiaries and providers were satisfied with The Travelers' performance. After excluding the number that did not answer

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or had no basis to judge, the results show that 84 percent of beneficiaries and 81 percent of providers were satisfied. It is doubtful whether this same level of satisfaction would be achieved if the other carriers were to process railroad Medicare claims.

Approximately 60 percent of railroad employees have no connection whatever with the Social Security Administration or the Health Care Financing Administration concerning their Medicare. Many of these railroad employees are insured by one of The Travelers group policies while they are working and by one of their supplemental policies after they became eligible for Medicare. They are accustomed to dealing with The Travelers and Board personnel. If area carriers were to process railroad Part B Medicare claims, railroad employees and beneficiaries would be required to deal with a new organization; this could be a difficult and confusing experience for railroad senior citizens.

By having a single carrier for railroad Medicare claims, the Board looks to one source for accountability. Any problems arising on eligibility, enrollment and premium deductions are handled quickly and effectively. Abandonment of the one-carrier concept would require the Board to establish liaison with area carriers and would necessitate a substantial increase in Board personnel.

The report also identifies the problem of misrouted Railroad Retirement Board Medicare claims. The problem does exist. However, our experience has not indicated that it is as prevalent as the report indicates. Misrouted claims are not a problem restricted solely to railroad Medicare. It also exists where there are two carriers within one area, or when Medicaid claims are inadvertently sent to a Medicare carrier. We agree that it will never be eliminated. However, a joint study is being conducted by the Board and The Travelers to identify those high volume providers who are the source of the problem. These providers will be contacted and given special instructions for filing railroad Medicare claims.

Fourteen carriers participated in the study regarding misrouted claims. The number of misrouted claims is a reporting item required by the Health Care Financing Administration. Three carriers were unable to furnish this data. However, the remaining carriers furnished the data and were able to distinguish railroad Medicare claims from misrouted area carrier claims and "crossover" Medicaid claims. Projections show that about 964,228 Railroad Retirement Board claims were misrouted in fiscal year 1977. We have been advised that the national figure for misrouted claims for fiscal year 1977 was 1,793,841. It is difficult for us to understand how The Travelers in processing three percent of the total national Medicare volume for fiscal year 1979 accounted for over 50 percent of the misrouted claims. In any event, a contemplated change in Medicare instructions should alleviate the problem of misrouted claims.

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We were pleased to see that The Travelers' reasonable charge determinations conform quite closely to those of area carriers. The Travelers' determinations will differ somewhat from area carriers and the differences are not always the result of insufficient data. They are also the result of geographical differences in the area used to determine prevailing charges.

It was recognized early in the program that these differences would exist. However, when they are identified, The Travelers revises its determinations to agree with the area carriers. The Travelers' reasonable charge screens for durable medical equipment, prosthetic devices and other items are developed by area carriers and used by The Travelers. Consequently, the actual differences between reasonable charge determinations made for the whole year are much less than the sample results.

The report also referred to The Travelers conversion to a regional online processing system and the costs incurred while implementing this system. Unfortunately, there was no mention that this same system was used by The Travelers for their area carrier operations in the States of Minnesota, Mississippi and Virginia. The costs for developing the system were absorbed under the Railroad Retirement Board contract. Thus, this system was implemented for these three States at minimal cost. The estimated savings to be derived from this system, therefore, are much greater than those realized solely under the Railroad Retirement Board contract.

There are many reasons for having one carrier process Part B Medicare claims for qualified railroad retirement beneficiaries. In our opinion, this arrangement is advantageous to our beneficiaries as well as to Board personnel who are responsible for administering the Medicare program. It would be somewhat difficult to differentiate between the advantages that the Board realizes from having the authority to contract with one carrier and the advantages that our beneficiaries derive from such an arrangement.

The Board suggests that, before recommending termination of Board authority to select a national carrier, careful reconsideration should be given to the magnitude of the impact of such termination on the Health Care Financing Administration, area carriers, and the 800,000 plus railroad beneficiaries.

Very truly yours,

William P. Adams
Chairman

C. J. Chamberlain
Labor Member

Earl Oliver
Management Member

Blue Cross
Association

Merritt W. Jacoby
Vice President
Medicare and
CHAMPUS Administration

840 North Lake Shore Drive
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May 4, 1979

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

Dear Mr. Ahart:

We appreciate this opportunity to comment on the draft report on Medicare contracting, which seems to us to reflect extensive evaluation of contractor judgements of the various alternatives under consideration. We were impressed, also, that examination of the competitive process in CHAMPUS contracting and the Medicare experiments resulted in awareness of the hazards to program service and quality implicit in several of the alternative proposals, leading to the recommendation for careful testing and evaluation as prerequisite to any far-reaching changes in the contracting arrangement.

All Medicare contractors are committed to the need for economies in program administration, but we are mindful also that cost reduction in some aspects of administration may not reduce total costs and might in fact, in some instances, be achieved only at risk to the ultimate program goal of service to Medicare beneficiaries. We are reassured that the necessity for an appropriate accommodation of administrative economies and program objectives is underscored in the report, and we anticipate that when proposals for change in the Medicare contracting process are under review in the Congress and the Executive Department there will be ample opportunity for us to provide detailed information supporting our common objective of achieving lower administrative cost without risk to program goals. Meanwhile, we do wish to furnish these reactions to the major findings of the report:

TOO MANY CARRIERS AND INTERMEDIARIES FOR EFFICIENT ADMINISTRATION OF PARTS A AND B

The report relies heavily on estimated cost savings to be achieved by elimination of duplicated fixed costs of contractors and the economies of scale to be obtained by larger claims volumes among the remaining contractors. But there are countervailing factors that have not been considered, and advantages of cost, service, and quality that would be sacrified in the proposed change. For example, there are cost elements that do not respond at all to volume changes, and some that react only insignificantly, and there are further considerations that have not been addressed, such as the locations of the remaining contractors with respect to the cost and availability of labor. There would also be losses of the savings that are realized now through administrative costs that are shared between the Medicare and non-Medicare operations of current contractors. There would also be added costs for the remaining contractors: enlarged communications and service capabilities, added staff travel for provider audits, new machine data links, and others.

We do not disagree in theory with the recommendation made in the report but suggest that the relevant countervailing factors need to be studied. If discussion of this recommendation should lead to a proposal for action, we should be glad to cooperate with the Department to identify and measure the probable effects of such factors as they may bear on the putative economies projected in the report. We would also recommend that the existing contractors should be consulted in the development of criteria and in planning, timing and other transitional considerations, in the event any such action is contemplated.

In this connection, it should be noted that the Blue Cross Association Prime Contract for Part A administration has already provided significant savings in administrative cost, establishing a single point of accountability for the government in its relationship with the participating Blue Cross Plans and thereby avoiding duplication of costs. The Association also provides a national telecommunications network which shares costs between Medicare and non-Medicare business, and a centrally developed and maintained electronic data processing system currently processing approximately 60% of Medicare Part A claims. Many centrally developed administrative tools and procedures have been furnished to the Plans, avoiding duplicate development costs; some of these have been adopted by the government for use by all intermediaries. Other opportunities for economies of scale and avoidance of unnecessary duplication of fixed costs have been offered but not accepted, including centralized handling of provider appeals and regionalization of electronic data processing. More detailed information on these matters has been provided to your staff.

APPENDIX IX

NEED TO EXPERIMENT WITH HAVING A SINGLE CONTRACTOR PROCESS ALL MEDICARE WORKLOAD IN A TERRITORY

We support a properly structured and evaluated test of the concept but believe the test should not be tied to competitive bidding. There may be opportunities for improved efficiences in combined administration of Parts A and B by a single contractor using an integrated electronic data processing system, but the counterbalancing factors discussed in connection with reducing the number of contractors are also relevant here. Furthermore, recognizing the negative effects of competitive bidding on service and quality, we believe consideration should be given to a test which does not include competitive bidding. Aside from the actual and likely effects of that process which the draft report identifies, there is also evidence that use of competitive bidding in the test would interfere with and obscure its objective and effects. We are willing to discuss alternative ways to structure such a test.

COMPETITIVE FIXED-PRICE PROCUREMENT - CAN IT WORK FOR MEDICARE?

We believe the fixed-price competitive bid procurement process is not appropriate for the Medicare program because it cannot accommodate the service and quality objectives of the program or the constant need for adjustments in administrative practice, and because of the implicit orientation of the contractor to profit and loss objectives rather than to service and quality. We have provided your staff with an analysis of the effects this procurement technique would have on the beneficiaries, providers of care, and the objectives Medicare was established to provide. These include:

- Significant risk of periodic defaults by contractors, with resulting disruptions of service to beneficiaries and payments to providers.

- Periodic change of contractors requiring many communications adjustments by beneficiaries and providers, a "learning curve" for each new contractor, and changes in policy interpretation and application to beneficiaries' services and provider payments.

- Introduction of rigidity of administration opposing constant changes of policy, procedure and priority.

- Introduction of substantial new costs related to appeals of awards, related litigation, and negotiations of price relief and performance penalties.

APPENDIX IX

- Orientation of the contractors to profit and loss effects as the priority consideration when considering every alternative decision, as opposed to service and quality.

- A natural adversary relationship between the contractors and the government, largely eliminating opportunities for mutual efforts to serve the beneficiaries.

- Probable eventual withdrawal from participation of contracting organizations best qualified by experience and philosophy to enhance achievement of program goals in partnership with government.

The draft report uncovers substantial evidence that such effects are already evident where the fixed price competitive bid process has been in effect. Litigation and service disruptions have been encountered. There are also indications of some of the other effects listed here. The Surveys and Investigations staff report to the House Committee on Appropriations on Management of Civilian Health and Medical Programs of the Uniformed Services, is relevant. In order to obtain a credible base of further information as to the effects of this procurement technique, existing experiments should be carefully and openly evaluated. The evaluating organization should be impartial and objective. An experienced public accounting firm is a possibility, as is your office.

In conducting such an evaluation, there should be examination of the new costs which accompany this process, as well as the more obvious reduction in administrative cost represented by bid prices. As the draft report points out, the reductions in contractor costs apparent in the experiments are in some measure due to factors unrelated to the competitive process. Contractors have moved operations to lower cost labor pools, and the experimental areas have involved contractors whose costs were not necessarily representative. We urge a careful evaluation of the competitive experiments now in progress before any others are pursued.

INCENTIVE CONTRACTING SHOULD IMPROVE PERFORMANCE AND REDUCE COSTS IN THE MEDICARE PROGRAM

We support a thorough exploration of the opportunities in incentive contracting. We are willing to work with the Health Care Financing Administration in the development of ways to test this alternative. Important to the success of this alternative are objective performance standards and real incentives.

OPPORTUNITY TO REDUCE COSTS BY ELIMINATING THE RAILROAD RETIREMENT BOARD'S CONTRACTING AUTHORITY

The recommended change in contracting arrangements for Railroad Retirement Board beneficiaries is not a matter with which we are sufficiently familiar to comment upon.

SAVINGS IN ADMINISTRATION OF MEDICARE-MEDICAID CROSSOVER CLAIMS

The development and analysis of the opportunities to improve administration of crossover claims and gain certain efficiencies appears reasonable to us. We support the recommendation.

Finally, as you know, the Medicare program is generally seen as a smoothly running program providing good service to beneficiaries and accepted by health care providers and professional practitioners. Implementation of reasonable and objective performance standards would be a major factor in identifying and dealing with poor performing contractors and those unable to achieve acceptable economies of scale. There are persuasive arguments that additional administrative funds could achieve net reductions in the larger costs of health care services in the areas of fraud and abuse, provider audit, and utilization review.

What should be avoided, in any event, is radical and abrupt change based on inadequate information that does not appropriately balance efficiency goals against service and quality of administration.

Sincerely,

Merritt W. Jacoby

Merritt W. Jacoby
Acting Senior Vice President
Government Programs Division

MWJ/dw

APPENDIX X

THE EQUITABLE LIFE ASSURANCE SOCIETY OF THE UNITED STATES
1285 Avenue of the Americas, New York, N.Y. 10019

F. J. MALLEY, JR.
Vice President
Health Programs Department

May 2, 1979

Mr. Gregory J. Ahart
Director
United States General Accounting Office
Human Resources Division
Washington, D. C. 20548

Re: B-164031(3)

Dear Mr. Ahart:

This response relative to the draft report on Medicare contracting prepared by the General Accounting Office is submitted on behalf of the twelve Carriers and Intermediaries who presently are members of the Medicare Administration Committee of the Health Insurance Association of America.*

The following comments are directed to the proposed Recommendations To The Secretary Of HEW as set forth in the Review section of the report.

The report addresses many of the concerns we have regarding the direction HCFA has taken in recent months in contracting for Medicare claims processing through competitive fixed price bidding.

We are convinced, based on the recent Illinois and New York awards, that they are being made simply on the basis of administrative cost without reference to any real or meaningful performance standards as they apply to beneficiary services or without apparent recognition of the possible impact on benefit costs. It is ironic that HCFA continues to pursue the fixed price method of contracting for Medicare administration, the same method that has been commonly used in Medicaid and CHAMPUS for a number of years, despite the problems encountered by those programs.

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*Aetna Life & Casualty, Connecticut General Life Insurance Company, CNA Insurance, Equitable Life Assurance Society of the United States, General American Life Insurance Company, Metropolitan Life Insurance Company, Mutual of Omaha Insurance Company, Nationwide Mutual Insurance Company, Occidental Life Insurance Company of California, Pan-American Life Insurance Company, Prudential Insurance Company of America, Travelers Insurance Company

Administrative costs are a relatively small percentage of total medicare costs. In fact, unit costs have been decreasing rather dramatically in recent years despite inflation and program growth. In light of the present escalation in the rate of inflation, we would have to question how any organization could realistically bid on a three or five year contract with any degree of certainty.

There is no real incentive under a fixed price approach to be concerned about benefit costs or beneficiary services. It is our understanding that certain major bidders (other than commercial companies) have stated that with government emphasis on fixed price contracts, they have had to eliminate many cost containment features from their bid in order to remain competitive.

There is also the danger that there might be attempts made to "buy" the business. We are not implying that this is what happened in the New York procurement, but one has to seriously question how the winning bid could be about 60% lower than the level at which the winning Carrier is presently operating.

Based upon what we consider to be totally unrealistic awards in Illinois and New York, we believe that the government will see the number of bidders in the future decreasing rather rapidly. HCFA will eventually be left with only one or two data processing concerns in the bidding arena, which could produce adverse effects on both the future cost and control of the Medicare program. It should be noted that a single data processing organization has been connected with the three fixed price awards made to date, namely, Maine, Illinois and New York.

To sum up our comments in this area, we do not believe that the prices quoted in the Illinois and New York awards can be achieved without serious consequences in terms of benefit cost and/or beneficiary services. Since these two contracts are not yet fully operational, there has been no opportunity to make a proper assessment. It seems, therefore, imperative to us that before the fixed price approach is adopted as standard that the existing experiments be evaluated over the full term of the contracts.

With respect to performance standards, we do not believe that they should be incorporated into the Medicare contracts at this time. Standards have neither been developed nor tested. We do, however, fully support development and use of appropriate standards for identifying poor or marginal performing contractors.

As to the combination of Parts A and B, we do not look on this as a matter of top priority. The merger of functions is not as simple or as logical as might appear on the surface because there are many more subjective determinations to be made under Part A than under Part B, both with respect to claims and audit, all of which have significant

program cost implications. Not to be overlooked is the fact that a combination of A and B would have a tendency to reduce the number of potential bidders since many Part B Carriers do not have an audit capability and, therefore, would be unable to compete effectively.

The report points to a merged claims processing operation as a possible benefit to be derived from the combination of Part A and Part B. None of the insurance organizations presently handling both Parts A and B in a particular jurisdiction have so merged their claims processing systems because of the vast differences between the two programs. The Part B program lends itself to a high degree of computerization, whereas the Part A program does not. Therefore, with respect to the recommendation that experiments be conducted to demonstrate the feasibility of merging Parts A and B (and its effectiveness in requiring an integrated software system), we agree and urge that any experimentation be limited in scope and carefully evaluated throughout the full term of the experiment.

We support the recommendation to experiment with incentive contracting, e.g., cost plus incentive fee. The prototype contract submitted by our Committee, and referred to in the report, was simply an example of this type arrangement. It was fully expected that all provisions would be subject to negotiation.

Any reduction in the number of Carriers and Intermediaries should not take place until appropriate performance standards have been developed and contractors provided a reasonable time frame in order to meet such standards. Under no circumstances should termination be based solely on administrative costs. Prime consideration must be given to beneficiary services which could be severely disrupted as was the case in CHAMPUS, as noted in the report.

The following comments are directed to the proposed Recommendations To The Congress as set forth in the Review section of the report.

It is not clear to us and, therefore, might not be clear to the Congress how the standby authority relative to fixed price procurement might operate from a procedural standpoint. Further elaboration on this concept would be helpful.

The recommendation to terminate the national RRB Carrier might be a cause for concern due to the fact that it will result in disruption of service and inconvenience to the RRB beneficiaries. It is our understanding that the Travelers Insurance Company will address the specific recommendations in a separate letter.

We endorse the recommendation that Medicaid crossover claims be processed by Medicare contractors using integrated data processing systems as our experience appears to indicate that such an approach would not impact beneficiaries-providers adversely and would be clearly cost effective.

In conclusion, we would point out that it is recognized that the Medicare program has operated fairly smoothly with its existing administrative structure. The Medicaid program, on the other hand, has experienced severe problems for many years. While we recognize that it was not within your charge from Congress, we would suggest that the General Accounting Office give consideration to recommending that priority emphasis be placed on the Medicaid program bringing it more in line from both an administrative and benefit standpoint with the Medicare program.

Changes in that program would appear to have the greatest potential for cost savings, an area of extreme importance today in light of continued pressure to cut Federal spending and reduce the rate of inflation.

We appreciate the opportunity to comment on this report.

Sincerely,

T. J. Scully, Jr.

Chairman
Medicare Administration Committee
Health Insurance Association of America

cc: Mr. P. M. Hawkins

MEDICARE

May 15, 1979

Mr. Gregory J. Ahart
Director
United States General Accounting Office
Human Resources Division
Washington, D.C. 20548

Dear Mr. Ahart:

General Accounting Office Report No. B164031(3)

In commenting on Chapter 9 of the captioned report, we are pleased that the General Accounting Office recognizes that The Travelers performance as carrier for the Railroad Retirement Board has improved substantially since the earlier report was issued in 1971. This report confirms that the quality of claim processing and time-to-payment has consistently been better than the national average. Based on your surveys a high degree of satisfaction exists with beneficiaries and providers as to the service being provided. The report recognizes that administrative costs have been contained, but it should be noted that these costs have been consistently decreasing.

The heavy emphasis placed on past experience and costs that could have been saved is not relevant and should not be considered in evaluating the current situation.

Our comments address five primary areas --- economies of scale, incremental costs, reasonable charge determinations, misrouted claims, and processing quality.

The report contains considerable detailed statistics and comparisons designed, in our opinion, to support a preconceived conclusion, as did the earlier GAO report. For example, in commenting on the anticipated savings, the report states "These savings would result from the economies of scale that are present in the larger claims processing operations of the area carriers." The material presented would then have one believe that substantial savings could be achieved because the Railroad Medicare offices cannot take advantage of the economies of scale. This is very misleading in that the report does not recognize that The Travelers is the Medicare-Part B carrier for the states of Minnesota, Mississippi, and Virginia. Using FY-1978 statistics, these states produced a volume of 3,821,000 claims. Combined with the 3,544,000 RRB claims, the total Travelers volume was 7,365,000 claims that were processed through the same system. The Travelers is the fourth largest carrier in the U.S. How can it be said that economy of scale is not present when our volume is greater than 90% of the Part B carriers. Even when considering the claim volume in the five individual Railroad Medicare offices, there were eleven area carriers with a claim volume smaller than the smallest Railroad Medicare office.

THE TRAVELERS INSURANCE COMPANIES
One Tower Square • Hartford, Connecticut 06115

It is indicated that fourteen (14) area carriers were asked to furnish estimates of incremental costs for processing RRB Medicare claims in their service area. We do not agree that the incremental cost theory is valid, particularly when applied to such a variable situation. The spread of incremental costs range from $.26 to $2.83. The estimates and conclusions drawn from them are not valid for a number of reasons. Only large carriers were used in the survey. It is indicated that these fourteen (14) carriers processed over 53% of the RRB Medicare claims. This means that there were fifty-three (53) carriers processing only 47%. Considering the heavily emphasized economies of scale theory, this would cause a substantial distortion. Secondly, statements by carriers without the responsibility of actually processing the claims are subject to serious question, particularly when one reported twenty-six (26) cents.

Extensive comments were made concerning reasonable charge determination, an area which is receiving considerable attention by the Health Care Financing Administration. HCFA has indicated preference for moving toward a fee schedule which would resolve the problem. Because of the effect of the economic factors now being applied, the Physicians Profiles are becoming more and more a fee schedule, whereby most charges are screened against the prevailing level.

The fact that different payments are made for the same procedure by different carriers is not new under the program. A beneficiary in Mississippi pays the same Medicare premium as a beneficiary in New York, yet the payments are vastly different. Carriers have their own geographic medical service areas; specialty groupings within those areas are different, and each has its own unique coding procedure. These all add up to differences in the payments being made.

Considerable attention is devoted to the number of physicians' charges required to establish a customary fee. It is doubtful that there is anything significant about these numbers in that they have constantly changed over the years.

A review of the Quarterly Report on Part B Reasonable Charge and Denial Activity will show that the percentage of reductions in covered charges due to reasonable charge determinations by the RRB carrier is almost identical to the national average, whereby other carriers varied from ten (10) percentage points above to eight (8) percentage points below the average.

It was never intended that the Railroad Medicare payments would exactly duplicate those made by the area carriers in every instance. The initial delegation provided that payments for services would " .. conform as closely as possible ...". After all of the extensive comparisons were made by the GAO, involving thousands of dollars, the net difference came out to the RRB having paid a total of $135 less than the area carriers. We believe that this is about as close as one could hope for, and can leave little doubt but that a reasonable degree of conformity is being achieved.

The report overstates the problem with misrouted claims, and fails to take into account some very simple solutions that could be accomplished without resorting to the major changes recommended.

For many years there was confusion caused by the fact that some RRB beneficiaries had HIC numbers with a prefix, and some with a suffix. This has now been corrected, whereby RRB beneficiaries have HIC numbers with a prefix providing for easy identification.

A recommendation made to HCFA, which they have agreed to implement, will substantially reduce misrouting. Carrier manual instructions currently require the area carriers to notify the beneficiary when a claim is being transferred to another carrier. With respect to Railroad Medicare claims, this not only causes delays but tends to perpetuate the problem. This notification requirement is being eliminated, and the area carriers directed to identify and transfer the claim at the front end of the claim process, thereby saving time and with little cost involved.

Additionally, The Travelers now has the capability to imprint claim forms for larger providers with a return address which will provide significant improvement.

Recognition is given in the report that there has been substantial improvement in the processing quality; however, it does not identify what this means in terms of program dollars. In FY-1978, the deductible-payment error rate for Railroad Medicare claims was 1.46% compared to a national average of 2.1%. These percentages, when applied to the total submitted charges for Railroad beneficiaries, produce a reduction in erroneous payments of over TWO MILLION DOLLARS.

In conclusion, it is evident that great effort was expended by the General Accounting Office to support the same recommendations made by them in 1971. We do not agree that the changes recommended are necessary, nor that the conclusions concerning costs savings are substantiated or indicative of current performance. Unfortunately, the report is biased in its findings and conclusions in that it omits many pertinent facts as shown in our comments. The reasons for the initial delegation and the subsequent change in statute by the 89th Congress are as valid today, if not more so, than when initiated in 1966. The Railroad Retirement Board has indicated their satisfaction with the service being provided as have Railroad Management and Labor.

Very truly yours

L. E. Carter
Second Vice President
Medicare Administration

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