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FEDERAL HEALTH CARE

Comments on H.R. 4401, the Health Care Infrastructure Investment Act of 2000

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Mr. Chairman and Members of the Subcommittee:

Thank you for inviting us to participate in today's hearing on H.R. 4401, the Health Care Infrastructure Investment Act of 2000. As you know, this is a companion to Senate bill S. 2312 of the same name. H.R. 4401 calls for the establishment of an advanced informational infrastructure to immediately process certain health benefits claims.

After briefly discussing the bill's provisions, we will address the current Medicare part B claims process and how it can be used to pay claims more quickly. We will then provide our perspectives on (1) the development of an immediate claim, administration, payment resolution, and data collection system that would initially be applied to the Medicare part B program; (2) applying this system to the Federal Employees Health Benefits Program (FEHBP); and (3) the role and composition of a proposed Health Care Infrastructure Commission. Finally, as requested, we will point out some of the lessons drawn from a failed HCFA information technology project in the mid-1990s that could pertain to the systems development effort envisioned by this bill.

H.R. 4401: The Health Care Infrastructure Investment Act of 2000

H.R. 4401 would establish a Health Care Infrastructure Commission within the Department of Health and Human Services (HHS) to design, construct, and implement an immediate claim, administration, payment resolution, and data collection system that would initially be used by the Medicare part B program.[1] This system would (1) immediately advise each provider and supplier of coverage determination; (2) immediately notify each provider and supplier of any incomplete or invalid claims, including the identification of missing data and coding errors; (3) immediately process clean claims[2] so that a provider or supplier may provide a written explanation of medical benefits, including costs and coverage to any beneficiary at the point of care; and (4) allow electronic payment of claims for which payment is not made on a periodic payment basis. The bill also calls for the commission to conduct and publicize a study, with final recommendations, on the design and construction of such a system within

[1]Medicare is a combination of two insurance programs, hospital insurance (part A) and optional supplementary insurance (part B), each with its own enrollment, coverage, and financing. The Supplementary Medical Insurance trust fund covers part B claims payments for medical services provided by physicians, laboratories, and an array of other providers and suppliers. In fiscal year 1999, Medicare part B fee-for-service costs were about $61 billion.

[2]42 U.S.C. 1395u(c)(2)(B)(i) defines a clean claim as one that has no defect or impropriety (including the lack of any required substantiating documentation) or particular circumstance requiring special treatment that prevents timely payment from being made on the claim.

3 years and establishes a timetable with specific performance measures for its initial, intermediate, and full implementation. Another key provision of H.R. 4401 that relates to the Medicare program is the elimination of section 1842(c)(3) of the Social Security Act (42 U.S.C. 1395u(c)(3)), which prohibits the payment of claims until after 13 calendar days from the date received if electronically submitted or until after 26 calendar days if manually submitted.

In addition, H.R. 4401 would affect FEHBP—the federal government's health benefits program for employees and retirees—which is run by the Office of Personnel Management (OPM). It would require OPM to adapt the immediate claim, administration, payment resolution, and data collection system for use by FEHBP and require FEHBP carriers to use that system. H.R. 4401 also sets a timetable with specific performance measures for initial, intermediate, and full implementation of the system.

Although H.R. 4401 is explicit in that the proposed system would cover the Medicare part B program and FEHBP, it is unclear whether other federal health programs would also be included in this system. H.R. 4401 calls for the establishment of an advanced informational infrastructure for "[f]ederal health benefits programs which consists of an immediate claim, administration, payment resolution, and data collection system . . . that is initially for use by carriers to process claims submitted by providers and suppliers under part B of the [M]edicare program . . . ." (In a later section, the bill requires that this system be applied to FEHBP.) The bill does not define "federal health benefits programs," and provides for inclusion of only Medicare part B and FEHBP in the system. However, if in the future the proposed system is intended to include other federal health benefits programs such as Medicare part A, Medicaid, veterans' health services, the Department of Defense's health services, and Indian health services, development and implementation of the system envisioned by the bill would be different and much more challenging.

These other federal health programs are markedly different. In some cases, the federal government acts like other large employers that contract with insurance companies and health plans to offer health benefits to employees and their dependents. In other cases, it acts like a large insurance company that pays directly for health care services. In still other instances, it acts like a large staff-model health maintenance organization[3] that operates a network of hospitals and employs health care professionals. Accordingly, if the proposed real-time claims processing

[3]In a staff-model health maintenance organization, physicians are salaried employees.

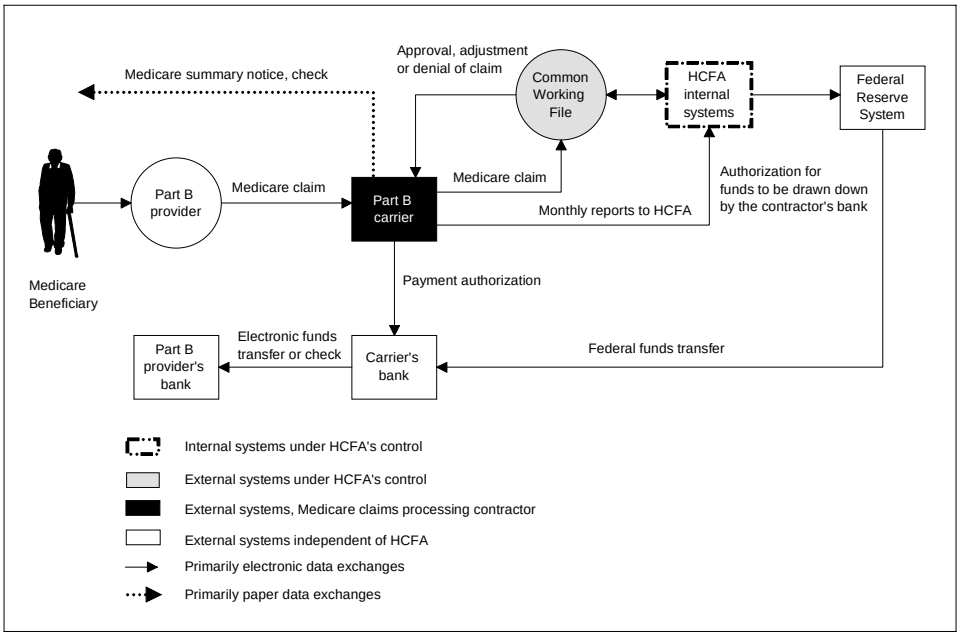
system were to later be intended to address the claims processing requirements of any of these programs, it would have a significant impact on the system's design and complexity.

Current Medicare Part B Claims Process

Administered by HHS' Health Care Financing Administration (HCFA), Medicare is the nation's largest health insurer, covering almost 40 million beneficiaries at a cost of over $200 billion annually. Medicare operates through a complicated administrative structure. Its authorizing legislation—title XVIII of the Social Security Act—required HCFA to contract with the private sector for claims processing and payment functions. This requirement has led to a large contractor network comprised of insurance companies responsible for processing Medicare claims in given states. These Medicare contractors are responsible for claims processing and administration, including (1) receiving claims; (2) judging their appropriateness; (3) paying appropriate ones promptly; (4) identifying potentially fraudulent claims or providers, and withholding payment, if necessary; and (5) recovering overpayments or inappropriate payments. Contractors develop a set of criteria to determine which claims to pay, guided by laws, regulations, the Medicare policy manuals, and periodic agency directives.

For the Medicare part B program, HCFA uses 22 companies doing business as carriers to process claims. Each carrier relies on one of four standard systems to process its claims, adding its own front-end and back-end processing systems. These systems interface with the common working file (CWF)—a set of nine databases containing beneficiary information for specific geographic regions—to authorize claims payments and determine beneficiary eligibility. The CWF obtains information, such as beneficiary enrollment data, from HCFA's internal systems. Contractors pay approved claims by check or by electronic funds transfers. Each day, contractors' banks draw money from the Federal Reserve System sufficient to cover the provider checks and electronic funds transfers expected to clear the bank during the next business day. Figure 1 provides an overview of the Medicare fee-for-service claims process for the part B program.

Figure 1: Overview of the Medicare Part B Fee-For-Service Claims Process

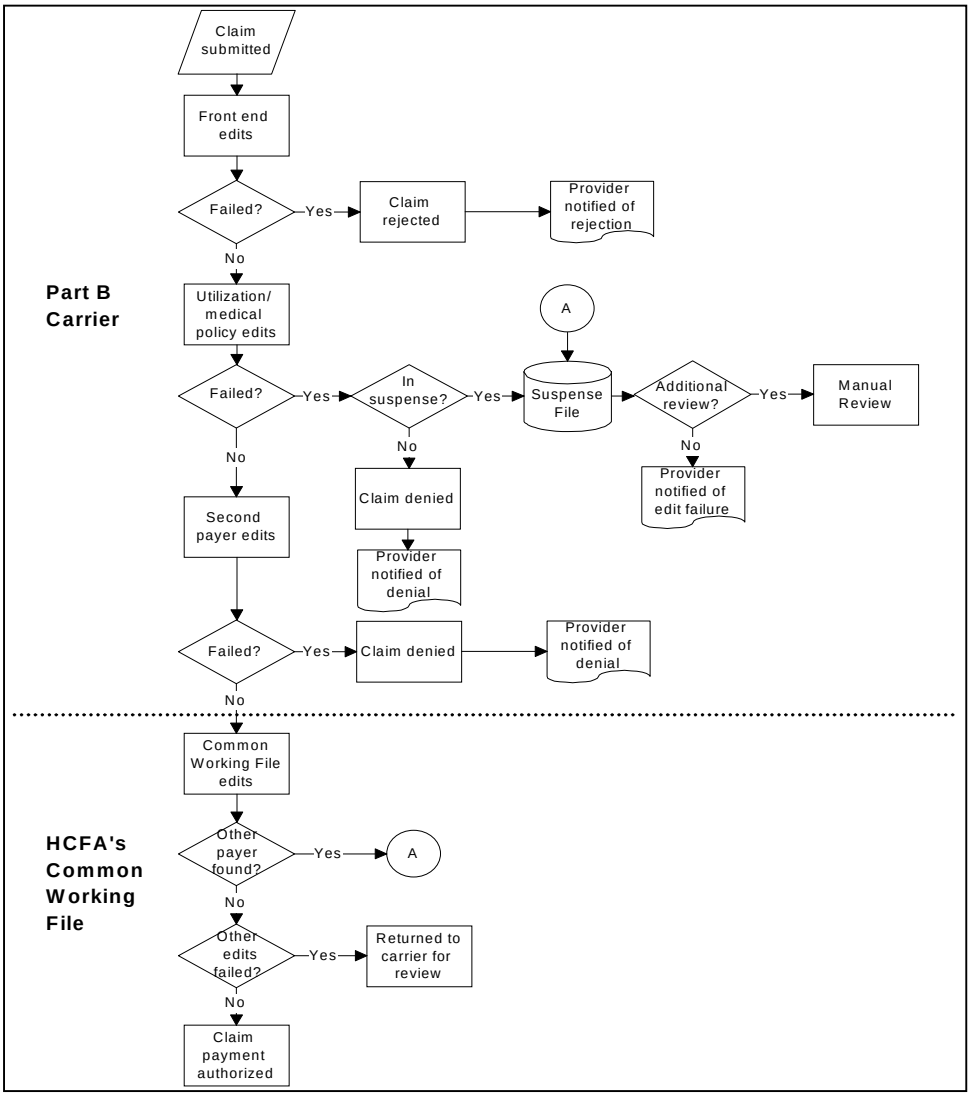


Note: The claims process also includes a data exchange with the Social Security Administration, which is used to determine beneficiary eligibility.

Source: GAO, from HCFA documentation.

In fiscal year 1999, about 81 percent of part B claims that were completed were submitted electronically by providers or billing services, which use one of two standard electronic formats. As illustrated in figure 2, once claims are submitted, carriers and HCFA use a variety of automated edits to determine the validity of these claims.

Figure 2: Example of a Part B Claims Automated Edit Process



Note: This flowchart does not reflect claims payment adjustments that may occur.

Source: GAO, verified by officials from two carriers.

Carriers generally use three types of edits before authorizing the payment of a claim. First, front-end edits are used to ensure that valid values are used and appropriate fields are completed. Claims that fail the front-end edits are rejected and returned to the provider. Second, carriers use utilization/medical policy edits to check claims against the medical-necessity criteria in medical policies. Utilization/medical policy edits are particularly important because Medicare pays providers a fee for covered medical services, which are identified through a complex, three-level coding system, the HCFA Common Procedure Coding System. Using these codes, utilization/medical policy edits flag indicators such as whether the medical diagnosis was appropriate for the patient's gender or age or whether the medical procedure exceeded the threshold allowed during a given year. These edits can result in (1) a claim passing to the next set of edits, (2) a claim denial, (3) a claim being suspended until a manual review by claims examiners (who may request additional documentation) is conducted, or (4) a claim adjustment. The third type of carrier edits check for other payers, which are other primary sources of payment, such as employer-sponsored insurance or third-party liability settlements. If another potential payer is identified, the claim is generally denied.

Once a claim passes the carrier edits, the claim is checked against one of the nine CWF's that are processed at seven different computer sites around the country. The CWF edits check for items such as beneficiary eligibility, deductibles and limits, and duplicate claims. These edits can result in (1) an authorized claim, (2) a claim returned to the carrier for further review, or (3) a claim adjustment. The CWF also checks for other payers and, if found, the claim is returned to the carrier for further review.

Medicare Part B Claims Could Be Paid Faster Using Current Processes, But Less Interest Would Be Earned

One outcome of developing an immediate claim, administration, payment resolution, and data collection system would be faster Medicare part B claims payments. However, most Medicare claims could be paid more quickly using current processes by simply eliminating the mandatory delay in paying claims. Specifically, by enacting the section of the bill that eliminates the mandatory claims payments delay until after 13 calendar days from the date of electronic submission (26 calendar days if submitted manually), the mean time to pay claims would likely be substantially reduced. The mean time for processing and paying a clean part B claim[4]

[4]In obtaining performance information from its carriers, HCFA defines a clean claim as one that did not require the carrier to investigate or develop outside of the carrier's Medicare operations on a prepayment basis. Ninety-nine percent of all completed paid claims were designated as clean claims in fiscal year 1999.

that required minimal or no manual intervention was 17.3 days in fiscal year 1999 (14.5 days for electronic submissions). However, HCFA estimates that carriers process almost two-thirds of all claims within 5 days.[5] Once processed and authorized for payment, the claims are held until the next payment cycle after the 13- or 26-day requirement has been met (carriers generally make payments every work day). The carrier then issues a check or authorizes an electronic funds transfer to pay the claim.

One drawback to eliminating the mandatory payment delay is that the Supplementary Medical Insurance trust fund, from which the Medicare part B program is funded, would lose some of the interest it earns on its balance if payments were made more quickly. Under HCFA's current claims processing environment, we estimate that the trust fund could lose as much as about $140 million in interest revenue annually if the mandatory payment delay were removed. This amount assumes (1) annual part B outlays of $60 billion, (2) that the average time to pay claims would drop from 17.3 days to 5 days, and (3) an average interest rate of about 7 percent on securities.[6] The amount the trust fund could lose may be even higher if a real-time claims processing system were implemented because the average time to pay a claim could drop below 5 days. The Medicare Supplementary Medical Insurance trust fund is financed by payments from federal government general revenues and by monthly premiums charged beneficiaries. Consequently, a decrease in interest earnings could prompt the need for additional appropriations or increases in beneficiaries' premiums to compensate for the interest that the trust fund would otherwise have earned.

[5]HCFA does not keep statistics on how much of the average claims processing time is due to computer processing; however, it estimated this time based on the time period from the date of claim receipt to the date that the authorized claim is returned to the carrier from the CWF, and assumed that carrier processing took an additional 2 days.

[6]We derived this interest rate by taking the weighted average of the interest rates of the outstanding bonds in the Supplementary Medical Insurance trust fund as of September 30, 1999.

Actions to Minimize Risks Necessary Before Developing an Immediate Claim, Administration, Payment Resolution, and Data Collection System

While the development of an immediate claim, administration, payment resolution, and data collection system to be used by the Medicare part B program might be feasible, it would significantly change the government's current processes because it would require the real-time processing of certain elements of the claims process that are currently performed in batch mode or manually.[7] In the abstract, a real-time Medicare part B claims process could be achievable if appropriate systems development policies and techniques are used. Although more beneficiaries might have to pay their copayments immediately, it could provide health care providers and beneficiaries with several benefits—primarily the immediate notification of approved or denied claims. However, without appropriate safeguards, a real-time claims processing system could involve serious risks because it opens the process to a possible rise in the number of improper Medicare payments.[8] In addition, the technical and cost risks associated with developing a real-time claims processing system could be considerable.

A Real-Time Medicare Claims Processing System Should Include Controls to Minimize Improper Payments

We have long identified Medicare as a high-risk program that is vulnerable to fraud, abuse, and payment errors.[9] Many of Medicare's vulnerabilities stem from its size and decentralized administrative structure, which make it a perpetually attractive target for exploitation and make payment errors more likely. Because wrongdoers are continually finding new ways to dodge program safeguards, HCFA and its contractors periodically revise their pre-payment edit and post-payment audit routines. As a result, the proposed real-time claims processing system must include appropriate internal controls to help ensure that operational problems are minimized and program integrity protected. Key to the design of appropriate controls is the effective assessment of both external and internal risks that an agency faces in achieving its objectives, as well as determining how risks should be minimized.[10]

[7]Real-time mode relates to processing that responds to an external event within a short and predictable time frame. Batch mode relates to processing application programs and their data individually, with one being completed before the next is started.

[8]HHS' Office of the Inspector General estimated improper Medicare fee-for-service payments at $13.5 billion for fiscal year 1999.

[9]*High-Risk Series: An Update* (GAO/HR-99-1, January 1999), *High-Risk Series: Medicare* (GAO/HR-97-10, February 1997) and *High-Risk Series: Medicare Claims* (GAO/HR-93-6, December 1992).

[10]The Comptroller General's *Standards for Internal Control in the Federal Government* provides a useful framework when considering the types of essential control activities that should be incorporated into a fully integrated information technology system.

A major internal control challenge that a real-time claims processing system would have to overcome is ensuring that prepayment processes currently performed manually are adequately addressed. Any new real-time claims process applied to all claims would have to find a way to accommodate existing manual processes (e.g., postpone until after claims payment or provide tentative claims approval in certain circumstances), such as in the case of claims examiners' reviews of claims that are suspended because they did not pass utilization/medical policy edits or in cases that involved claims in which Medicare should be the secondary, rather than primary, payer. This latter issue is particularly problematic because determining another insurer's liability can be a time-consuming process of discovering whether insurance coverage overlaps and, if so, ascertaining Medicare's liability. If issues such as these are not adequately addressed, additional improper Medicare payments can result.

It is also essential that current program safeguards, such as the edit process illustrated in figure 2, not be compromised. The utilization/medical policy edits that address the often complex art of coding claims are a particular area of concern. As previously mentioned, HCFA's Common Procedure Coding System uses three levels of codes:

- Level 1, the American Medical Association's Physicians' Current Procedural Terminology, consists of a list of 5-digit codes for most of the services performed by physicians. These codes are used to bill for most procedures and services but have limited selections for describing supplies, materials, and injections.

- Level 2 are national codes that supplement the level 1 codes and are used to bill for a range of services and supplies such as vision services and surgical supplies. These codes have a uniform description nationwide, but due to what is known as "carrier discretion," their processing and reimbursement are not necessarily uniform.

- Level 3 are local codes developed by individual Medicare carriers. The codes are often used to describe new services, supplies, and materials, as well as to report procedures and services that have been deleted from Current Procedural Terminology codes but are still recognized and reimbursed by the carrier.

The Medicare coding system is difficult to use because it (1) attempts to identify codes for all accepted medical procedures, including codes to describe minor procedures that are components of more comprehensive procedures, and (2) changes every year. For example, the fee for surgery often includes the cost of related services for the global service period,

that is, for a set number of days before and after the surgery. To prevent overpayment in these cases, Medicare carriers need to identify when claims for surgery include codes that represent related services and reduce the payment accordingly. These complexities can inadvertently lead providers to submit improperly coded claims. They also make the Medicare program vulnerable to abuse from providers or billing services that attempt to maximize reimbursement by intentionally submitting claims containing inappropriate combinations of codes.

Because a real-time claims processing system can be particularly vulnerable to code manipulation (e.g., through repeated submission of fraudulent claims until they pass the system's edits), it would be prudent to exclude problem providers from participating in a real-time system and require that new providers complete a probationary period before they become eligible to participate. In another situation—agency "fast pay" initiatives (when payment authorization is made prior to verifying receipt and acceptance of goods or services)—we have similarly stated that agencies should limit its use to those cases in which suppliers have had and continue to have good ongoing business relationships with the agency.[11] While the system proposed by H.R. 4401 is not a "fast pay" situation, it would be prudent to employ these same controls since Medicare has areas in which mispayment and fraud have been particular problems. For example, medical equipment supply is an area vulnerable to fraud, as indicated by its the high payment error rate. Indeed, according to fiscal year 1997 and 1998 Department of Justice reports, a few medical equipment suppliers were able to enroll in the Medicare program and obtain millions of dollars in fraudulent payments before post-payment reviews and utilization analyses were able to identify the fraudulent activity.[12]

Further, ensuring that adequate documentation controls (e.g., detailed history files and/or logs) are in place and enforced to ensure that the electronic trail is not lost or tampered with would be particularly important in a Medicare real-time processing environment. The importance of maintaining detailed Medicare payment histories and medical records is demonstrated by the results of HHS' Office of the Inspector General's fiscal year 1999 claims review. The Office of the

[11] *Streamlining the Payment Process While Maintaining Effective Internal Control* (GAO/AIMD-21.3.2, May 2000).

[12] *Department of Justice, Health Care Fraud Report*, Fiscal Year 1997 and *Department of Justice, Health Care Fraud Report*, Fiscal Year 1998.

Inspector General found that claim payment histories and provider medical records were essential to identifying the payment errors it found.

Technical and Cost Risks Should Also Be Considered

In addition to the Medicare part B improper payment implications of H.R. 4401, other considerations to be taken into account are the technical and cost risks associated with the development and implementation of a real-time claims processing system. The Clinger-Cohen Act requires agency heads to design and implement a process for maximizing the value and assessing and minimizing the risks of information technology acquisitions. Guidance prepared by the Office of Management and Budget and by us on how to implement such a process calls on agencies to assess projects' benefits, costs, and risks.[13] Items to consider before undertaking an information technology project include the project's return on investment, its link to the business' objectives or strategic plan, and evidence of compliance with the organization's overall systems architecture. Without such analyses, it is risky to require that this system be implemented.

Response times, which can be slowed by the amount and type of telecommunications involved and the complexity of processing, are a critical factor in the success of real-time systems. An example of a systems development that failed, in part due to a response time problem, is the Bureau of Land Management's Automated Land and Mineral Record System Initial Operating Capability. As we testified in March 1999, during an operational assessment test and evaluation, users reported that system response time problems were severe or catastrophic at all test sites.[14] Because of this and other problems and after obligating over $67 million, the Bureau of Land Management decided that the Initial Operating Capability was not deployable. While a high-quality system design would reduce the risk of slow response times, hundreds of thousands of providers could be submitting millions of transactions daily (carriers completed action on almost 718 million Medicare part B claims in fiscal year 1999). Moreover, it is critical that system controls (such as the many and varied edits previously discussed) not be compromised in an effort to achieve reasonable response times.

[13] *Evaluating Information Technology Investments: A Practical Guide* (OMB, November 1, 1995) and *Assessing Risks and Returns: A Guide for Evaluating Federal Agencies' IT Investment Decision-Making* (GAO/AIMD-10.1.13, February 1997).

[14] *Land Management Systems: Major Software Development Does Not Meet BLM's Business Needs* (GAO/T-AIMD-99-102, March 4, 1999). Other problems that the operational assessment test and evaluation discovered were that the system did not meet requirements and that data converted from legacy databases were not accurate.

Security, already a major concern in the Medicare program, must also be adequately addressed in any proposed real-time claims processing system. H.R. 4401 requires that the real-time claims processing system include strict security measures that guard system integrity, including protecting the privacy of patients and the confidentiality of personally identifiable health insurance data. Implementing such requirements, however, is not easy.

Both HHS' Office of the Inspector General[15] and we[16] have reported that HCFA's computer controls do not effectively prevent unauthorized access to, and disclosure of, sensitive Medicare information. This problem could be compounded if appropriate security controls are not designed into the proposed system. In particular, without appropriate controls, electronic connections can provide a path that can be used by hackers and others to gain access to databases that contain sensitive information or to simply disrupt operations.

Recent experiences with the Melissa and "ILOVEYOU" computer viruses demonstrate the formidable challenge the federal government faces in protecting its information technology assets and sensitive data.[17] Although key government services remained largely operational, these viruses were disruptive and provided evidence that computer attack tools and techniques are becoming increasingly sophisticated. Moreover, if the design for the real-time claims processing system includes a World Wide Web-based system, the possibility of other types of attacks must also be considered and addressed. For example, a "denial-of-service" attack (e.g., a web site is flooded with fake requests for pages) can make it difficult or even impossible for legitimate customers to access a web site or cause the targeted system to crash.[18] Computer attacks are also a cause for broader

[15] *Report on the Financial Statement Audit of the Department of Health and Human Services for Fiscal Year 1999*, Report No. A-17-99-00002, February 2000.

[16] *Financial Management: Agencies Face Many Challenges in Meeting the Goals of the Federal Financial Management Improvement Act* (GAO/T-AIMD-00-178, June 6, 2000); and *Medicare Financial Management: Further Improvements Needed to Establish Adequate Financial Control and Accountability* (GAO/AIMD-00-66, March 15, 2000).

[17] *Information Security: The Melissa Computer Virus Demonstrates Urgent Need for Stronger Protection Over Systems and Sensitive Data* (GAO/T-AIMD-99-146, April 15, 1999); *Information Security: "ILOVEYOU" Computer Virus Emphasizes Critical Need for Agency and Governmentwide Improvements* (GAO/T-AIMD-00-171, May 10, 2000); and *Critical Infrastructure Protection: "ILOVEYOU" Computer Virus Highlights Need for Improved Alert and Coordination Capabilities* (GAO/T-AIMD-00-181, May 18, 2000).

[18] *Information Security: Recent Attacks on Federal Web Sites Underscore Need for Stronger Information Security Management* (GAO/T-AIMD-99-223, June 24, 1999).

information security concerns across government because of the inability to detect, protect against, and recover from computer attacks; inadequately segregated duties, which increase the risk that people can take unauthorized actions without detection; and weak configuration management processes.

Developing a Single Real-Time Claims Processing System for Both Medicare Part B and FEHBP Would Be Challenging

Because Medicare part B and FEHBP are substantially different programs, it would be difficult to design and implement a single system to process claims under both programs, as called for by H.R. 4401. Specifically, H.R. 4401 requires that (1) OPM adapt the immediate claim, administration, payment resolution, and data collection system for use by the FEHBP and (2) carriers participating in FEHBP use the system to satisfy certain minimum requirements for claim submission, processing, and payment.

Under FEHBP, the government contracts with private plans to finance or provide care to federal workers and retirees for negotiated annual premiums. The government runs no plans, pays no claims, and its financial obligations are limited to its share of the cost of the private plan premiums and certain administrative costs. For 2000, federal employees could select from seven nationwide fee-for-service plans,[19] six fee-for-service plans open to specific groups, and hundreds of health maintenance organization plans available throughout the nation.

As we explained in August 1998, Medicare and FEHBP are significantly different.[20] For example, HCFA and its carriers authorize claims payments and monitor abuse or fraud, while these roles are delegated to the hundreds of health plans that are enrolled under FEHBP.[21] In addition, traditional Medicare covers the same standard package of services and requires the same deductibles, coinsurance, and copayment requirements for all beneficiaries. In contrast, FEHBP does not require participating plans to cover a standard or core benefits package. Although all plans offer inpatient hospital and outpatient medical coverage as well as certain OPM-required services, specific benefits vary. These differences would make it challenging and costly to design and implement a real-time claims processing system for both programs. Moreover, FEHBP carriers may balk at being forced to implement a system that was not developed with their

[19]Three of these plans have two options (standard and high).

[20]*Federal Health Programs: Comparison of Medicare, the Federal Employees Health Benefits Program, Medicaid, Veterans' Health Services, Department of Defense Health Services, and Indian Health Services* (GAO/HEHS-98-231R, August 7, 1998).

[21]A single company can administer multiple health plans.

particular systems and processes in mind, and it could cause them to drop out of the program.

Role and Composition of the Health Care Infrastructure Commission Should Be Carefully Considered

The implications of having a real-time claims processing system that would initially be used by Medicare part B carriers and be developed and implemented by the seven-member Health Care Infrastructure Commission instead of HCFA should be carefully considered.[22] Specifically, the bill charges the commission, which does not include HCFA, with designing, constructing, and implementing a real-time claims processing system. Adding another organization to the already complicated Medicare process would compound the project's complexity. Moreover, any system related to processing Medicare part B claims would greatly affect HCFA's current systems as well as its future systems development. Further, the bill is silent on whether the commission would also be responsible for maintaining the system, which raises additional uncertainties about the commission's and HCFA's respective roles.

The commission could elect to use HCFA for the development, implementation, and maintenance of the system. In such a case, if a real-time claims processing system is to be developed, it may be more fitting for the proposed commission to oversee HCFA's actions, rather than develop and implement the system itself. Such oversight could include evaluating the system design and monitoring HCFA's development and implementation actions.

Aside from its role, the composition of the commission also needs to be carefully considered. In particular, having health care and financial management expertise on the commission would be critical. As currently conceived, though, the commission includes several officials from federal agencies with expertise in advanced information technology but not health care or financial management. Specifically, the bill explicitly calls for each official appointed to the commission to "be an expert in advanced information technology" but does not address health care or financial management expertise. If a real-time claims processing system is to be developed, as envisioned by the bill, consideration should be given to including key HCFA and carrier officials with health care claims

[22]The commission would be chaired by the Secretary of Health and Human Services and have members from the Department of Defense's Defense Advanced Research Projects Agency, the Department of Veterans Affairs, the National Aeronautics and Space Administration, the National Science Foundation, the Office of Management and Budget, and the Office of Science and Technology Policy. The bill also allows the chairman of the commission to appoint an executive director and other personnel and to procure temporary and intermittent services.

processing, program integrity, and financial management expertise on the commission.

One reason it is important for HCFA and its contractors to be part of the commission is that the development of a real-time claims processing system could overlap—and possibly conflict with—ongoing and planned HCFA initiatives, which could be costly and disruptive to both efforts. For example, HCFA plans to transition from four to two standard Medicare part B systems (one is only for durable medical equipment carriers) by fiscal year 2003. Initiatives such as this would clearly affect, and be affected by, a real-time claims processing system.

Other entities that should be considered for membership in the commission if the real-time claims processing system set out in the bill is to be developed are OPM and providers. A representative from OPM should be considered as a member of the commission since, as currently called for in the bill, any system developed would be applied to the FEHBP. Moreover, it may be desirable to have a representative from the provider community on the commission, since a real-time claims processing system would also significantly affect providers.

Past HCFA Failure Could Provide Useful Lessons for Proposed System

A past HCFA system development failure could provide valuable lessons in the type of approach that could be taken to determine whether a cost-effective, real-time claims processing system can be built. In the mid-1990s HCFA attempted to improve the efficiency and effectiveness of its Medicare operations by developing one unified computer system—the Medicare Transaction System (MTS)—to replace its existing standard systems. This single system would have integrated data from Medicare part A and part B and managed care and provided a comprehensive view of billing practices. As we previously reported, the MTS project encountered problems from the very beginning.[23] It was plagued with schedule delays, cost overruns, and the lack of effective management and oversight. Ultimately, in August 1997, HCFA terminated the MTS contract on which it had spent over 3 years and about $80 million. Although about $50 million of this amount was for software development (the other $30 million went to internal HCFA costs), this failed project did not produce integrated claims processing software. As we testified in September 1997, MTS provided HCFA with a huge learning experience

[23] *Medicare: New Claims Processing System Benefits and Acquisition Risks* (GAO/HEHS/AIMD-94-79, January 25, 1994) and *Medicare Transaction System: Strengthened Management and Sound Development Approach Critical to Success* (GAO/T-AIMD-96-12, November 16, 1995).

about the difficulty of acquiring such a large system under a single contract and a better understanding of the requirements for developing a Medicare claims processing system.[24]

The learning experience HCFA gained from MTS can provide lessons for the proposed real-time claims processing system. In particular, as we reported in May 1997, MTS was not adequately managed as an investment.[25] HCFA had not followed practices that are essential if management is to make informed information technology decisions. Such practices include preparing a valid cost-benefit analysis, considering viable alternatives and assessing risks, and evaluating how the proposed technology will contribute to improvements in mission performance.

While H.R. 4401 requires the commission to perform a study on the design and construction of the proposed real-time claims processing system, the bill does not require that analyses such as these be performed, which can reduce risks and help ensure that information technology projects achieve maximum return on investment. Accordingly, the proposed system could benefit from the completion of investment management analyses before a decision is made about whether the system should be implemented. These analyses could determine whether cost-effective ways to address the issues that we have outlined exist.

Another lesson that can be learned from the MTS project is that a phased approach can reduce the financial, schedule, and technical risks of a project. The original MTS schedule was developed on the basis of a grand design approach, in which the complete system would be implemented at one time.[26] A phased approach can reduce the risks inherent in any large computer development effort—cost overruns, schedule delays, and the system's failure to perform as expected. Accordingly, it might also be desirable to take a phased approach to the proposed real-time claims processing system, which could reduce its risks.

In summary, H.R. 4401 has worthwhile objectives and would offer benefits to providers and beneficiaries in that decisions on authorized and denied claims would be provided immediately. Nevertheless, Medicare part B

[24] *Medicare Automated Systems: Weaknesses in Managing Information Technology Hinder Fight Against Fraud and Abuse* (GAO/T-AIMD-97-176, September 29, 1997).

[25] *Medicare Transaction System: Success Depends Upon Correcting Critical Managerial and Technical Weaknesses* (GAO/AIMD-97-78, May 16, 1997).

[26] HCFA later changed its implementation plan to a phased approach.

claims could be paid more quickly using HCFA's current processes without such a system. Paying claims faster, however, may not be desirable because Medicare's Supplementary Medical Insurance trust fund would lose interest revenue.

Before an implementation decision is made, it is particularly important to demonstrate that a real-time claims processing system can be designed that provides the safeguards necessary to minimize improper payments. Moreover, because of the complexity of the Medicare process, additional analyses of the technical and cost risks of a real-time claims processing system would be prudent before requiring that it be developed and implemented. In addition, the administrative and benefits differences between Medicare and FEHBP would make the development and implementation of a system applicable to both programs difficult. Further, the role and makeup of the commission should be carefully considered to help ensure that any such system would take into account the current Medicare environment, as well as health care and financial management issues. Finally, lessons learned in HCFA's MTS failure demonstrate that it is important that critical analyses be performed before implementation decisions are made. Accordingly, it may be premature to require implementation of the system envisioned by the bill until such analyses are completed.

Mr. Chairman, this concludes our statement on H.R. 4401. We have also provided additional technical comments on the bill to your staff. We would be pleased to respond to any questions that you or other members of the Subcommittee may have at this time.

Contacts and Acknowledgments

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