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STATEMENT OF
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BEFORE THE
SUBCOMMITTEE ON HEALTH
HOUSE WAYS AND MEANS COMMITTEE

ON

ELECTRONIC DATA SYSTEMS FEDERAL'S PERFORMANCE AS A MEDICARE CONTRACTOR IN ILLINOIS

Corporations'

Mr. Chairman and Members of the Subcommittee, we are pleased to be here today to discuss our ongoing evaluation of Electronic Data Systems Federal Corporation's (EDSF) performance as a Medicare contractor in Illinois.

Beneficiaries and providers in Illinois have experienced an entire year of poor performance by EDSF. This experimental contract has caused a tremendous outcry from beneficiaries and providers. Members of the Congress, the Health Care Financing Administration (HCFA), the contractor, and the media have literally been flooded with complaints.

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On January 15, 1980, we were asked by the Subcommittee to evaluate this and two other experimental fixed-price contracts in Medicare as a follow-up to our June 1979 report 1/ on Medicare claims processing. As requested by the Subcommittee, our testimony today addresses the problems experienced by EDSF since contract award and the efforts taken by HCFA and EDSF to deal with them. A more detailed evaluation of these experimental contracts will be submitted to the Subcommittee at a later date.

1/"More Can Be Done To Achieve Greater Efficiency In Contracting For Medicare Claims Processing," HRD-79-76, June 29, 1979.

In our June 1979 report to the Congress dealing with contracting for Medicare claims processing, we expressed concerns about the potential impact of competitive fixed-price contracting on the Medicare program and its beneficiaries. We cautioned that based on our review of prior experience in the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) and Medicare, that the new experiment in Illinois offered greater potential problems than an earlier satisfactory experiment in Maine. Unfortunately, our concerns proved to be valid in Illinois.

During the first 6 months of the EDSF contract ending September 30, 1979, the pending claims count reached a high of 454,000--with corresponding backlogs in beneficiary and provider correspondence and requests for reviews of amounts previously paid. The claims backlog was reduced to 173,000 by the end of December 1979; however, because of large unexplained increases in claims received in January and February of this year, the claims backlog had climbed to 254,000 by the end of March and EDSF also had over 100,000 unanswered letters at that time.

Although EDSF has demonstrated the ability over the last 6 months to process an average of about 425,000 claims a month, it has yet to demonstrate the ability to process and pay claims without a lot of errors. For comparable periods in 1978 and 1979, the EDSF error rates on processed claims have been two to three times as high as the previous

carriers. While EDSF has shown some improvement, the error rates are still high when compared with other carriers in the country.

Overall, EDSF performance in Illinois has been poor. Under the contract, there are five quantifiable workload performance standards dealing with timeliness and quality of claims processing. Since the inception of the contract, EDSF has met none.

BACKGROUND

The Medicare program has three ongoing experiments in part B that are testing competitive fixed-price procurement --in Maine, Illinois, and upstate New York. Medicare contracts with carriers which process claims for physicians and other practitioner services (part B) and intermediaries which process claims for facility services (part A). As required by Title XVIII of the Social Security Act, these contracts have traditionally been on a cost reimbursement basis.

Medicare part B beneficiaries in Illinois had been serviced by the Health Care Service Corporation (Blue Shield) in Cook County and the Continental Casualty Insurance Company (Continental) in the remainder of the State. In 1978 HCFA used its experimental authority to solicit fixed-price proposals to serve Illinois the entire State.

On March 31, 1978, HCFA issued the request for proposal

(RFP) for the experimental contract. The RFP called for a firm fixed price covering all carrier services to be performed in Illinois over the term of the contract--July 1, 1978, through September 30, 1983. Claims processing was to, and did, 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 during which the successful bidder (EDSF) was to work with HCFA and the incumbent carriers to ensure a smooth change.

Five organizations submitted proposals--Chicago Blue Shield, the General American Life Insurance Company, EDSF, Continental, and the Prudential Insurance Company. Four offerors were Medicare carriers, and the fifth, EDSF, was a major data processing subcontractor in Medicare.

HCFA evaluated each proposal on the basis of company experience, the quality of the technical proposal, and price. Weights were assigned to these factors: company experience--35 percent, technical proposal--20 percent, and price--45 percent. EDSF, which finished fourth in the technical category and third in experience, placed first overall in the scoring because its price ($41.8 million) was lowest and the price factor had the highest weight.

While it is difficult to estimate administrative cost savings which may result from the competitive award of the

Previous to the start of the experimental contracts GAO was asked to review the potentials.

Illinois contract, we estimate a savings of about $20.6 million over the life of the contract.

GAO REPORT ON CONTRACTING IN MEDICARE

~~We~~ GAO anticipated the potential for problems with the contract change in Illinois. Not only was EDSF inexperienced in performing a number of carrier functions in Medicare, but ~~we believed~~ simply changing from two contractors to one in a State with a high claim volume could cause problems.

Our June 1979 report to the Congress expressed major concerns about the potential impact of competitive fixed-price contracting on the Medicare program. The report also discussed the problems experienced by CHAMPUS in its efforts to obtain competitive fixed-price contracts.

Although CHAMPUS is a much smaller program than Medicare, the type of contractors and the administrative structure of the programs are similar. We identified some problems that Medicare was likely to encounter if it entered a competitive environment.

Limited experience under the first competitive experimental Medicare contract in Maine indicated that, once initial conversion problems were worked out, a satisfactory level of performance could be maintained. We cautioned that the Maine experiment might not represent what would happen with other fixed-price procurements in Medicare because Maine had a relatively small claims volume and claims processing was

taken over by an experienced carrier already processing a much larger workload. In addition, the Maine experiment involved only one incumbent carrier who withdrew voluntarily from the program. We pointed out that Illinois (and upstate New York, the third competitive experiment) involved a much larger claims volume with more than one incumbent carrier and there was greater potential for problems to develop.

We reported to the Congress that we were not prepared to recommend a broad legislative change to permit the Department of Health, Education, and Welfare (HEW) to use fixed-price contracting 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 had not been determined. Failure to assure adequate controls over benefit payments could more than offset savings in administrative costs.

--Performance under such contracts in CHAMPUS had not been good, and many contracts had been terminated or not renewed, resulting in disruption in program administration and services.

As a new contractor takes over there are startup problems that may result in a period of lower performance and service. We concluded that HEW's experiments required further evaluation before a broad change to competitive fixed-price contracting is legislatively authorized for Medicare. HEW should determine whether

--claims processing performance and beneficiary and provider services will suffer during and after contractor changeover,

--the Government is willing to accept the problems of contractor turnover in exchange for lower administrative costs,

--past poor performers under cost contracts can significantly lower costs and improve performance under competitive procurement,

--program payments (which account for 97 percent of total program costs) will be adequately controlled, and,

--the selection process and contract design used in the experiments are sufficient to guarantee a smooth procurement system.

EDSF WORKLOAD PROBLEMS

EDSF assumed responsibility for Cook County from Blue Shield on April 1, 1979. At that time HCFA reported that all major transition activities between Blue Shield and EDSF were completed without significant difficulty. EDSF received 137,000 claims from Blue Shield between March 19 and March 29, 1979, including 72,000 unprocessed claims which it picked up daily beginning March 19 and 65,000 claims in various stages of processing. At the end of April EDSF reported 158,000 claims pending. This backlog continued to grow and although EDSF has taken steps to reduce it to a more manageable level, it still remains a problem. There is also a large correspondence backlog.

According to HCFA, EDSF's performance during the first 3 months was poor. On June 30, after 3 months of operations,

EDSF's pending workload reached 200,000 claims--more than three times the level projected by EDSF for that date, and almost four times the pending workload Blue Shield had on hand on June 30, 1978.

HCFA had serious concerns about the backlog of work and the poor quality of claims processing. It had identified severe problems in beneficiary services and professional relations. Also, the number of telephone lines was inadequate to handle the number of incoming calls from beneficiaries and providers.

EDSF attributed most of the problems to difficulty in recruiting, training, and maintaining a stable workforce. HCFA reported on July 9, that since June 1, over one third of EDSF's employees had either been terminated or resigned.

The problems continued to grow in almost all operational areas. EDSF processed less claims in August than it did in July and about 200,000 less claims than it received during the 2 months. The pending claims count was up to 400,000 by the end of August. 1/ Huge backlogs also existed in the correspondence area and in requests for reviews of initial claims determination. 2/

1/EDSF received 11,000 unprocessed claims from Continental when it took over responsibility for the rest of the State on July 1.

2/Medicare's appeal process consists of informal reviews and fair hearings. A request for a review of an original claims determination is a prerequisite to a fair hearing.

The pending claims count reached a high of 454,000 by the end of September 1979. This inventory represented approximately 7 weeks work on hand of which 36 percent was on hand for over 30 days. At the end of September there were also 59,000 items of correspondence pending--42 percent more than 30 days old.

EDSF decided that its workload problems could not be significantly improved with the workforce available in the Des Plaines labor market. EDSF officials told us the decision to locate in Des Plaines was one of the worst decisions ever made by EDSF corporate management. The location was in a low unemployment area and commuting to it is difficult except by automobile. After struggling with high turnover and absenteeism, and poor recruiting experience for its first 6 months of operations, EDSF decided to open two additional claims processing offices--in Springfield and Marion. It also brought in a detail of EDSF staff from other locations to assist in the correspondence backlog. The number of staff increased from an equivalent of 362 full-time people in July to 538 in December 1979. At the end of March 1980, EDSF had an equivalent of 577 full-time staff.

EDSF also redesigned its telephone system to provide better service for beneficiaries and providers. The new phone system which became operational on September 4, 1979, increased the number of incoming lines available and has

the capacity to handle approximately 2,500 calls a day.

Claim receipts from July through December were consistently in the 300,000-400,000 per month range. In October for the first time EDSF began processing more claims than it received. In December EDSF processed 558,000 claims--over 200,000 more than it received for the month--reducing the claims backlog to 173,000 at years end.

EDSF's production statistics for the 6 months ending December 31, 1979, show that its claim production was higher than Blue Shield's and Continental's production the year before. EDSF received 15 percent more claims than Blue Shield and Continental during the same period of the preceding year and EDSF also processed 18 percent more claims.

In January, February, and March 1980, EDSF experienced a large increase in claims receipts. Receipts for these 3 months were 31 percent (318,000 claims) higher than experienced by Blue Shield and Continental in the same months of 1979. EDSF maintained nearly the level of processing it had established in the last 3 months of 1979, yet the backlog climbed because of the high receipts. At the end of March, EDSF had a backlog of 254,000 claims and 113,000 items of correspondence.

EDSF staff is currently working a large amount of overtime and additional staff has been brought in to get

the backlogs down. With these added resources, EDSF should be able to reduce the backlogs to more manageable levels. Should EDSF continue to experience the increased claims volumes of recent months, however, it will have to further increase the size of its staff.

POOR QUALITY OF CLAIMS PROCESSING REMAINS A PROBLEM

For the last 6 months, EDSF has processed an average of 425,000 claims per month. It has not, however, demonstrated the capability to process claims without a lot of errors or to provide quality services to beneficiaries and providers. EDSF continues to have a very high error rate in its claims processing as shown by the carrier quality assurance program developed by HCFA and used by all Medicare carriers.

The quality assurance program provides a systematic review of a sample of claims drawn from claims processed to completion by the carrier during a given reporting period. The review identifies various types of processing errors, including those affecting reimbursements. The results of the review are included in a report designed to provide a basis for evaluating and comparing carrier performance. HCFA's regional office personnel validate the carrier's results by subsampling about 10 percent of the carrier's sampled claims.

There are two error rates reported--the occurrence error rate 1/ and the payment/deductible error rate 2/. These rates are computed by a formula which considers the number of errors found by the carrier and by the HCFA quality review staff. The number of errors found by HCFA are given more weight in the formula.

EDSF's occurrence error and payment/deductible error rates have been much higher than those experienced by either Blue Shield or Continental in prior years. The following table shows the error rates for Blue Shield and Continental for the quarters ended March, June, September, and December 1978. It also shows the estimated total payment/deductible errors 3/ by both contractors.

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

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

3/Estimated total payment/deductible error--the statistical estimate of the total of all combined payment and deductible errors, in favor of claimants, in favor of the Government, or combined, in the file of processed claims from which the samples were drawn.

	Blue Shield			Continental		
Quarter ending	Occurrence error rate	Pay/ded error rate	Total estimated pay/ded error (millions)	Occurrence error rate	Pay/ded error rate	Total estimated pay/ded error (millions)
March 1978	14.2	2.9	$1.6	12.0	2.8	$1.4
June 1978	15.0	2.1	1.2	10.8	3.0	1.4
Sept. 1978	15.0	1.9	1.0	11.8	2.9	.7
Dec. 1978	9.3	2.5	1.5	10.2	2.2	1.0

EDSF's error rates and the median rates for all other carriers are shown below. The payment/deductible error rate is very important because it reflects on the accuracy of the carrier's benefit payments. As the table shows, EDSF's estimated total payment/deductible error increased from $4.1 million, for the quarter when it had only Cook County, to $10.1 million for the 3 months ending December 31, 1979.

Quarter ending	Occurrence error rate: EDSF	Occurrence error rate: All other carriers (median)	Pay/ded error rate: EDSF	Pay/ded error rate: All other carriers (median)	Total estimated pay/ded error: EDSF
June 1979	34.7	8.5	8.1	2.0	$4.1 million
Sept. 1979	32.5	8.0	6.6	2.2	6.2 million
Dec. 1979	25.6	9.3	5.8	2.5	10.1 million

For its first 9 months of operations, 1/ EDSF had a total estimated payment/deductible error of $20.3 million dollars. This amount is about evenly divided between overpayments and underpayments. For the same months (April through December for Blue Shield and July through December for Continental), a year before, the previous contractors had made an estimated $5.4 million error.

HCFA has also expressed serious concerns about the poor quality of EDSF's claims process. A February 11, 1980, memorandum from the Regional Medicare Director to the HCFA Regional Administrator concerning EDSF's workload status at the end of January reported on poor quality--citing miscoding of procedures by the claims entry clerks as the major cause:

1/We were not able to obtain final data for the March 1980 quarter. However, preliminary figures released by HCFA on April 24, show EDSF's occurrence error rate and payment/deductible error rate was 24.2 and 4.7, respectively. HCFA also reported that the total estimated payment/deductible error was $7.6 million.

> The quality of the claims process continues to be a major concern. The primary reason for the poor quality continues to be due to miscoding of procedures by the [claims entry clerks]. ***Although we expect some improvement in the error rates for the fourth quarter as compared to the third quarter, they will still be well in excess of the median error rates of all carriers. A related concern is the quality of EDSF's quality assurance program. Our review of the subsample reveals approximately twice as many errors as are being detected by the EDSF review of the sample. Also, we have found in the subsample some exact duplicate claims processed in December which should have been automatically denied. Instead, they were paid without even suspending. We have asked for an explanation."

Our review of a sample of EDSF's claims support HCFA's findings.

According to HCFA officials, EDSF's poor claims quality creates further concern about the accuracy of the upcoming reasonable charge update. This update is a procedure all carriers go through once a year about this time in order to update the amount Medicare will pay for particular services during the next year. Medicare's reimbursements are based on the dollar amounts of submitted charges during the previous calendar year. A carrier must accumulate and store in its computer all charges by physicians for each medical procedure code.

Considering the high rates of input errors, we believe that EDSF's computer files contain a large amount of "contaminated" data. The impact of this contaminated data

on future reimbursements is unknown at this time. This is an area that HCFA needs to carefully review immediately.

One of the most difficult and critical tasks to be completed by EDSF during the transition period was the conversion of procedure codes and terminology systems. 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 basis for medical coverage and payment determination.

We believe that the procedure code conversion was an important task because our prior work involving changes in contractors has shown that a major problem has been provider unrest caused by inconsistencies in the amounts paid by old and new contractors. Any reductions in payment levels could be particularly troublesome in Illinois, because most payments represent reimbursements to beneficiaries.

EDSF was required to implement a single coding system in Illinois instead of two different systems used by the previous contractors. The system proposed by EDSF in its technical proposal was the one used by Blue Shield. It was EDSF's stated intention, as one of its major transitional tasks, to convert the coding system used by Continental to that used by Blue Shield.

According to EDSF and HCFA regional officials, it was decided during the transitional period that neither incumbent's system was compatible to EDSF's highly sophisticated computer system. EDSF began work instead on a new and different coding system.

The director of EDSF's Illinois operations told us they knew before they prepared their proposal to HCFA about problems with Blue Shield's coding system including its incompatability with EDSF's data processing system. EDSF officials also told us they expected HCFA to approve the use of CPT-4 1/ as an alternative coding system. CPT-4 is used by Illinois' Medicaid program and thus, is familiar to many providers.

On November 29, 1978, EDSF requested HCFA to approve use of CPT-4. The RFP, however, specifically stated that the coding system to be used could be either of the existing Illinois Medicare systems or another system then approved for use by HCFA at other Medicare carriers. CPT-4 is not approved for use at any Medicare carrier. EDSF's request to use it was denied.

There is little documentation available at either EDSF or HCFA to trace the step by step efforts in develop-

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1/CPT-4--the Current Procedural Terminology, 4th Edition, which is published by the American Medical Association.

ing the coding system. There is evidence, however, that EDSF did begin work on another coding system before the use of CPT-4 was denied. In December 1978, EDSF began giving segments of its coding system to HCFA for approval. Final approval was not given until April 24, 1979; however, preliminary approval was given on February 5.

Although EDSF's procedure code conversions were essentially approved by HCFA prior to April 1, there was a significant "hurry-up" effort on the part of both EDSF and HCFA to get the system approved.

EDSF's medical advisor, who was hired in July 1979 told us the coding system needed improvement. She said EDSF staff have encountered problems with the system and that these problems contribute to the poor data entry results that have been identified. She hopes to continually improve the system, and is seeking HCFA approval for major revisions.

Specific details on these problems, whether they could have been avoided and just what their full impact has been we don't know at this time. We are in the process of evaluating whether EDSF's coding system has changed reimbursement levels in Illinois, and this effort will not be completed for several months.

HCFA'S MONITORING EFFORTS

HCFA has developed a detailed monitoring plan for evaluating EDSF's performance. Results of the monitoring plan

have been reported for the quarter ending December 1979. Time has not permitted us, however, to evaluate the adequacy of HCFA's monitoring efforts.

Formal monitoring of EDSF's performance against the contract standards began with the quarter ending December 31, 1979. HCFA's monitoring is divided into two parts--System One and System Two. System One has five workload-related standards and is measured on the basis of reports submitted by EDSF which include the quality assurance assessments made by HCFA and EDSF. System Two standards deal with EDSF's functional performance. The adequacy of seven major functions is evaluated through various tests and examinations of operations by HCFA's Chicago Regional Office staff. These seven functions are claims process, coverage and utilization safeguards, program reimbursement, computer operations, beneficiary services and professional relations, program integrity, and quality assurance.

If EDSF fails to satisfy, on a quarterly basis, the established performance standards, the total price paid to the carrier is reduced by one eighth of one percent of the total fixed price or $52,250 for each standard failed. If EDSF fails all 5 standards in System One and all 7 standards in System Two, and fails to correct the System Two deficiencies, EDSF stands to lose a maximum of $627,000 per quarter.

EDSF failed all five System One standards for the quarter ending December 31, 1979, and was assessed financial penalties of $261,250. It also failed three of the five standards for the quarter ending March 31, 1980. Preliminary data on the error rates indicate EDSF will fail the other two standards, but final data is not available at this time. A description of the standards and EDSF's performance are shown below. Also included is EDSF's performance for its first two quarters of operations, although financial penalties did not apply.

Standard	EDSF performance quarter ending 6/30/79	9/30/79	12/31/79	3/31/80
1. 75 percent of claims must be processed in 15 days or less	44.5%	39.1%	37.6%	46.6%
2. No more than 12 percent of claims pending at end of month can be over 30 days old	31.1%	27.6%	50.0%	23.2%
3. Occurrence error rate must be less than the median of all other carriers	34.7 (median-8.5)	32.5 (median-8.0)	25.6 (median-9.3)	a/
4. Payment/deductible error rate must be less than the median of all other carriers	8.1 (median-2.0)	6.6 (median-2.2)	5.8 (median-2.5)	a/
5. Average processing time for informal reviews must be 25 days or less	28.2 days	41.5 days	63.2 days	82.5 days

a/According to HCFA the final data for this quarter will not be available until June.

HCFA's detailed plan for the System Two monitoring was issued in September 1979. It was based on a draft of a contractor performance evaluation program, which is being developed by the HCFA central office. The plan contains a series of 110 performance elements--21 mandatory and 89 other non-mandatory performance elements with point values.

In order for EDSF's performance to be acceptable on a specific functional area, it must satisfy all mandatory performance criteria associated with that area and attain 90 percent of the points for that area's non-mandatory performance elements. EDSF is allowed a grace period of not less than 15 days to correct the deficiencies. This grace period commences with EDSF's receipt of HCFA's evaluation results. Presently HCFA follows-up on the deficiencies during its monitoring in the subsequent quarter. Thus the tests and examinations made for the January through March 1980 quarter constitute the evaluation for that quarter as well as the follow up on the previous quarter's deficiencies.

EDSF's performance was not satisfactory for the quarter ending December 1979 on three of the seven functions--claims process, coverage and utilization safeguards, and beneficiary services and professional relations.

One of the deficiencies noted by HCFA is EDSF's lack of responsiveness to beneficiary inquiries. This problem is also of concern to us, as well as the apparent indiscriminate and inappropriate use of computer generated form letters to request additional information for processing claims. One situation brought to our attention by a local Congressman illustrates the basis for our concerns.

On June 25, 1979, "Mary O", an 81-year old beneficiary, submitted three bills totaling $264.00. On July 12, 1979, EDSF sent her an unsigned form letter requesting her health insurance claim number, her sex, and the effective dates of her Medicare coverage. The form letter stated that if EDSF did not hear from her in two weeks, her claim would be denied. "Mary O" submitted a copy of her health insurance card which contained the requested information on July 18, 1979. On July 27, 1979, EDSF sent "Mary O" the same unsigned form letter, to which "Mary O" responded closing with this plea:

> "Please send me a letter giving me the details otherwise I am completely confused as to what you need or what is wrong."

On August 9, and August 23, EDSF sent "Mary O" two more of the same unsigned form letters and on August 30, 1979, EDSF sent her a check for $95.20 to cover one of the three bills.

On September 14, 1979, EDSF sent "Mary O" still another of the same form letters which requested the same information, which if not received in nine days would result in the denial of her claim. On October 1, 1979, "Mary O's" daughter wrote to EDSF requesting a reply from an identifiable human being which would spell out just what the problems were so that

"Mary O" could respond to someone other than a computer and be paid. On October 12, EDSF sent "Mary O" still another of the same unsigned form letters. At the request of a local Congressman, EDSF looked into this case and on November 30 and December 5, the remaining two bills were paid.

In our view, the use of ominous form letters to request information from Medicare beneficiaries is completely inappropriate. HCFA should be reviewing the content of EDSF's computer-generated form letters and the circumstances under which they are used to see whether they are consistent with the purposes and objectives of the Medicare program. We think that form letters should identify a person who the respondent may contact concerning any questions he/she may have. We also believe HCFA should be reviewing EDSF's apparent difficulties in linking up beneficiary responses to requests for additional information.

EDSF EFFORTS TO DEAL WITH PERFORMANCE PROBLEMS

EDSF has demonstrated a committment to resolving its performance problems. It has continually made managerial shifts in an effort to improve performance. More significantly, EDSF has made a number of modifications to its operational setup in an effort to improve performance.

According to HCFA officials, one of EDSF's biggest weaknesses was its lack of experienced first-line supervisors.

They pointed out that EDSF was not able to attract such supervisors from either of the incumbent carriers and that this contributed to their low productivity and the high number of clerical errors.

EDSF has attempted to fill this void by bringing in experienced personnel from its other locations around the country--principally where EDSF has Medicaid contracts. Some of these managers have transferred permanently, while others are on loan for periods up to 90 days.

Much of their efforts to date have been to "put out fires," such as reducing the backlog, responding to congressional inquiries, and resolution of certain problem cases as they occur. However, they also have been working with problems of more long-term importance, such as improving the procedure coding system and the quality of claims processing.

EDSF has also established a task force during the first week of April 1980, to deal with the poor quality of claims processing and with beneficiary and provider services. The objectives of the quality assurance group are to reduce the clerical error rate, improve the clerical staff training, improve reference materials used by the clerical staff, improve productivity, and eliminate the system related errors.

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On the basis of our work to date, we believe that there are three issues which require HCFA's immediate attention,

Two of these issues could help to improve the quality of EDSF's claims processing and beneficiary service activities and the third would help provide timely information to HCFA management on an important reimbursement issue.

1. One primary purpose of a quality assurance program is to provide program management with information as to what kind of errors are being made, why they are being made, and who is making them so that management can develop a corrective action plan. HCFA staff have told us that they have identified about twice as many errors in the quality claims review as identified by EDSF. Available statistics support this. HCFA needs to help EDSF improve the quality of its own quality assurance reviews so that the differences between the EDSF and HCFA results are minimized. We believe that more reliable EDSF quality control results would provide EDSF and HCFA management with better information with which to identify and correct the basic causes for the poor quality of EDSF claims processing activities.

2. Improvements are needed in the area of beneficiary services particularly with respect to the responsiveness and appropriateness of EDSF's computer-generated form letters to Medicare beneficiaries in Illinois. ~~We believe~~ HCFA needs to review the content and use of EDSF's correspondence with beneficiaries.

3. Under Medicare the reasonable charge reimbursement levels for each year beginning July 1 and ending June 30 are based on the claims data for the previous calendar year. In other words, the determination of the amounts to be reimbursed for the year beginning July 1, 1980, is to be based on the claims processed during calendar year 1979. This process is referred to as a "reasonable charge update."

As previously discussed because of the 25 to 35 percent occurrence error rate experienced by EDSF since April 1979, we believe EDSF's computer files contain a large amount of "contaminated" data and the possible effects of the data on reimbursement levels are unknown. We understand that HCFA intends to wait until EDSF completes its reasonable charge update, which is scheduled for the end of May, before assessing the impact of the contaminated data. Today is April 28--and July 1, 1980, is only two months away. We believe HCFA needs to give immediate attention to this matter--if only for the most common medical procedures--to assess the magnitude of the problem with contaminated data and develop alternative courses of action, if needed.

Finally--in addition to the previous three suggestions--there should also be a realization that it may not be in the best interest of the beneficiaries, providers, or the Government to permit this contract to run unchanged for 3 more years unless performance significantly improves. Therefore, ~~we believe~~ that HCFA needs to develop a contingency plan for the whole or partial replacement of EDSF as the Medicare carrier in Illinois. To minimize the adverse impact of such a changeover, HCFA's contingency plan should focus on the following two items:

(1) identifying existing high performing and experienced carriers that would be willing and able to pick up all or part of the workload or functions, and

(2) establishing a realistic timetable for the gradual transition of workloads or functions which would have the smallest possible adverse impact on beneficiary and provider services.

Mr. Chairman, this concludes our statement. As we mentioned, there are a number of issues we are still exploring at EDSF. We plan to furnish you the results of our review at a later time when our work is completed. We will be pleased to respond to any questions you or other members of the Subcommittee may have.