

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**ELECTRONIC MEDIA CLAIMS AND
CONTRACTORS' FOR-PROFIT
SUBSIDIARIES**

A MANAGEMENT ADVISORY REPORT



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INSPECTOR GENERAL**

OEI-12-91-01410

EXECUTIVE SUMMARY

PURPOSE To discuss current practices at several Medicare contractors which have an impact on electronic media claims (EMC) submission.

BACKGROUND Both the Health Care Financing Administration (HCFA) and the OIG have become aware of allegations that certain contractors refuse to cooperate with some billing services which wish to submit EMC. This refusal would violate HCFA's instructions to provide the formats and edits needed to bill. These contractors, among others, are also alleged to require use of their subsidiaries' software to submit EMC, which might violate antitrust law.

MAJOR FINDINGS The four contractors (three intermediaries and one carrier) reviewed appear to provide for EMC submission of Medicare claims for most types of providers, in accord with Transmittal 1507.

The three intermediaries, however, refuse to accept direct computer-to-computer EMC submissions for their private line of business unless the provider uses their subsidiary's software for the transaction.

The contractors' practices of requiring billing services and health care providers to use the contractors' for-profit EMC subsidiaries may violate Federal antitrust laws.

MAJOR RECOMMENDATIONS To enhance increased EMC activity, the HCFA should:

- Monitor compliance with Transmittal 1507, particularly the timeliness with which contractors fulfill requests for lists of edits.
- Determine the number and type of subsidiaries at each contractor, and their roles with respect to Medicare.
- Consider the use of a clearinghouse, which would receive and distribute claims from all providers for all payers.
- Remain aware of contractors' general business operations. Anti-competitive activity may have a negative effect on innovation and technological growth in the industry, and limit HCFA's future options. Consider requiring bidders on future contracts to guarantee equal acceptance of properly-formatted claims from all billers to all payers, both private and Medicare.

The HCFA's comments on the draft of this report were taken into consideration in revising the final report. The comments are appended in full.

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PURPOSE

The purpose of this management advisory report is to discuss current practices at several Medicare contractors which have an impact on electronic media claims (EMC) submission.

BACKGROUND

The director of the Health Care Financing Administration's (HCFA) Bureau of Program Operations asked the Office of Inspector General to determine if EMC submission was being impeded by contractor policies. A national billing service has alleged that various contractors have not made available to them the formats and edits needed to submit error-free electronic claims, which they believe has had the effect of limiting free and open competition and thus raising costs to Medicare. Additionally, both billing services and health-care providers have alleged that some contractors refuse to accept direct computer-to-computer EMC submissions except when submitted through the contractors' for-profit EMC subsidiaries.

The HCFA had issued instructions to intermediaries (contractors which process claims for institutional providers, such as hospitals and skilled nursing facilities) in December 1990. These instructions, issued as Transmittal 1507, Medicare Intermediary Manual, Part 3 - Claims Process, require intermediaries to provide detailed copies of their consistency edits to all providers interested in EMC submission and to provide copies of edits and billing procedure changes to all providers and bill submitters from whom they receive EMC.

The Secretary of Health and Human Services has publicly supported uniform, automated record-keeping procedures, including EMC. Medicare is the largest single payment source for many hospitals. Since HCFA usually contracts with only one intermediary per State, that State's intermediary has an disproportionate impact on the hospitals because of its unique status vis-a-vis Medicare.

Hospitals have transferred many record-keeping functions to integrated computer systems. The advent of the Prospective Payment System (PPS) in 1983 generated interest in computer systems which could link the demographic, financial and clinical data needed to generate a Medicare claim. For many hospitals, the ideal billing system would be one which would download information from a variety of sources into a computer program which would then create "claims" for every insurer responsible for the hospital's patients. Such a program could then send the claims electronically to computer systems for Medicare, Medicaid, Blue Cross, and other commercial insurance, without the need for rekeying or reformatting any of the necessary data.

Some hospitals have created such programs, working with their various insurers; others have purchased such systems from or through billing services; and still others have access to clearinghouses which redirect claims to various sources, with or without editing them. Being required by one insurer to use a certain software program, or language inconsistent with other insurers', defeats the efficiencies achieved by these sophisticated programs.

The health insurance industry has changed greatly since Blue Cross plans came into existence in the 1930's. Two early advantages that allowed for the growth of the plans were their tax-exempt status and special relationships with hospitals, whose administrators and trustees formed the boards of the plans. Most Blue Cross plans provided service benefits, rather than indemnifying the patient or employer against losses. Thus State insurance regulators required their reserves to be services rather than cash. All these features have changed: Blue Cross plans lost their tax-exempt status in 1986; their boards are no longer composed of hospital representatives; some plans are now "mutual" plans, which return operating surpluses to policy-holders. Additionally, many plans have created for-profit subsidiaries which carry out functions formerly done "in-house," including marketing, claims processing, and product development, and own subsidiaries such as health maintenance organizations and life insurance companies.

The practice of requiring customers to purchase one, possibly unwanted, good or service before allowing them to purchase a desired good or service is known as "tying." Antitrust law generally prohibits this practice. Similarly prohibited are price fixing and allocation of territories by market rivals. Although the McCarran-Ferguson Act of 1945 exempts the "business of insurance" from the antitrust laws, this exemption does not apply to activities of insurance companies unrelated to the underwriting or spreading of risk and the relationship between the insurer and the insured. Legislation has been introduced in both the Senate (S. 430, introduced by Senator Metzenbaum) and House (H.R. 9, introduced by Representative Brooks) calling for modifications of the McCarran-Ferguson Act, which has over the years come to be widely interpreted as exempting insurance companies from antitrust laws. Both versions would outlaw tying, among other anti-competitive behaviors, in the insurance industry.

METHODS

We conducted interviews with contractor personnel at three intermediaries (Blue Cross of Arizona, Blue Cross of South Carolina, and Blue Cross of Virginia) and one carrier (Blue Shield of Maryland), health-care providers and associations, billing agencies, and HCFA staff, regarding practices at these contractors. We did not attempt to verify allegations related to activity before Transmittal 1507 was issued. Our primary focus was the ease with which providers can electronically submit Medicare claims, but we also tried to determine the forces within the contractors which have an impact on EMC.

FINDINGS

The four contractors reviewed appear to provide for EMC submission of Medicare claims for most types of providers, in accord with Transmittal 1507. We believe that they no longer refuse to cooperate with requests for edits.

The three intermediaries, however, refuse to accept direct computer-to-computer EMC submissions for their private line of business unless the provider uses their subsidiary's software for the transaction. This subverts the prohibition in Transmittal 1507 against requiring rekeying of claims data, since Medicare claims can be submitted electronically. The effect, however, is that hospitals have to use the subsidiary's system for all types of claims, or have two systems running concurrently, in order to bill computer-to-computer to all insurers. Billing services which have devised systems to better meet their customers needs must purchase the contractor's services as well, making their prices less competitive than they would otherwise be.

Contractors may have a marketing advantage as a result of their Medicare contract. They market their EMC package as superior to competitors' in the services offered, since they have more direct access to the status of pending claims, including Medicare claims. However, this claim may not in fact be true, since private billing services can offer hospitals other enhancements, tailored for the hospital's overall accounting system.

Small providers or groups of providers may not be able to submit Medicare claims electronically in all jurisdictions, even when they have the capability (or have contracted with a billing service) to do so, because contractors have not made the necessary modifications to their systems. Because the providers are small, the contractors feel they are a low priority. Their small size, however, is what makes them financially vulnerable to delayed paper claims and the wait for a remittance advice in order to bill a supplemental payer.

The contractors' practices of requiring billing services and health care providers to use the contractors' for-profit EMC subsidiaries may violate Federal antitrust laws.

RECOMMENDATIONS

To enhance increased EMC activity, the HCFA should:

Monitor compliance with Transmittal 1507, particularly the timeliness with which contractors fulfill requests for lists of edits.

Require regional office contractor representatives to determine the number and type of subsidiaries at each contractor, and their roles with respect to Medicare.

Work with contractors which are not able to accommodate electronic bills from all types of providers to develop simple generic programs, for example, which small providers can use in different jurisdictions. This would be simplified by more consistent carrier programs and systems.

Consider using a clearinghouse, which would receive and distribute claims from all providers for all payers. Effective and efficient administration of the Medicare program may require such an initiative, as EMC and computerized medical records form a larger part of the claims system. Such a clearinghouse could be an existing one, one created by a consortia of contractors, or one created centrally by HCFA.

Remain aware of your contractor's general business operations. Those insurers which have used aggressive tactics to compel providers to use their subsidiary's products or services are then able to further aggrandize their market share. This anti-competitive activity may have a negative effect on innovation and technological growth in the industry, and limit HCFA's future options. The HCFA may wish to consider requiring bidders on future contracts to guarantee equal acceptance of properly-formatted claims from all billers to all payers, both private and Medicare.

In commenting on the draft version of this report, HCFA indicated they believe they lack the authority to address potentially-abusive behavior in the contractors' private lines of business. Thus, we have eliminated a recommendation that HCFA consult with the Antitrust Division of the Department of Justice concerning the contractors' activities. We have kept and expanded upon the last recommendation regarding contractors' business activities in relation to their work for HCFA and added a recommendation that HCFA consider the use of a clearinghouse. These recommendations attempt to identify ways HCFA can address those contractor activities which inhibit electronic submission of claims while remaining within the scope of HCFA's current authority.

APPENDIX: HCFA's COMMENTS



Camden Brown HCB

SEP 13 1991

Memorandum

cc HA KA

Date

From Gail R. Wilensky, Ph.D. *grw*
Administrator

Subject OIG Draft Management Advisory Report - "Electronic Media Claims and Contractors' For-profit Subsidiaries," OEI-12-91-01410

To Inspector General
Office of the Secretary

We have reviewed the subject draft management advisory report. At the Health Care Financing Administration's request, OIG reviewed current practices at Medicare contractors to determine if electronic media claims (EMC) submission was being impeded by contractor policies.

The report found that three of the four contractors reviewed refuse to accept direct computer-to-computer EMC submissions for their private line of business unless the provider uses its subsidiary's software for the transaction. OIG alleges that this practice could then make billing services that have devised systems for Medicare billing less competitive, since the provider would be required to purchase the contractor's services in any case.

The report contains five recommendations. Our comments on these recommendations, as well as a general comment on the report, are attached.

Thank you for the opportunity to review this draft management advisory report. Please advise us whether you agree with our position on the report's recommendations at your earliest convenience.

Attachment

IG	<input checked="" type="checkbox"/>
PDIG	<input checked="" type="checkbox"/>
DIG-AS	<input type="checkbox"/>
DIG-EI	<input checked="" type="checkbox"/>
DIG-OI	<input type="checkbox"/>
AIG-MP	<input checked="" type="checkbox"/>
OGC/IG	<input type="checkbox"/>
EX SEC	<input checked="" type="checkbox"/>
DATE SENT	<u>9/13</u>

SEP 13 1991

RECEIVED

Comments of the Health Care Financing Administration (HCFA) on the
OIG Draft Management Advisory Report - "Electronic
Media Claims and Contractors' For-profit Subsidiaries"
OEI-12-91-01410

Recommendation 1

HCFA should monitor compliance with Transmittal 1507, particularly the timeliness with which contractors fill requests for lists of edits.

Response

We agree with this recommendation. In addition, we are drafting electronic media claims (EMC) instructions which will prohibit contractors from favoring providers or billing services that submit claims through the parent companies' for-profit subsidiaries.

Recommendation 2

HCFA should consult with the Antitrust Division of the Department of Justice to determine whether the contractors' actions violate antitrust laws.

Response

We disagree with this recommendation. As the report points out, the questionable actions on the part of contractors occur only in their private lines of business with which HCFA is not directly involved. Therefore, we believe it would be inappropriate for us to approach the Department of Justice (DOJ) concerning possible antitrust violations in these private businesses. Such action should be taken by the company or entity that believes it is being harmed by a contractor's policies.

Recommendation 3

HCFA should require regional office (RO) contractor representatives to determine the number and type of subsidiaries at each contractor, and their roles with respect to Medicare, perhaps as part of the Annual Contractor Evaluation Report (ACER).

Response

We agree and have already undertaken such action. On May 21, 1991, we sent a memorandum to all the ROs directing them to obtain this information from their contractors. We will update this data periodically, although we are not yet sure that the ACER is the proper means for doing so.

Recommendation 4

HCFA should work with contractors who are not able to accommodate electronic bills from all types of providers to develop simple generic programs, for example, which small providers can use in different jurisdictions. This would be simplified by more consistent carrier programs and systems.

Response

We agree with this recommendation. This will be an ongoing process. The recently implemented Carrier National Standard EMC Format will help eliminate inconsistent requirements among the carriers, thereby improving the EMC situation for multi-jurisdiction providers. In addition, we are currently expanding the Medicare Manual instructions to require contractors to accept all bill and media types electronically.

Recommendation 5

HCFA should consider contractors' general business operations when awarding Medicare contracts.

Response

We do not agree with this recommendation. We agree the idea has merit. However, neither sections 1816 and 1842 of the Social Security Act nor the Federal Acquisition Regulations extends to HCFA the authority to delve into a contractor's private lines of business as part of the contracting process. Unless a contractor has been convicted or is under indictment for some violation of the law, or we have received substantial evidence of misconduct, we have no way of knowing what a contractor does in its non-Medicare lines of business.

General Comment

This draft report is rather sparse with respect to specific facts. For example, four intermediaries are mentioned in the draft report but are not identified. While we have learned informally which intermediaries were investigated, it is difficult to respond to OIG's findings without knowing specific facts concerning each intermediary. It would be helpful to us if the final version of this report included more specific details.