Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

SECONDARY ANALYSIS OF MEDICARE PROVIDER READINESS FOR Y2K

JUNE GIBBS BROWN
Inspector General

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June Gibbs Brown
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Secondary Analysis of Medicare Provider Readiness for Y2K, OEI-03-98-00252

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Health Care Financing Administration

In your comments on our report, "Y2K Readiness of Medicare Providers," you indicated that the Health Care Financing Administration (HCFA) would appreciate receiving additional information about our provider survey results. Specifically, you requested that we (1) address differences in the Year 2000 (Y2K) readiness from an urban versus rural perspective, and (2) determine if there was a relationship between providers who contract with vendors for claims submission and those providers' awareness of Medicare contractor outreach.

Overall, we found little difference between urban and rural providers on most Y2K issues. There was also little difference in responses between providers who used a billing service for claims submission and those who did not. However, there were some instances where both these and other variables had an impact.

In addition to addressing these issues, we have also analyzed the Y2K survey responses to determine if other variables, including provider size and managed care participation, had an impact on Y2K readiness.

Our report on Y2K readiness was based on a stratified random sample in which we over-sampled rural providers. Therefore, for a more in-depth analysis, we needed to calculate weighted frequencies from our survey responses in order to allow for the over-representation of rural providers in our sample. Additionally, we decided to remove "N/A" responses (not applicable or no response given) from our analysis. Table 1, on page 2, shows the weighted percentage of providers who responded in each category. We then used chi-square tests to determine if differences between two groups were statistically significant. For the purposes of this analysis, we determined statistical significance based on a 95 percent confidence level, meaning that we can be 95 percent confident that the differences between two groups are not due to random chance.

Table 1: Percentage of Providers

	Hospital	Nursing Facility	Home Health Agency	DME Supplier	Physician
Rural	48%	38%	32%	26%	17%
Urban	52%	62%	68%	74%	83%
Small Provider	35%	19%	20%	29%	36%
Medium Provider	29%	60%	51%	44%	41%
Large Provider	35%	21%	30%	27%	23%
Billing Service	64%	32%	40%	33%	40%
No Billing Service	36%	68%	60%	67%	60%
Managed Care	69%	42%	41%	54%	69%
Non-Managed Care	31%	58%	59%	46%	31%
Chain	32%	32%		10%	
Non-Chain	68%	68%		90%	
Freestanding		75%	45%		
Non-freestanding		25%	55%		
Group Practice					53%
Sole Practitioner					47%

For hospitals and nursing facilities, we defined small as having 50 beds or less, medium as between 51 and 150 beds, and large as more than 150 beds. For home health agencies, we defined small as seeing 100 patients or less per year, medium as 101 to 500 patients per year, and large as more than 500 patients per year. For durable medical equipment (DME) suppliers, we defined small as submitting 150 claims or less per year, medium as between 151 and 2000 claims per year, and large as more than 2000 claims per year. For physicians, we defined small as seeing 1500 patients or less per year, medium as 1501 to 7500 patients per year, and large as more than 7500 patients per year. All percentages may not total 100 percent due to rounding.

URBAN AND RURAL PROVIDERS

Overall, there was little significant difference between urban and rural providers regarding most Y2K issues. However, there were a few specific areas where the responses of urban and rural providers differed.

- Rural hospitals were more likely to report having financial and personnel problems, while urban hospitals reported more problems with external vendors. Additionally, urban hospitals were more likely to have renovated their billing systems and to have identified all of their external vendors and contractors than rural hospitals.

- Urban nursing facilities were more aware of changes to HCFA forms and of the availability of free contractor software than rural nursing facilities. Furthermore, urban nursing facilities were more likely to have identified all of their external vendors and contractors.

- Of home health agencies that could not enter 8-digit dates on the HCFA-1450 form, 71 percent of urban agencies said they would be able to within 6 months; only 38 percent of rural agencies reported they would be able to do so. In

addition, urban home health agencies were more likely to have renovated their medical records systems.

- ➤ Rural DME suppliers were more likely to have renovated their medical records systems.

- ➤ Rural physicians were more aware than urban physicians of contractor Y2K efforts and the availability of free software. Urban physicians were more likely to have identified all of their external vendors and contractors.

USING EXTERNAL BILLING SERVICES FOR CLAIMS SUBMISSION

We found that providers' contracting with a billing service for claims submission and payment activities had a significant impact on just a few variables.

- ➤ Hospitals using a billing service were much more confident in their ability to enter 8-digit dates on HCFA forms, were more aware of Medicare contractor outreach, and were more likely to have requested free contractor software.

- ➤ Nursing facilities using a billing service were less aware of the availability of the free contractor software.

- ➤ Home health agencies using a billing service were more likely to have identified all of their external vendors and contractors.

- ➤ Physicians not using a billing service reported more dissatisfaction with contractor outreach. Additionally, they were more likely to have discussed Y2K issues with their external vendors.

ADDITIONAL ANALYSIS

In completing our analysis, we examined several other variables to determine if additional factors affected providers' Y2K awareness and readiness. There were very few statistically significant relationships between these variables and our survey questions. We have provided a summary of those that were statistically significant, by provider type.

Hospitals

1. Hospitals that were part of a managed-care organization were more likely to have inventoried and renovated their biomedical equipment.

2. Chain hospitals were much less aware of issues regarding HCFA claim forms and Medicare contractor outreach. For example, while 32 percent of chain hospitals did not

know if they could enter 8-digit dates on the HCFA-1500 form, only 15 percent of non-chain hospitals did not know this.

3. Large hospitals (more than 150 beds) were significantly ahead of small hospitals (50 beds or less) in most areas, including assessment, renovation, and communication with vendors. Additionally, 45 percent of small hospitals reported having financial problems, compared to only 20 percent of large hospitals.

Nursing Facilities

1. Nursing facilities that provided care for managed-care organizations were more likely to have developed strategies for dealing with their computer systems and biomedical equipment. Nursing facilities with managed-care contracts also were more likely to have assessed and renovated their clinical systems and biomedical equipment. These nursing facilities also reported having better interaction with their vendors.

2. Chain nursing facilities seem to be trailing non-chains in the billing area. For example, only 38 percent of chains reported that their billing systems were ready, while 56 percent of non-chains said their billing systems were ready.

3. Only 29 percent of freestanding nursing facilities had developed Y2K contingency plans. Meanwhile, 49 percent of non-freestanding facilities had made contingency plans.

Home Health Agencies

1. Non-freestanding home health agencies had taken more steps to prepare their biomedical equipment for Y2K than freestanding agencies. In addition, non-freestanding agencies reported better communication with external vendors.

2. Large home health agencies reported significantly more progress than did small and medium-sized agencies in both their billing and clinical systems. Furthermore, while 60 percent of large home health agencies had developed Y2K contingency plans, only one-third of small and medium-sized agencies had done so.

Durable Medical Equipment Suppliers

1. No chain DME suppliers reported having financial or personnel problems due to Y2K. However, 16 percent of non-chains reported financial problems and 21 percent reported personnel problems. Additionally, chain suppliers were more confident in their ability to enter 8-digit dates on HCFA-1500 forms.

2. Large DME suppliers were more likely to have developed Y2K strategies than small or medium-sized suppliers. Large suppliers also reported better cooperation with their

external vendors. In addition, more than three-quarters of large suppliers indicated they could enter 8-digit dates on HCFA-1500 forms; approximately half of small and medium-sized suppliers reported they could do the same.

Physicians

1. Over 80 percent of physicians providing service for a managed-care organization were aware of changes to the HCFA-1500 form, while less than 60 percent of physicians who were not part of a managed-care plan knew about the changes.

2. Physicians who are part of a group practice reported higher levels of Y2K strategizing and system renovation than sole practitioners. Additionally, group physicians reported better communication with their external vendors.

3. Larger physician practices were more likely to have discussed Y2K issues and tested data exchange with external vendors. Furthermore, 82 percent of large practices were receiving Y2K assistance from external sources, while only 56 percent of medium-sized practices and 29 percent of small practices were receiving outside assistance.

We are making no recommendations, as our goal is to respond to your request for additional analysis of our Y2K survey data. We hope that this analysis is helpful in shaping your continued efforts to assist Medicare providers in their Y2K readiness activities. There is no requirement for you to comment on this report. However, if you have any comments or questions, please call me or George Grob, Deputy Inspector General for Evaluation and Inspections, or have your staff contact Mary Beth Clarke at (202) 619-2481.

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