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MEDICARE: OVERSIGHT ON PAYMENT DELAYS

HEARING

BEFORE THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

NINETY-NINTH CONGRESS

SECOND SESSION

JACKSONVILLE, FL

MAY 23, 1986

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MEDICARE: OVERSIGHT ON PAYMENT DELAYS

FRIDAY, MAY 23, 1986

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Jacksonville, FL.

The committee met, pursuant to notice, at 9 a.m., at the Senior Citizens Center, Jacksonville, FL, Hon. Lawton Chiles presiding.

Present: Senator Chiles.

Staff present: Bently Lipscomb, deputy staff director, Senate Budget Committee.

OPENING STATEMENT BY SENATOR LAWTON CHILES, PRESIDING

Senator CHILES. Good morning. It's good to see you here at the Mary Singleton Senior Citizens Center.

As you probably are all aware, May has been designated Older Americans' Month. I am particularly pleased to see so many of our seniors here this morning to participate in this hearing.

Before we start I think it might be helpful to spend just a few minutes setting the framework for what we have to accomplish in order to finish our hearing this morning. I think this is a very serious issue that we are looking into and we have four panels of witnesses to hear from, so our time is not unlimited. We have to conclude before noon.

I want to allow everyone who wants to speak to be heard, but I am afraid that won't be possible during our formal hearing, therefore, I want to ask our staff to hand out hearing comment forms at this time so that those who wish to bring information to the committee's attention will have the opportunity to do so even if they don't testify formally.

If you would like a testimony form, please raise your hand when the staff people get to your seats and we will consider all of the testimony sheets for the official record.

Additionally, I want to tell you that we brought a couple of our staff specialists in the Medicare claims area today to work with anybody that has a specific problem that they hope to get solved. Blue Cross has also brought some of their staff to work with you. So if anyone has a particular individual problem with something that you want me to look into, you can go to the Barber room now, or at any time during the morning and they will work with you individually. You can come and go from the auditorium as you need to meet the staff in the Barber room.

One more thing, I put my mailing address at the bottom of these testimony sheets and I would be very happy to hear from you for the next week or so if you have information about this hearing to

share with us after you leave here today. Of course, I am always glad to hear from you any other time if you have something which you need to bring to my attention or some problem which you think we might help you with.

Now, the Barber room, I understand, is right outside the auditorium and to your left. If you have a specific problem that you think we might be able to help you with, we will see if we can help you with it.

I want to welcome all of you to the hearing of our Aging Committee this morning on the subject of Medicare payment delays. About 3 months ago it started becoming apparent that we were developing a problem. Over all of last year my office received about 15 to 20 complaints from beneficiaries about slow payments from Medicare. That was over all of last year, 15 to 20 complaints. By March of this year, we were getting 5 to 10 complaints a week and over the past 5 workdays in our office the count totaled 89.

On March 21, I wrote the Administrator of the Health Care Financing Administration, which they call HCFA for short, asking for specifics regarding a policy we had heard the Health Care Financing Administration was considering. That policy was supposed to raise the minimum Medicare processing time to 18 days.

Now, I want to let all of you know that I have something in common with those people who write Medicare and don't hear from them promptly. It has been 60 days since I wrote, and as of today, I still don't have a reply from that letter.

In early April, I asked Florida Blue Cross and Blue Shield, the company that processes the majority of the Medicare claims in Florida, to give me a briefing on what was causing the surge in complaints. They came to Washington and they told the entire Florida congressional delegation what the extent of the backlog was. The information they shared with us was very disturbing, both from a Florida point of view and also from a national point of view.

In Florida, at the end of fiscal year 1984, we had about 280,000 claims pending that had not been totally processed. Now, that sounds like a lot of claims and it is a lot, but it came to about the amount received in 4 days mail. So, in other words, they were within 4 days of being caught up with 268,000 claims. Blue Cross said it would have been reasonable to expect that these claims would have been processed in approximately 6 days and the beneficiaries would have been sent their checks.

Now, that is the good news. The bad news was that under the constraints that were being placed on them by HCFA, the Health Care Financing Administration, they expected to have over 2 million claims pending by the end of this fiscal year, and that year ends September 30, 1986. Worse yet, they expected that because of funding cutbacks it was going to take them 40 days to process those claims and the beneficiaries or providers, might, at best, be 50 days in getting their checks.

So, over a 2-year period the amount of time necessary to get a check back had gone up over 40 days. Medicare would owe doctors and beneficiaries at the end of September, this year, about $185 million, just within the State of Florida.

I was concerned about what was happening to the patients and doctors in Florida. But, I am also concerned about the national budget. I want to know why we are moving expenditures that should have been paid this year into 1987, by design.

I asked for an accounting on a national basis and I found out that it is now projected that because claims intentionally won't be processed, nationally, we will owe almost $5 billion. At the end of last year, fiscal year 1985, we owed about $2.5 billion that we carried over into this year. In 1 year, we doubled that amount.

I know that we need to reduce the budget deficit. I have been totally committed to that goal for the few years. But, this is not the way to do it, and we are not reducing the Federal debt if we are just putting off the payment of these claims. Literally what we are doing is that we are seeing the Federal Government float their bills. Now, you know it is against the law to kite checks by starting to spend money you don't have. It is also against the law to float, to try to use money by holding somebody else's money, and using it over a period of time. That is what I see the Federal Government doing here, building up a float. What we are seeing is these backlogs of claims going from $2½ billion to $5 billion, and next year it could go much higher. Then we are building up a big bubble and that bubble has got to come home to roost some day.

That is the kind of problems that I see building here. We have to try to get on top of it. I think it is tremendously important that we try to do that right away. We have to try to get control of this situation. I believe holding this hearing today is the next logical step in that process, and I look forward to hearing from our witnesses today.

Our first panel will be Mrs. Susan H. Keller of Daytona Beach, Mrs. Myer de Leeuwe of Daytona Beach and Mr. Clyde Herzog of Jacksonville, FL, and Mr. Herzog is accompanied by Susan Sorenson from the office of Dr. Nicolitz.

I want to thank you all for coming here today. You have all in some way contacted our office about the problems you are having and I think you will help us lay out the scope of the problems that we are facing.

Mrs. Keller, we are going to start with you and ask if you could briefly tell us what problems you ran into.

STATEMENT OF SUSAN H. KELLER, DAYTONA BEACH, FL

Mrs. KELLER. I am a cancer patient. I had three operations for cancer last spring. My husband was alive then. Whether or not he had problems collecting from Medicare, I do not know, because he would not have worried me with it. However, my husband quite suddenly was taken ill and died on November 27.

I felt like a child that had been left totally alone. I have a son who is an attorney, who informed me exactly what to do. I did those things. The doctors' offices, of course, filed all the bills. When I came home from Christmas vacation, or whatever you want to call it, from South Carolina where my son kept me until after the first of the year, he came home with me and he told me, "Mother, go down and file daddy's will with the probate judge. It leaves you

with total control as the administratrix, then go to Social Security and have all this filed," which I did.

In the meantime, I began to get the doctors' bills back and they were just saying, "We cannot pay this because we are not sure that you are the person who is to receive these bills. We are not sure this is a proper bill. You will have to get the doctor to say that he will not accept assignment."

If you have ever seen one of these forms, ladies and gentleman, it is on there, "Will you accept this assignment?" It has yes or no and he had marked "No" on that about three times.

This bill was $587. It has been filed, I think—I asked the lady to count it the other day, because frankly I had a temper tantrum one day and tore a bunch of them up, but she did not have on her file exactly how many times but we figured conservatively four or five times. When I called the 800 number—in the meantime, however, I had gone to Social Security twice and they had filled it out. They had assured me that this would take care of the situation. When I received it back for the fourth or fifth time I was completely kerflummoxed.[1] I don't know any other word to use.

I called the 800 number given me and I would like to tell you exactly what was said. I said, "Hello," and this voice said, "How did you get this number?" And I said, "Off of a piece of paper that you gave to me that it says beneficiaries can call. I am my husband's beneficiary, and only beneficiary."

"Well, you are not supposed to have it and you do exactly what it says on that sheet." I said, "Lady, I have done that five times." Well, with that I hung up and I did have a temper tantrum and I went to my Congressman, who happens to be Mr. Bill Chappell's office, and I said "I can't handle this anymore. Somebody has got to do something." They handled it, and the bill was paid, a very cut down bill, but paid within 9 days.

I have another bill pending for $650. It was filed November 26. I have paid it. I am entitled to receive it. I am executrix of record with the probate judge, and I haven't heard one thing.

I am not going to starve to death, but it gets mighty unhandy to keep on paying doctors' bills. I have been frightened to file my own, which are now 300, 400, or 500 dollars' worth since that time, because I am so afraid they will get mixed up, and they won't pay my husband's bills and I want that to be finished.

Now, that is my own personal problem. The thing I cannot understand is two of my doctors had sent bills in from their office. These bills are still on my deductible, therefore, they owe me nothing and they have been finished in less than 4 weeks and I have proof in this little paper.

Now, I find it passing strange that when they owe me money it takes them 6 months, but when they don't owe me money, when I am on the deductible, they can finish it up in 4 weeks. I have a little question there, and I would certainly like to ask somebody about it.

Thank you very much.

Senator CHILES. Thank you very much, Mrs. Keller.

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[1] The word "kerflummoxed" comes from the Joel Chandler Horn's Uncle Remus stories about Brer' Rabbit and Brer' Fox and means completely and irrevocably confused.

Mrs. de Leeuwe.

STATEMENT OF MRS. MYER DE LEEUWE, DAYTONA BEACH, FL

Mrs. DE LEEUWE. Thank you. This will be my first complaint. I sent in a bill on April 12. I have not received one answer. When I called I do get nasty answers. I do not like to be treated that way in the first place.

Second, if you can get the people on the phone anyway, they have terrible excuses. "The computer broke down." That is a big fib. I know.

I have here, my husband was in the hospital lately 5½ days. The hospital days is—only the hospital bill is $3,435. The doctors' bill is $2,646 for 5½ days. How can I pay that on $875 of Social Security? You please give me an answer.

When my husband goes in the hospital I had to pay $400 up front, otherwise the doctor would not operate. While my husband was in the hospital I got a bill to put my husband to sleep, $500. Don't you think this is a little outrageous? I think everybody should look in, in the first place, the doctors' bills and hospital bills and the return of my money. I pay a lot of money on insurance. I do like to have a little return.

Thank you.

Senator CHILES. My understanding is that these delays and the fact that you have not been able to get the return, is putting you in the position where you might have to mortgage your house?

Mrs. DE LEEUWE. Mortgage the house? I cannot afford to mortgage the house. First of all, the bank would not give me another mortgage anyway. I do already have a mortgage on my house. If I go to a bank and they ask, "What is your income?" They just look at me and say, "Lady, what do you want from me?" I cannot afford another mortgage. I cannot sell the house in Daytona. Daytona has overbuilt. Already in Daytona they have 5,000 houses, brandnew homes on sale. I can't. I tried to sell my house. I cannot do it. Nobody is buying. What am I going to do? Put all of my money toward the doctors and the hospitals?

Senator CHILES. When you call the number trying to get help you say it takes several days to get through?

Mrs. DE LEEUWE. It takes about a day and a half. It is always busy that 800 number, busy, busy, busy. I don't know whether they take the horn off or what. It takes an awful long time to get the people and then you get a nasty answer. I have a doctor's bill coming back of $90. I call 6 weeks later. They said, "I mailed the checks." After 3 months, they claim the check was lost.

Senator CHILES. The check was lost?

Mrs. DE LEEUWE. They claim. I don't know.

Senator CHILES. We thank you again for your testimony. We will try to help you.

Mr. Herzog, is from Jacksonville, and he is accompanied by Susan Sorenson from the doctor's office.

STATEMENT OF CLYDE HERZOG, JACKSONVILLE, FL, ACCOMPANIED BY SUSAN SORENSON

Mr. HERZOG. I had two cataract operations. I had one last year around June, and I went to Dr. Nicolitz' office. At that time they told me I would have to pay the doctor's bill and they would file with the insurance company for me, which they did.

Within a couple of months everything was paid. The total bill came to approximately $4,000. Everything was paid except 100 and some odd dollars. I was satisfied with that. Everything went along fine.

Then I had another cataract operation around January 15. It was the same procedure; they would file for me. I received a bill February 20 from Dr. Nicolitz for $2,185. So just to make sure that they had filed, I called Dr. Nicolitz' office. She said, "Yes, we filed it. Don't worry about it until you get your money from Medicare and then you can pay us." I said, "Will that be all right?" She said, "Yes." I said, "OK, fine."

So, March 3, I got a statement from Blue Cross and Blue Shield stating that Medicare will have to process this claim first. I couldn't understand it. I don't know what happened, whether the doctor's office sent it to Blue Cross and Medicare both and Medicare got it first or what.

About that time I had some problems with my teeth. I forgot about this for a while. I thought I would start checking and see what happened. So April 28, I called Medicare and talked to a woman to see if they received the claim and she stated there was no claim for a Herzog at the present time.

So I thought that was strange. I explained to her that I received a statement from Blue Cross stating they had received a claim and it would have to be processed through Medicare first. She said it must have been mailed to the wrong address. She said, "We are in the same building but they have different addresses."

So I called Dr. Nicolitz' office the same day and talked to Susan. I explained the situation to her and she stated the claim had been filed January 23, 1986; and February 14, 1986, was filed again. So in the meantime, I waited and the doctor was sending me bills that were past due.

May 5, I got another statement from Blue Cross and Blue Shield stating that they had received a claim that would have to be processed through Medicare first. So I couldn't understand what was going on there again.

So I called Dr. Nicolitz' office again, talked to a girl by the name of Sherry and explained the same thing to her about Medicare not having received anything and I was getting statements from Blue Cross, stating that they had received notices from Dr. Nicolitz.

I was receiving past due notices from Dr. Nicolitz. I asked her about it and she said, "Well, can you send a few dollars in?" So I did. I sent them $685 for that month, and that is the last I have heard.

Senator CHILES. How long have you been waiting overall then?

Mr. HERZOG. Since January.

Senator CHILES. Since January?

Mr. HERZOG. Right.

Senator CHILES. And this is roughly $2,000 that you have been waiting on since January?

Mr. HERZOG. Right. Now, John Caffey, the anesthesiologist, sent me a bill; said that they had applied for my insurance. All right. I received a statement from Blue Cross on March 17. They paid it. They paid what was left of what Medicare hadn't paid and they were satisfied. I haven't heard from them since.

Senator CHILES. But you still haven't received your claim, the first claim you were talking about here?

Mr. HERZOG. Correct.

Senator CHILES. So the doctor did not accept assignment of the claim to start with?

Mr. HERZOG. No, I was responsible for it. That is right.

Senator CHILES. Susan, can you tell us if the experience that Mr. Herzog has had, is unique to him or do other claims that Dr. Nicolitz has had run the same way?

Ms. SORENSON. This is typical. This is a very typical case. The percentage, I am not certain, of outstanding claims on nonassigned claims. The average payment turnaround time for our patients has been 4 to 6 months.

Senator CHILES. Four to six months?

Ms. SORENSON. Four to six months. As far as I am aware, for the last 5 years I have been doing this, the address has always been the same. I eat it, sleep it, drink it.

Senator CHILES. Do you notice that the time is getting longer?

Ms. SORENSON. It is progressively getting longer. It used to be that the turnaround time was approximately 50 days. If I could ever get a payment on a claim in 20 days I would have been a very happy person, and so would my employer. I have never had one come back that quickly.

The past year, since May of last year, the time has stretched out progressively from 2 months, to 3 months and now 6 months.

As a matter of fact, in April of this past year I finally received payment for a patient whose surgery took place in April 1985. We were finally paid 1 year later, April 1986, for surgery which took place in 1985. These people in most offices end up going to the credit bureau for nonpayment unless they have a physician who is willing to work with them and understand what is happening in the Medicare system.

It has been my experience that Mr. Herzog is typical of the turnaround time before receiving payment. The excuses that are given to the patient have caused the patient to come back to the physician saying, "You didn't file the claim. They never received the claim."

Well, that became such a commonplace excuse, that I started batching my claims to Medicare and sending them return receipt requested. Someone has to sign for them now, so when that excuse comes back from a patient, that the claim was never received, I keep a list of those patients and the date that batch went in, and if that excuse is given a patient, I just tell them it is an out-and-out lie.

Senator CHILES. You are saying this excuse of mistaken address or wrong address, you have been using that same address for——

Ms. SORENSON. For 5 years.

Senator CHILES. For 5 years.

Ms. SORENSON. They have not moved anywhere that I know of. We will receive payment on claims that were done 4 weeks before we receive it on claims that were done 6 months ago on the same patient. So what is happening to the claims once they reach that building is beyond us. Our time is spent in refiling and refiling and refiling the same claim, and in Mr. Herzog's case it has been filed three times.

Senator CHILES. Thank you very much for your testimony.

Mrs. KELLER. Most of us are carrying supplementary insurance which we can do absolutely nothing with until we receive the Medicare. Mine costs me $53.80 a month taken out of my pension fund. I want to keep that insurance so I am not owing people when I die or am ill, and we cannot file one thing until we get our claim.

Senator CHILES. Until you get your claim you cannot file for your supplementary insurance?

Mrs. KELLER. Until we get a claim we cannot file anything on the supplementary insurance.

Senator CHILES. Even though you are paying a healthy premium for that every month?

Mrs. KELLER. Every month of my life it comes out of my pension funds.

Senator CHILES. We want to work with each of you all to try to help you in your individual cases and see if we can do something to speed that up for you. Thank you for your testimony.

We will now hear from our second panel: First, Dr. William J. Garoni who is a general surgeon and the past president of the Duval Medical Association. He is representing the Florida Medical Association of Jacksonville, and Mr. Arjona, president of Dade County Medical Rental & Sales in Miami, FL.

Doctor, we appreciate your coming today and we would like to hear from you.

STATEMENT OF DR. WILLIAM J. GARONI, JACKSONVILLE, FL, REPRESENTING THE FLORIDA MEDICAL ASSOCIATION

Dr. GARONI. Good morning, Senator. It is with great pleasure that I am here and I appreciate this opportunity to represent the 15,000 doctors who are members of the Florida Medical Association. In essence what has happened to us is over the last 2 or 3 years we have noticed that the timeframe of our reimbursement has been extended. It seems that in the last 3 to 6 months the time it takes to get a claim paid when you accept assignment through the Medicare Program has gone from 60 days to as long as 5 months.

In addition to that, because of previous problems with the fiscal intermediary, many physicians have put a computer program in their offices which is supposed to speed up reimbursement. This was a personal expenditure to the physicians' offices.

Senator CHILES. You are encouraged to do this, I understand.

Dr. GARONI. Yes, sir.

Senator CHILES. By Blue Cross, Blue Shield? They encouraged you to do that to speed up the process?

Dr. GARONI. Well, they came in and—actually what they did was they took a part of the workload off them and put it on physicians and for a short period of time, even on that system, they were paying within 15 days. Now, that has gone to 30, 35 or 40 days.

It seems after talking to physicians around Duval County and reading letters from physicians all over the State of Florida, I think what is happening is smaller claims are handled quickly and larger claims, as they were just discussing, that fairly large surgical claim, are held up in an effort, I think, to back up the money for probably the purpose to make interest on it.

I cannot emphasize enough the physicians who accept assignment who have large Medicare population patients, this type of action is putting a severe strain on their practice.

In essence, we are already working on a 1984 July fee schedule when we accept Medicare. As you know, they are in a frozen mode, as far as fees are concerned, so that puts us already in a situation where when we take a Medicare assignment we are already behind as far as our overhead payments are concerned, but for them to keep the money for the 3 to 5 months puts an even more severe strain on us, and there are many physicians in the State of Florida who are unable to meet the financial responsibilities of their own, such as their payroll to their employees or their malpractice insurance payments which are very great.

In fact, many doctors, and we have letters from a large number, have actually had to take loans out because if they have a big Medicare population, say 60 to 70 percent and they go through a 3-month holdup period, that completely stops their income, essentially for that period of time, so there are many doctors who have had severe financial problems with this.

I think probably another one of the biggest problems is that it has been interfering with doctor/patient relations. The Medicare recipient often feels that the physician is involved through some type of a filing error. In fact, I think at times it may even be intimated that that is the problem, so the patient—these patients, most of them, are on some type of fixed income level and the physician is in a position where he is not getting paid. The patient is getting letters if they are not taking assignment, or if you take assignment, the patient is being treated like a second-class citizen, and I think it really has developed into a——

Senator CHILES. You are talking about situations where many times our senior citizens are afraid. They don't know whether or not they are going to have the money to pay these claims or how they will handle their bills. You are saying in these straits they don't know whether the physician is at fault——

Dr. GARONI. Absolutely.

Senator CHILES. They are just kind of frustrated and not sure who to blame in that situation.

Dr. GARONI. Absolutely. So it is ultimately blamed on us.

Senator CHILES. That is not a very healthy healing relationship between doctor and patient.

Dr. GARONI. It makes a very severe problem, and if you forget to dot an i, they are going to reject your claim. I can tell you. It has got to be exactly perfect and once they have rejected it, then that gives them another 50 days to run it through the cycle.

So you have got two situations here. You have got the situation where the physician takes the assignment. He is being penalized doubly by taking a decreased fee and also having to wait twice or three times as long, so if the doctor does not take assignment, if he goes to the patient for the money, then the patient has got the severe problem, unless they happen to be extremely wealthy, of where they are going to get the money to pay for this over a 5 or 6 months' period, and a lot of us, even if we don't take assignment—many doctors take assignment of some patients and others they don't, will wait, let the patient wait and pay you when they get the money, because they don't have the money to pay you out of cash flow, so we will let them get their check often before they pay us.

So, I think it is a very bad situation as far as patient-doctor relationship. It is putting a severe handicap on physicians who are taking care of large Medicare populations.

Senator CHILES. Are there fewer doctors who will take assignments?

Dr. GARONI. That is another one of the major problems. That is another one of the things I was going to bring up. It penalizes the physician to take assignments. It is much easier for the doctor to tell the patient, "OK, you owe me money, and you get it from the fiscal intermediary." And, I can tell you that I have a trained lady who is an expert in handling insurance and her hair gets whiter every month. I can't imagine a person who has not been involved in this kind of system effectively dealing with that fiscal intermediary. I have had patients almost break down and cry when they get caught in that maze when they are trying to get a bill paid themselves. There is an award almost to the fiscal intermediary for them not paying us on time. I mean, you know, there is a feeling, "This is OK if we don't pay. This makes us look better. We have got more money. We are holding it up longer," so I think in essence the medical population, the doctors and the patients are being shortchanged by this being allowed to continue and happen, and we hear now that they may extend it even longer, which is going to make even a greater strain.

Senator CHILES. Tell me what you have heard, how you heard it, and where you heard it.

Dr. GARONI. Well, actually, I read it in the paper Saturday. I cut that out and I was going to bring it in. I don't know whether that is the news being late catching up with what is going on or whether that is just the hallmark of the future, but they were saying that they think it is costing the trust fund a lot more money because when they paid a claim, and they intimated they were being paid in 15 days, which was the biggest fantasy I have ever seen, but anyway, by paying the claims gradually it is costing them the interest rate, so they were going to attempt to extend that time, save the money and increase their interest rate.

Senator CHILES. A little float?

Dr. GARONI. Yes, sir. This was in our Sunday paper, if you would like to look at it. It just points out that is what is going on.

Senator CHILES. Thank you very much for your assistance.

[The prepared statement of Dr. Garoni follows:]

STATEMENT

of the

FLORIDA MEDICAL ASSOCIATION

to

Senator Lawton Chiles

RE: Medicare Contractor Delays in Processing
Medicare Part B Claims

Presented by

William J. Garoni Jr., M.D.
Committee on Health Care Financing

May 23, 1986

Florida Medical Association
760 Riverside Avenue
Jacksonville, Florida 32204

GOOD MORNING. MY NAME IS WILLIAM GARONI. I HAVE BEEN PRACTICING GENERAL SURGERY IN JACKSONVILLE FOR THE PAST 20 YEARS AND I AM HERE TODAY REPRESENTING THE FLORIDA MEDICAL ASSOCIATION. I AM CURRENTLY CHAIRMAN OF THE FLORIDA MEDICAL ASSOCIATION'S COMMITTEE ON HEALTH CARE FINANCING. IT IS INDEED A GREAT HONOR AND PRIVILEGE TO HAVE THIS OPPORTUNITY TO ADDRESS YOU TODAY WITH REGARDS TO THE CURRENT PROBLEMS OUR MEMBERS ARE ENCOUNTERING WITH THE DELAY IN MEDICARE REIMBURSEMENT.

I WOULD LIKE TO BEGIN BY STATING THAT IN THE FISCAL INTERMEDIARY'S, BLUE CROSS/BLUE SHIELD OF FLORIDA, INC., TIMES: FLORIDA HEALTH CARE, JULY/AUGUST ISSUE OF 1985, IT REPORTED THAT A BULLETIN WAS SENT EXPLAINING THE DELAYS IN MEDICARE B CLAIMS PROCESSING, STATING THAT MEDICARE B IS STILL EXPERIENCING UNUSUALLY LARGE CLAIMS VOLUME. FOR THE PERIOD OF JANUARY THROUGH JUNE, 1985 THE INCREASE IN CLAIMS RECEIVED WAS 18 PERCENT OVER THE PREVIOUS YEAR OR MORE THAN DOUBLE THE PROJECTED INCREASE. IT WENT ON FURTHER TO STATE THAT THE DEFICIT REDUCTION ACT OF 1984 HAS BEEN IDENTIFIED AS A PRIMARY REASON FOR THE UNEXPECTED INCREASE IN CLAIMS VOLUME. NORMAL STAFF ADDITIONS, PRODUCTIVITY IMPROVEMENTS AND EXTENSIVE OVERTIME HAVE NOT BEEN SUFFICIENT TO HANDLE THE INCREASE IN CLAIMS. A FULL TIME SECOND SHIFT WAS ESTABLISHED WITH ADDITIONAL EMPHASIS PLACED ON PAPERLESS CLAIMS PROCESSING TO REDUCE DELAYS.

THE HEALTH CARE FINANCING ADMINISTRATION INCREASED THE NUMBER OF REGULATIONS THESE NEW REGULATIONS INCLUDED REQUIRING, UNDER THE MEDICARE SECONDARY PAYOR PROGRAM, THE CARRIER TO COORDINATE MEDICARE BENEFITS WITH OTHER INSURANCE COVERAGE FOR CERTAIN BENEFICIARIES INCLUDING QUALIFIED WORKING, ELDERLY, AND THEIR SPOUSES; MANDATED UTILIZATION SCREENS, AND INCREASED EMPHASIS ON OTHER PREPAYMENT REVIEW REQUIREMENTS.

IN AN ARTICLE DEVELOPED FOR THE FMA BY BLUE CROSS/BLUE SHIELD OF FLORIDA, INC., DATED MAY 21, 1986, IT STATED THAT "THE EFFECTIVE LEGISLATIVE AND REGULATORY ACTIONS BY THE FEDERAL GOVERNMENT ACCUMULATED WITH GRAMM/RUDMAN, COMBINED WITH FLORIDA'S GROWING MEDICARE CLAIMS VOLUMES HAVE CREATED CONDITIONS WHICH ARE GOING TO ENSURE DISRUPTIONS OF SERVICE AND SLOWER CLAIMS PAYMENT." AS THIS

BUDGET REDUCTION PERTAINS TO FLORIDA, THEY WENT ON TO STATE THAT "THIS FUNDING LEVEL DOES NOT CORRELATE WITH ANTICIPATED CLAIMS VOLUME." BLUE CROSS/BLUE SHIELD OF FLORIDA, INC. HAS PROJECTED 20.6 MILLION CLAIMS FOR FISCAL YEAR 1986.

THE CURRENT FUNDING LEVEL WILL NOT ALLOW BLUE CROSS/BLUE SHIELD OF FLORIDA, INC. TO PROVIDE ACCEPTABLE SERVICE TO FLORIDA'S BENEFICIARIES AND PROVIDERS. IT IS ESTIMATED THAT THEY ARE CURRENTLY BUDGETED TO ONLY COVER 19 MILLION CLAIMS AND, FURTHERMORE, THE YEAR ENDING INVENTORY WILL HAVE APPROXIMATELY 2.1 MILLION CLAIMS WITH ALMOST HALF OF THESE BEING MORE THAN THIRTY DAYS OLD.

I HAVE MENTIONED THESE FACTS TO YOU FOR FISCAL YEARS 1985 AND 1986 TO BRING TO YOUR ATTENTION THE FACT THAT THIS DELAY IN MEDICARE CLAIMS PROCESSING HAS INCREASED TO AN UNCONTROLLABLE LEVEL. PHYSICIANS WHO HAVE ENCOUNTERED THESE CLAIM DELAYS ARE EXPERIENCING GREAT DIFFICULTIES IN OPERATING THEIR PRACTICES, ESPECIALLY, THOSE PRACTICES WHICH ARE HEAVILY MEDICARE ORIENTED. IN ADDITION, THE TIME IT TAKES TO DETERMINE THE STATUS OF THE CLAIM, AS WELL AS THE CLAIMS THAT HAVE BEEN REJECTED BECAUSE OF CODING ERRORS JUST ADDS TO THE DELAY.

CURRENTLY MY PRACTICE CONSISTS OF APPROXIMATELY 50 PERCENT MEDICARE PATIENTS, AND I AM A MINIMUM OF FIVE MONTHS BEHIND IN CLAIMS TO BE PROCESSED AND PAID. THIS HAS A DETRIMENTAL AFFECT TO THE CASH FLOW OF MY PRACTICE. I HAVE SALARIES TO PAY, INSURANCE AND OTHER OFFICE EXPENSES THAT NEED TO BE PAID ON A REGULAR BASIS, IN ORDER TO KEEP MY PRACTICE OPERATING.

I BRING TO YOUR ATTENTION THE FACT THAT CONGRESS HAS TRIED TO ENCOURAGE DOCTORS TO ACCEPT ASSIGNMENT AND TO PARTICIPATE IN THE MEDICARE PROGRAM BY PROVIDING QUICKER TURNAROUND. THE RECENT DELAYS AND PROBLEMS IN CLAIMS PROCESSING THAT PHYSICIANS HAVE ENCOUNTERED WILL ENCOURAGE PHYSICIANS NOT TO PARTICIPATE IN THE PROGRAM.

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THE FMA STAFF HAS RECEIVED A PHENOMENAL AMOUNT OF CALLS FROM AROUND THE STATE FROM PHYSICIANS WHO ARE EXPERIENCING THIS DELAY AND THE ACTUAL EFFECT THAT IT IS HAVING ON THEIR PRACTICE. ONE PHYSICIAN IN JACKSONVILLE ESTIMATES THAT HIS TURNAROUND TIME IS A MINIMUM OF 2-3 MONTHS TO PROPERLY GET A CLAIM PAID ONCE IT HAS BEEN SUBMITTED. ANOTHER PRACTICING FAMILY PRACTITIONER BY THE NAME OF DR. MCAULIFF HAS OVER $100,000 ACCRUED IN BACK PAYMENTS FOR MEDICARE SERVICES AND A 3 MONTH TURNAROUND TIME. A PHYSICIAN OUT OF GRAND ISLAND, FLORIDA HAS DECIDED NOT TO PARTICIPATE IN THE PROGRAM BECAUSE OF DELAYS IN RECEIVING REIMBURSEMENT FOR PROVIDING SERVICES TO MEDICARE PATIENTS. THIS WAS BACK IN MAY, 1985. ANOTHER PHYSICIAN OUT OF MIRAMAR, FLORIDA STATES THAT THE FISCAL INTERMEDIARY IS DELAYING PROCESSING CLAIMS AT AN INCREASING RATE AND THEN DENYING CLAIMS AT A MUCH HIGHER RATE FOR FURTHER INFORMATION WHICH LEADS TO EVEN FURTHER DELAYS IN PROVIDING REIMBURSEMENT FOR MEDICARE SERVICES. THIS IN ITSELF HAS HAD A DETRIMENTAL EFFECT ON THE PHYSICIAN'S PRACTICE. ONE CRITICAL EXAMPLE OF WHAT KIND OF EFFECT THE DELAY IN PROCESSING HAS HAD IS FROM A PRACTICING OPHTHALMOLOGIST IN BARTOW, FLORIDA. THIS PHYSICIAN STATED THAT SINCE JULY, 1985, MEDICARE REIMBURSEMENT TO THE PATIENT AND THE PHYSICIAN HAS BEEN INTERMITTENT, AT BEST. THIS PHYSICIAN HAD NON-REIMBURSED CLAIMS OVER $150,000 COVERING A 5 MONTH PERIOD WHICH ULTIMATELY RESULTED IN THIS PHYSICIAN TAKING OUT BANK LOANS OF $75,000 AND $60,000 IN ORDER TO KEEP HIS PRACTICE OPERATING. THE MAJORITY OF HIS PATIENTS WERE MEDICARE PATIENTS AND, THEREFORE, A LOT OF HIS INCOME WAS BASED ON THE REIMBURSEMENT PROVIDED BY THE MEDICARE PROGRAM. DELAYING MEDICARE PAYMENTS IS ALSO A DISADVANTAGE TO THE PATIENT WHO IS PAYING THE PHYSICIAN FOR HIS SERVICES AND NOT BEING REIMBURSED BY MEDICARE IN A TIMELY MANNER. ANOTHER PHYSICIAN IN DAYTONA BEACH IS CURRENTLY EXPERIENCING A FIVE MONTH DELAY IN CLAIMS REIMBURSEMENT (WELL OVER $100,000). HIS PRACTICE IS PREDOMINANTLY MADE UP OF MEDICARE PATIENTS (75 TO 80 PERCENT). THE PHYSICIAN IS CURRENTLY IN THE PROCESS OF OBTAINING A LOAN TO KEEP HIS PRACTICE GOING.

I CANNOT EMPHASIZE ENOUGH THE DETRIMENTAL EFFECTS THIS HUGE DELAY IN CLAIM REIMBURSEMENT IS HAVING ON THE PRACTICE OF MEDICINE AND I CAN ASSURE YOU THAT IF IT CONTINUES, THIS WILL DISCOURAGE PHYSICIANS FROM PARTICIPATING IN THE MEDICARE PROGRAM AND TO ACCEPT ASSIGNMENT. DELAYS IN CLAIM PROCESSING DISCOURAGES ASSIGNMENT ON THE VERY CLAIMS FOR WHICH ASSIGNMENT MAY MOST BENEFIT THE BENEFICIARIES AND MAY FORCE SOME PHYSICIANS TO RE-EXAMINE THE NUMBER OF MEDICARE PATIENTS IN THEIR PRACTICE.

THE FLORIDA MEDICAL ASSOCIATION STRONGLY OBJECTS TO THE DELIBERATE MEDICARE POLICIES TO DELAY PAYMENTS AT THE EXPENSE OF MEDICARE BENEFICIARIES AND PROVIDERS OF SERVICE UNDER THE MEDICARE PROGRAM.

THE FLORIDA MEDICAL ASSOCIATION WOULD URGE YOU TO TAKE WHATEVER STEPS ARE NECESSARY TO ASSURE PROMPT PAYMENT OF CLAIMS UNDER PART B OF THE MEDICARE PROGRAM THROUGH ADEQUATE APPROPRIATIONS AND OTHER PROGRAM MODIFICATIONS TO IMPROVE CLAIMS PROCESSING.

ONE CLOSING COMMENT IS THAT BLUE CROSS/BLUE SHIELD OF FLORIDA, INC. HAS INFORMED THE FLORIDA MEDICAL ASSOCIATION THAT PROVIDERS SHOULD NOT CONTACT BLUE CROSS/BLUE SHIELD OF FLORIDA, INC. UNTIL AT LEAST EIGHT WEEKS AFTER MAKING A CLAIM. I CAN ASSURE YOU THAT ONLY THE PROVIDER AND, MOST IMPORTANTLY, THE MEDICARE PATIENT BEAR THE BRUNT OF ANY SAVINGS REALIZED BY THE HEALTH CARE FINANCING ADMINISTRATION. THE HEALTH CARE FINANCING ADMINISTRATION IS NOT DEALING WITH REALITY WHEN A PHYSICIAN HAS TO TAKE A OUT LOAN IN ORDER TO KEEP A PRACTICE OPERATING WHEN MEDICARE REIMBURSEMENT IS DELAYED.

SENATOR, I WOULD BE GLAD TO ANSWER ANY OF YOUR QUESTION.

Senator CHILES. Mr. Arjona, you are in the medical supply business, I understand? You are from Dade County?

STATEMENT OF IGNACIO ARJONA, MIAMI, FL, PRESIDENT, DADE COUNTY MEDICAL RENTAL & SALES, INC.

Mr. ARJONA. Yes, sir. I am in this business for 16 years and beginning May 1985, I started to have a problem and the problem was delaying the payments. I had to borrow money from last year.

Senator CHILES. You had to borrow money?

Mr. ARJONA. Last year and this year, I had to take a second mortgage on my house in March to get another $20,000 to pay the payroll taxes. I was behind. I had to pay for interest for that. It cost me a lot more money to run my office because I have to pay the interest on that.

Now, I can't keep up with this. I have about 600 to 700 customers every month and my average income is $48,000 to $56,000 a month and I only receive between about $20,000 to $22,000 back.

Senator CHILES. You are only getting back about half of what your charges are?

Mr. ARJONA. Right. It takes me 8 weeks to get that money back. In March I had so much stress, I have high blood pressure and I went to intensive care and it cost me another $1,400 because my insurance pays the 80 percent and the anxiety, it is a lot of anxiety for me and for my family dealing with these problems.

Senator CHILES. So the average time for collecting these bills is up to how long now?

Mr. ARJONA. I would say 45 to 65 days right now to get part of the money. Last year I believe I got about seven advance payments that go ahead into my account.

Senator CHILES. You are accepting assignments for the patients?

Mr. ARJONA. Yes, sir; about 92 percent of my customers are Medicare.

Senator CHILES. What would happen if you did not accept assignment for those patients?

Mr. ARJONA. Those customers would never get reimbursed. They don't know how to fill it out correct, the claim.

Senator CHILES. They don't know how to fill out the claims?

Mr. ARJONA. No, sir. I have to fill out a prescription signed by a doctor and many times they deny claims for the reason there are no medical prescriptions. That means they are losing the prescriptions. I don't know where they go. They just give me so much problems and anxiety. People call me every day. I have to pay my overhead. I got about $10,000 liability insurance for the trucks and car and right now I am behind in that payment. I am behind in payroll taxes. I don't know what I am going to do if it keeps going on.

Senator CHILES. This is what the float means to you, the fact that you can't get paid?

Mr. ARJONA. It seems like they do everything to delay the claims. The performance of the carriers in relation to the claims, they don't perform no more. They are asking for delay in the payments. That is what I hear now.

Senator CHILES. You had to go to the hospital with high blood pressure?

Mr. ARJONA. Yes, sir; last March. I don't know what I am going to do. I am behind, you know. I don't know what I am going to do by the end of June.

Senator CHILES. How much in claims do you have outstanding now?

Mr. ARJONA. According to what I see the last few weeks. for last year, I have about 240 claims. That means about $42,000 or $43,000, and right now——

Senator CHILES. If you had that money, you wouldn't be in any trouble?

Mr. ARJONA. No, sir; and from this year I put in $21,000 in the computer, so another—I would say total $100,000.

Senator CHILES. So you have roughly $100,000 outstanding?

Mr. ARJONA. Yes, sir.

Senator CHILES. And the average age of those claims is what?

Mr. ARJONA. From that point, August, September, October, and November 1985. The other 25 I would say 60 days, about that and 25 is only about 25 days.

Senator CHILES. From what you know about what is happening in Dade County, are doctors running into this same problem?

Mr. ARJONA. Same problems. Doctors are having the same problems. Some people I know will have to close by the end of June if something doesn't happen.

Senator CHILES. Do you know anybody who has had to close their business?

Mr. ARJONA. Some people like me are having a very difficult time and they will close by the end of June if they don't get soon in a better position with the carrier pending claims.

Senator CHILES. Dr. Garoni, you say that this is putting a severe strain on the doctors out there. Do you know any who have given up their practice?

Dr. GARONI. We have received letters from several physicians who have had to take out loans like this gentleman. It looks like we will have doctors in that position very soon.

Senator CHILES. Take out a loan to maintain their cash flow?

Dr. GARONI. It is like everything else, if this keeps up you have to do something.

Senator CHILES. I think our witnesses have been able to show us that people who are actually claimants, our seniors, are not being paid their money. They are having to refile their claims over and over. They are seeing tremendous delays. And now we are hearing that the medical providers, the doctors and the people who provide medical services are also experiencing this tremendous delay. We can also see what that delay is causing.

Doctors are refusing to take assignments. That means a tremendous additional strain on our senior citizens. They are having to pay the money out of their pockets, they have to wait to be paid, and then we are seeing the people who provide medical services literally having to borrow money and have their health break down because the Federal Government won't pay them. We will now hear from a panel of Blue Cross, Blue Shield people: First, Mr. Tony Favino, the senior president for operations, Blue Cross and Blue Shield. He is accompanied by Mr. Alan Spielman, executive

director of the Federal Financing and Tax Legislation Division, National Blue Cross and Blue Shield in Washington.

Mr. Vavino is accompanied by Steve Davis, vice president of Medicare, part B, and Mr. Bill Long, director of Government Programs, Blue Cross and Blue Shield of Florida.

Mr. FAVINO. Good morning, Senator.

Senator CHILES. Good morning, Mr. Favino. You have heard our testimony here. Of course, part of it is people saying that they are not able to contact your office. They are not able to get their claims processed. They are having these tremendous delays. Why is that happening?

Mr. FAVINO. If you will allow us to present our testimony, I believe we will be able to respond to those questions, Senator.

Senator CHILES. Yes, sir.

STATEMENT OF ANTONIO FAVINO, JACKSONVILLE, FL, SENIOR VICE PRESIDENT FOR OPERATIONS, BLUE CROSS AND BLUE SHIELD OF FLORIDA, INC., ACCOMPANIED BY STEVE DAVIS, VICE PRESIDENT FOR MEDICARE PART B, AND BILL LONG, DIRECTOR OF GOVERNMENT PROGRAMS, BLUE CROSS AND BLUE SHIELD OF FLORIDA, INC.

Mr. FAVINO. As you know, I am senior vice president of operations for Blue Cross and Blue Shield of Florida and with me is Steve Davis, vice president for Medicare part B, and Bill Long, director of Government Programs.

We appreciate the opportunity to testify on the administration of the Medicare Program in Florida. Bill Long will present our testimony and each of us will be available to respond to your questions after the testimony.

Mr. LONG. Senator, I am Bill Long, director of Government Programs for Blue Cross and Blue Shield of Florida, and I would like to mention today that we appreciate the interest you have demonstrated in the problems that face Medicare contractors and the resulting problems as they impact the Medicare beneficiaries and providers here in Florida.

Blue Cross and Blue Shield of Florida serves as a contractor for both Medicare part A and Medicare B in Florida. We have been deeply involved in this program for the past 20 years, since the Medicare Program began, and we are proud of our association with this most important program.

As the Medicare contractor, we serve over 2 million Medicare beneficiaries, 250 part A providers and 45,000 physicians and suppliers in Florida.

In the fiscal year 1985 we processed over 2 million Medicare part A hospital claims and 18.7 million part B physician and supplier claims. This accounted for a total payout of over $4 billion.

The administration of the Medicare Program is complex and our responsibility as a Medicare contractor includes processing claims for both beneficiaries and physicians, responding to and dealing with providers and beneficiaries' inquiries, controlling Medicare benefit payouts, and implementing complex legislative, administrative and regulatory changes.

We take seriously our commitment to provide service to Medicare beneficiaries and providers in Florida. Our staff has achieved an exemplary record, especially over the past few years in administering these programs. We have consistently achieved high performance standards as measured against other Medicare contractors nationwide and have been a leader in innovation with programs such as electronic media claims submission.

We also play a vital role in the direct control of program expenditures for our audit and utilization review activities and third-party liability claim collection. Our part A and part B medical and utilization review and Medicare secondary payer programs achieved program savings of over $109 million in fiscal year 1985, and the estimated savings were approximately $113 million for fiscal year 1986.

Severe funding cutbacks in fiscal year 1986 for contractors to process claims and answer inquiries, and increased number of administrative requirements and the funding prospects for fiscal year 1987, all combine to seriously threaten our continuation of this success.

Senator CHILES. Now, stop right there for a minute. You said three things. I think you said severe funding cutbacks increased screening requirements and what was the third thing that you said?

Mr. LONG. The potential we face for funding in 1987 and out years.

Senator CHILES. Are you telling me that you are provided less money and required to do more in the way of screening and providing?

Mr. LONG. Yes, sir, we are, and the fight that you mentioned against the deficit is affecting everyone. The amount of money that is allocated to contractors to actually process claims and answer inquiries has been affected by that fight.

Senator CHILES. But you just told me you were able to save $106 million by being able to screen and you described the work that you are doing in taking out illegal claims or fraudulent claims, and claims that were wrongfully processed. You are not going to be able to save that moey if you are not given enough money to do that job, are you?

Mr. LONG. That is true.

Senator CHILES. Or does that simply mean that the person that is filing their claim just has to wait that much longer because you are required to do certain things?

Mr. LONG. Primarily that is what is occurring. The additional administrative and screening requirements are placed on contractors in an attempt to save this kind of money. Additional funding has not been provided to offset the delay for the extra responsibilities which have to be carried out to accomplish that, so the amount of time it takes us to get to the claim and to apply the screens is significant.

Senator CHILES. You have two things that you have to do. You have to process the claim and you also have to screen. Have you received any instruction from HCFA. Do they think it is more important that you do the screening than you do the processing?

Mr. LONG. We have received additional funding to do some screening of these medical procedures in terms of audit and utilization review of new types of services. However, there haven't been additional administrative funds provided to allow us to process the claims and to answer the inquiries.

Senator CHILES. So you are saying there has been a cutback in the amount of funds for the general administration of processing the claims but some additional money for the screening process?

Mr. LONG. In fiscal 1986 we received about a 3-percent increase in our budget for Medicare Part B, but if you look at the claims administration and the beneficiary services part of the budget, we actually received a 3-percent decrease in those funds. Overall we went up a small amount but we have received less funding for the actual claims processing function.

Senator CHILES. Do you have more claims to process than you had the year before?

Mr. LONG. Claims receipts are expected to increase by about 10 percent this fiscal year.

Senator CHILES. So with a 10-percent increase in the number of claims, you are getting roughly 10 percent less than you had the year before?

Mr. LONG. To administer the program, yes, sir.

Senator CHILES. And you also had a carryover from the year before?

Mr. LONG. That is true. You are never going to reach a point where you zero out on claims. So every fiscal year——

Senator CHILES. But is the carryover building, that is what I want to know?

Mr. LONG. It has increased from 200,000 to 500,000, and we are projecting it will be over 2 million this year.

Senator CHILES. What you are saying is that the testimony we heard from the two ladies and the gentleman here today is typical of what we are going to hear, or that we will hear more of in the State of Florida?

Mr. LONG. It is hard to say that is typical because we process 20.6 million claims a year. It is a very, very large program and in April, we processed over 2 million claims. That is an awful lot of claims to process that result in money being paid to people.

Not all of these people have had to wait 6 months. I can't say it is typical but you are going to see more and more delay.

Senator CHILES. It is building?

Mr. LONG. The average is building and when you build the average time, these special circumstances that fall outside the norm being to create the situations you have heard described today.

Senator CHILES. I don't know if you were here when I gave my opening statement, but I was saying that the experience in my office has been that we got about 10 to 15 complaints a year, last year. We then saw that go up to our getting that many a month. In the last 5 days, 5 working days before this hearing, we had 89 people contact our office.

So your feeling is that that number is going to increase?

Mr. LONG. There is no question that it will.

Senator CHILES. Those are just the people who called my office. That is not to say how many called other Congressmen or don't know to make a phone call.

Mr. LONG. We expect about 3 million beneficiaries to call us this year too, and write to us, so it is increasing.

Senator CHILES. How many calls are you getting on your 800 number, your WATS line? Have you increased those lines? We heard people say it takes 1½ or 2 days to even get you on the line.

Mr. LONG. We currently have, I believe it is 62 inward WATS lines to serve the State of Florida and I am sure we are receiving 5,000 to 10,000 calls a day over that WATS line. We do not have the money available to increase the number of WATS lines to provide the service level that people have come to expect from us.

Senator CHILES. Well, do you know what the chances are that somebody will get a busy signal when they call, or how many times those lines are all busy? Have you done any studies on that?

Mr. LONG. We monitor that very closely, and we have seen that climb from about 2 in every 10 to about 5 to 6 in every 10.

Senator CHILES. So 5 out of 10 people who call you are going to get a busy signal?

Mr. LONG. Yes, sir.

Senator CHILES. We also heard some people say that when they got you, they weren't getting very courteous treatment. What is the reason for that?

Mr. LONG. There is no excuse for that. A courteous response is something that we owe these people. It hurts me to hear them say this. We have in-place training procedures demonstrating how people are supposed to handle telephone calls and I can't answer specifically why that happened.

Senator CHILES. Has it been harder to get qualified people to handle those WATS lines, given the kind of build-up that you have?

Mr. LONG. Yes. Our concern is not so much——

Senator CHILES. Do you have a turnover problem?

Mr. LONG. That is our concern. In my estimating, answering that 800 number is probably as tough a job as you are going to find because nobody calls to tell you they appreciate your handling their claim. Our people under those circumstances do an excellent job. What we are afraid of is because we can't give them any relief with additional help and additional lines that we could potentially lose trained, experienced people, and that the problem would become more critical.

Senator CHILES. Because of the slowdown that we have talked about, that you are now experiencing due to HCFA, how long does it take you to get a claim into the system? During that period can you tell somebody where the claim is?

Mr. LONG. I think it is important to understand that we are receiving approximately 80,000 claims a day, a very large number. As you know, in Florida we get a lot of winter residents, an influx of winter residents and visitors, so between November and May our claims volume increase significantly.

In our mailroom the claims are opened and a control number is put on them within 1 or 2 days. From that point until we can actually have an examiner start entering the claim for processing is

probably running 15 to 20 days now and will increase as the number of claims we receive outstrips our ability to process them.

Senator CHILES. So, right now, from the time that you get it in, it takes 1 or 2 days to open your mail. Then before you can get a claims examiner on that claim, because of the numbers and the fact that you don't have the administrative cost to do that, we are looking at 14 to 15 days, did you say, before you can pick it up again?

Mr. LONG. At least, and it is probably running 20 days.

Senator CHILES. Twenty days before they can pick it up again?

Mr. LONG. Yes.

Senator CHILES. What kind of time averages are we going to run after they have the claim to process?

Mr. LONG. It will probably run another 10 to 15 days after it is entered into the system.

Senator CHILES. These are average numbers, so obviously some are going to be handled quicker but there is a group that is going to take considerably longer?

Mr. LONG. Yes.

Senator CHILES. Can you give me a range of what you are talking about from the quickest to the longest?

Mr. LONG. If you take the example you have heard mentioned this morning of electronic claims, those by far are the most efficient submission process.

Senator CHILES. That is where the doctor has a computer in his office and he puts something into that computer and it goes to you electronically?

Mr. LONG. That skips a lot of the manual processes that we have to go through to get the claim in to be processed, so if you take one of those they could go straight from the computer in the doctor's office into our computer it probably would be turned around within a week or two. But on the other end, you get a nonassigned claim from an individual with bills from multiple doctors or suppliers. One that needs additional information, and if it meets the criteria for additional medical screening the total time could extend over 120 days.

Senator CHILES. Upward of 120 days, about 6 months time. Dr. Garoni is saying that even though these people have put in the computers they are noticing time delays as well.

Mr. LONG. I would imagine that they are noticing some delays because even electronically submitted claims have to go against the additional screens required in our attempts to control unnecessary medical payments.

Senator CHILES. Has HCFA told you to slow down the processing of these health care claims or the electronic claims?

Mr. LONG. We have over the past couple of years received notice that it is the intent to gradually slow the claims payment time. Prior to this notice, if we receive a claim, and on the first day it went through the system, we could pay it. That was acceptable. That has been revised where you can only pay once a week on electronic claims and 2 weeks for hard copies.

Senator CHILES. For what kind of claims?

Mr. LONG. Paper claims.

Senator CHILES. Paper claims.

Mr. Long. Nonelectronic submissions.

Senator Chiles. So additional to the fact that you don't have the administrative costs to put on the people, they literally have said, "Don't process that claim within 1-day turnaround," even if you could?

Mr. Long. Yes.

Senator Chiles. Mr. Long, Congress has tried to say that HCFA should establish the amount of money they should give to the State for an agency like yours to process the claims based on the unique circumstances that you have. Is that being taken into consideration over the last couple of years? Do they consider the fact that we have a tourist population that bulges into Florida and doubles our claims 5 or 6 months of the year? Do they look at the fact that we have many new people move into the State of Florida and bring their claims? Is that being taken into consideration?

Mr. Long. I would definitely say that Florida is a unique State in terms of Medicare population because we do have so many move in from out of State. These people lose the network of support they have built up with their friends, their doctor, and their families. These people come into this environment and they are almost on their own and they look to us as the Medicare contractor to assist them more so than they might in another State.

That along with the influx, and the growth rate, all contribute to a need to recognize individual contractor's needs. I don't think these factors were taken into account sufficiently. Otherwise, I don't think we would have received the funding cut.

Senator Chiles. How many claims do you think that you will have unprocessed at the end of this fiscal year, September 30, 1986?

Mr. Long. Based on our current rate of processing claims, our projected receipts of 20.6 million claims, we would have right at 2.1 million claims outstanding.

Senator Chiles. 2.1 million?

Mr. Long. In some stage of processing.

Senator Chiles. How many did you have September 30, 1985?

Mr. Long. 512,000.

Senator Chiles. How many claims did HCFA pay you for processing for this year?

Mr. Long. Our funding, our budget this year is based on processing 19 million claims.

Senator Chiles. Well, if you were paid for funding 19 million claims and you are processing how many?

Mr. Long. We expect to receive——

Senator Chiles. 20.6 million?

Mr. Long. Yes, sir.

Senator Chiles. You didn't keep it a secret from HCFA what you thought you were going to process?

Mr. Long. No, sir, we did not.

Senator Chiles. So in effect they have underfunded you for the claims that you will actually be processing?

Mr. Long. Yes, sir.

Senator Chiles. And the other funding represents what you are going to end up not being able to process?

Mr. Long. It will be that amount plus what we normally carry over.

Senator CHILES. What your normal carryover would be? Have you made HCFA aware of these circumstances?

Mr. LONG. We certainly did. We didn't feel that the physicians and the providers and the suppliers and the beneficiaries in the State of Florida would accept what was going to occur as a result of this underfunding.

We brought this to HCFA's attention and it is our understanding that they have requested funds be released from contingency funds available to contractors.

Senator CHILES. But have they made any money available to you at this time?

Mr. LONG. No, sir.

Senator CHILES. But you understand that there is a contingency fund and they are in the process of making some money available?

Mr. LONG. Yes, sir.

Senator CHILES. How much money do you need?

Mr. LONG. $1.3 to $1.4 million would make up the amount we were reduced from this year's budget. I would like to make a point. Going back to the buildup between November and May, getting $1.3 million in May does very little to impact the buildup, and even though——

Senator CHILES. What you are saying is that if you got that money now, that would not keep the buildup from getting bigger?

Mr. LONG. It would have some impact, but even then we would be running behind. It would take a lead time because we would have to recruit, hire and train staff and even after we did that, by the end of the fiscal year we would still be carrying an inventory much larger than normal.

Senator CHILES. Have you done any projections as to what you will be carrying a year from now, September 1987, if this continues?

Mr. LONG. We have not done any projections because the bottom line would be based on what our funding is for 1987. We know we would carry over, around 2 million claims, and would add to that about 22 million claims to be processed, so we would have to process around 24 million claims for the fiscal year 1987.

Senator CHILES. Again, as I characterized it, you are building up a bubble here. Is that what you see happening in the State of Florida to your claims?

Mr. LONG. Yes, especially if funding levels continue at present levels or drop, which automatically cuts from Gramm-Rudman might cause. Then next year would be just an increasing and compounding of that buildup.

Senator CHILES. Tell me what you see as the negative aspects of this? Is there any negative impact on Blue Cross private supplementary insurance program?

Mr. LONG. I think you have heard mentioned today that people do not separate Blue Cross and Blue Shield from Medicare in Florida. We are the ones on the front line. Our name is on the check and we answer the phone, and if their check gets delayed from Medicare, if they don't get the proper answer, or it just takes too long, that could reflect poorly on our private Blue Cross and Blue Shield business and that does concern us.

Then again, the morale of the people is affected by this.

Senator CHILES. How long does it take you to process a private claim?

Mr. LONG. I believe the timeframe is 7 days.

Senator CHILES. As opposed to—now we are talking about 120 days?

Mr. LONG. Yes, sir. Again, that is an outside——

Senator CHILES. An outside figure?

Mr. LONG. Yes, sir.

Senator CHILES. All right, sir. I interrupted you several times. I don't know whether or not you have something else in your statement. Your statement in full will be included in our record.

Mr. LONG. You hit quite a few of the points that I did have to make. We did have some recommendations, if I may?

Senator CHILES. All right, sir.

Mr. LONG. I would like to make one point, that Blue Cross as a Medicare contractor has demonstrated over the past few years that we have the experience, knowledge, and technology to process very large volumes of claims and at an acceptable and expected service level.

Our situation is that we are not funded to be able to take advantage of that capability. It is in existence. We just don't have the fuel to drive it.

You really cut through this. Some of the recommendations we would like to make, and I think you do need to hear them at this point to avert what we term a crisis in the Medicare administration that could be on us in the future.

First the funding that is available for fiscal year 1986 claims processing cost in the contingency fund should be released to the contractor immediately. The quicker that you can put that to use, the better this year will be.

Second, there is funding that has been identified in the Comprehensive Budget Reconciliation Act of 1985 for programs safeguard activities and we feel that that should be forthcoming quickly too, so that it can be properly utilized as well as possibly reallocating some of those funds to supplement claims processing.

Our third recommendation is that sufficient funding for claims processing and beneficiary services should be placed in the fiscal year 1987 budget to allow us to bring service levels back to a point where beneficiaries and physicians feel that they are adequate.

We strongly feel that in setting yearly budgets, that HCFA should negotiate with individual contractors recognizing individual circumstances involved, and we feel that these negotiations should be concluded early enough so that contractors will have available to them that money in a timely fashion so that they can plan and implement plans to keep this type of thing from occurring.

Senator CHILES. When did you find out this year how much money you were going to have?

Mr. LONG. The finalization of the budget didn't happen until March.

Senator CHILES. When do you need to know?

Mr. LONG. We need to know in late summer or early fall so that——

Senator CHILES. The year before?

Mr. LONG. Yes, sir. We can hire those people and have them trained and efficient in December, January, and February when our peak volumes hit.

Senator CHILES. You mean you started in the fiscal year of September and didn't know until March what you would have?

Mr. LONG. We went through various revisions. We were not certain. As you are aware, I am sure, this year we started under a continuing resolution, there really was not a budget in place and we——

Senator CHILES. You were half into your year, 5 or 6 months into your year before you were finalized?

Mr. LONG. Yes, sir. The final recommendation is that if the Government does go forward with the policy to delay claims payments, that we should clearly separate claims processing from payments. We as a contractor should be allowed to process the claim as quickly as we can, and if the decision is not to pay it, let's hold the check. That would allow us if someone calls, we could at least tell them, "Yes, we have processed your claim. It is scheduled to be mailed out on x day," rather than the confusion that is occurring under the current conditions.

Senator CHILES. Which is causing all of the refiling and causing all the additional expense for your company?

Mr. LONG. Yes, sir.

Senator CHILES. Can you tell us what percent of the complaint calls that you are getting relate to this delayed payment?

Mr. LONG. It is my understanding that about 65 percent of our inquiries are what we term status inquiries, "Where is my money?"

Senator CHILES. Sixty-five percent?

Mr. LONG. Yes, sir.

Senator CHILES. All right, sir. Mr. Spielman, you are going to tell us something about the national picture as Blue Cross, Blue Shield sees it?

[The prepared statement of Mr. Long follows:]

TESTIMONY

OF

BLUE CROSS AND BLUE SHIELD OF FLORIDA, INC.

ON

MEDICARE ADMINISTRATION

BEFORE

SENATE SPECIAL COMMITTEE ON AGING

BILL LONG

DIRECTOR, GOVERNMENT PROGRAMS

MAY 23, 1986

PREPARED STATEMENT OF BILL LONG

Good morning Senator, I am Bill Long, Director of Government Programs for Blue Cross and Blue Shield of Florida. I would like to mention that we appreciate the interest you have demonstrated in the problems that face Medicare contractors nationwide and the resultant impact on beneficiaries and providers.

Blue Cross and Blue Shield of Florida serves as the contractor for both Medicare Part A and Part B in Florida. We have been deeply involved in Medicare since its beginning over 20 years ago, and we are proud of our association with this most important program. As a Medicare contractor, we serve over 2 million Medicare beneficiaries, 250 Part A providers and 45,000 physicians and suppliers in Florida. In fiscal year 1985, we processed over 2 million Part A

hospital claims and 18.7 million Part B physician/supplier claims accounting for a total Medicare benefit payment of over $4 billion.

Administration of the Medicare program is complex. Our responsibilities as a Medicare contractor include: processing claims from both beneficiaries and providers; responding to and dealing with beneficiary and provider inquiries; controlling Medicare benefit payments; and implementing complex legislative, administrative and regulatory policy changes. We take seriously our commitment to provide service to the beneficiaries and providers in Florida.

Our staff has achieved an exemplary record especially over the last few years in administering these programs. We have consistently achieved high performance standards as

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measured against other Medicare contractors nationwide and have been a leader in innovation with programs such as electronic media claims submission.

We also play a vital role in the direct control of program expenditures through our audit and utilization review activities and third party liability collections. Our Part A and Part B medical and utilization review and Medicare as Secondary Payer programs achieved program savings of over $109 million in Fiscal Year 1985, and we estimate a savings of approximately $113 million for Fiscal Year 1986.

Severe funding cutbacks in Fiscal Year 1986 for contractors to process claims and answer inquiries, an increased number of administrative requirements and the funding prospects for Fiscal Year 1987 combine to seriously threaten the continuation of our record of success.

The Gramm-Rudman-Hollings Balanced Budget Act recently reduced the congressionally appropriated funding available to Medicare contractors for Fiscal Year 1986 from $978.5 million to $937 million. In addition, the administration further reduced contractor funding by $2.1 million in the form of a rescission request. Blue Cross and Blue Shield of Florida's share of this cutback was $1.3 million. The General Accounting Office has estimated that the nationwide Fiscal Year 1986 budget is $100 million short of what contractors need to maintain adequate service levels for beneficiaries and providers.

In Fiscal Year 1986, when Medicare Part B claims volume in Florida is expected to rise by 10 percent, Medicare Part B funding levels have only increased by 3 percent, and the portion of the budget allocated for claims processing functions has actually decreased by 3 percent. This means claims volume is rising approximately 3 times faster

than funding levels. While Part A funding is tight for Fiscal Year 1986, we feel it is currently adequate.

Recently, the Health Care Financing Administration (HCFA) has initiated programs to gradually slow the payment of Medicare claims. With the advent of Gramm-Rudman, HCFA accelerated its position on claims payment delays and notified us that funds would not be available to process all the claims we would receive. It was stated that the Fiscal Year 1986 funding should result in our claims inventories increasing to 18 work days on hand, which equates to an average payment time of approximately 30 days. In a program as large and complex as Medicare, there will be some claims that take much longer to process for various reasons, such as medical necessity review and a need for additional information.

The problem with this strategy, as it relates to Florida, is that HCFA has significantly underestimated our claims volumes and the impact of the seasonal influx of winter residents and visitors. We expect to receive 20.6 million Medicare Part B claims during Fiscal Year 1986; however, our funding level is based on processing only 19 million claims. Under these funding restrictions, by the end of the fiscal year, we will have over 2.1 million claims to be worked with almost half being over 30 days old. Our work days on hand could be as high as 28 days and our average claims payment time will be approximately 40 days. To put this in perspective, our Part B claims inventory at the end of Fiscal Year 1985 was 6 days and our claims payment time was 14 days.

Budget allocations for Medicare contractors are currently determined under authority granted HCFA by the

Deficit Reduction Act of 1984. It is our contention that these budget limits are set by formula without negotiations of necessary adjustments to take into account individual contractor circumstances. For instance, Florida, because of its moderate climate, attracts an influx of winter residents and visitors. This causes a significant increase in our Medicare claims volumes from November through May. For this reason, we must have adequate funding available at the beginning of the fiscal year to hire and train the required number of employees to meet our peak season workloads. Otherwise, we quickly lose ground as inventories build. Providing the needed funding later in the year is much less effective in addressing the problems created by the peak season workloads.

In addition to claims delays caused by reduced funding, as additional emphasis is placed on initiatives to increase medical necessity reviews and identify situations and collect payments where Medicare is not the primary payer,

the normal claims processing time will increase. For example, HCFA has recently identified 16 additional situations where contractors must conduct thorough manual reviews to establish the medical necessity of services rendered. Previously, claims containing these situations would not have been delayed for review, they would have gone straight to payment. We are in agreement with HCFA's position regarding the need to ensure proper benefit payments; however, since they are mandating these additional requirements without a corresponding increase in funding, claims payments are going to be delayed.

Our primary concern is the impact that the reduced funding and increased payment time policy will have on our ability to continue to provide the service levels beneficiaries and physicians have come to expect. The current funding limitation is already adversely impacting our performance. Inventories of claims to be worked are

growing and claims payments are being delayed. If this trend continues, more and more inquiries will be received with a corresponding increase in response time, and it will become increasingly difficult for beneficiaries to gain access to our staff through the toll free telephone lines.

We are also very concerned that, as a result of claims payment delays, physicians and suppliers will drop out of or elect not to participate in the Medicare Program. This would be an understandable action on their part but it would shift the financial burden to thousands of beneficiaries who would suffer increased out-of-pocket expense and the added confusion of having to deal with a complex program without assistance.

The lack of adequate funds to maintain expected service levels not only has a negative impact on the beneficiaries and providers, it also impacts our staff. Morale begins to

suffer when inventories of claims to be processed increases and no relief appears to be in sight. A potential impact of decreased staff morale is the loss of trained and experienced employees which add to the delays.

Senator, we have worked hard to obtain our reputation as a service oriented company and take pride in our accomplishments.

We are doing our best to meet the needs of the beneficiaries and providers and have implemented cost-effective programs to increase our productivity. For example, we have instituted a night shift of claims examiners to make maximum usage of existing space and equipment. We are utilizing part-time employees, primarily college and high school students, in jobs requiring less training, and we continue to aggressively promote the use of electronic media claims by providers. We have demonstrated

over the past several years that we have the knowledge, experience and technology to administer the program under less than desired circumstances. However, under current funding conditions, even with our most professional efforts, disruptions in service and slower claims payments are a certainty.

We believe that Medicare beneficiaries and participating physicians and hospitals alike find this situation to be totally unacceptable. We have notified HCFA of the potential impacts. Recently, the HCFA regional office in Atlanta has recognized our need and has recommended that Florida receive additional money from the contingency fund available to contractors for Fiscal Year 1986. If this money is forthcoming, the potential impacts I have described will be reduced. However, these reductions will not occur immediately due to the lead time required to recruit, hire and train additional staff, and it is

important to understand that the inventory levels will still be substantially higher than previous years.

An equally important issue is the Fiscal Year 1987 budget levels for Medicare contractors that are currently being determined by Congress. According to the Blue Cross and Blue Shield Association estimates, the administration's request of $957 million plus a $50 million contingency fund nationally will be $140 million less than is required by contractors.

Here in Florida, this funding shortage will be compounded by the effects of carrying over the 2.1 million claims pending at the end of Fiscal Year 1986 and adding another 22 million claims to be processed in Fiscal Year 1987.

Complicating this issue even further is the uncertainty about the automatic budget cuts required by the Gramm-Rudman-Hollings legislation. Medicare administrative funding is not covered by the special rule limiting Medicare program cuts to 2 percent in Fiscal Year 1987. Should the Gramm-Rudman-Hollings Act trigger automatic cuts in domestic programs on the order of 20 percent, the Medicare administrative system will experience massive disruption on a scale never before seen.

Over the years, we have demonstrated that we have the ability and technology to process all of the claims we will receive and to provide the expected levels of service; however, under the existing and potential future funding restrictions, we will not be able to take advantage of this capacity.

In closing, we would like to present our recommendation of actions we believe must be taken to avert a crisis in Medicare administration:

1) Funding available in the Fiscal Year 1986 contingency fund should be released immediately to contractors.

2) Funding identified in the Comprehensive Budget Reconciliation Act of 1985 for program safeguard activities should be immediately released and a portion of these funds should be reallocated for claims processing and beneficiary services.

3) Sufficient contractor funding for claims processing and beneficiary services should be provided in Fiscal Year 1987 to return the program to service levels considered adequate by beneficiaries and providers.

4) In setting annual budgets for contractors, HCFA should negotiate an appropriate budget level with each contractor recognizing the contractor's local circumstances, performance and costs during the preceding year and performance expectations for the next year.

These negotiations should be concluded well in advance of the beginning of the fiscal year so that the contractor can adequately plan and implement the necessary programs to achieve agreed upon levels of service.

5) If the government does go forward with a policy of delaying payment of claims, we recommend that it:

- Clearly separate claims processing from claims payment -- it is more efficient and less disruptive

for contractors to process all claims received and then delay payment than not to process large numbers of claims.

- Clearly and publicly explain the new payment policy.

- Anticipate that the policy will generate a larger volume of costly inquiries for a long time to come in spite of public explanations.

- Realize that to make the 30 day standard a reality for the great majority of claims -- and not just an average with wide variations around it -- claims processing would have to be adequately funded. This would help to ensure that those groups of beneficiaries and providers whose claims are most difficult to process are not unjustly penalized.

We appreciate the opportunity you have provided for us to discuss the problems and provide our recommendations on improving the administration of the Medicare program and hope that the information we have provided will be helpful to the Committee.

STATEMENT OF ALAN SPIELMAN, WASHINGTON, DC, EXECUTIVE DIRECTOR, FEDERAL FINANCING AND TAX LEGISLATION, NATIONAL BLUE CROSS AND BLUE SHIELD ASSOCIATION

Mr. SPIELMAN. Yes. Thank you, Mr. Chairman.

The Blue Cross and Blue Shield Association is the national coordinating organization for the 80 Blue Cross and Blue Shield plans around the country. Under contracts with the Health Care Financing Administration, our association and member plans serve as Medicare intermediaries and carriers responsible for the day-to-day administration of this program.

Nationally we process 85 percent of Medicare part A bills which are primarily for hospital services, and 62 percent of Medicare part B bills for medical services.

We appreciate this opportunity to provide a national perspective on the problem of Medicare payment delays and growing backlogs of unprocessed claims. We believe the major cause of this problem is twofold. First, there simply has not been enough money for the most basic of contractor functions: claims processing. If my colleague would put our first chart up there, I will illustrate the situation.[1]

This chart shows that while the volume of Medicare claims is increasing dramatically—that is the top line up there—the actual funding allocated to process these claims has actually decreased. We have seen just since fiscal year 1984 a bottoming out of claims processing funding.

Senator CHILES. Now, the first line, so I can read that going up there, is the volume of claims?

Mr. SPIELMAN. Yes.

Senator CHILES. And it has gone from 278.2 million to 382.1 million?

Mr. SPIELMAN. Yes, sir.

Senator CHILES. Over what period of time?

Mr. SPIELMAN. That is over a 3-year period and I might add that it is a conservative estimate. That 382 million figure is the Government's current estimate. We, in fact, think that figure is more likely to be 394 million, so the actual line should be much higher.

Senator CHILES. All right. And the bottom line now is the amount of money you are getting for processing those claims?

Mr. SPIELMAN. Yes.

Senator CHILES. And that has actually declined over that same 3-year period, you are saying, while the numbers have gone up?

Mr. SPIELMAN. That is right, and that confirms your point, Senator, that this is a situation of having to do more with much less. The increasing complexity of claims processing has also an impact.

Senator CHILES. These charts will be placed in the record.

Mr. SPIELMAN. The second cause of this problem is the administration's current policy of delaying the payment of Medicare claims in order to maximize interest on the Medicare trust funds.

In particular, the administration has testified before Congress that delaying claims payments under the part B Medicare will result in a savings of $62 million this year alone.

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[1] See p. 53.

The effects of inadequate claims processing funding and the decision to delay Medicare payments are now beginning to be felt across the Nation. We will put up the second chart to illustrate that.[2]

This chart shows the dramatic increase that has occurred nationwide in the part B contractor's inventory of unprocessed claims. That is basically the work on hand at the end of the period. We did not project these figures out to fiscal year 1987, but just fiscal year 1983 through the current year. You can see the dramatic increase that has occurred over this 3-year period.

Senator CHILES. Under 5 million claims to over 16 million claims in that period of time?

Mr. SPIELMAN. Yes. A 266-percent increase.

Senator CHILES. Prior to 1983 was that relatively flat, that curve?

Mr. SPIELMAN. Yes, sir.

Senator CHILES. So while we heard in Florida that we have gone now to 2 million claims from 500,000 and less than that the year before, this is what we are seeing nationwide in the part B inventory?

Mr. SPIELMAN. Yes, sir. Moreover the chart reflects actual figures from the second quarter. By the end of the year, we expect to have a 10 million claim inventory of unprocessed claims nationwide.

Senator CHILES. So we will go off the charts?

Mr. SPIELMAN. Yes. Moreover, within this growing inventory, the proportion of claims that are over 30 days old has increased rapidly. Building up claims backlogs and slowing down the payment of those claims does not save administrative costs? Quite the opposite. What it does is generate more beneficiary and provider inquiries and more duplicate claims, adding further to the backlog and to the cost of processing that backlog.

Also, as you have heard previously, it is difficult for contractors to respond to questions about claims that have not yet been processed through the system. While delaying claims payments does save money for the Medicare trust fund, it should be recognized that beneficiaries and providers pay the cost.

We are concerned that physicians who currently accept assignment of the part B may not do so as claim payments slow down. This would result in a likely increase in the patient's out-of-pocket liability.

We believe that making specific program changes in Medicare would be a more appropriate approach to deficit reduction than delaying claims payment.

The Blue Cross and Blue Shield Association has recommended that Congress adopt a budget for Medicare contractors for fiscal year 1987 that will enable them to process all the claims that they receive plus a large proportion of the unprocessed claims left over from the current year. We are also recommending that the funds——

Senator CHILES. What kind of budget do you think that needs to be? Do you have any numbers?

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[2] See p. 54.

Mr. SPIELMAN. We do have a precise estimate. At this point we are estimating approximately $140 million over and above the administration's request for part A and part B of Medicare. We are also recommending that the funds needed to process claims be specifically earmarked within the total contractor budget so that we don't have a situation of robbing Peter to pay Paul.

The Congressional General Accounting Office, the American Association of Retired Persons, and numerous organizations representing providers of health services have all expressed concerns at the national level about the adverse effect of the inadequate funding of Medicare claims processing.

Thank you, Mr. Chairman. That concludes my statement.

Senator CHILES. From your perspective then, what you are telling us is that this is not just a Florida problem we are seeing. This is not an aberration based on the fact that Florida does have growth and does have people that come in the winter. This is a national problem and a nationwide problem we are facing?

Mr. SPIELMAN. Yes, sir.

Senator CHILES. And also that this is not a problem that has peaked. It is a problem that will continue.

Mr. SPIELMAN. No; it has not peaked yet. In some areas it will be felt more toward the end of the fiscal year and in other areas it will be felt later.

Senator CHILES. In Florida, certainly our problems are severe. Can you name other States that have problems as severe as Florida?

Mr. SPIELMAN. Well, I think you have to look at the States with a high proportion of Medicare patients.

Senator CHILES. So, again, you are talking about Arizona? You are talking about California; Texas?

Mr. SPIELMAN. Yes; I think that is correct, sir.

Senator CHILES. Those kinds of States.

Mr. SPIELMAN. Yes, although even in other States where the volume is lower, there can be a serious problem.

Senator CHILES. Is this a problem that is accidental in its occurrence or is this a problem that is sort of deliberate strategy?

Mr. SPIELMAN. Well, there are two aspects of it. It is true that the Gramm-Rudman cuts on the Medicare administrative budget, which was not exempted, did reduce the funding available to HCFA to accomplish this purpose, but I would also add that there is a policy, as I stated, of delaying claims payment. If I may quote from the testimony that the administration has provided nationally, they indicated that they believe that "some of the steps taken to live within the fiscal year 1986 budget level, such as increasing the payment cycle, are sound financial management initiatives that should be continued even in a less constrained budget environmental."

This is the testimony provided to the House Ways and Means Committee by a top HCFA official.

Senator CHILES. Additional though to the Gramm-Rudman-Hollings' cut there was even additional, was there not, of $2 million?

Mr. SPIELMAN. Yes. The administration requested that in order to get the total amount of funding back to the level they initially recommended and——

Senator CHILES. Congress has actually put in more money?

Mr. SPIELMAN. Yes, absolutely. The Senate Appropriations Committee did take action, not only to put money in but they specifically indicated their view that the claims backlog not be allowed to increase.

Senator CHILES. We are dealing with a supplemental appropriation bill now. It has passed the House and it is on the floor of the Senate and ready to be on the Calendar of the Senate. Has any request been made to put in additional funds? We have many areas—no one knew exactly what Gramm-Rudman-Hollings was going to do with a 4.3-percent cut. In many areas, we said this is an area where a cut would be intolerable. We have to fix it. We have got to add some more money. We will be putting more money in for the Federal Aviation authority. We are putting more money in for the Coast Guard and some of these areas that we know are critical.

Has the administration made an effort to put more money in this area?

Mr. SPIELMAN. No; there hasn't been, Senator. In fact, the administration has proposed cutting some more money here. I would also add that the situation is not unlike the situation of the Internal Revenue Service. The total budget for the Medicare contractors, because they can prevent fraudulent claims and what have you, has returned to the Treasury $9 for every $1 spent on it, so, in fact——

Senator CHILES. You are saying we are being pennywise and pound foolish. When you can get $9 back for $1 put in, it doesn't make much sense to take out the dollar.

Mr. SPIELMAN. Yes.

Senator CHILES. This is shooting yourself in the foot.

Mr. SPIELMAN. Yes.

Senator CHILES. What can you tell me about what you have been told in regard to extending the delay over the next year, or what they expected to do to extend the delaying time—delaying process?

Mr. SPIELMAN. Well, I would quote back again from the administration's testimony before the House Ways and Means Committee. In that testimony, they indicate that an increase in contractors' claims payment time has been necessitated from an average payment time at the end of fiscal year 1985 of 15.6 days under part A and 20 days under part B to 30 days under both programs by the end of fiscal year 1986. Because we are not yet into fiscal year 1987, HCFA has not yet issued instructions with respect to that year.

I would mention that our estimates of the administration's budget request for fiscal year 1987 suggests that for part B programs, payment cycles would be higher than 30 days. In fact, it would be around 40 days using HCFA's own formula to convert claims inventory to the payment cycle.

Senator CHILES. Using their own formula it would be higher than 30 days and it could be as high as 40 days?

Mr. SPIELMAN. Yes, sir.

Senator CHILES. You said in your statement that you believe that making specific program changes would be a more appropriate approach to deficit reduction than delaying claims payment.

What program changes are you talking about?

Mr. SPIELMAN. Well, we have supported under part B, for example, efforts to identify specific procedures that may be overpriced in relationship to changing technology. For example, some procedures now take much less time to perform than they did 10 years ago when the pricing was initially established.

We have supported that and we have worked with the Senate Finance Committee on ways to accomplish that. I would also point out that HCFA is proceeding in that direction as well. It is just a question of priorities.

Senator CHILES. Well, we thank you all very much for your testimony. Just to make sure that I understand your testimony before you leave, what you are saying is that you have the expertise, Blue Cross Blue Shield has the expertise to be able to handle these claims in an expeditious manner.

You know that you can do it if you are given the wherewithal to be able to do that, if you are given the administrative costs to be able to do it; is that right?

Mr. SPIELMAN. Yes, sir.

Senator CHILES. You are saying these delays we are now seeing with regard to everything from the answering of the phone calls to the having of people refile their claims, all of these delays are basically because you are not getting sufficient funds?

Mr. SPIELMAN. That is correct.

Senator CHILES. Well, we thank you for your testimony.

[The prepared statement of Mr. Spielman follows:]

Prepared Statement of Alan P. Spielman

Mr. Chairman, I am Alan P. Spielman, Executive Director, Federal Financing and Tax Legislation for the Blue Cross and Blue Shield Association. The Association is the coordinating organization for all of the nation's 80 Blue Cross and Blue Shield Plans. The Blue Cross and Blue Shield organization has been deeply involved in Medicare since the program's beginning 20 years ago. Under contracts with the Health Care Financing Administration, our Association and member Plans serve as Medicare intermediaries and carriers responsible for the day-to-day administration of the program. Nationally, we process 85% of all Medicare Part A bills, including nearly all hospital bills, and 62% of Part B claims for medical services.

We appreciate this opportunity to provide a national perspective on the problem of Medicare payment delays and growing backlogs of unprocessed claims. We believe that the major cause of this problem is twofold. First, there simply has not been enough funding for the most basic of contractor functions: claims processing. The attached chart illustrates that while the volume of Medicare claims is increasing dramatically, the funding allocated to process these claims has actually decreased. I would also note that we believe the actual claims volume for FY 1987 will be much higher than the government's projection which was used in preparing this chart. Thus the actual gap between workload and funding will be much wider if the Administration's budget request is accepted by the Congress.

Second, the Administration has testified before Congress that its current policy is to delay the payment of Medicare claims in order to maximize interest on the Medicare trust funds. In particular, the Administration has testified that delaying claims payment under Part B of Medicare will result in "savings" of $62 million in interest this year alone.

The effects of inadequate claims processing funding and the government's decision to delay Medicare payments are now beginning to be felt across the nation. The second attached chart shows the dramatic increase that has occurred in Part B contractors' inventory of unprocessed claims. From FY 1983 to the second quarter of this year, the number of claims still unprocessed at the end of the period rose from about 4.5 million to 16.5 million, a 266 percent increase. By the end of FY 1986, we estimate that there will be over 20 million Part B claims left unprocessed, practically double the FY 1985 level. Moreover, within this growing inventory, the proportion of claims that are over 30 days old is increasing rapidly.

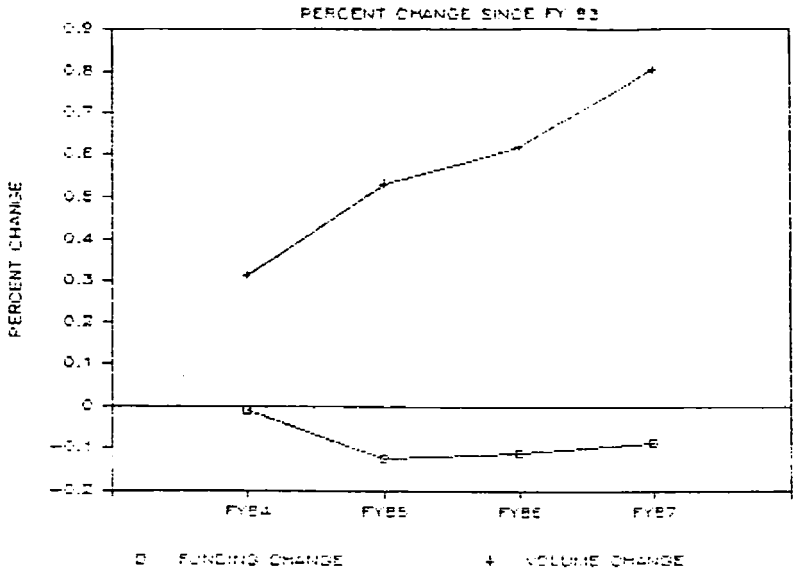
Building up claims backlogs and slowing down the processing and payment of those claims does not save administrative costs. Quite the opposite. What it does is generate more beneficiary and provider inquiries and more duplicate claims, adding further to the backlog - and to the costs of processing that backlog. Moreover, it is difficult for contractors to respond to inquiries about claims that have not yet been processed. While delaying claims payments does save money for the Medicare Trust Funds, it should be recognized that beneficiaries and providers pay the cost. We are concerned that physicians who currently accept assignment under Part B may opt to not accept assignment as claims payments slow

down. The result would be a likely increase in the patient's out-of-pocket liability. We believe that making specific program changes in Medicare would be a more appropriate approach to deficit reduction than delaying claims payment.

The Blue Cross and Blue Shield Association has recommended that Congress adopt a budget for Medicare contractors for FY 1987 that will enable them to process all the claims they will receive that year as well as a large proportion of the unprocessed claims left over from FY 1986. We are also recommending that the funds needed to process claims be specifically earmarked within the total contractor budget. The Congressional General Accounting Office, the American Association of Retired Persons, and numerous organizations representing providers of health services have all expressed concerns at the national level about the adverse effects of inadequate funding for Medicare claims processing.

This concludes my testimony, Mr. Chairman. I would be pleased to respond to any questions.

FUNDING AND VOLUME LEVELS



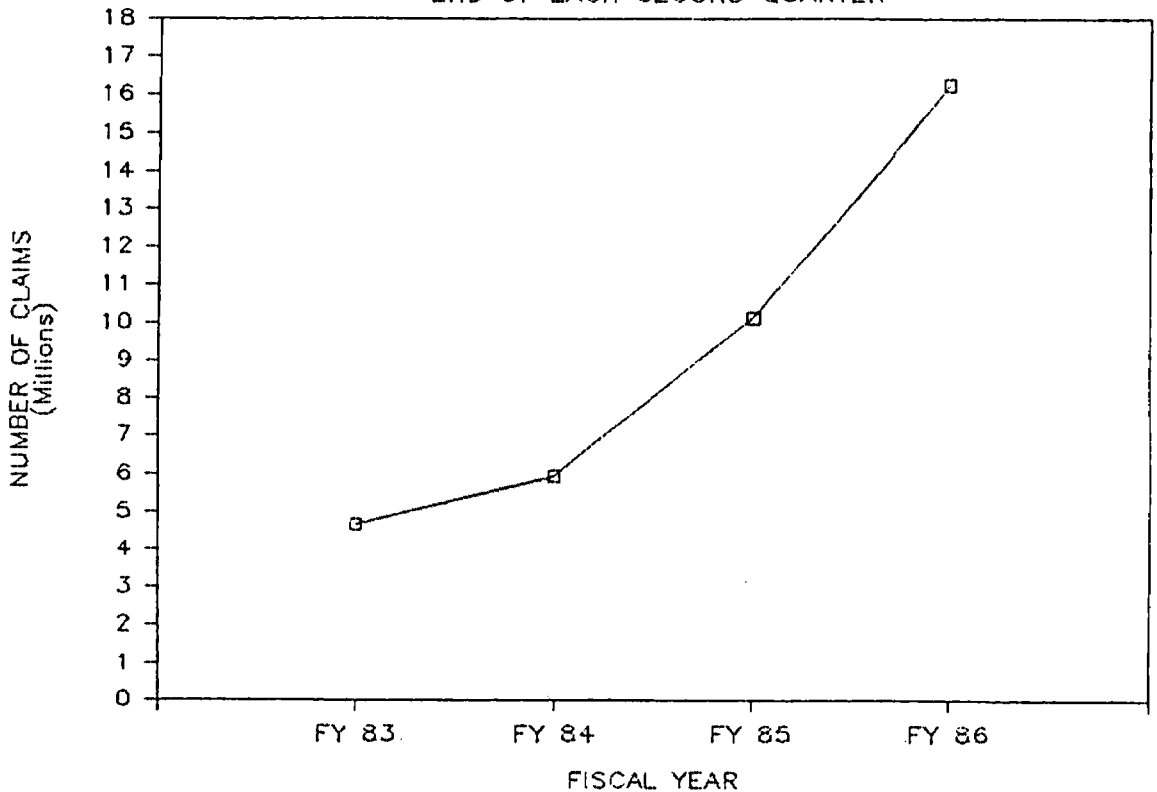
FUNDING VS. VOLUME
FY 84 TO FY 87

FISCAL YEAR	MEDICARE PARTS A & B VOLUME	PERCENT CHANGE IN VOLUME (1)	CLAIMS PROCESSING FUNDING	PERCENT CHANGE IN FUNDING (1)
FY84	278,200,000	31.18%	$566,400,000 (2)	-1.00%
FY85	324,700,000	53.10%	$501,000,000 (2)	-12.43%
FY86	343,500,000 *	61.97%	$508,200,000 (3)	-11.17%
FY87	382,100,000 *	80.17%	$522,300,000 (4)	-8.70%

* Projected
(1) Since FY 1983
(2) Administration Request
(3) As of 4/1/86
(4) HCFA Allocation

PART B ENDING INVENTORY

END OF EACH SECOND QUARTER



Our fourth panel will be George Holland, regional administrator of Health Care Financing Administration, Department of Health and Human Services, Atlanta, GA.

He is accompanied by Richard L. Morris, associate regional administrator for program operations, Health Care Financing Administration, also out of Atlanta.

STATEMENT OF GEORGE HOLLAND, ATLANTA, GA, REGIONAL ADMINISTRATOR, HCFA, DEPARTMENT OF HEALTH AND HUMAN SERVICES, ACCOMPANIED BY RICHARD L. MORRIS, ASSOCIATE REGIONAL ADMINISTRATOR FOR PROGRAM OPERATIONS, HCFA, ATLANTA, GA

Mr. HOLLAND. I have a statement.

Senator CHILES. Your statement in full will be included in the record and we will let you proceed to digest that for us or give that as you will.

Mr. HOLLAND. It does cover a lot of the points. My name is George Holland. I am the regional administrator of the Health Care Financing Administration, region 4, out of Atlanta. I am accompanied by Dick Morris, director of program operations for the region. I am pleased to be here today to discuss the agency's role in administering the Medicare Program and the issue in regard to the timeliness of payment and adequacy of contract performance.

We share a mutual concern for encouraging Medicare contractors to perform as efficiently and effectively as possible. Simply stated, our objective is to gain good contractor performance at a reasonable price. We have used a number of means to achieve this goal and we have had additional improvements in performance and cost and beyond that let me state that as a whole the Medicare contractors have done an outstanding job in implementing program changes, protecting program dollars and serving beneficiaries and providers. They have done this in an increasingly efficient and professional manner and this program could not run without them. We need their expertise.

I would like to take this opportunity to publicly acknowledge their contribution and thank them for it.

The improvements that we have made in program administration have not been achieved without some pain. Ways of doing business have had to be changed in both HCFA and the contractor community. HCFA has set tough standards for price and performance and contractors have responded with new and improved management techniques, incorporating advanced computer systems, workloads, and consolidation of data processing. We plan to work together with the contractors to provide high-quality and efficient administration of the Medicare Program which we all expect.

Before I get into the current budget situation and mutual payment contents, I would like to provide a brief overview of the Medicare contracting process. In 1965 when the program was enacted, Congress adopted an administrative structure which was compatible with the existing practice within the private health insurance administration.

Our Federal Government contracts with public and private organizations to facilitate payments to provide services and benefits,

these organizations are known as intermediaries under part A and carriers under part B. The Federal funding to Medicare contractors has increased from $93 million in 1969 to $1 billion requested in 1987.

At present we have 91 contractors in the Medicare Program, 54 intermediaries and 36 carriers. Under part A, the hospital insurance portion of Medicare, hospitals and skilled nursing facilities are permitted to nominate private insured to act as their intermediary in dealing with Medicare while health agencies are assigned by HCFA to a regional area and claims for services which are rendered to providers are reimbursed by intermediaries direct to the institution.

Carriers interact with providers and beneficiaries under part B, the supplemental medical insurance portion of Medicare and the law provides that the Federal Government should select carriers from within the private health insurance industry to act as the Government's fiscal agent.

For the most part carriers and intermediaries are cost reimbursed subject to standards established by HCFA and these costs are approximately 1.2 percent of the total program costs, compared to 1.8 in 1980.

The ratio of administrative cost to total cost is better than that of the majority of the organizations providing health insurance in the private sector.

Here in Florida, Florida Blue Cross and Aetna are our primary intermediaries and Florida Blue Shield is our carrier. In fiscal year 1985 these contractors processed 2.8 million claims for part A and 18.8 million claims for part B.

It is a big program. It represents 4.8 and 7.1 percent of the total claims processed nationally for A and B.

HCFA's contract management strategy continues to evolve as operating goals are achieved and program characteristics of Medicare changes. Our approach in goals must remain adaptable for responding to anticipated program changes and future budget restraints.

As we consider how best to manage the contract we need to keep in mind the success realized over the last few years. Unit costs are down 27 percent in part A and 15 percent in part B since fiscal 1983.

Expenditures on safeguard activities have risen dramatically. Audit expenditures are up 87 percent since 1982 and medical review up 96 percent since 1983, and a whole new activity of Medicare as a secondary payer has begun.

At the same time a considerable number of changes have been implemented ranging from standard billing forms and codes to the prospective payment system in A and the participating physician program in part B.

Our contractor strategy calls for the objective establishment of goals. We are pleased with the progress which we have achieved in these areas. These include control of program outlays, services to beneficiaries and providers, uniform national management and prompt and accurate response to program change, good flow data and reasonable cost of administration.

A number of tools exist which provide our basic day-to-day framework for management and foremost among these is a contract and performance evaluation program or CPEP. CPEP was implemented in 1980 using standards to measure contractor performance. The development of CPEP was evolutionary in nature with refinements and improvements made each year based on the contract.

I would be remiss if I did not mention here that Florida Blue Cross received the highest ranking in the Nation in 1985 CPEP scores. We are proud of their achievement and the significant improvement they made from the previous year.

Senator CHILES. Now, if they received the highest ranking in the Nation, you complimented them earlier, you said they are one of the most effective providers across the Nation. Why is it when you plan to cut the providers, that you cut them all uniformly? You cut the one that is the most efficient just as much? They won't have the fat.

Mr. HOLLAND. I was saying Florida Blue Cross. Florida Blue Shield did not score as high. On the B side they made significant improvement, but they are not at the top of the list. They range about the middle.

Senator CHILES. Let me ask you this: Why do you cut anybody who is at the top of the list the same way you cut anybody else?

Mr. HOLLAND. We do price for claim and estimates. We negotiated on a price for Blue Cross.

Senator CHILES. What you are saying is there is no payoff for being effective?

Mr. HOLLAND. There is a payoff in the CPEP scores and ratings.

Senator CHILES. CPEP scores doesn't help you any in trying to take care of your people do they? You can put that score on the wall, but I don't see that that score gives you anything.

Mr. HOLLAND. At the same time when you are working on a price, like any business, you approach the company saying you want to do $2.06 per claim versus $2.08——

Senator CHILES. Do you look at anything about the fact that we have this bulge of tourist population coming down here, that we are the fastest growing State with the largest senior citizen population in the Nation? You didn't take that into consideration, you just said, "We are going to cut everybody in the program the same"?

Mr. HOLLAND. The process is to do an estimate. Obviously in this case, the estimate was wrong on how many claims we would process this year and our estimate was way off for the State of Florida.

Senator CHILES. Well, if that estimate was off last September what have you done since September?

Mr. HOLLAND. Well, since September we are getting right back to Gramm-Rudman and contingency. I understand contingency funds were released yesterday which constitute $14 million that can be moved up. In the State of Florida we have $750,000 coming down and it should arrive this afternoon to help out, buy down about 520,000 claims.

Senator CHILES. It was their testimony here today that they need about $1.3 million and you are saying that they are going to get $750,000?

Mr. HOLLAND. At this point, yes. The $750,000 cleaned us out on the existing counts. Fourteen million is available as of, I believe, tomorrow or the next day, and the second decision will have to be made for Florida as to whether that money will move and subject to the estimates and analysis.

Senator CHILES. You are talking about the contingency funds, the COBRA money now?

Mr. HOLLAND. 1986. No, the contingency fund of $14 million plus COBRA. COBRA has a lot of strings on it where it is going, as the gentleman mentioned before, like productivity, medical review and audit. We have a lot more freedom in the $14 million in contingency funds, to move that one.

Senator CHILES. Why did it take until yesterday to release the contingency fund?

Mr. HOLLAND. We have had some problems. I have been on conference calls on this thing. The estimates were wrong. The total volume of claims jumped dramatically.

Senator CHILES. I'll tell you what, Mr. Holland, I just wish like hell I had held this hearing a lot sooner. It might have been the day before the hearing, if I had held this hearing 6 months ago, we might have the contingency funds now. [Applause.]

Senator CHILES. I haven't heard an answer.

Mr. HOLLAND. If you had held this hearing 6 months earlier? I don't know. The other thing that was pointed out earlier, when we had problems pushing this budget up, we were under this continuing resolution. It was really causing problems, because if you are floating on last year's budget estimates, you can't move additional money in.

Senator CHILES. Mr. Holland, all that would make sense if HCFA had come to the Congress and said,

> Look, we need some help. You are not giving us enough money. We are not going to be able to process these claims. We are building a backlog here, and this backlog is creating a critical mass and it may blow up in our face.

I haven't heard any of that.

Mr. HOLLAND. HCFA is staying with the position in 1986, we did get 963——

Senator CHILES. The 963 was more than HCFA asked for.

Mr. HOLLAND. Right.

Senator CHILES. Yes, sir. So Congress put in more money than you asked for and you were cut back some, and the administration tried to rescind more of that, even after the cuts.

I want to read you something that is in the—this came out of the Appropriations Committee language. It says:

> The committee believes an adequate funding level for Medicare administrative functions is essential to maintain the integrity of the Medicare program and be sure of the timely and appropriate processing of claims. Further, the committee believes that first priority should be given to claim payment functions to reduce claim backlogs and to prevent any further deterioration of the quality and timeliness of claims processing functions.

It went on to say that—and the conferees put this in:

> The conferees want to urge that any cost-cutting measures be implemented in a careful manner with the understanding that the processing of Medicare claims is an important function and that saving measures not undermine beneficiary services, professional relations, productivity, investment or program safeguards.

Now, that is Congress trying to express itself and trying to express what it thinks the public policy should be, but would you say HCFA has followed this policy, Mr. Holland?

Mr. HOLLAND. I would say within the budget.

Senator CHILES. Within the budget? Would you say that instructing the——

Mr. HOLLAND. With the unanticipated volume. It just went out of sight.

Senator CHILES. Well now, that is the unanticipated volume. But now, Mr. Holland, what about instructing people, "Don't process a claim in 9 days, go to 18 days and the next year we want you to go to 30 days"?

Now, does that zero in with what the Congress has tried to say?

Mr. HOLLAND. Again, you said you held this hearing and things are happening. I think that process might also be under dispute. We have new people come in to HCFA, Dr. Roper and others, and I think they are taking a hard look at things.

Senator CHILES. You are not saying that process is not fair, because we know that the testimony was given.

Mr. HOLLAND. Oh, yes, Kevin Moley gave that testimony.

Senator CHILES. Mr. Moley gave that testimony that we were going to go to a 30-day delay.

Mr. HOLLAND. That is right, before the committee and I think some second thoughts on that were had last week. I believe the testimony was that we would probably end up around 30 days but we will also shoot and try to come in under it, if we get the money.

Senator CHILES. There is a lot of difference between saying we may end up at 30 days and saying we expect to be at 30 days.

Mr. HOLLAND. Right.

Senator CHILES. This was your policy from the start to be at 30 days. So what you are saying is when Mr. Moley's testimony was given and he was speaking, for HCFA at that time, he was not telling Congress they wanted to see this happen?

Mr. HOLLAND. That is the question to me on Mr. Moley's statement, from what you read in the book and what Mr. Moley said, there does seem to be a difference.

Senator CHILES. As the regional administrator in the Atlanta office, have you ever been told that Congress expected this?

Mr. HOLLAND. Yes.

Senator CHILES. You have?

Mr. HOLLAND. And we have been doing our best to adhere to it out of the region with the money we are allowed.

Senator CHILES. But you weren't able—that wasn't coming when you said you were going from 18 to 30 days, that wouldn't be adhering to this?

Mr. HOLLAND. That is national policy.

Senator CHILES. So what we are talking about here is something greater than the fact that you have more claims out there. What we are talking about here is something that was a definite policy.

Mr. HOLLAND. You mean the 30 days?

Senator CHILES. That is right. What you are telling me now is that you think that this policy may be influx now, and we may be able to see some change?

Mr. HOLLAND. There may be some changes.

Senator CHILES. Well, you are telling me we may get a check down here today. When do you think we are going to get a change in this policy?

Mr. HOLLAND. I am not sure. It is under review by the new team and they are taking a look at it.

UNIDENTIFIED SPEAKER. Who is the new team?

Mr. HOLLAND. The new team, Dr. Roper, the new administrator.

Senator CHILES. Well, I want to say to you, Mr. Holland, I sure hope that we do get a change. If we don't, then I am going to be very disappointed if Congress doesn't do something in this area. Because to me, it just shows that to people in this administration, Congress is just sort of an impediment that is out there. They are supposed to sort of do what we want them to do. It doesn't seem to make a whit what Congress expresses when they put something in like this, that we want to see these claims processed. Literally, it seems to me that if Congress said that, and then as you said, there is a cutback in funds, you all ought to be coming to Congress and saying, "Hey, wait a minute, boys, you can't have it both ways. You can't say you want the claims to be processed and not give us the money. We think it will take *x* number of dollars to do this."

That would put it on Congress. Are we going to live up to our language in what we say or not? But you haven't done that.

Mr. HOLLAND. The other thing is though, when you take a look at the stats—we have statistics like you wouldn't believe from 1986.

Mr. MORRIS. The workload reports we have from Florida Blue Shield for the month of April show that 86 percent of the claims were processed within 30 days, which would leave 14 percent——

Senator CHILES. But 86 percent within 30 days, I think 30 days is unacceptable! Now see, you are starting off with 30 days as acceptable. We were down to 9 days and we were raising Cain with Blue Cross, Blue Shield, "Why can't we get the time down?"

Mr. HOLLAND. We are also doing 59 percent between 0 and 15 days. Fifty-nine percent are processed between 0 and 15 days.

Senator CHILES. Well, 59 percent, you know this isn't baseball, and that means again, looking at that number, that is 31 percent out there that are not getting their claims within that period of time. Those are the people we are hearing from today. They are going to have to mortgage their house. A fellow is going into the hospital with high blood pressure because he can't borrow enough money to stay ahead. We are seeing doctors refuse to take assignment, and that means this puts a further burden on our senior citizens. These are the people who don't know how to cope. These are the people who worry about this all the time. It is all they think about! It causes a further deterioration of their health, because they have to worry about this.

You say you don't pay your hardware store for 30 days, so it is all right not to pay these people for 30 days. That is the most callous statement I think you can possibly make! I don't think it levels, at all, with the public policy that Congress has tried to set forth. Congress is trying to do something about the deficit. I am. I am the ranking Democrat on the Budget Committee, but this is not an area I want to cut.

We are talking about government services. Which services should be provided? The other side of that is, and it is a very practical side, that we are going to save $9 for $1 that we put in here. So it doesn't make sense from a fiscal standpoint, and it doesn't make sense from a public policy and humane standpoint that we are going to cut services to these people, least of all. Many of them can't take care of themselves. [Applause.]

Mr. Holland, I want to say that the most hopeful things I have heard from you today are two things, the first is that the check is in the mail. I hope that is going to be correct?

Mr. HOLLAND. It makes life a lot easier in the region when the check is in the mail.

Senator CHILES. And the other is that you think the policy that we heard is going to be changed. It is not carved in stone?

Mr. HOLLAND. It is being reviewed.

Senator CHILES. It is being reviewed? Well, I want to be very carefully kept up with what that review is. I want to tell you that I am going to try to help in that review process, and try to see that the Congress helps too. I have found no one, that I know of, in the Congress has backed off of the statement that I read to you, that the Appropriations Committee put in, the statement of the conferees urging where these savings should be made.

If we had anything from HCFA saying, "We need additional funds," as I said, we would have put a supplemental request in. We tried to take care of the Federal Aviation Authority. We tried to take care of a number of authorities who said, "We got caught in the Gramm-Rudman cuts," and for goodness sakes you all have done enough in the way of statistics and figures that you have got to be aware of the growth that is going on.

You have got to know that that is something to be taken into consideration.

Mr. HOLLAND. The next year's budget we jump up to $957 with a $50 million contingency.

[The prepared statement of Mr. Holland follows:]

Prepared Statement of George Holland

My name is George Holland and I am the Regional Administrator of the Health Care Financing Administration (HCFA) for Region IV. I am accompanied by Dick Morris, the Director of Program Operations for the Region. I am pleased to be here today to discuss my Agency's role in administering the Medicare program, in particular, issues in regard to the timeliness of payment and the adequacy of contractor funding.

INTRODUCTION

We share a mutual concern for encouraging Medicare contractors to perform as efficiently and effectively as possible. Simply stated, our objective is to gain good contractor performance at a reasonable price. We have used a number of means to achieve this goal and believe that additional improvements in performance and price are quite possible.

At the outset, let me state that as a whole, the Medicare contractors have done an outstanding job in implementing program change, in protecting program dollars and in serving beneficiaries and providers. They have done this in an increasingly efficient and professional manner. This program cannot run without them; we want and need their expertise. We want to take this opportunity to publicly acknowledge their contribution and to thank them for it.

The improvements which we have made in program administration have not been achieved without some pain. Ways of doing business have had to be changed in both HCFA and the contractor community. HCFA has set tough standards for price and performance. Contractors have responded with new and improved management techniques incorporating advanced computer systems, improved work flow, and consolidation of

data processing. We plan to continue to work together with the contractors to provide the high quality and efficient Administration of the Medicare program which we all expect.

BACKGROUND

Before I discuss the current budget situation and the issue of payment timeliness, I would like to provide a brief overview of the Medicare contracting process. In 1965, when the Medicare program was enacted, Congress adopted an administrative structure which was compatible with the existing practice within the private health insurance industry. The Federal Government contracts with public and private organizations to facilitate payments to providers of services and to beneficiaries. These organizations are known as intermediaries under Part A and carriers under Part B. Federal funding for Medicare contractors has increased from $93 million in 1969 to $1.0 billion now requested for 1987.

At present there are 91 Contractors in the Medicare program - 54 intermediaries, 36 carriers, and one combined intermediary/carrier. Under Part A, the Hospital Insurance portion of Medicare, hospitals and skilled nursing facilities (SNFs) are permitted to nominate a private insurer to act as their intermediary in dealing with Medicare. Home health agenices (HHAs) are assigned by HCFA to regional intermediaries. Claims for services rendered by providers are reimbursed by intermediaries directly to institutions.

Carriers interact with providers and beneficiaries under Part B, the Supplemental Medical Insurance portion of Medicare. The Law provides that the Federal Government should select carriers from within the private health insurance industry to act as the Government's fiscal agent in the processing of claims and reimbursement of beneficiaries, physicians, and other suppliers. In addition to processing claims and making payments, intermediaries and carriers review the medical necessity of claims submitted, identify situations and collect payments where Medicare is not the primary payer, and recover overpayments when it is determined that an incorrect payment has been made. Additionally, both intermediaries and carriers provide information and guidance to beneficiaries and providers on administration of the program.

For the most part, carriers and intermediaries are cost reimbursed subject to standards established by HCFA. Total administrative costs of both HCFA and the contractors is now approximately 1.2 percent of total program costs, compared to 1.8 percent in 1980. The ratio of administrative costs to total costs is better than that of the majority of organizations providing health insurance in the private sector.

Here in Florida, Florida Blue Cross and Aetna are our primary intermediaries and Florida Blue Shield is our carrier. In FY 1985, these contractors processed 2.8 million claims for part A and 18.8 million claims for Part B. This represents 4.8 and 7.1 percent of the total claims processed nationally for part A and part B, Respectively.

CURRENT MANAGEMENT STRATEGY

HCFA's contractor management strategy continues to evolve as operating goals are achieved and as the program characteristics of Medicare change. Our approach and our goals must remain adaptable for responding to anticipated program changes and future budget constraints.

As we consider how best to manage the Medicare contractors, we need to keep in mind the considerable success realized over the last few years. Unit costs are down 27 percent in Part A and 15 percent in Part B since FY 83. Expenditures on payment safeguard activities have risen dramatically. Audit expenditures are up 87 percent since FY 82, medical review up 96 percent since FY 83 and a whole new activity of Medicare as a secondary payer has begun. At the same time, a considerable number of changes have been implemented ranging from standard billing forms and codes to the Prospective Payment System (PPS) in Part A and the participating physician program in Part B.

Our contractor strategy flows from the objectives established for our contractors. We are pleased with the progress which has been achieved in each of these areas. These objectives include: the control of program outlays; service to beneficiaries and providers; uniform national management; prompt and accurate reponse to program change; prompt and accurate flow of data; and reasonable cost of administration.

A number of tools exist which provide our basic day-to-day framework for management. Foremost among these is the Contractor Performance Evaluation Program (CPEP). The CPEP, implemented in 1980, uses standards to measure contractor performance. The development of CPEP has been evolutionary in nature with refinements and improvements made each year often based on contractor input. We believe that CPEP provides a good basis for establishing performance requiements and identifying poor performers.

I would be remiss if I did not mention here that Florida Blue Cross received the highest ranking in the nation in the FY 1985 CPEP, we are proud of their achievement and of the significant improvement they made from the previous year. Florida BS also made significant gains in performance during the past year and we hope that additional progress can be achieved in the current year.

In addition to CPEP, the budget negotiation process, which provides funding against contractor standards, and the workload management system, which integrates change into day-to-day operations, accentuate our management capability.

Our contractor management abilities have been refined since the beginning of the Medicare program. We now have the knowledge to prescribe in detail contractor functions and have proven that we can competitively select contractors capable of good performance. Recently in Section 2326 of the Deficit Reduction Act of 1984

(DEFRA), Congress provided us with the authority to set standards for the administrative costs of our intermediaries and carriers based on the performance of economically and efficiently run contractors. In order to implement this new authority, we have developed statistical standards for most elements of unit cost and are proceeding with a contract to develop engineered standards for unit cost.

CONTRACTOR BUDGET AND PAYMENT CYCLE

We know that the FY 86 contractor budget is tight. Congress appropriated $963 million with a $15 million contingency fund. The Gramm-Rudman-Hollings cuts reduce contractor funding to $922 million with a $14.4 million contingency. To live within this budget, an increase in contractor claims payment time was necessitated. The payment time increased from an average at the end of FY 85 of 15.6 days under part A and 20.0 days under part B to 18.7 days for part A and 25 days for part B as of March of this year. I should note that the payment cycle of Florida Blue Cross, which is 9.4 days, is significantly below the national average, while the cycle for Florida Blue Shield, which is at 25.6 days, is a little above the national average. Aetna, with a 22.7 days cycle, is also above the national average.

I am well aware of the impact that the increase in payment time has had on providers and beneficiaries. At my office in Atlanta, we have seen an increase in complaints as a result of the slowdown in the payment cycle. I know that this is one of the major reasons why Florida Blue Shield has been having trouble meeting our standard in regard to

phone access. Even with the addition of 5 new lines in April, they have not been able to handle all of the calls from providers and beneficiaries inquiring about delayed payments.

We should keep in mind, however, that the increase in payment time is not due solely to the budget constraints of Gramm-Rudman-Hollings, at least three other factors have had a significant impact.

- First, consistent with developments throughout the health care market, there is an increased concern about medical review and third party liability. New medical necessity reviews and efforts to indentify situations, and collect payment, when Medicare is not the primary payer slow down claims processing.

- Second, the dramatic increase that we have experienced in outpatient bills as a result of the prospective payment system, and of lab bills as a result of DEFRA has had a negative impact on processing time given our tight budget.

- Finally, when operating problems occur in a system of this size they have a significant impact. Our contractors will process over 350 million claims in FY 86 from over 17,000 institutions, 450,000 physicians, 75,000 suppliers, and 31 million beneficiaries. Consequently, a problem impacting a relatively small percentage of claims could affect a substantial number

of providers and beneficiaries. A recent example in this area is the impact on payment to home health agencies resulting from the introduction of new medical review forms.

We are currently reviewing the payment cycle situation. At the very least, we will do our best to maintain a payment cycle as close to thirty days as possible. We believe that our FY 87 contractor budget, which would provide $957 million, with a contingency fund of $50 million for unanticipated workload increases and operating costs, represents an adequate funding level for our contractor activities. This level would support a payment cycle of at least 30 days.

The funding level for many aspects of the contractor budget is determined on an individual contractor basis by using statistical standards to determine the reasonable and necessary cost of performance. These standards, authorized by DEFRA, are based upon the actual performance of current Medicare contractors. Claims processing, inquiries, reconsiderations, and hearings and appeals functions are managed in this manner. The use of statistical standards is a common management technique. While they are challenging, they are fair and necessary management tools to establish a cost reimbursement limit.

Other aspects of contractor performance have minimum spending levels

or floors established. These floors are used in the payment safeguard functions of audit, medical review and Medicare secondary payor recoveries. In combination with specific performance protocols, these spending floors work to assure full performance of payment safeguard activities and maximize the protection of trust fund dollars.

The use of these techniques to determine reasonable and necessary cost of administration, in combination with performance quality standards, provides the basic framework for contractor management.

CONCLUSION

Our Management actions over the last few years have been tough and demanding. They are also reasonable and will always be tempered by the fact that this work must remain attractive to private sector contractors. Similary, a high level of beneficiary and provider satisfaction must be maintained. We do not contemplate that this work will ever be federalized. This tempering notion protects our private sector contractors and our beneficiaries and providers from unreasonable demands being placed inside existing or contemplated authorities. In our opinion, it is the most prudent way to move the Medicare contracting area into the future.

Mr. Chairman, that concludes my statement. I will now be happy to answer any questions that you may have.

Senator CHILES. I think that Florida is also entitled to some special consideration. Two things, one is that Blue Cross and Blue Shield has done an effective job and there probably is not as much slack where they haven't.

Two, due to this tremendous growth we are experiencing in Florida plus the bulge we experience here in the tourist season when our population literally almost doubles again with people, and they have claims during that time.

Well, I want to thank the Senior Citizens Center for allowing us to hold the hearing here and especially George Shealy for his help and we are going to recess our hearing now for a new minutes.

I will be back here after just a few minutes recess to talk to anyone individually who has something to say, and as I tried to point out earlier, we have some people here to try to help people with their claims if they are particular claims.

We will stand in recess now. Mr. Holland, we thank you for appearing here today.

[Formal hearing recessed at 11 a.m.]

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