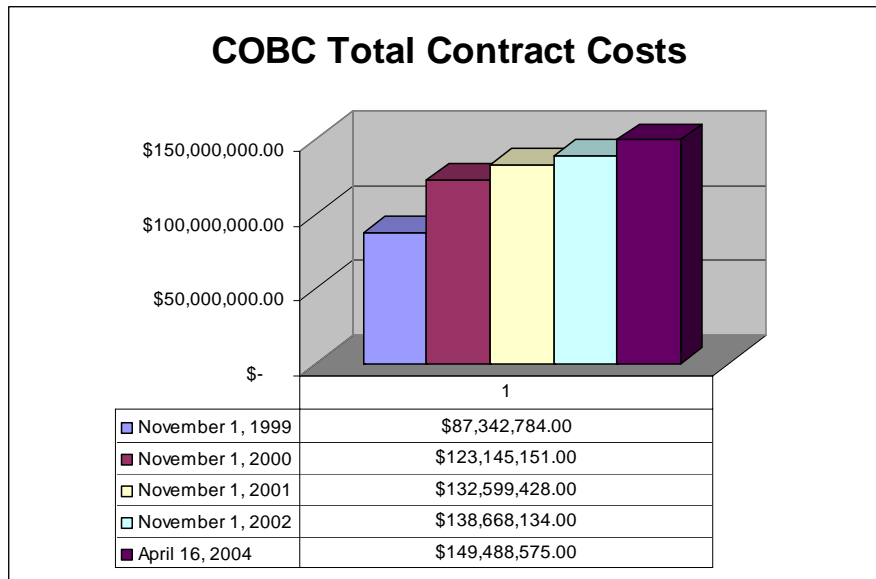


Summary of Costs/Issues on CMS Contract #500-00-0001

CMS contract #500-00-0001 is being expanded beyond its original scope to include a new process for the crossover of Medicare claims. The new process creates a government monopoly where a private sector, competitive solution existed. The new process uses tax dollars where the current process uses private capital. The new process delays secondary payments. The new process establishes vulnerability by having all Medicare Crossover claims go through a single process point.

In addition, the cost of this contract continues to escalate. So far, the contract has increased over 60% as shown below. And, the original scope of work is still not done!



In November, 1999, CMS let a 5-year contract to GHI of New York to be the sole Coordination of Benefits Contractor (COBC) for Medicare. The actual contract was let to a consortium of 5 companies that included GHI, United Systems of Arkansas, Douglas Consulting and Computing Services, VIPS Healthcare Information Solutions, and TRW, Inc. According to CMS transmittal AB-00-36 Change Request 1163 dated May 2000, the role of the COB Contractor is to “consolidate activities that support the collection, management and reporting of all other health insurance coverages of Medicare beneficiaries, as well as all insurance coverage obligated to pay primary to Medicare.” Crossover was not part of the original scope of work in this contract. In the statement of work, phase four was defined as “negotiate, execute and maintain COBA’s for exchanging eligibility information and Medicare paid claims data for the purpose of coordinating accurate benefit payments by Medicare and other insurers.” Since transmittal AB-02-095 Change Request 2216 defines Crossover as the exchange of adjudicated Medicare claims for secondary liability determination, **Crossover should not be part of the COB contractor role define in May 2000.**

Almost 5 years later, the portion of the contract regarding the COBA has not been implemented. CMS now intends to implement this part of the contract in 2004 – in the 5th year of a 5 year contract. CMS has also expanded the scope of this work to include the actual crossing of the claims--- work that companies such as HDM have been performing effectively and efficiently for the healthcare industry for most of this contract period. According to CMS, there are 500,000,000 Crossover claims each year. Also according to CMS, the COBC has handled 2,000,000 IEQs (Initial Enrollment Requests) each year of this contract. Adding the Crossover of claims to this contract results in a significant, material increase in this contract scope as there are almost 2,000,000 Crossover claims EACH DAY!

The addition of Crossover to this Contract (CMS contract #500-00-0001) is not in the best interest of the Medicare beneficiaries, the providers of healthcare and the taxpayers, and needs to be STOPPED!!!

CONCLUSIONS

Several reasons exist to request CMS to study and/or rebid this contract. They are:

(1) Monopoly vs. Free Market

First and foremost, the model being proposed creates a bureaucratic monopoly. The American system is based on free market solutions. When the free market is allowed to work, a more efficient and effective method is found...entrepreneurial companies such as HDM have built their reputation by finding a better way to improve healthcare transaction processing. In a bureaucratic, monopolistic model, just the opposite occurs. The solution may be ideal when it is designed, but by the time the solution is completed, it is obsolete and rarely changes, as this model contains no incentive to innovate. Such is the case here.

Because of Y2K, September 11, and a labor strike, GHI did not fulfill the COBA – Phase 4 of the contract. Conversely, during this same time period, HDM developed a nationwide clearinghouse to create efficiencies in this process including value added services, such as reformatting standard into non-standard data (and vice versa) and customized editing.

The GHI contract was an original 5 year term with annual options which can be renewed for an additional 5 years. Once a vendor has such a contract for a long period, it is essentially a “contract for life” and will not result in the most efficient process and will discourage other entrepreneurial firms from helping the government find a better way to process health care transactions.

(2) Cost Plus vs. Per Transaction

The payment method in the GHI contract will result in higher payments by the government. The GHI contract is “cost plus.” This contracting model invites excess and eliminates much of the motivation to constantly review processes and reduce costs. Also, cost-plus contracts allow the opportunity to “hide” costs. The incentive under a cost plus contract is for the company to have higher costs and be sure to “cover” as much of its costs as possible.

Other clearinghouses charge on a per transaction basis. There are only two numbers to negotiate --- the number of transactions and the cost per transaction. The number of transactions can be tracked by the system and can be cross-verified to the number of claims processed by the CMS contractors (or on the “Common Working File” under the new model). The cost per transaction is tracked to ensure it is being reduced over time. Auditing and control is much more straightforward and achievable. The result is a lower cost to the American taxpayers.

(3) Changes in the Market

Much has changed since 1999 when this bid was let. In 1999, HDM processed 61,691 claims. This year, HDM will process over 30 million claims. GHI has yet to every process a claim; yet, they are being given the awesome responsibility of handling the entire crossover system, a system that affects over half the Medicare beneficiaries, most of the nation’s providers of service and all of the Medicare Supplemental Insurers. Technology has changed with more reliance on client-server vs. mainframe and a reduction in computing costs. Clearinghouse costs have dropped in this timeframe as well.

(4) Back Up/Disaster Plan

With all Medicare Claims being crossed by one vendor, continuity of the system should a disaster or even a minor outage occurs is a major concern. The back up/disaster plan has not been shared with the industry. Utilization of multiple vendors would strengthen CMS’s ability to ensure that processing continues. An outage in such a centralized system will create a stoppage of millions of claims --- even if the outage is for a day or less. Even a slight delay in such a significant number of claims will impact all the stakeholders; providers of healthcare, insurance companies and Medicare beneficiaries.

