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# H.R. 4401, THE HEALTH CARE INFRASTRUCTURE INVESTMENT ACT OF 2000

## HEARING

BEFORE THE

SUBCOMMITTEE ON GOVERNMENT MANAGEMENT, INFORMATION, AND TECHNOLOGY

OF THE

COMMITTEE ON GOVERNMENT REFORM
HOUSE OF REPRESENTATIVES

ONE HUNDRED SIXTH CONGRESS

SECOND SESSION

ON

**H.R. 4401**

TO AMEND TITLE XVIII OF THE SOCIAL SECURITY ACT TO PROVIDE FOR A MORATORIUM ON THE MANDATORY DELAY OF PAYMENT OF CLAIMS SUBMITTED UNDER PART B OF THE MEDICARE PROGRAM AND TO ESTABLISH AN ADVANCED INFORMATIONAL INFRASTRUCTURE FOR THE ADMINISTRATION OF FEDERAL HEALTH BENEFITS PROGRAMS

JULY 11, 2000

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# H.R. 4401, THE HEALTH CARE INFRASTRUCTURE INVESTMENT ACT OF 2000

**TUESDAY, JULY 11, 2000**

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON GOVERNMENT MANAGEMENT,
INFORMATION, AND TECHNOLOGY,
COMMITTEE ON GOVERNMENT REFORM,
*Washington, DC.*

The subcommittee met, pursuant to notice, at 10 a.m., in room 2154, Rayburn House Office Building, Hon. Stephen Horn (chairman of the subcommittee) presiding.

Present: Representatives Horn, Biggert, Ose, Turner, amd Maloney.

Staff present: J. Russell George, staff director and chief counsel; Bonnie Heald, director of communications; Bryan Sisk, clerk; Elizabeth Seong, staff assistant; Will Ackerly, Chris Dollar, and Davidson Hulfish, interns; Michelle Ash and Trey Henderson, minority counsels; and Jean Gosa, minority clerk.

Mr. HORN. The Subcommittee on Government Management, Information, and Technology will come to order. We are here today to discuss proposed legislation that would set up a health care infrastructure capable of delivering immediate point-of-service information to health care providers and Medicare beneficiaries regarding their Medicare insurance coverage and reimbursements.

Senator Richard Lugar of Indiana, who is joining us today, first introduced the proposal in the Senate as S. 2312, the Health Care Infrastructure Act of 2000. I have introduced a similar measure, H.R. 4401, in the House.

[The text of H.R. 4401 follows:]

I

106TH CONGRESS
2D SESSION

# H. R. 4401

To amend title XVIII of the Social Security Act to provide for a moratorium on the mandatory delay of payment of claims submitted under part B of the Medicare Program and to establish an advanced informational infrastructure for the administration of Federal health benefits programs.

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IN THE HOUSE OF REPRESENTATIVES

MAY 9, 2000

Mr. HORN (for himself, and Mr. CALVERT) introduced the following bill; which was referred to the Committee on Commerce, and in addition to the Committee on Ways and Means, and Government Reform, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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# A BILL

To amend title XVIII of the Social Security Act to provide for a moratorium on the mandatory delay of payment of claims submitted under part B of the Medicare Program and to establish an advanced informational infrastructure for the administration of Federal health benefits programs.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

1 **SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

2 (a) SHORT TITLE.Ð This Act may be cited as the
3 ``Health Care Infrastructure Investment Act of 2000''.

4 (b) TABLE OF CONTENTS.Ð The table of contents of
5 this Act is as follows:

Sec. 1. Short title; table of contents.
Sec. 2. Moratorium on delayed payments under contracts that provide for the disbursement of funds.
Sec. 3. Establishment of the Health Care Infrastructure Commission.
Sec. 4. Study and final recommendations; timetable for implementation of advanced informational infrastructure.
Sec. 5. Application of advanced informational infrastructure to the FEHBP.
Sec. 6. Authorization of appropriations.

6 **SEC. 2. MORATORIUM ON DELAYED PAYMENTS UNDER**
7 **CONTRACTS THAT PROVIDE FOR THE DIS-**
8 **BURSEMENT OF FUNDS.**

9 Section 1842(c) of the Social Security Act (42 U.S.C.
10 1395u(c)) is amended by striking paragraph (3).

11 **SEC. 3. ESTABLISHMENT OF THE HEALTH CARE INFRA-**
12 **STRUCTURE COMMISSION.**

13 (a) ESTABLISHMENT.Ð There is established within
14 the Department of Health and Human Services a Health
15 Care Infrastructure Commission (in this section referred
16 to as the ``Commission'') to coordinate the expertise and
17 programs within and among departments and agencies of
18 the Federal Government for the purposes of designing and
19 implementing an advanced informational infrastructure
20 for the administration of Federal health benefits pro-
21 grams.

22 (b) DUTIES.Ð The Commission shallÐ

1 (1) establish an advanced informational infra-
2 structure for the administration of Federal health
3 benefits programs which consists of an immediate
4 claim, administration, payment resolution, and data
5 collection system (in this section referred to as the
6 ``system'') that is initially for use by carriers to
7 process claims submitted by providers and suppliers
8 under part B of the medicare program under title
9 XVIII of the Social Security Act (42 U.S.C. 1395j
10 et seq.) after conducting the study under section
11 4(a)(1);
12 (2) implement such system in accordance with
13 the final recommendations published under sub-
14 section (a)(2) of section 4 and the timetable set
15 forth under subsection (b) of such section; and
16 (3) carry out such other matters as the Sec-
17 retary of Health and Human Services (in this sec-
18 tion referred to as the ``Secretary''), in consultation
19 with the other members of the Commission, may
20 prescribe.
21 (c) MEMBERSHIP.Ð
22 (1) NUMBER AND APPOINTMENT.Ð The Com-
23 mission shall be composed of 7 members as follows:
24 (A) The Secretary, who shall be the chair-
25 person of the Commission.

1 (B) One shall be appointed from the Na-
2 tional Aeronautics and Space Administration by
3 the Administrator.
4 (C) One shall be appointed from the De-
5 fense Advanced Research Projects Agency by
6 the Director.
7 (D) One shall be appointed from the Na-
8 tional Science Foundation by the Director.
9 (E) One shall be appointed from the Office
10 of Science and Technology Policy by the Direc-
11 tor.
12 (F) One shall be appointed from the De-
13 partment of Veterans Affairs by the Secretary.
14 (G) One shall be appointed from the Office
15 of Management and Budget by the Director.
16 (2) REQUIREMENTS.Ð Each of the members ap-
17 pointed under subparagraphs (B) through (G) of
18 paragraph (1) shallÐ
19 (A) have been appointed as an officer or
20 employee of the agency by the President by and
21 with the advice and consent of the Senate; and
22 (B) be an expert in advanced information
23 technology.
24 (3) DEADLINE FOR INITIAL APPOINTMENT.Ð
25 The members of the Commission shall be appointed

1 by not later than 3 months after the date of enact-
2 ment of this Act.
3 (d) MEETINGS.Ð
4 (1) IN GENERAL.Ð The Commission shall meet
5 at the call of the chairperson, except that it shall
6 meetÐ
7 (A) not less than 4 times each year; or
8 (B) on the written request of a majority of
9 its members.
10 (2) QUORUM.Ð A majority of the members of
11 the Commission shall constitute a quorum, but a
12 lesser number of members may hold hearings.
13 (e) COMPENSATION.Ð Each member of the Commis-
14 sion shall serve without compensation in addition to that
15 received for the services of such member as an officer or
16 employee of the United States.
17 (f) STAFF.Ð
18 (1) IN GENERAL.Ð The chairperson of the Com-
19 mission may, without regard to the civil service laws
20 and regulations, appoint and terminate an executive
21 director and such other additional personnel as may
22 be necessary to enable the Commission to perform
23 its duties.
24 (2) COMPENSATION.Ð The chairperson of the
25 Commission may fix the compensation of the execu-

1 tive director and other personnel without regard to
2 the provisions of chapter 51 and subchapter III of
3 chapter 53 of title 5, United States Code, relating
4 to classification of positions and General Schedule
5 pay rates, except that the rate of pay for the execu-
6 tive director and other personnel may not exceed the
7 rate payable for level V of the Executive Schedule
8 under section 5316 of such title.

9 (3) DETAIL OF GOVERNMENT EMPLOYEES.Ð
10 Any Federal Government employee may be detailed
11 to the Commission without reimbursement, and such
12 detail shall be without interruption or loss of civil
13 service status or privilege.

14 (g) PROCUREMENT OF TEMPORARY AND INTERMIT-
15 TENT SERVICES.Ð The chairperson of the Commission
16 may procure temporary and intermittent services under
17 section 3109(b) of title 5, United States Code, at rates
18 for individuals which do not exceed the daily equivalent
19 of the annual rate of basic pay prescribed for level V of
20 the Executive Schedule under section 5316 of such title.

21 (h) TERMINATION.Ð The Commission shall terminate
22 on the date on which the system is fully implemented
23 under section 4(b)(3).

1 **SEC. 4. STUDY AND FINAL RECOMMENDATIONS; TIME-**
2 **TABLE FOR IMPLEMENTATION OF ADVANCED**
3 **INFORMATIONAL INFRASTRUCTURE.**

4 (a) STUDY AND FINAL RECOMMENDATIONS.Ð

5 (1) STUDY.Ð The Commission shall conduct a
6 study during the 3-year period beginning on the date
7 of enactment of this Act on the design and construc-
8 tion of an immediate claim, administration, payment
9 resolution, and data collection system (in this section
10 referred to as the ``system'') thatÐ

11 (A) immediately advises each provider and
12 supplier of coverage determinations;

13 (B) immediately notifies each provider or
14 supplier of any incomplete or invalid claim,
15 includingÐ

16 (i) the identification of any missing
17 information;

18 (ii) the identification of any coding er-
19 rors; and

20 (iii) information detailing how the
21 provider or supplier may develop a claim
22 under such system;

23 (C) allows for proper completion and re-
24 submission of each claim identified as incom-
25 plete or invalid under subparagraph (B);

1 (D) allows for immediate automatic proc-
2 essing of clean claims (as defined in section
3 1842(c)(2)(B)(i) of the Social Security Act (42
4 U.S.C. 1395u(c)(2)(B)(i)) so that a provider or
5 supplier may provide a written explanation of
6 medical benefits, including an explanation of
7 costs and coverage to any beneficiary under
8 part B of the medicare program under title
9 XVIII of the Social Security Act (42 U.S.C.
10 1395j et seq.) at the point of care; and
11 (E) allows for electronic payment of claims
12 to each provider and supplier, including pay-
13 ment through electronic funds transfer, for each
14 claim for which payment is not made on a peri-
15 odic interim payment basis under such part.
16 (2) FINAL RECOMMENDATIONS.Đ
17 (A) PUBLICATION.Đ Not later than 3 years
18 after the date of enactment of this Act, the
19 chairperson of the Commission shall publish in
20 the Federal Register final recommendations
21 that reflect input from each interested party,
22 including providers and suppliers, insurance
23 companies, and health benefits management
24 concerns using a process similar to the process
25 used for developing standards under section

1172(c) of the Social Security Act (42 U.S.C. 1320d–1(c)).

(B) CONSIDERATIONS.—In developing the final recommendations to be published under subparagraph (A), the Commission shall—

(i) make every effort to design system specifications that are flexible, scalable, and performance-based; and

(ii) ensure that strict security measures—

(I) guard system integrity;

(II) protect the privacy of patients and the confidentiality of personally identifiable health insurance data used or maintained under the system; and

(III) apply to any network service provider used in connection with the system.

(b) TIMETABLE.—The timetable set forth under this subsection is as follows:

(1) INITIAL IMPLEMENTATION.—Not later than 5 years after the date of enactment of this Act, the system shall support—

1 (A) 50 percent of queries regarding cov-
2 erage determinations;
3 (B) 30 percent of determinations regarding
4 incomplete or invalid claims; and
5 (C) immediate processing at the point of
6 care of 40 percent of clean claims submitted by
7 providers and suppliers under part B of the
8 medicare program.
9 (2) INTERMEDIATE IMPLEMENTATION.Ð Not
10 later than 7 years after the date of enactment of
11 this Act, the system shall supportÐ
12 (A) 70 percent of queries regarding cov-
13 erage determinations;
14 (B) 50 percent of determinations regarding
15 incomplete or invalid claims; and
16 (C) immediate processing at the point of
17 care of 60 percent of clean claims submitted by
18 providers and suppliers under part B of the
19 medicare program.
20 (3) FULL IMPLEMENTATION.Ð Not later than
21 10 years after the date of enactment of this Act, the
22 system shall supportÐ
23 (A) 90 percent of queries regarding cov-
24 erage determinations;

1 (B) 60 percent of determinations regarding
2 incomplete or invalid claims; and
3 (C) immediate processing at the point of
4 care of 40 percent of the total number of claims
5 submitted by providers and suppliers under
6 part B of the medicare program.

7 **SEC. 5. APPLICATION OF ADVANCED INFORMATIONAL IN-**
8 **FRASTRUCTURE TO THE FEHBP.**

9 (a) IN GENERAL.Ð The Office of Personnel Manage-
10 ment (in this section referred to as the ``Office'') shallÐ
11 (1) adapt the immediate claim, administration,
12 payment resolution, and data collection system es-
13 tablished under section 3 (in this section referred to
14 as the ``system'') for use under the Federal employ-
15 ees health benefits program under chapter 89 of title
16 5, United States Code; and
17 (2) require that carriers (as defined in section
18 8901(7) of such Code) participating in such pro-
19 gram use the system to satisfy certain minimum re-
20 quirements for claim submission, processing, and
21 payment in accordance with the timetable set forth
22 in subsection (b).
23 (b) TIMETABLE.Ð The timetable set forth in this sub-
24 section is as follows:

1 (1) INITIAL IMPLEMENTATION.Ð Not later than
2 5 years after the date of enactment of this Act, the
3 Office shall require that carriers use the system to
4 process not less thanÐ
5 (A) 50 percent of queries regarding cov-
6 erage determinations;
7 (B) 30 percent of determinations of incom-
8 plete or invalid claims; and
9 (C) immediate processing at the point of
10 care of 10 percent of the total number of
11 claims.
12 (2) INTERMEDIATE IMPLEMENTATION.Ð Not
13 later than 7 years after the date of enactment of
14 this Act, the Office shall require that carriers use
15 the system to support not less thanÐ
16 (A) 70 percent of queries regarding cov-
17 erage determinations;
18 (B) 50 percent of determinations regarding
19 incomplete or invalid claims; and
20 (C) immediate processing at the point of
21 care of 20 percent of the total number of
22 claims.
23 (3) FULL IMPLEMENTATION.Ð Not later than
24 10 years after the date of enactment of this Act, the

1 Office shall require that carriers use the system to
2 support not less thanÐ
3 (A) 90 percent of queries regarding cov-
4 erage determinations;
5 (B) 60 percent of determinations of incom-
6 plete or invalid claims; and
7 (C) immediate processing of 35 percent of
8 the total number of claims.

9 **SEC. 6. AUTHORIZATION OF APPROPRIATIONS.**

10 (a) IN GENERAL.Ð There are appropriated to the
11 Health Care Infrastructure Commission established under
12 section 3, out of any funds in the Treasury that are not
13 otherwise appropriated, such sums as may be necessary
14 to carry out the provisions of this Act.

15 (b) AVAILABILITY.Ð Any sums appropriated under
16 subsection (a) shall remain available until the termination
17 of the Health Care Infrastructure Commission under sec-
18 tion 3(h).

○

Mr. HORN. The Federal Government currently provides insurance coverage to millions of workers and retirees under a wide array of complex programs. This legislation seeks to create a health care information architecture that could ultimately be used by all of the Federal Government's insurance plans. As proposed, S. 2312 and H.R. 4401 would set up a commission to oversee the design, creation and implementation of a system to handle only Part B of the Medicare program and the Federal Employees Health Benefits Program.

Part B covers the payments for physicians, laboratories, equipment, supplies and other practitioners. In fiscal year 1999 Medicare Part B fee-for-service expenditures were approximately $61 billion.

The overriding goal of this proposed legislation by Senator Lugar is to streamline and simplify these programs for both beneficiaries and their health care providers, while ensuring beneficiaries that the privacy of their medical records is protected.

At this point, since the Senator has a vote coming up in the Senate, I'd like to introduce the author of this legislation. We're delighted to have him as our first witness.

The distinguished Senator from Indiana, Richard Lugar, welcome.

[The prepared statement of Hon. Stephen Horn follows:]

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ONE HUNDRED SIXTH CONGRESS

# Congress of the United States
## House of Representatives

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**OPENING STATEMENT**
**Chairman Stephen Horn**
**Subcommittee on Government Management,**
**Information and Technology**
Tuesday, July 11, 2000

A quorum being present, the Subcommittee on Government Management, Information, and Technology will come to order. We are here today to discuss proposed legislation that would set up a health care infrastructure capable of delivering immediate point-of-service information to health care providers and Medicare beneficiaries regarding their Medicare insurance coverage and reimbursements.

Senator Richard Lugar from Indiana, who is joining us today, first introduced the proposal in the Senate as S. 2312, the "Health Care Infrastructure Act of 2000." I have introduced a similar measure, H.R. 4401, in the House.

The Federal Government currently provides insurance coverage to millions of workers and retirees under a wide array of complex programs. This legislation seeks to create a health care information architecture that could ultimately be used by all of the Federal Government's insurance plans. As proposed, H.R. 4401 would set up a commission to oversee the design, creation, and implementation of a system to handle only Part B of the Medicare program and the Federal Employees Health Benefits Program.

The overriding goal of this proposed legislation is to streamline and simplify these programs for both beneficiaries and their health care providers, while ensuring beneficiaries that the privacy of their medical records is protected.

At the same time, the measure intends to curb the Government's tremendous financial loss due to erroneous Medicare payments. Last year, the Inspector General at the Department of Health and Human Services estimated that the Medicare fee-for-service program lost $13.5 billion due to erroneous payments. We want to ensure that this legislation would enhance the internal controls that allowed these errors to occur at the Health Care Financing Administration, which administers the program.

In addition, this bill is intended to complement and encourage HCFA's efforts to comply with the Health Insurance Portability and Accountability Act of 1996.

Today, we hope learn from those who would be most affected by the "Health Care Infrastructure Act of 2000," whether this bill -- as proposed -- attains those goals.

I would especially like to welcome my colleague from the Senate, Senator Richard Lugar from Indiana who will testify on our first witness panel. Our second panel includes representatives of the physicians, hospitals and home health care industries that provide medical services to Medicare beneficiaries.

Although the private insurance companies that process Medicare claims declined our invitation, we are very pleased to have Mr. Arthur Lehrer, Senior Vice President of VIPS, whose company is responsible for maintaining the information technology systems for many of those contractors.

In addition, we welcome Mr. Robert Hicks, Chairman and Chief Executive Officer of RealMed, an Indiana firm that has developed an information system, similar to that envisioned in the proposed legislation.

We welcome each of our panelists today, and look forward to your testimony.

**STATEMENT OF HON. RICHARD G. LUGAR, A U.S. SENATOR FROM THE STATE OF INDIANA**

Senator LUGAR. Thank you very much, Mr. Chairman. I'm honored that you have asked me to testify. I appreciate so much your contribution to our joint efforts.

As you know, the primary goal of the Lugar-Horn bill is to build an advanced infrastructure to efficiently process the vast number of basic transactions that clog the pipeline and drain scarce health care resources in our country. We target immediate transaction, including point of service verification for insurance coverage, point of service screening for incomplete or erroneous claim submissions and point-of-service resolution of clean claims. This would include providing patients with an understandable explanation of their own payment obligations and coverage benefits before they leave the doctor's office.

An advanced claims processing infrastructure would allow doctors to spend more time treating patients; it would enable doctors' offices and insurance companies to reduce the cost of claims processing; and it would give patients a more timely understanding of treatments and costs. Such an infrastructure would represent both a huge improvement in the quality of Medicare and a source of enormous annual savings for the program and the wider health care economy.

The act is designed to spur Federal and private sector investment. For that reason, the bill would require insurers who participate in the Federal Employees Health Benefits Plan to apply the same technological innovations.

Let me take a moment to describe the often complicated and confounding billing process that our senior citizens confront when they go to the doctor. As a senior, when you present yourself for care in the doctor's office, you produce your Medicare card, as well as proof of identification. The staff photocopies your card and gives you a clipboard of forms to fill out. Meanwhile, they call to verify your coverage with the insurer. By now, we all recognize that we need to arrive at the office early to fill out the forms.

However, unlike private insurance, which allows the patient to pay a copayment and leave the office feeling relatively secure that their treatment has been paid for, seniors often have no idea what has been paid for or what they owe. In fact, it is not infrequent for seniors to be asked to sign a form that says, "I understand that this procedure may not be covered by Medicare." They often assume that it will be covered and are quite disconcerted when a bill shows up.

Adding to the confusion, seniors often must deal with the complications of the supplemental insurance. Beneficiaries receive a Medicare monthly statement, and receive statements from their supplemental insurer and they are likely to receive a statement from the doctor. Even a modest series of visits to a primary care physician and a specialist or two can yield a mountain of paperwork and unanswered questions for a Medicare recipient.

I have had beneficiaries contact my office to say that they just don't understand their paperwork. Often they can't tell if their claim has been paid. The first thing my staff tells them to do is

to call their doctor to verify that their claim has been filed. Sometimes it has not been filed.

Many people would be surprised to learn that doctors are not required to file their Medicare claims right away. And some doctors hold on to claims and file once a month or, in some instances, even every 6 months. This is a commonly accepted practice and fits within current Medicare filing requirements. It adds to the uncertainty and worry of seniors that they cannot verify that the claim has been paid.

I also have heard from doctors who are so frustrated by the system they forgo participation in Medicare altogether. According to estimates, I am told that each practicing doctor requires an average of two-and-a-half administrative staff to fill out paperwork. Doctors themselves spend an average of 2 hours on insurance paperwork each day.

I was pleased to see on June 20th HCFA announced that it will test simplified or have test-simplified coding guidelines for doctors. This would be a good step.

I envision a system that would allow most claims to be approved before the patient leaves the doctor's office. A patient could submit a claim for tests and learn immediately not only if they qualify, but also the amount that Medicare would approve for payment and any balance they would owe.

In addition, the doctor's office could immediately correct a claim filed to Medicare that was kicked back because of missing information. Not only would this allow the patient to leave the office knowing what Medicare would pay, it would also save the office the time and expense of refiling claims.

Mr. Chairman, today nearly every industrial sector is involved in a race to apply new information technology to gain greater efficiencies. Yet government health care programs, which are enormously important to so many Americans, still use a patchwork of outdated technology.

Creating an advanced infrastructure that is capable of immediately processing most health care transactions is a big task, but it is well within our technological capability. One only has to consider that for years we have been using credit cards to purchase items at almost any location in the world. With a single swipe and a few seconds for verification, we can purchase everything from groceries at the supermarket to a hotel room or restaurant meal on a different continent. None of us in Congress should be satisfied with claims that health care is too big or too complicated to undergo a similar information technology revolution.

In fact, this concept is being advanced now in the private sector. Last fall, I saw it in action at RealMed, a growing high-tech firm in Indiana that specializes in real-time resolution of medical claims. I was impressed, first, by the simplicity of their product, but more so by the sweeping change it has brought to companies who have contracted with this firm, RealMed, to handle their bills. Representatives of RealMed will testify, I understand, on a later panel about their system and their findings before you this morning.

But it is not hard to fathom the value for the Federal Government of the advances that RealMed was putting into practice. The

HCFA spends nearly 1 in 8 Federal dollars. Real-time processing of HCFA's 1 billion claims per year would produce an extraordinary monetary and efficiency savings.

Given this potential, we need to put the government's best information technology talent to work on the problem. The Commission that our bill establishes was designed to harness the full intellectual resources of the Federal Government regarding the design of large, complex and distributed computer systems. Institutions such as DARPA, the National Science Foundation and NASA have been instrumental in putting the United States at the forefront of this technology.

Of course, we can't talk about information technology progress without giving attention to the issue of medical privacy, by itself a policy issue of great importance. For several years, the Congress has been engaged in this debate and the committees of jurisdiction have been studying the options diligently. We have not yet formed a consensus. It is my hope we will do so in the near future.

This is an issue that is crucial to the successful implementation of a modern medical infrastructure. Building such an infrastructure will require a nationwide standard of privacy because electronic payment systems will not know State borders. I hope that with your committee's experience in these matters, you are taking steps to provide recommendations on this important issue.

There are other benefits that improving the health care payment infrastructure can bring to HCFA, to patients and to doctors. One of the foremost is better information about what the government is paying for or wasting its money on, and I think this is why HCFA has reacted positively to our bill.

Cutting into the estimated $13.5 billion in annual Medicare fraud and the enormous costs of administration would benefit all Americans. Further qualitative targets can also be realized by better data management and an accurate accounting of the number of mammograms, flu shots, MRIs or hip replacements for which Medicare pays.

Mr. Chairman, I appreciate the work and the interest that you and your committee have shown toward advancing this concept. I know that you share my concerns, and I look forward to working with you and members of the committee to ensure that the Lugar-Horn bill will serve the best interests of each individual in the Medicare health care continuum from patient to provider to payer.

I thank you very much for this opportunity.

[The prepared statement of Hon. Dick Lugar follows:]

# Dick Lugar

## U.S. Senator for Indiana

Contact: Andy Fisher 202-224-2079 or Tiffany Steele 202-224-7435 Date: 7/11/00

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*The following is the testimony delivered by Senator Lugar before the United States House of Representatives Subcommittee on Government Management, Information and Technology, the Committee on Government Reform, chaired by Representative Stephen Horn of California. July 11, 2000, 10 am, Room 2154 Rayburn House Office Building.*

*The Health Care Infrastructure Investment Act*

Mr. Chairman, I appreciate the opportunity to testify on the Lugar-Horn Health Care Infrastructure Investment Act.

As you know, the primary goal of the Lugar-Horn bill is to build an advanced infrastructure to efficiently process the vast number of basic transactions that now clog the pipeline and drain scarce health care resources. We target immediate transactions, including: point of service verification of insurance coverage, point of service screening for incomplete or erroneous claim submissions, and point of service resolution of clean claims. This would include providing patients with an understandable explanation of their own payment obligations and coverage benefits before they leave the doctor's office.

An advanced claims processing infrastructure would allow doctors to spend more time treating patients; it would enable doctors' offices and insurance companies to reduce the cost of claims processing; and it would give patients a more timely understanding of treatment and costs. Such an infrastructure would represent both a huge improvement in the quality of Medicare and a source of enormous annual savings for the program and the wider health care economy.

The Act is designed to spur Federal and private sector investment. For that reason, the bill would require insurers who participate in the Federal Employees Health Benefits Plan to apply the same technological innovations.

Let me take a moment to describe the often-complicated and confounding billing process that our seniors confront when they go to the doctor. As a senior when you present yourself for care in the doctor's office, you produce your Medicare card, as well as proof of identification. The staff photocopies your card and gives you a clipboard of forms to fill out. Meanwhile, they call to verify your coverage with the Insurer. By now, we all recognize that we need to arrive at the office early to fill out forms.

However, unlike private insurance, which allows the patient to pay a co-payment and leave the office feeling relatively secure that their treatment has been paid for, Seniors often have no idea what has been paid for, or what they owe.

In fact, it is not infrequent for seniors to be asked to sign a form that says "I understand that this procedure may not be covered by Medicare." They often assume that it will be covered, and are quite disconcerted when a bill shows up. Adding to the confusion, seniors often must deal with the complications of supplemental insurance. Beneficiaries receive a Medicare monthly statement, they receive statements from their supplemental insurer, and they are likely to receive a statement from the doctor. Even a modest series of visits to a primary care physician and a specialist or two can yield a mountain of paperwork and unanswered questions for a Medicare recipient.

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I also have heard from doctors who are so frustrated by the system that they forgo participation in Medicare altogether. According to estimates, I am told that each practicing doctor requires an average of two and a half administrative staff to fill out paperwork. Doctors themselves spend an average of two hours on insurance paperwork per day.

I was pleased to see that on June 20th HCFA announced that it will test simplified coding guidelines for doctors. This would be a good step: but we must go further.

I envision a system that would allow most claims to be approved before the patient leaves the doctor's office. A patient could submit a claim for tests and learn immediately not only if they qualify, but also the amount that Medicare would approve for payment and any balance they may owe.

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Mr. Chairman, I appreciate the work and the interest you and your committee have shown toward advancing this concept. I know that you share my concerns, and I look forward to working with you and members of this committee to ensure that the Lugar-Horn bill will serve the best interests of each individual in the medicare health care continuum — from patient to provider to payer.

Again, I thank you for the opportunity to discuss the Lugar-Horn bill with you today.

Mr. HORN. Thank you very much, Senator. It's a very good, succinct view of your legislation.

I want to turn now to Mr. Turner, our distinguished ranking member—the gentleman from Texas, Mr. Turner.

Mr. TURNER. Thank you, Mr. Chairman.

Senator Lugar, thank you for your testimony. This legislation that you and Chairman Horn have joined together in support of and advocacy of I think is very important piece of legislation. It has the potential to save millions of dollars in taxpayer money, and it is certainly, I think, noted by anyone who's had contact with the Medicare system that the need for improved administration and processing is a very significant need.

I have heard a lot of complaints from providers over the years regarding frustration they have experienced with the system, and I know Chairman Horn has provided a lot of leadership for our committee, trying to implement technology and make government more efficient and more effective. And this certainly in keeping with that overall goal they know we all share.

So I appreciate the fact that you have come over to our side this morning and testified before our committee, and we will look forward to working with you to be sure the objective is obtained.

Thank you so much for being here, Senator.

Mr. HORN. I thank the gentleman.

Mr. Turner has a lot of rural hospitals in his area, and we're concerned about those, too; and I hope that the Senate and the House will be able to solve the problems for the disproportionate in urban America as well as rural America.

I now call on the vice chairman of the subcommittee, Mrs. Biggert, the gentlewoman from Illinois. She has a very worthwhile bill that we will be looking at in a hearing in the next month. So she has a great interest in the Medicare situation also.

Mrs. Biggert.

Mrs. BIGGERT. Thank you, Mr. Chairman.

And welcome, Senator Lugar, to our committee. I am really interested in cutting out the administrative costs and, particularly, in the issue of Medicare fraud. Maybe you could expand just a little bit on how this bill will be able to reduce the fraud, waste and abuse that we have found.

Senator LUGAR. I would just respond briefly that by having this audit trail from the beginning, with the resolution of who pays what and who gets what at the very beginning, the possibilities of the fraud that comes from claims that are not paid or claims that are unknown or paperwork that is lost or the refiling back and forth, rob the—in other words, at the moment of truth, the moment where the patient sees the doctor or the nurse, then we all know what the insurance got paid, the doctor got paid, the hospital got paid, and it's resolved.

Now, conceivably, there could be fraud right at that moment, all of these people in collusion; but this is less likely. The fraud and abuse is more likely to occur in these interim weeks and months—the lost papers, the filed, the uncertainty of who is responsible.

Mrs. BIGGERT. So we won't find that someone who claims that their office is in the middle of the Miami Airport, that location will no longer exist as a payment center?

Senator LUGAR. Not unless they have a patient there in the middle of the Miami Airport and an insurance company willing to vouch for both of them.

Mrs. BIGGERT. Thank you very much.

Mr. HORN. The gentleman from California, Mr. Ose, who has also rural hospitals and has a great interest in the Medicare program.

Mr. OSE. Thank you, Mr. Chairman.

Senator, welcome. I do have one question. I notice on the membership of the committee that there are Secretaries appointed to the Commission, and then there's a member from NASA, DARPA, National Science and the Office of Science and Technology, VA and the OMB. The question I have, as I was reading this material for this morning's hearing, was that we have trustees for Medicare right now, and there are four statutory appointments and two discretionary appointments.

I'm curious, do you have any information as to whether or not those six people have looked at this issue in terms of the IT infrastructure that will allow us to get to the point that we're trying to get to?

Senator LUGAR. No, I do not, sir. I don't know what examination they have made, and it is a very important point. The reason for these members that are mentioned from these agencies is, they have a great deal of experience in this infrastructure technology. But clearly people who have responsibility for Medicare have got not only to sign off on this, but have got to shape it. So the governance has got to include these people, and hopefully they will be enthusiastic.

I'm led to believe, having talked about this issue—principally before the medical community, the hospital community, in my home State of Indiana, at various conferences—that there is, if not unanimous feeling that something like this should be done, but usually pauses, as this is really a very big subject and probably a multiyear business; but not objection, conceptually, to the idea that it would be ideal to know all of this at the moment of truth, the moment of service.

Mr. OSE. I do want to compliment you and Chairman Horn for coming up with this proposal. I checked on my question that I just presented to Senator Lugar, and I went back into the trustee's reports from 2000, to the IT report, the data of which actually originated in 1997; I found no evidence that the trustees for OASDI have even looked at that question. So the bill has merit is what I'm reporting back to you.

With that, I will yield back and get my phone.

Mr. HORN. I know the Senator has a vote coming up, but Mr. Ryan has just joined us. We are delighted to have him, the gentleman from Wisconsin, a fellow Midwesterner.

Senator LUGAR. We've enjoyed having Mr. Ryan before the Agriculture Committee, and we share a feeling that's very strong about health care to rural areas and the extension to the communities there.

Mr. HORN. Since I grew up on a farm, I am also very sympathetic.

Mr. RYAN. This bill may be the only chance to get relief to the Midwest dairy farmers, so I applaud the effort.

Senator LUGAR. That was our last meeting.

Mr. HORN. Well, thank you, Senator. We appreciate your coming over here.

OK. We will now continue on Mr. Turner and my opening statement here.

Just to note the overview that we hope to learn from those who would be affected by the Health Care Infrastructure Act whether this bill, as proposed, attains those goals. So we expect our witnesses to be very frank, and we would welcome expertise from those in the audience to please file with us a letter or a brief statement on this, because we will be marking up the bill within the next few weeks and it will move very rapidly.

So our second panel after the General Accounting Office and others—second panel will include representatives of physicians, hospitals, home health care industries that provide medical services to Medicare beneficiaries. Among the witnesses, although we'll introduce them at the time, is Marcy Zwelling-Aamot, M.D., a practicing physician from my own hometown of Long Beach and former president of the Long Beach Medical Association.

Although the private insurance companies that process Medicare claims declined our invitation, we're pleased to have Mr. Arthur Lehrer, the second vice president of VIPS, whose company is responsible for maintaining the information technology system of many of these contractors. In addition, we welcome Mr. Robert Hicks, the chairman and chief executive officer of RealMed, that was mentioned by the Senator, an Indiana firm that has developed an information system similar to that envisioned in the proposed legislation.

So we're delighted to have all of you today, and Mr. Turner has some additional remarks, and then we'll proceed with the first panel after Senator Lugar.

Mr. TURNER. I'll just file my remarks for the record, Mr. Chairman.

[The prepared statement of Hon. Jim Turner follows:]

Statement of the Honorable Jim Turner
GMIT Hearing: H.R. 4401, "The Health Care Infrastructure Investment Act of 2000"
July 11, 2000

Thank you, Mr. Chairman. Medicare is the nation's largest health insurer, providing health care insurance for Americans age 65 and older and many of the nation's disabled citizens. 39.2 million Americans depend on this $200 billion program for health care treatment. The Health Care Financing Administration currently manages the Medicare program through over 60 contractors who process about 900 million claims each year and pay benefits. About 85% of Medicare services are provided on a fee-for-service basis.

We know that the processing of the massive volume of claims for Medicare's fee-for-services programs is very complex and presents an enormous challenge to the agency. The rate of erroneous payments remains excessively high. In fiscal year 1999, for example, the department's Inspector General estimated that the program's erroneous payments amounted to approximately $13.5 billion. I was disappointed to learn that one of every $10 spent by Medicare was an improper payment. In addition, the system is not user-friendly. Health care providers say they must submit a claim for their services rendered before they can find out basic information such as whether or not the service will be covered

or whether a patient is enrolled in the Medicare fee-for-service program or a Medicare Health Maintenance Organization. Moreover, providers say that Medicare's medical coding system is inadequate, leading to coding errors and delayed payments.

H.R. 4401, which was introduced by Chairman Horn, amends the title XVIII of the Social Security Act to provide for a moratorium on the mandatory delay of payment of claims submitted under part B of the Medicare Program and to establish an advanced informational infrastructure for the administration of federal health benefit programs. Medicare' s size, complexity, and lack of management controls are problems worthy of this Subcommittee's attention, and I commend the Chairman for his leadership on this issue. I would also like to welcome the witnesses here this morning and am pleased that Senator Lugar will be joining us. It is my hope that as a result of this hearing, we will have a better understanding of what needs to be done to ensure that Americans receive health care treatment in a timely, efficient, and less complex manner.

Mr. HORN. Without objection, and they will be in the record as if read.

Any other opening statements you wish to be put in the record?

All right. Well, let us start.

Mrs. BIGGERT. Yes, Mr. Horn, I have an opening statement I would like to be put in the record.

Mr. HORN. Sure, and we'll put that in as read. So, in other words, it's big print and people can read it easily.

We will now have the first witness list that will come up and that is Gary Christoph, Ph.D., Chief Information Officer of the Health Care Financing Administration; Joel Willemssen, not new to this committee, he's been our major resource on Y2K for 4 years. He's Director of Civil Agencies Information Systems, U.S. General Accounting Office. He's accompanied by Gloria L. Jarmon, Director of Health, Education and Human Services, Accounting and Financial Management Issues, U.S. General Accounting Office, part of the legislative branch; and Donald Hunts, the Senior Evaluator, Accounting and Financial Management Issues of the U.S. General Accounting Office.

So next would be Marcy Zwelling-Aamot, M.D., treasurer, Los Angeles County Medical Association, former president, Long Beach Medical Association, and then David Sparks, senior vice president, Finance, Providence Hospital, here in Washington, DC; Donald Kovatch, the comptroller, Potomac Home Health Care, Rockville, MD, on behalf of the National Association for Home Care; Arthur Lehrer, senior vice president, as I have noted, VIPS, Inc.; and Robert Hicks, chairman and chief executive officer, RealMed.

Let me explain how we do business here, our friends from the General Accounting Office know, but we will swear all witnesses to affirm that their testimony is the truth. And No. 2, please don't read your statement to us. We've read them. Summarize it and keep it to about 5 minutes, 6 minutes, 7 minutes, whatever. We'd like to, one, go through that formal testimony so we can have a dialog between you because we're interested in relating to your experiences, and please tell us line by line either now or in the next week or so as to where you think we could do something a lot better in either Senator Lugar's version or mine, which is generally his version also. So that's why we welcome your expertise here. So if you will stand up, raise your right hands, we will give you the oath.

[Witnesses sworn.]

Mr. HORN. The clerk will note that all the witnesses and their staff have taken the oath, and we will go down the list and start with Mr. Gary Christoph, Chief Information Officer of Health Care Financing Administration. He's done a very good job as we saw him through the Y2K bit. We're glad to have him here, and Mr. Christoph, it's all yours.

**STATEMENTS OF GARY CHRISTOPH, PH.D., CHIEF INFORMATION OFFICER, HEALTH CARE FINANCING ADMINISTRATION; JOEL WILLEMSSEN, DIRECTOR, CIVIL AGENCIES INFORMATION SYSTEM, U.S. GENERAL ACCOUNTING OFFICE, ACCOMPANIED BY GLORIA L. HARMON, DIRECTOR, HEALTH, EDUCATION AND HUMAN SERVICES, ACCOUNTING AND FINANCIAL MANAGEMENT ISSUES, U.S. GENERAL ACCOUNTING OFFICE, AND DONALD HUNTS, SENIOR EVALUATOR, ACCOUNTING AND FINANCIAL MANAGEMENT ISSUES, U.S. GENERAL ACCOUNTING OFFICE; MARCY ZWELLING-AAMOT, M.D., TREASURER, LOS ANGELES COUNTY MEDICAL ASSOCIATION, FORMER PRESIDENT, LONG BEACH MEDICAL ASSOCIATION; DAVID SPARKS, SENIOR VICE PRESIDENT, FINANCE, PROVIDENCE HOSPITAL, WASHINGTON, DC, ON BEHALF OF THE AMERICAN HOSPITAL ASSOCIATION; DONALD KOVATCH, COMPTROLLER, POTOMAC HOME HEALTH CARE, ROCKVILLE, MD, ON BEHALF OF THE NATIONAL ASSOCIATION FOR HOME CARE; ARTHUR LEHRER, SENIOR VICE PRESIDENT, VIPS, INC.; AND ROBERT HICKS, CHAIRMAN AND CHIEF EXECUTIVE OFFICER, REALMED**

Mr. CHRISTOPH. Thank you, Mr. Chairman. Chairman Horn, Congressman Turner, other distinguished members of the committee, thank you for inviting me to discuss the Health Care Financing Administration's information technology and architecture and H.R. 4401, the Health Care Infrastructure Improvement Act of 2000.

We appreciate the opportunity to be here today to share our information technology plans and our vision for achieving the goals that are espoused in H.R. 4401. I have prepared some written remarks that I ask to be included for the record, but I'll briefly discuss the key points.

Assuring access to health care services for our beneficiaries is a priority for our agency. The need for cutting edge, modern information technology and a strategic information technology vision are critical to this mission. The health care industry is becoming, as others have noted, increasingly data and technology intensive. The demands on our outdated information technology architecture are greater than ever before. Clearly we must modernize and expand our information technology capabilities in order to meet today's needs and tomorrow's challenges successfully.

Medicare is already the most highly automated, most efficient and fastest payer in the health insurance industry. Our costs are low, roughly $1 to $2 to process each claim, and over 90 percent of Medicare claims today are processed electronically and paid on average within 15 days after receipt. We have been able to achieve this despite our archaic information technology environment. Nonetheless, there is an urgent need to update our systems.

We learned a great deal about how to proceed last year when we successfully met the year 2000 challenge. Now with our resources no longer committed to that effort we are refocusing on the technological promise of the new millennium. Our comprehensive modernization plan will support more efficient operations and our systems will be easier and less expensive to maintain. It also will help us develop innovative ways to manage data, to be more responsive

to new initiatives and to support efforts to improve health outcomes for our beneficiaries.

Your legislation, H.R. 4401, Mr. Chairman, includes some interesting provisions that could benefit beneficiaries, providers and our program management. We strongly agree with the bill's information technology service concepts. Our target IT architectural goals for the whole agency include central core relational data bases, standard interfaces, modular applications, real-time claims processing and security and privacy controls fundamentally built in so as to enable Internet communication amongst and between HCFA, its contractor partners, providers and beneficiaries. Thus we have much in common in our plans with what you propose in H.R. 4401.

However, the legislation's mechanisms and means raise some concerns about potential program integrity problems and other serious unintended consequences that we need to better understand. I look forward to discussing these with you further today.

We must ensure that any proposal to modernize Medicare's information technology environment maintains Medicare's strong beneficiary privacy protections, strengthens our ability to identify, analyze and respond to fraudulent schemes, and carefully takes into account our own legacy systems. Past experience teaches us that our systems modernization efforts must proceed incrementally, that we need to build modularly, plan meticulously, manage with prudence and savvy and above all not bite off more than we can chew.

Equally important is incorporating the requirements set forth in the Clinger-Cohen Act and the so-called Raines rules into our internal systems governance processes to help ensure that our decision-making is sound and disciplined. In addition, we must ensure that our agency has the resources to attract and recruit the information technology talent and subject matter experts we need to successfully implement these system changes.

We are already making substantial progress in modernizing our Medicare systems architecture. To facilitate more efficient operations, as well as develop innovative and secure ways to manage and access data, our ultimate goal of course is to improve the health outcomes for the more than 39 million Americans who depend on the Medicare program every day. We realize that undertaking such a large system modernization effort is by no means a simple task, but with careful planning and by taking incremental steps I am confident we will meet this challenge successfully.

We welcome your continued input as we move forward and we do appreciate your continued interest. I am happy to answer any questions you may have.

[The prepared statement of Mr. Christoph follows:]

**Statement**

**of**

**GARY CHRISTOPH, Ph.D.**

**CHIEF INFORMATION OFFICER**

**HEALTH CARE FINANCING ADMINISTRATION**

**Before the**

**HOUSE GOVERNMENT REFORM COMMITTEE**

**SUBCOMMITTEE ON GOVERNMENT**

**MANAGEMENT, INFORMATION & TECHNOLOGY**

**on**

**H.R. 4401, THE HEALTH CARE INFRASTRUCTURE**

**IMPROVEMENT ACT OF 2000 & HCFA's INFORMATION**

**TECHNOLOGY INFRASTRUCTURE**

**JULY 11, 2000**

**Testimony of**
**GARY CHRISTOPH, Ph.D.**
**CHIEF INFORMATION OFFICER**
**HEALTH CARE FINANCING ADMINISTRATION**
**on**
**H.R. 4401, THE HEALTH CARE INFRASTRUCTURE IMPROVEMENT ACT OF 2000 AND HCFA's INFORMATION TECHNOLOGY ARCHITECTURE**
**before the**
**HOUSE COMMITTEE ON GOVERNMENT REFORM**
**SUBCOMMITTEE ON GOVERNMENT MANAGEMENT, INFORMATION, & TECHNOLOGY**
**July 11, 2000**

Chairman Horn, Congressman Turner, other distinguished members of the Committee, thank you for inviting me to discuss the Health Care Financing Administration's (HCFA) information technology architecture and H.R. 4401, the "Health Care Infrastructure Improvement Act of 2000." We appreciate the opportunity to share our information technology plans and vision for achieving goals espoused in H.R. 4401.

Assuring access to health care services for our beneficiaries is a priority for our Agency and the need for cutting-edge modern information technology, and a strategic information technology vision, are both critical to this mission. Today's health care industry is becoming increasingly data- and technology-intensive. As a result, the demands on our outdated information technology architecture are greater than ever before. We must modernize and expand our capabilities in order to meet today's needs and tomorrow's challenges.

Medicare is already the most highly automated, most efficient, fastest payer in the health insurance industry, despite our archaic information technology environment. Our costs are roughly $1 to $2 to process each claim, compared to $6 to $10 or more for private insurers. Over 90 percent of Medicare claims are processed electronically, and we pay those claims on average in 14.9 days after receipt. Most providers must wait far longer to receive claims payment from commercial insurers. Nonetheless, there is an urgent need to update our systems.

We learned a great deal about how to proceed last year when, in partnership with Congress and over one million health care providers across the country, we successfully met the Year 2000 challenge. Now, with our resources no longer committed to that effort, we are refocusing on the technological promise of the new millennium with a comprehensive plan to modernize our systems architecture. It will support more efficient operations and be easier and less expensive to maintain. It also will help us develop innovative ways to manage data, be more responsive to new initiatives, and support efforts to improve health outcomes for our beneficiaries.

Your legislation, H.R. 4401, Mr. Chairman, includes several substantive suggestions for meeting those goals. We strongly agree with the bill's information technology service concepts. However, the mechanisms and means raise some concerns about potential program integrity problems and other serious unintended consequences that we need to understand. This Subcommittee's continuing support in this critical area is much appreciated. The need to modernize our systems is urgent. I can assure you that this continues to be a key priority of our Administrator, Nancy-Ann DeParle. And, as Chief Information Officer, it is my number one goal.

**Medicare's Current Information Environment**

To effectively discuss the issues raised in H.R. 4401, it is important for us to understand the context of Medicare's current, complex information technology environment. The complexity of this environment is driven by the increasingly data-intensive nature of modern health care and as we strive to meet our mission of providing health insurance coverage to some 39 million older and disabled Americans. Expanded responsibilities resulting from legislation, such as the Health Insurance Portability and Accountability Act, the Balanced Budget Act, and the recent Balanced Budget Refinement Act, also challenge us to continually amend our systems. We need to provide timely solutions and ready access to information for a wide-variety of customers. But our overall ability to do so is limited by the outdated nature of our current information technology infrastructure.

Our current information technology infrastructure is made up over 100 different "legacy" systems -- operations that were developed at the outset of the Medicare program some 35 years ago. They are automated, but reflect the business and design philosophies of the mid 1960s, an era when claims processing was largely done with paper and computers were seen only as efficient ways of automating manual processes. The large number of systems is an artifact of the historical structure of the program which, by law, relies on a number of different private insurance companies to process and pay claims. Each of these claims processing contractors has been free to develop their own unique information technology and business processes.

As a result, each Medicare business function is today a separate monolithic, "stovepipe" system with limited ability to locate information and share information with other systems. While these systems tend to be quite efficient at what they were designed to do, they can only produce and process data in a limited "batch-wise" fashion and the results are not always of the desired quality. These stovepipe systems are also restricted in their ability to accommodate unstructured information, such as documents, e-mail, or on-line services. In addition, the overall structure of these systems is generally not well documented, and any existing documentation may not be complete, since the systems were added to and changed over time in a patchwork fashion.

**Current Information Technology Needs**

Prompt access to accurate and wide-ranging data about beneficiaries, program trends and costs, and other financial information is critical to the long-range success of the Medicare program. Data about beneficiary needs and characteristics are essential for assessing beneficiaries' functional status over time, conducting appropriate beneficiary education programs, and reaching vulnerable populations. Also, comparative data, benchmark and quality indicators, and outcome-oriented measures are needed to help us to ensure that beneficiaries have access to new technologies and emerging medical practices, as well as to measure the effectiveness of our programs and policies.

Similarly, beneficiary outcome and assessment data are critical to our ability to evaluate different service delivery models or specific intervention strategies. Data also are helpful in highlighting population or treatment setting trends, or the impact of program changes on different beneficiary groups. Finally, improving our access to cost and financial data related to our policies and programs, particular interventions or outcomes, or different types of service delivery, will help us to more effectively evaluate various financing options and expenditure trends, as well as detect and prevent fraud, waste, and abuse.

**Information Technology Vision**

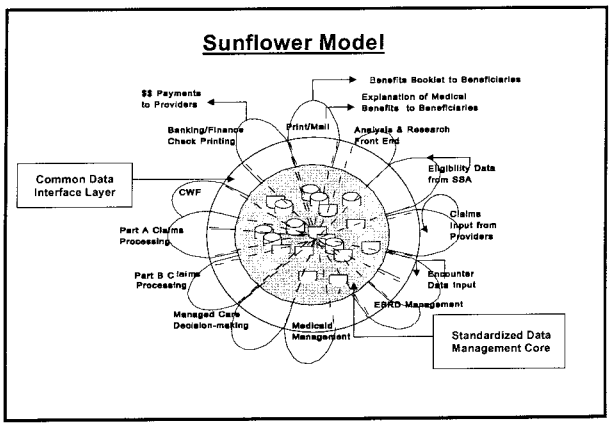
Our information technology vision, developed in the first several months after I was appointed as HCFA Chief Information Officer, has several key goals. They include:

- Making sure all our systems speak the same language and that our employees understand our information technology assets;
- Making sure that our data are standardized and integrated so that all our systems can readily transfer information – so they can speak to one another;
- Making sure all our systems have rigorous data quality controls;
- Making sure our data and information assets are effectively managed and protected; and
- Making sure our data and information are put to good use in improving program management and service to beneficiaries and providers

We also want to take advantage of modern day advances that make it possible for us to adapt information technology to support our business processes, not the reverse. In the past, our information processing operations were defined by the capabilities of existing technology and how best to adapt our business processes to existing proprietary technology. Under our information technology vision, the information itself, not the stovepipe processing of the information, will be the structure's foundation.

Under this new systems architecture, data management becomes the core process, and all individual business practices, such as claim processing, financial audits, or research queries, are viewed as data operations.

This information-centric architecture resembles a "sunflower-like" model, which optimizes the management of information and the efficient flow of information.




Under the sunflower model, primary database management occurs in the middle, or core, and individual business functions are supported by specialized systems represented by petals. All databases are accessible by the various business processes, supported by modular systems that are compatible with different programs, and accessible by various business processes through standard interfaces. This model provides prompt and broad access to data, is highly reliable, and ensures flexibility, allowing us to quickly respond to local system variations, future needs, and emerging technologies.

The first step in reaching these goals is standardizing Medicare's claims processing systems. By mid-2003, we anticipate having a single system for processing Medicare Part A claims, a single system for most Part B claims, and a single system for durable medical equipment claims, rather than several monolithic systems that we have had.

We also are now assessing the current capabilities of our Common Working File, which is the current linchpin of our claims processing system. And we are evaluating options

for an integrated general ledger accounting system to better control and monitor Medicare accounting functions at our Central Office headquarters in Baltimore and at our claims processing contractors.

These are just the first steps. As we move forward, it is critical that we prudently plan our overall systems modernization effort and take incremental steps to achieve our goals. The difficult lessons learned in our efforts to implement the Medicare Transaction System make clear that a "big bang" approach is not appropriate or feasible. We are committed to following the astute guidance of the Clinger-Cohen Act that prescribed concise, well-planned, and strongly managed modernization.

**Concerns with H.R. 4401**

We greatly appreciate this Subcommittee's support for our efforts to modernize Medicare's information technology systems. Chairman Horn, the legislation you are sponsoring, the Health Care Infrastructure Improvement Act of 2000, includes some interesting provisions that could benefit beneficiaries, providers, and our program management. We would like to explore these ideas further with you. However, we also have some substantial concerns about the bill's potential to negatively impact our program integrity efforts and have other unintended consequences.

***Beneficiary Impact.*** The system that is envisioned by H.R. 4401 could help beneficiaries by giving them instant information on whether a specific service will be covered and what their copayment obligation will be. It also would raise important concerns about privacy.

Medicare has an excellent record of protecting the confidentiality of beneficiary information and we are working to further improve technical and administrative security controls in our claims processing systems. For example, we are implementing a Medicare Contractor Information System Security Initiative to improve security controls in contractor claims processing systems. We also intend to make future investments in technical controls like intrusion detection and data encryption.

We are concerned, however, that the system as proposed in H.R. 4401 could greatly increase the possibility of security breaches. The system would afford immediate and unprecedented electronic access to beneficiary eligibility, entitlement, utilization, and claims data to providers. Many experts, including me, believe that insiders with access represent the greatest risk to security and privacy of beneficiary data.

Use of "smart card" technology also raises additional security and privacy issues that must be evaluated and addressed. Strong, national-scale protections would be needed, such as individual identifiers for every beneficiary and provider, (known as "public key infrastructure") in order to be confident of any such system's ability to adequately ensure the privacy of individual health data. While we have participated in efforts to develop such a system, there are many difficult, unresolved issues. These issues include additional administrative requirements and costs for providers. And the Administration has rightfully decided not to proceed with the issuance of personal identity cards until privacy protections are in place.

***Provider Impact.*** The system that is envisioned by H.R. 4401 might have important benefits for physicians and other Medicare providers. For example, allowing providers to know in real time whether a claim has been filed properly and how to correct any mistakes has obvious advantages. There would be an ability to establish links to further explanation of rules and local medical review policies. And there would be the potential for providers to use just one Internet site to submit claims and access coverage information for all patients, whether covered by Medicare, commercial, or other insurers.

However, there may be some unintended consequences for providers with the system. Even with use of the Internet, there may be substantial costs for point-of-service terminals in all provider offices, especially if such a system uses smart cards that record beneficiary information. We must remember that the cost, even if relatively small per unit, would be multiplied by the more than one million providers who provide care to Medicare beneficiaries. Providers may have already invested in computer systems and

networks whose functions are generally duplicated by the new terminals that might be necessary for such a system. Any new infrastructure proposal relying on new technologies would have to evaluate these impacts.

There also may be a potential to disrupt or increase costs for providers if they would need to conduct billing operations onsite during busy clinic hours instead of offsite or off-hours, as many do now. Providers with low-incomes and little current reliance on technology could be disadvantaged.

***Prompt Payment.*** Medicare is already the fastest payer in the health insurance industry. We pay electronic claims on average in 14.9 days, which is much faster than private insurers. A recent study of private health insurance payers by the Ohio State Medical Association found that 42 percent missed the State's statutory deadline of payment within 24 days for undisputed claims. Other data show that private payers typically reimburse paper claims only after 90 to 120 days. In fact, the law stipulates that, if our contractors do not pay claims within 30 days, we must pay interest on the claim. Therefore, we keep a close eye on ensuring that claims are paid timely.

Current law also mandates that we wait a minimum of 14 days to pay claims that have been submitted electronically, and 27 days for those submitted on paper. This requirement affords us time needed to conduct prepayment medical review. Prepayment medical review is an essential part of our program integrity efforts, and is far more cost-effective than the alternative known as "pay and chase," in which we must attempt to recoup funds that have been improperly paid out.

It also is important to understand that removing the 14-day minimum delay, as H.R. 4401 would do, would create a substantial, one-time charge to the Treasury that would have important implications on how this bill is scored, and may require a budgetary offset.

***Program Integrity.*** The system that is envisioned in H.R. 4401 offers a number of positive features. It would make it easier to contact a beneficiary to confirm that services

had, in fact, been delivered while the service delivery is still fresh in the beneficiary's mind. It might also be easier to identify, analyze, and respond to fraudulent schemes more quickly.

However, as mentioned above, this system would severely limit our ability to conduct prepayment review. Many improper claims appear to be appropriate as submitted, and only by review of the medical record can errors be identified. Identifying these errors before payment is made is far more cost effective than the "pay and chase" approach that the system envisioned in H.R. 4401 would require.

The proposed system also inadvertently increases Medicare's vulnerability to abuse by supplying immediate feedback on why claims are rejected. This would allow unscrupulous providers to adjust the claims accordingly, and to resubmit fraudulent claims designed to evade our automatic payment error prevention system.

There also would be an increased potential for theft of a beneficiary's personal identification and "smart cards" that could create new opportunities for fraud and abuse.

***System Overhaul.*** The grand scope of H.R. 4401 seems appealing on its surface. However, Medicare's own difficult experience with such an effort in our attempt to develop the Medicare Transaction System, along with similar experiences at other agencies, suggest that a good deal of caution is warranted before embarking on any such endeavor. We must remember the lessons of past efforts at our agency and others in attempting to build a single, "big-bang" system and, instead, plan our modernization carefully, proceed incrementally, and build modularly. We must take into account our own legacy systems, proceed incrementally, build modularly, plan meticulously, manage with prudence and savvy, and above all not bite off more than we can chew. The rapid evolution of information technology generally makes it unwise to specify specific goals and timeframes for 5 and 10 years in the future.

That is why we have incorporated the requirements set forth in the Clinger-Cohen Act and subsequent guidance from the Office of Management and Budget -- the so-called Raines' Rules -- into our internal systems governance processes to ensure that our decision making is sound and disciplined. The Clinger-Cohen and Raines' Rules investment management principles, such as prototyping, testing, feasibility and risk assessment, and risk mitigation, guide all of our information technology decisions. The Agency also established my position, Chief Information Officer, as the person responsible for overseeing the information technology investment and planning processes of our Agency. We work in close conjunction with the Department of Health and Human Services Chief Information Officer, John Callahan. And, as required by Clinger-Cohen, we carefully assess the needed resources and the financial impact of our information technology investments before we make any investments.

The separate commission as suggested under the legislation would seriously compromise our ability to maintain these essential safeguards. It would hamper successful planning and development practices as set forth in Clinger-Cohen. Furthermore, taking on such a questionable and ambitious endeavor would be particularly daunting for an external commission made up of individuals who have no experience with or understanding of Medicare's unique structure and requirements. I do not believe such an undertaking could succeed without a principal role for Medicare's own Chief Information Officer, the HHS Chief Information Officer, and extensive input from other Agency and Departmental information technology experts who do have this knowledge.

Moreover, the short implementation timeframes as called for in the legislation would not allow the Agency to follow sound management, design, and financial practices prior to implementing the new infrastructure. Separating the information technology from policy decisions is problematic and contrary to the principles embodied in our information technology architecture. Setting policy without understanding what is possible on the technology-side may force the design of a system that is impossible to build.

We share many of the strategic objectives of the legislation. However, we believe our current, careful management approach, which reflects the careful and deliberative management requirements of Clinger-Cohen, will lead to superior information technology decision-making, management, and investment.

**Conclusion**

We are making progress in modernizing our Medicare systems architecture. This effort will facilitate more efficient operations and help us to develop innovative and secure ways to manage and access data. Our ultimate goal is, of course, to improve health outcomes for the more than 39 million Americans who depend on the Medicare program every day. Undertaking such a large systems modernization effort is by no means a simple task, but with careful planning and by taking incremental steps I am confident we will meet this challenge successfully. We share many mutual information technology goals and we welcome your continued input as we move forward. Again, we appreciate your continued interest, and I am happy to answer your questions.

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Mr. HORN. Thank you, Dr. Christoph. The fine resume that precedes you will be automatically in the record when we called your name, and we'll do that with all witnesses because you bring a great amount of expertise to this hearing.

I now bring the next principal witness, who is Joel Willemssen, the Director of the Civil Agencies Information System of the U.S. General Accounting Office, and he has a lot of his experts here, as I have noted earlier, and we appreciate very much your testimony, and we dreamed up last night, oh, a few other projects you might want to do in relation to this and get them done by last week if you will. We're all busy. We know you will do a great job. So go ahead and tell us your view in the General Accounting Office.

Mr. WILLEMSSEN. Thank you, Mr. Chairman, Ranking Member Turner, members of the subcommittee, thank you again for inviting us here to testify today. Joining me is Gloria Jarmon, who's responsible for our financial management and overpayments work at Medicare. As requested, I'll briefly summarize our testimony.

H.R. 4401 has worthwhile objectives and would offer benefits to providers and beneficiaries. Specifically, implementation of the real-time claims processing system proposed in the bill would lead to decisions on authorized and denied claims being provided immediately. However, most Medicare claims could be paid more quickly using current processes by eliminating existing mandatory delay in paying claims. A drawback to eliminating this mandatory delay is that the Medicare Trust Fund would lose some of the interest it currently earns. Beyond this, there are a number of other challenges that would need to be successfully addressed to implement the proposed system.

First, before an implementation decision is made, it's particularly important to demonstrate that a system can be designed that provides the safeguards necessary to minimize improper payments. For example, any new real-time system for all claims would have to find a way to accommodate existing processes such as claims examiners reviews that are suspended because claims did not pass certain edits. Further, because a real-time system can be vulnerable to code manipulation through repeated submission of fraudulent claims until they pass the system's edit, it would be prudent to have appropriate controls to screen providers using the system.

Second, technical and cost risks should be considered and analyzed before embarking on design and implementation. For example, analyses covering costs, benefits, risks and the adherence to HCFA's guiding systems architecture are essential to reducing the risks of this proposed system.

Third, as recognized in the bill, computer security must be adequately addressed in any proposed system. GAO and the Inspector General have previously reported on HCFA's lack of effective computer security controls.

Fourth, developing a system to be initially used for Medicare part B and then to also be used for the Federal Employees Health Benefits Program and potentially other Federal health benefits programs would be very challenging. These programs have substantially different underlying program requirements which would make designing a single system for them quite difficult.

Fifth, the role and composition of the commission identified in the bill as responsible for developing and implementing the proposed system needs to be carefully considered. Namely, issues such as how the proposed system would affect HCFA's and existing contractors' systems development and maintenance activities and how to ensure that appropriate health care and financial management expertise is included in the commission would need to be addressed.

In tackling these implementation challenges, it's instructive to keep in mind HCFA's experience with a prior system development failure in the mid-1990's. Mr. Chairman, as I testified before you in May 1997, this system known as the Medicare Transaction System [MTS], was plagued with schedule delays, cost overruns, and the lack of effective management and oversight. Ultimately, HCFA terminated the MTS contract after it had spent about $80 million but had not received one line of software.

Two key lessons came out of that experience: One, that major projects such as MTS must be managed as investments with periodic assessments of costs, benefits, risks, and other alternatives and, two, that a phased approach to major projects can reduce the risks inherent in any large computer development effort. Such lessons could be valuable in considering how to best proceed with the development and implementation of a real-time claims processing system.

That concludes a summary of our testimony. Thank you.

[The prepared statement of Mr. Willemssen follows:]

United States General Accounting Office

GAO

Testimony

Before the Subcommittee on Government Management, Information and Technology, Committee on Government Reform, House of Representatives

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# FEDERAL HEALTH CARE

# Comments on H.R. 4401, the Health Care Infrastructure Investment Act of 2000

Statement of Joel C. Willemssen
Director, Civil Agencies Information Systems
and
Gloria L. Jarmon
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Accounting and Financial Management Issues
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Mr. Chairman and Members of the Subcommittee:

Thank you for inviting us to participate in today's hearing on H.R. 4401, the Health Care Infrastructure Investment Act of 2000. As you know, this is a companion to Senate bill S. 2312 of the same name. H.R. 4401 calls for the establishment of an advanced informational infrastructure to immediately process certain health benefits claims.

After briefly discussing the bill's provisions, we will address the current Medicare part B claims process and how it can be used to pay claims more quickly. We will then provide our perspectives on (1) the development of an immediate claim, administration, payment resolution, and data collection system that would initially be applied to the Medicare part B program; (2) applying this system to the Federal Employees Health Benefits Program (FEHBP); and (3) the role and composition of a proposed Health Care Infrastructure Commission. Finally, as requested, we will point out some of the lessons drawn from a failed HCFA information technology project in the mid-1990s that can be applied to the systems development effort envisioned by this bill.

## H.R. 4401: THE HEALTH CARE INFRASTRUCTURE INVESTMENT ACT OF 2000

H.R. 4401 would establish a Health Care Infrastructure Commission within the Department of Health and Human Services (HHS) to design, construct, and implement an immediate claim, administration, payment resolution, and data collection system that would initially be used by the

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Medicare part B program.[1] This system would (1) immediately advise each provider and supplier of coverage determination; (2) immediately notify each provider and supplier of any incomplete or invalid claims, including the identification of missing data and coding errors; (3) immediately process clean claims[2] so that a provider or supplier may provide a written explanation of medical benefits, including costs and coverage to any beneficiary at the point of care; and (4) allow electronic payment of claims for which payment is not made on a periodic payment basis. The bill also calls for the commission to conduct and publicize a study, with final recommendations, on the design and construction of such a system within 3 years and establishes a timetable with specific performance measures for its initial, intermediate, and full implementation. Another key provision of H.R. 4401 that relates to the Medicare program is the elimination of section 1842(c)(3) of the Social Security Act (42 U.S.C. 1395u(c)(3)), which prohibits the payment of claims until after 13 calendar days from the date received if electronically submitted or until after 26 calendar days if manually submitted.

In addition, H.R. 4401 would affect FEHBP—the federal government's health benefits program for employees and retirees—which is run by the Office of Personnel Management (OPM). It would require OPM to adapt the immediate claim, administration, payment resolution, and data collection system for use by FEHBP and require FEHBP carriers to use that system. H.R. 4401 also sets a timetable with specific performance measures for the FEHBP system's initial, intermediate, and full implementation.

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[1]Medicare is a combination of two insurance programs, hospital insurance (part A) and optional supplementary insurance (part B), each with its own enrollment, coverage, and financing. The Supplementary Medical Insurance trust fund covers part B claims payments for medical services provided by physicians, laboratories, and an array of other providers and suppliers. In fiscal year 1999, Medicare part B fee-for-service costs were about $61 billion.
[2]42 U.S.C. 1395u(c)(2)(B)(i) defines a clean claim as one that has no defect or impropriety (including the lack of any required substantiating documentation) or particular circumstance requiring special treatment that prevents timely payment from being made on the claim.



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Although H.R. 4401 is explicit in that the proposed system would cover the Medicare part B program and FEHBP, it is unclear whether other federal health programs would also be included in this system. H.R. 4401 calls for the establishment of an advanced informational infrastructure for "[f]ederal health benefits programs which consists of an immediate claim, administration, payment resolution, and data collection system . . . that is initially for use by carriers to process claims submitted by providers and suppliers under part B of the [M]edicare program . . . ." (In a later section, the bill requires that this system be applied to FEHBP.) The bill does not define "federal health benefits programs," and provides for inclusion of only Medicare part B and FEHBP in the system. However, if in the future the proposed system is intended to include other federal health benefits programs such as Medicare part A, Medicaid, veterans' health services, the Department of Defense's health services, and Indian health services, development and implementation of the system envisioned by the bill would be different and much more challenging.

These other federal health programs are markedly different. In some cases, the federal government acts like other large employers that contract with insurance companies and health plans to offer health benefits to employees and their dependents. In other cases, it acts like a large insurance company that pays directly for health care services. In still other instances, it acts like a large staff-model health maintenance organization[3] that operates a network of hospitals and employs health care professionals. Accordingly, if the proposed real-time claims processing system were to later be intended to address the claims processing requirements of any

[3]In a staff-model health maintenance organization, physicians are salaried employees.



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of these programs, it would have a significant impact on the system's design and complexity.

CURRENT MEDICARE PART B
CLAIMS PROCESS

Administered by HHS' Health Care Financing Administration (HCFA), Medicare is the nation's largest health insurer, covering almost 40 million beneficiaries at a cost of over $200 billion annually. Medicare operates through a complicated administrative structure. Its authorizing legislation—title XVIII of the Social Security Act—required HCFA to contract with the private sector for claims processing and payment functions. This requirement has led to a large contractor network comprised of insurance companies responsible for processing Medicare claims in given states. These Medicare contractors are responsible for claims processing and administration, including (1) receiving claims; (2) judging their appropriateness; (3) paying appropriate ones promptly; (4) identifying potentially fraudulent claims or providers, and withholding payment, if necessary; and (5) recovering overpayments or inappropriate payments. Contractors develop a set of criteria to determine which claims to pay, guided by laws, regulations, the Medicare policy manuals, and periodic agency directives.

For the Medicare part B program, HCFA uses 26 companies doing business as carriers to process claims. Each carrier relies on one of four standard systems to process its claims, adding its own front-end and back-end processing systems. These systems interface with the common working file (CWF)—a set of nine databases containing beneficiary information for specific geographic regions—to authorize claims payments and determine beneficiary eligibility. The CWF obtains information, such as beneficiary enrollment data, from HCFA's internal systems. Contractors



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pay approved claims by check or by electronic funds transfers. Each day, contractors' banks draw money from the Federal Reserve System sufficient to cover the provider checks and electronic funds transfers expected to clear the bank during the next business day. Figure 1 provides an overview of the Medicare fee-for-service claims process for the part B program.

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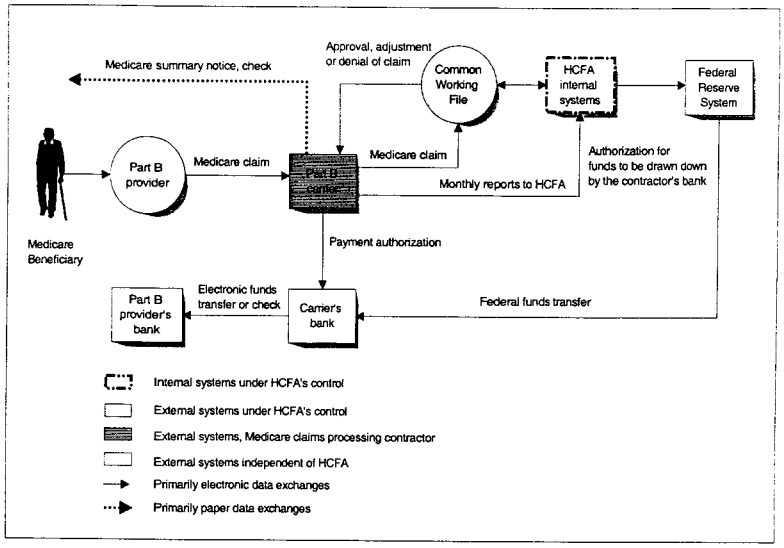
Figure 1: Overview of the Medicare Part B Fee-For-Service Claims Process




Note: The claims process also includes a data exchange with the Social Security Administration, which is used to determine beneficiary eligibility.

Source: GAO, from HCFA documentation.

In fiscal year 1999, about 81 percent of part B claims that were completed were submitted electronically by providers or billing services, which use one of two standard electronic formats. As illustrated in figure 2, once claims are submitted, carriers and HCFA use a variety of automated edits to determine the validity of these claims.

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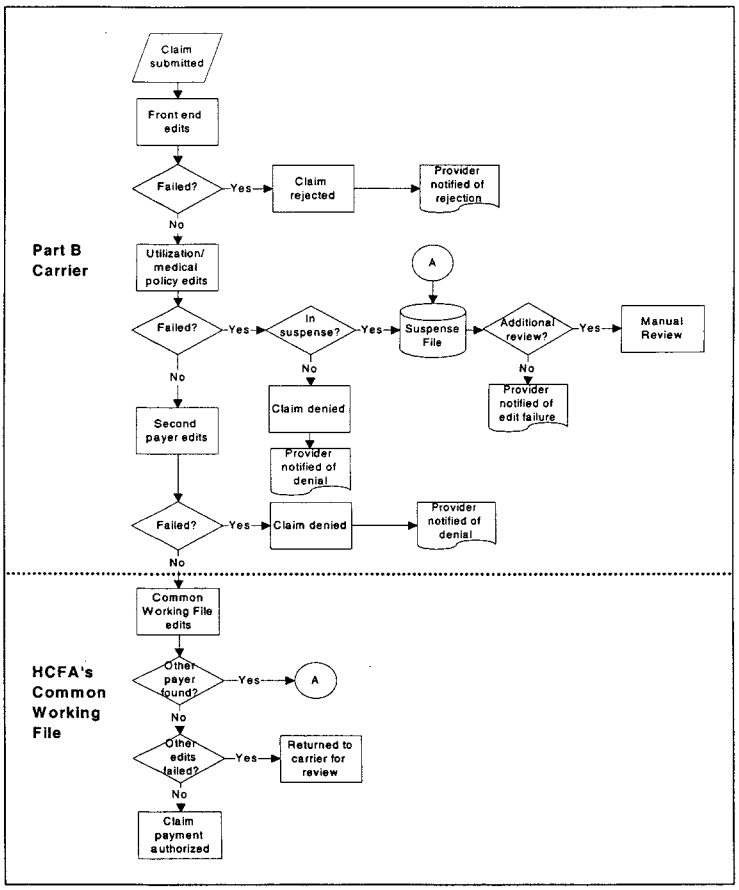
Figure 2: Example of a Part B Claims Automated Edit Process




Note: This flowchart does not reflect claims payment adjustments that may occur.

Source: GAO, verified by officials from two carriers.



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Carriers generally use three types of edits before authorizing the payment of a claim. First, front-end edits are used to ensure that valid values are used and appropriate fields are completed. Claims that fail the front-end edits are rejected and returned to the provider. Second, carriers use utilization/medical policy edits to check claims against the medical-necessity criteria in medical policies. Utilization/medical policy edits are particularly important because Medicare pays providers a fee for covered medical services, which are identified through a complex, three-level coding system, the HCFA Common Procedure Coding System. Using these codes, utilization/medical policy edits flag indicators such as whether the medical diagnosis was appropriate for the patient's gender or age or whether the medical procedure exceeded the threshold allowed during a given year. These edits can result in (1) a claim passing to the next set of edits, (2) a claim denial, (3) a claim being suspended until a manual review by claims examiners (who may request additional documentation) is conducted, or (4) a claim adjustment. The third type of carrier edits check for other payers, which are other primary sources of payment, such as employer-sponsored insurance or third-party liability settlements. If another potential payer is identified, the claim is generally denied.

Once a claim passes the carrier edits, the claim is checked against one of the nine CWFs that are processed at seven different computer sites around the country. The CWF edits check for items such as beneficiary eligibility, deductibles and limits, and duplicate claims. These edits can result in (1) an authorized claim, (2) a claim returned to the carrier for further review, or (3) a claim adjustment. The CWF also checks for other payers and, if found, the claim is returned to the carrier for further review.



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MEDICARE PART B CLAIMS COULD BE PAID FASTER USING CURRENT PROCESSES, BUT LESS INTEREST WOULD BE EARNED

One outcome of developing an immediate claim, administration, payment resolution, and data collection system would be faster Medicare part B claims payments. However, most Medicare claims could be paid more quickly using current processes by simply eliminating the mandatory delay in paying claims. Specifically, by enacting the section of the bill that eliminates the mandatory claims payments delay until after 13 calendar days from the date of electronic submission (26 calendar days if submitted manually), the mean time to pay claims would likely be substantially reduced. The mean time for processing and paying a clean part B claim[4] that required minimal or no manual intervention was 17.3 days in fiscal year 1999 (14.5 days for electronic submissions). However, HCFA estimates that carriers process almost two-thirds of all claims within 5 days.[5] Once processed and authorized for payment, the claims are held until the next payment cycle after the 13- or 26-day requirement has been met (carriers generally make payments every work day). The carrier then issues a check or authorizes an electronic funds transfer to pay the claim.

One drawback to eliminating the mandatory payment delay is that the Supplementary Medical Insurance trust fund, from which the Medicare part B program is funded, would lose some of the interest it earns on its balance if payments were made more quickly. Under HCFA's current

[4]HCFA defines a clean claim as one that did not require the carrier to investigate or develop outside of the carrier's Medicare operations on a prepayment basis. Ninety-nine percent of all completed paid claims were designated as clean claims in fiscal year 1999.

[5]HCFA does not keep statistics on how much of the average claims processing time is due to computer processing; however, it estimated this time based on the time period from the date of claim receipt to the date that the authorized claim is returned to the carrier from the CWF, and assumed that carrier processing took an additional 2 days.



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claims processing environment, we estimate that the trust fund could lose as much as about $140 million in interest revenue annually if the mandatory payment delay were removed. This amount assumes (1) annual part B outlays of $60 billion, (2) that the average time to pay claims would drop from 17.3 days to 5 days, and (3) an average interest rate of about 7 percent on securities.[6] The amount the trust fund could lose may be even higher if a real-time claims processing system were implemented because the average time to pay a claim could drop below 5 days. The Medicare Supplementary Medical Insurance trust fund is financed by payments from federal government general revenues and by monthly premiums charged beneficiaries. Consequently, a decrease in interest earnings could prompt the need for additional appropriations or increases in beneficiaries' premiums to compensate for the interest that the trust fund would otherwise have earned.

## ACTIONS TO MINIMIZE RISKS NECESSARY BEFORE DEVELOPING AN IMMEDIATE CLAIM, ADMINISTRATION, PAYMENT RESOLUTION, AND DATA COLLECTION SYSTEM

While the development of an immediate claim, administration, payment resolution, and data collection system to be used by the Medicare part B program might be feasible, it would significantly change the government's current processes because it would require the real-time processing of certain elements of the claims process that are currently performed in batch mode or manually.[7] In the abstract, a real-time Medicare part B claims process could be achievable if

[6]We derived this interest rate by taking the weighted average of the interest rates of the outstanding bonds in the Medicare Supplementary Medical Insurance trust fund as of September 30, 1999.
[7]Real-time mode relates to processing that responds to an external event within a short and predictable time frame. Batch mode relates to processing application programs and their data individually, with one being completed before the next is started.



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appropriate systems development policies and techniques are used. Although more beneficiaries might have to pay their copayments immediately, it could provide health care providers and beneficiaries with several benefits—primarily the immediate notification of approved or denied claims. However, without appropriate safeguards, a real-time claims processing system could involve serious risks because it opens the process to a possible rise in the number of improper Medicare payments.[8] In addition, the technical and cost risks associated with developing a real-time claims processing system could be considerable.

A Real-Time Medicare Claims
Processing System Should Include
Controls to Minimize Improper Payments

We have long identified Medicare as a high-risk program that is vulnerable to fraud, abuse, and payment errors.[9] Many of Medicare's vulnerabilities stem from its size and decentralized administrative structure, which make it a perpetually attractive target for exploitation and make payment errors more likely. Because wrongdoers are continually finding new ways to dodge program safeguards, HCFA and its contractors periodically revise their pre-payment edit and post-payment audit routines. As a result, the proposed real-time claims processing system must include appropriate internal controls to help ensure that operational problems are minimized and program integrity protected. Key to the design of appropriate controls is the effective assessment

[8]HHS' Office of the Inspector General estimated improper Medicare fee-for-service payments at $13.5 billion for fiscal year 1999.
[9]*High-Risk Series: An Update* (GAO/HR-99-1, January 1999), *High-Risk Series: Medicare* (GAO/HR-97-10, February 1997) and *High-Risk Series: Medicare Claims* (GAO/HR-93-6, December 1992).



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of both external and internal risks that an agency faces in achieving its objectives, as well as determining how risks should be minimized.[10]

A major internal control challenge that a real-time claims processing system would have to overcome is ensuring that prepayment processes currently performed manually are adequately addressed. Any new real-time claims process applied to all claims would have to find a way to accommodate existing manual processes (e.g., postpone until after claims payment or provide tentative claims approval in certain circumstances), such as in the case of claims examiners' reviews of claims that are suspended because they did not pass utilization/medical policy edits or in cases that involved claims in which Medicare should be the secondary, rather than primary, payer. This latter issue is particularly problematic because determining another insurer's liability can be a time-consuming process of discovering whether insurance coverage overlaps and, if so, ascertaining Medicare's liability. If issues such as these are not adequately addressed, additional improper Medicare payments can result.

It is also essential that current program safeguards, such as the edit process illustrated in figure 2, not be compromised. The utilization/medical policy edits that address the often complex and subtle art of coding claims are a particular area of concern. As previously mentioned, HCFA's Common Procedure Coding System uses three levels of codes:

[10]The Comptroller General's *Standards for Internal Control in the Federal Government* provides a useful framework when considering the types of essential control activities that should be incorporated into a fully integrated information technology system.



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- Level 1, the American Medical Association's Physicians' Current Procedural Terminology, consists of a list of 5-digit codes for most of the services performed by physicians. These codes are used to bill for most procedures and services but have limited selections for describing supplies, materials, and injections.

- Level 2 are national codes that supplement the level 1 codes and are used to bill for a range of services and supplies such as vision services and surgical supplies. These codes have a uniform description nationwide, but due to what is known as "carrier discretion," their processing and reimbursement are not necessarily uniform.

- Level 3 are local codes developed by individual Medicare carriers. The codes are often used to describe new services, supplies, and materials, as well as to report procedures and services that have been deleted from Current Procedural Terminology codes but are still recognized and reimbursed by the carrier.

The Medicare coding system is difficult to use because it (1) attempts to identify codes for all accepted medical procedures, including codes to describe minor procedures that are components of more comprehensive procedures, and (2) changes every year. For example, the fee for surgery often includes the cost of related services for the global service period, that is, for a set number of days before and after the surgery. To prevent overpayment in these cases, Medicare carriers need to identify when claims for surgery include codes that represent related services and reduce the payment accordingly. These complexities can inadvertently lead providers to submit improperly coded claims. They also make the Medicare program vulnerable to abuse from



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providers or billing services that attempt to maximize reimbursement by intentionally submitting claims containing inappropriate combinations of codes.

Because a real-time claims processing system can be particularly vulnerable to code manipulation (e.g., through repeated submission of fraudulent claims until they pass the system's edits), it may be prudent to exclude problem providers from participating in a real-time system and require that new providers complete a probationary period before they become eligible to participate. In another situation—agency "fast pay" initiatives (when payment authorization is made prior to verifying receipt and acceptance of goods or services)—we have similarly stated that agencies should limit its use to those cases in which suppliers have had and continue to have good ongoing business relationships with the agency.[11] While the system proposed by H.R. 4401 is not a "fast pay" situation, it would be prudent to employ these same controls since Medicare has areas in which mispayment and fraud have been particular problems. For example, medical equipment supply is an area vulnerable to fraud, as indicated by its the high payment error rate. Indeed, according to fiscal year 1997 and 1998 Department of Justice reports, a few medical equipment suppliers were able to enroll in the Medicare program and obtain millions of dollars in fraudulent payments before post-payment reviews and utilization analyses were able to identify the fraudulent activity.[12]

Further, ensuring that adequate documentation controls (e.g., detailed history files and/or logs) are in place and enforced to ensure that the electronic trail is not lost or tampered with would be

[11] *Streamlining the Payment Process While Maintaining Effective Internal Control* (GAO/AIMD-21.3.2, May 2000).
[12] *Department of Justice, Health Care Fraud Report*, Fiscal Year 1997 and *Department of Justice, Health Care Fraud Report*, Fiscal Year 1998.



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particularly important in a Medicare real-time processing environment. The importance of maintaining detailed Medicare payment histories and medical records is demonstrated by the results of HHS' Office of the Inspector General's fiscal year 1999 claims review. The Office of the Inspector General found that claim payment histories and provider medical records were essential to identifying the payment errors it found.

Technical and Cost Risks
Should Also Be Considered

In addition to the Medicare part B improper payment implications of H.R. 4401, other considerations to be taken into account are the technical and cost risks associated with the development and implementation of a real-time claims processing system. The Clinger-Cohen Act requires agency heads to design and implement a process for maximizing the value and assessing and minimizing the risks of information technology acquisition. Guidance prepared by the Office of Management and Budget and by us on how to implement such a process calls on agencies to assess projects' benefits, costs, and risks.[13] Items to consider before undertaking an information technology project include the project's return on investment, its link to the business' objectives or strategic plan, and evidence of compliance with the organization's overall systems architecture. Without such analyses, it is risky to require that this system be implemented.

Response times, which can be slowed by the amount and type of telecommunications involved

[13] *Evaluating Information Technology Investments: A Practical Guide* (OMB, November 1, 1995) and *Assessing Risks and Returns: A Guide for Evaluating Federal Agencies' IT Investment Decision-Making* (GAO/AIMD-10.1.13, February 1997).



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and the complexity of processing, are a critical factor in the success of real-time systems. An example of a systems development that failed, in part due to a response time problem, is the Bureau of Land Management's Automated Land and Mineral Record System Initial Operating Capability. As we testified in March 1999, during an operational assessment test and evaluation, users reported that system response time problems were severe or catastrophic at all test sites.[14] Because of this and other problems and after obligating over $67 million, the Bureau of Land Management decided that the Initial Operating Capability was not deployable. While a high-quality system design would reduce the risk of slow response times, hundreds of thousands of providers could be submitting millions of transactions daily (carriers completed action on almost 718 million Medicare part B claims in fiscal year 1999). Moreover, it is critical that system controls (such as the many and varied edits just discussed) not be compromised in an effort to achieve reasonable response times.

Security, already a major concern in the Medicare program, must also be adequately addressed in any proposed real-time claims processing system. H.R. 4401 requires that the real-time claims processing system include strict security measures that guard system integrity, including protecting the privacy of patients and the confidentiality of personally identifiable health insurance data. Implementing such requirements, however, is not easy.

[14] *Land Management Systems: Major Software Development Does Not Meet BLM's Business Needs* (GAO/T-AIMD-99-102, March 4, 1999). Other problems that the operational assessment test and evaluation discovered were that the system did not meet requirements and that data converted from legacy databases were not accurate.



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Both HHS' Office of the Inspector General[15] and we[16] have reported that HCFA's computer controls do not effectively prevent unauthorized access to, and disclosure of, sensitive Medicare information. This problem could be compounded if appropriate security controls are not designed into the proposed system. In particular, without appropriate controls, electronic connections can provide a path that can be used by hackers and others to gain access to databases that contain sensitive information or to simply disrupt operations.

Recent experiences with the Melissa and "ILOVEYOU" computer viruses demonstrate the formidable challenge the federal government faces in protecting its information technology assets and sensitive data.[17] Although key government services remained largely operational, these viruses were disruptive and provided evidence that computer attack tools and techniques are becoming increasingly sophisticated. Moreover, if the design for the real-time claims processing system includes a World Wide Web-based system, the possibility of other types of attacks must also be considered and addressed. For example, a "denial-of-service" attack (e.g., a web site is flooded with fake requests for pages) can make it difficult or even impossible for legitimate customers to access a web site or cause the targeted system to crash.[18] Computer attacks are also a cause for broader information security concerns across government because of

[15] *Report on the Financial Statement Audit of the Department of Health and Human Services for Fiscal Year 1999*, Report No. A-17-99-00002, February 2000.
[16] *Financial Management: Agencies Face Many Challenges in Meeting the Goals of the Federal Financial Management Improvement Act* (GAO/T-AIMD-00-178, June 6, 2000); and *Medicare Financial Management: Further Improvements Needed to Establish Adequate Financial Control and Accountability* (GAO/AIMD-00-66, March 15, 2000).
[17] *Information Security: The Melissa Computer Virus Demonstrates Urgent Need for Stronger Protection Over Systems and Sensitive Data* (GAO/T-AIMD-99-146, April 15, 1999); *Information Security: "ILOVEYOU" Computer Virus Emphasizes Critical Need for Agency and Governmentwide Improvements* (GAO/T-AIMD-00-171, May 10, 2000); and *Critical Infrastructure Protection: "ILOVEYOU" Computer Virus Highlights Need for Improved Alert and Coordination Capabilities* (GAO/T-AIMD-00-181, May 18, 2000).
[18] *Information Security: Recent Attacks on Federal Web Sites Underscore Need for Stronger Information Security Management* (GAO/T-AIMD-99-223, June 24, 1999).



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the inability to detect, protect against, and recover from computer attacks; inadequately segregated duties, which increase the risk that people can take unauthorized actions without detection; and weak configuration management processes.

## DEVELOPING A SINGLE REAL-TIME CLAIMS PROCESSING SYSTEM FOR BOTH MEDICARE PART B AND FEHBP WOULD BE CHALLENGING

Because Medicare part B and FEHBP are substantially different programs, it would be difficult to design and implement a single system to process claims under both programs, as called for by H.R. 4401. Specifically, H.R. 4401 requires that (1) OPM adapt the immediate claim, administration, payment resolution, and data collection system for use by the FEHBP and (2) carriers participating in FEHBP use the system to satisfy certain minimum requirements for claim submission, processing, and payment.

Under FEHBP, the government contracts with private plans to finance or provide care to federal workers and retirees for negotiated annual premiums. The government runs no plans, pays no claims, and its financial obligations are limited to its share of the cost of the private plan premiums and certain administrative costs. For 2000, federal employees could select from seven nationwide fee-for-service plans,[19] six fee-for-service plans open to specific groups, and hundreds of health maintenance organization plans available throughout the nation.

[19]Three of these plans have two options (standard and high).

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As we explained in August 1998, Medicare and FEHBP are significantly different.[20] For example, HCFA and its carriers authorize claims payments and monitor abuse or fraud, while these roles are delegated to the hundreds of health plans that are enrolled under FEHBP.[21] In addition, traditional Medicare covers the same standard package of services and requires the same deductibles, coinsurance, and copayment requirements for all beneficiaries. In contrast, FEHBP does not require participating plans to cover a standard or core benefits package. Although all plans offer inpatient hospital and outpatient medical coverage as well as certain OPM-required services, specific benefits vary. These differences would make it challenging and costly to design and implement a real-time claims processing system for both programs. Moreover, FEHBP carriers may balk at being forced to implement a system that was not developed with their particular systems and processes in mind, and it could cause them to drop out of the program.

## ROLE AND COMPOSITION OF THE HEALTH CARE INFRASTRUCTURE COMMISSION SHOULD BE CAREFULLY CONSIDERED

The implications of having a real-time claims processing system that would initially be used by Medicare part B carriers and be developed and implemented by the seven-member Health Care Infrastructure Commission instead of HCFA should be carefully considered.[22] Specifically, the

[20] *Federal Health Programs: Comparison of Medicare, the Federal Employees Health Benefits Program, Medicaid, Veterans' Health Services, Department of Defense Health Services, and Indian Health Services* (GAO/HEHS-98-231R, August 7, 1998).

[21] A single company can administer multiple health plans.

[22] The commission would be chaired by the Secretary of Health and Human Services and have members from the Department of Defense's Defense Advanced Research Projects Agency, the Department of Veterans Affairs, the National Aeronautics and Space Administration, the National Science Foundation, the Office of Management and Budget, and the Office of Science and Technology Policy. The bill also allows the chairman of the commission to appoint an executive director and other personnel and to procure temporary and intermittent services.



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bill charges the commission, which does not include HCFA, with designing, constructing, and implementing a real-time claims processing system. Adding another organization to the already complicated Medicare process would compound the project's complexity. Moreover, any system related to processing Medicare part B claims would greatly affect HCFA's current systems as well as its future systems development. Further, the bill is silent on whether the commission would also be responsible for maintaining the system, which raises additional uncertainties about the commission's and HCFA's respective roles.

The commission could elect to contract with HCFA for the development, implementation, and maintenance of the system. In such a case, if a real-time claims processing system is to be developed, it may be more fitting for the proposed commission to oversee HCFA's actions, rather than develop and implement the system itself. Such oversight could include evaluating the system design and monitoring HCFA's development and implementation actions.

Aside from its role, the composition of the commission also needs to be carefully considered. In particular, having health care and financial management expertise on the commission would be critical. As currently conceived, though, the commission includes several officials from federal agencies with expertise in advanced information technology but not health care or financial management. Specifically, the bill explicitly calls for each official appointed to the commission to "be an expert in advanced information technology" but does not address health care or financial management expertise. If a real-time claims processing system is to be developed, as envisioned by the bill, consideration should be given to expanding the composition of the

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commission to include key HCFA and carrier officials with health care claims processing, program integrity, and financial management expertise.

One reason it is important for HCFA and its contractors to be part of the commission is that the development of a real-time claims processing system could overlap—and possibly conflict with—ongoing and planned HCFA initiatives, which could be costly and disruptive to both efforts. For example, HCFA plans to transition from four to two standard Medicare part B systems (one is just for durable medical equipment carriers) by fiscal year 2003. Initiatives such as this would clearly affect, and be affected by, a real-time claims processing system.

Other entities that should be considered for membership in the commission if the real-time claims processing system set out in the bill is to be developed are OPM and providers. A representative from OPM should be considered as a member of the commission since, as currently called for in the bill, any system developed would be applied to the FEHBP. Moreover, it may be desirable to have a representative from the provider community on the commission, since a real-time claims processing system would also significantly affect providers.

PAST HCFA FAILURE COULD PROVIDE
USEFUL LESSONS FOR PROPOSED SYSTEM

A past HCFA system development failure could provide valuable lessons in the type of approach that could be taken to determine whether a cost-effective, real-time claims processing system can be built. In the mid-1990s HCFA attempted to improve the efficiency and effectiveness of its



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Medicare operations by developing one unified computer system—the Medicare Transaction System (MTS)—to replace its existing standard systems. This single system would have integrated data from Medicare part A and part B and managed care and provided a comprehensive view of billing practices. As we previously reported, the MTS project encountered problems from the very beginning.[23] It was plagued with schedule delays, cost overruns, and the lack of effective management and oversight. Ultimately, on August 15, 1997, HCFA terminated the MTS contract on which it had spent about 3 and 1/2 years and about $80 million. Although about $50 million of this amount was for software development (the other $30 million went to internal HCFA costs), this failed project did not produce integrated claims processing software. As we testified in September 1997, MTS provided HCFA with a huge learning experience about the difficulty of acquiring such a large system under a single contract and a better understanding of the requirements for developing a Medicare claims processing system.[24]

The learning experience HCFA gained from MTS can provide lessons for the proposed real-time claims processing system. In particular, as we reported in May 1997, MTS was not adequately managed as an investment.[25] HCFA had not followed practices that are essential if management is to make informed information technology decisions. Such practices include preparing a valid cost-benefit analysis, considering viable alternatives and assessing risks, and evaluating how the proposed technology will contribute to improvements in mission performance.

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[23] *Medicare: New Claims Processing System Benefits and Acquisition Risks* (GAO/HEHS/AIMD-94-79, January 25, 1994) and *Medicare Transaction System: Strengthened Management and Sound Development Approach Critical to Success* (GAO/T-AIMD-96-12, November 16, 1995).
[24] *Medicare Automated Systems: Weaknesses in Managing Information Technology Hinder Fight Against Fraud and Abuse* (GAO/T-AIMD-97-176, September 29, 1997).
[25] *Medicare Transaction System: Success Depends Upon Correcting Critical Managerial and Technical Weaknesses* (GAO/AIMD-97-78, May 16, 1997).



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While H.R. 4401 requires the commission to perform a study on the design and construction of the proposed real-time claims processing system, the bill does not require that analyses such as these be performed, which can reduce risks and help ensure that information technology projects achieve maximum return on investment. Accordingly, the proposed system could benefit from the completion of investment management analyses before a decision is made about whether the system should be implemented. These analyses could determine whether cost-effective ways to address the issues that we have outlined exist.

Another lesson that can be learned from the MTS project is that a phased approach can reduce the financial, schedule, and technical risks of a project. The original MTS schedule was developed on the basis of a grand design approach, in which the complete system would be implemented at one time.[26] A phased approach can reduce the risks inherent in any large computer development effort—cost overruns, schedule delays, and the system's failure to perform as expected. Accordingly, it might also be desirable to take a phased approach to the proposed real-time claims processing system, which could reduce its risks.

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In summary, H.R. 4401 has worthwhile objectives and would offer benefits to providers and beneficiaries in that decisions on authorized and denied claims would be provided immediately. However, Medicare part B claims could be paid more quickly using HCFA's current processes

[26]HCFA later changed its implementation plan to a phased approach.



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without such a system. Paying claims faster, however, may not be desirable because the Medicare Supplementary Medical Insurance trust fund would lose interest revenue.

Before an implementation decision is made it is particularly important to demonstrate that a real-time claims processing system can be designed that provides the safeguards necessary to minimize improper payments. Moreover, because of the complexity of the Medicare process, additional analyses of the technical and cost risks of a real-time claims processing system would be prudent before requiring that it be developed and implemented. In addition, the administrative and benefits differences between Medicare and FEHBP would make the development and implementation of a system applicable to both programs difficult. Further, the role and makeup of the commission should be carefully considered to help ensure that any such system would take into account the current Medicare environment, as well as health care and financial management issues. Finally, lessons learned in HCFA's MTS failure demonstrate that it is important that critical analyses be performed before implementation decisions are made. Accordingly, it may be premature to require implementation of the system envisioned by the bill until such analyses are completed.

Mr. Chairman, this concludes our statement on H.R. 4401. We have also provided additional technical comments on the bill to your staff. We would be pleased to respond to any questions that you or other members of the Subcommittee may have at this time.

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**Contacts and Acknowledgments**

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Mr. HORN. Thank you and I assume the rest of your colleagues will also be helping to respond on questions and there's nothing else to be said on the basic presentation.

Mr. WILLEMSSEN. Yes, sir.

Mr. HORN. Let us now move to Marcy Zwelling-Aamot, who's the former president of the Long Beach Medical Association and now the treasurer of the Los Angeles County Medical Association. We're delighted to have a true professional on the firing line with us today and we look forward to your testimony. It will also be sprightly I realize.

Dr. ZWELLING-AAMOT. Thank you, Mr. Chairman, and thank you, committee, for the privilege of allowing me to testify today. This bill is a well-intended bill but it is grossly misguided and I would like to speak to the issue of claims data versus clinical data.

The unintended consequences of submitting claims data is that we make bad conclusions. It has been said garbage in, garbage out. As a clinician I treat patients. I treat human beings, I do not treat coded representations of persons. And yet that is the data that the system currently compiles. Making a larger system a real-time based system is a wonderful thought, but inherent in it is the danger that the data that you collect is just bad data and that the conclusions then are wrong. That's what happens today.

Making that system faster, while I'll tell you as a clinician it would be wonderful to get paid on time, it would be wonderful to be able to decrease my staff. They must have to submit claims, quote, legitimately but I would suggest to you that the duplicitousness of this system is not the provider, the provider as a physician, a hospital, or as home health agency, but the system itself. The system is the fabricator because it doesn't work.

Remember the only reason that I contact HCFA is for reimbursement purposes. That data, however, is used for a multitude of purposes, some of them quite dangerous. For instance, epidemiologically, we make statements about our Nation's health based on this data. I'd like to give you a perfect example, if you will, of why that data is really not good data.

Just last week a patient in my office with abdominal pain came in and we realized that all her tests were completely normal. So I took the time to speak with her only to find that her pain was probably of a somatic nature and was probably because of some abuse that she had received as a child. Her father had recently died, these things were coming to the fore. We spent 30 to 45 minutes. I got her to the proper clinicians, that being a psychiatrist and a psychologist, and now it's my duty to code that visit. Do I code it abdominal pain? Somatic pain? Depression? Abuse? My choice as to how I might select that code will then delegate what's in that patient's file from here on out.

We talk about the privacy issues. I'm not a particularly private person in the sense that if somebody's going to say something about me I don't mind as long as it's true, but imagine that the government has data that is not true. How dangerous. It may prevent a patient from getting insurance later in their life, it may prevent them from getting a job. Bad data is far worse than no data.

I might also note, Mr. Chairman, that because the coding system's purpose is only the exchange of dollars, I would not code de-

pression for that patient, even though it was a very important part of her medical problem, and the reason is because by just adding depression to the code, my reimbursement becomes 60 percent of the allowed. Now it has often been said that physicians are not good business people. I conclude that that is probably correct, but our common sense has not gone astray, and so we don't code some of these things. We could talk if you have any questions later about how that data is collected in terms of how many lines of data are transmitted to HCFA and what they do with the data and the need for us to get the right code on the right line so the right procedure is compensated, but again I stress to you, Mr. Chairman, that the purpose of our communication with HCFA at this point in time and every other insurance company is based on claims reimbursement data which does not represent the clinical condition.

What I would like this committee to do is to take a step back and realize that we really must start over in terms of the data that's collected in real-time at the time of the patient visit in an ICU. We should not conclude that patient has high blood pressure. We should specifically state what that blood pressure is. The conclusions also come later, not in the making of the code.

Myself, I treat people, not numbers. And unless you have the winning lottery number as a physician I'm just not interested in coded systems. I think they're dangerous and I think that our country as a whole deserves more accurate data.

I'll summarize with a TV show that I saw this morning, Good Morning, America. I was pleased to see Dr. Lila Nautergal, who was my mentor at NYU, talking about estrogen. Throughout her testimony on the TV she kept alluding to the fact that we don't have good data, we don't have good data, breast cancer is plastered across the front pages of our paper and yet we don't know what causes breast cancer. We make surmises, we make guesses, again based on a coded system that's based on claims and we don't have the data. We have 250 million people in this country, we have tons of data in doctors' offices. It never gets put into any computerized system. It never gets melted down into any particular clinical code, and it sits unutilized in our offices and in files.

I thank you again for the opportunity to speak to you on this matter and I'll answer any questions when they come.

[The prepared statement of Dr. Zwelling-Aamot follows:]

Statement of Marcy Zwelling-Aamot, M.D.
before the
Subcommittee on Government Management, Information, and Technology
on
H.R. 4401, the "Health Care Infrastructure Investment Act of 2000"
July 11, 2000

Thank you, Mr. Chairman.

It's a privilege to be here today. It's an honor to have the opportunity to speak to a congressional subcommittee. Outside of the obvious, I have a passion for the subject of clinically based medical record-keeping systems, and I'm thrilled to be able to speak to that specific issue.

The Health Care Infrastructure Investment Act of 2000 is a well-intended, but fails to address the serious problem that has infiltrated the entire health care industry.

Currently, we have a claims-based computer system handling most medical claims. Every insurer has its own system including Medicare, Champus, and other government funded systems.

There are many dangers inherent in a claims-based system. It is clear that a simple code cannot accurately reflect any patient-care visit. HCFA has tried laboriously over many years to try to perfect an E&M system so that a code might reflect the care given. But it's absolutely impossible to develop such a system.

Let me give you an example. A patient came to my office complaining of abdominal pain. As it turns out, her studies were negative, and we were able to ascertain that this was a somatic pain. After 30 minutes of face-to-face patient communication, it was clear to me that the patient had innumerable family issues, including abuse. She needed immediate attention, and our office saw that she found the appropriate follow up. I called her later in the week to check on her. How do I code that visit? Abdominal pain? Somatic pain? Abuse? Depression?

There is no right answer; but doctors are forced to make these decisions every day. We document for the sake of reimbursement because the system only accepts claims data. How might Medicare find out about the phone call? It doesn't. Even if I render further treatment over the phone. It is not reimbursed and is not documented by current claims-based systems.

Health care documentation is scarce, if not horrible. HCFA declares there is duplicity. But, physicians are too busy caring for patients to memorize codes that, in our mind, are irrelevant to the care we deliver. Medicare knocks on our door and accuses us of fraud. That is generally not true. We are clinicians. We treat humans problems not coded representations of those problems. An insurance or government clerk without a medical

school education or any clinical training enters codes into a computer and judges our care accordingly. As an example of interference in healthcare delivery from those outside the medical profession, members of Congress took it upon themselves to determine the appropriate length of stay for a new mother. Based on what data? None… there isn't any. The lengths of stay for a new mother depend upon dozens of variables. When the mother is clinically capable of going home, she is discharged. That may be several hours to several days after she delivers.

Moreover, the government and other collectors of claims data make decisions based on this erroneous data. When asked, HCFA admitted to me that it accepts only one line of diagnostic coding per HCFA claim… but over the life of the patient, the agency said that it expects to get all of the diagnoses documented in its system. Yet, HCFA denies treatment based on a diagnosis missing from the claim. There is no means of getting the proper data to HCFA in order to fully support reimbursement. It is no wonder that the Office of Inspector General finds many documentation "errors." The system promotes errors. Making a bigger, bad system does not solve anything.

Further, you may or may not be aware that if I were to add depression to a list of diagnoses I submit to Medicare for payment, HCFA will decrease my reimbursement to 60% of the allowed. No physician is going to purposely cut his or her reimbursement particularly when these types of cases are terribly time consuming. There is no place in the current system to document all the phone calls to the patient, other physicians, therapists, etc.

What about the cash paying patient? There is no data available because no claims are submitted. Don't their diseases matter in the public decision-making processes? Consider the diagnosis of obesity -- the most costly disease in our delivery system at this time. The treatment is not covered by most insurance and not by the government-funded programs. Yet, insurance carriers publish data regularly about obesity, its consequences, effective treatments, and general cost to society. I would challenge you that most obesity is treated on a cash basis for the aforementioned reasons and there is no basis for these "conclusions". The data is just plain wrong or nonexistent. Garbage in. Garbage out. (No pun intended.)

The system is not designed to be correct. It is designed to deliver dollars. By its very structure, it is so flawed that the data being collected is bad, incorrect data. This is not fraud. The system doesn't collect the truth (clinically speaking, of course). In my opinion, enhancing a system that is generically flawed would be a huge mistake and a waste of money. More importantly, you could completely destroy the integrity of my profession while directly and negatively impacting the health of millions of Americans.

The data that is collected by claims-based systems is just wrong data. It allows for bad decisions. The system, itself, creates many of the issues that HCFA brings to Congress such as the discrepancy in "length of stay" for a given diagnosis in various demographic areas. You cannot directly compare codes and assume that the care being delivered is

equal, any more than you might assume that every red blouse is equal in texture, coloration, quality and style.

I personally conducted a study on my own patients and their prescriptions. Pacificare, an HMO with whom I contract, insists that physicians hold pharmacy risk. My IPA sends a check to Pacificare for my patients' medications. I am the champion prescriber; I write more dollars of prescriptions than any other physician in my Independent Practice Association. I was curious why that was the case, so I asked Pacifcare for its "data" concerning my prescribing habits, and I investigated. I might add as an aside, that I had to go through many too many hoops just to get the data. Pacificare does not readily give its data to physicians.

There was an error rate of 30%. Patients were documented by Pacificare to be taking medication that they had never taken. I was "charged" for medications for patients whom I had not seen in years. The prices quoted were incorrect (I actually went to pharmacies and collected their data about reimbursement). And yet, Pacificare claims that its data is accurate enough to insist that I be charged tens of thousands of dollars per year for the privilege of delivering care. The issues of drug benefit or necessity are not even discussed. This is a crude, if not rude, system based in fiction. This type of behavior threatens my ability to deliver good health care. Pacificare assumes that the data alone gives it the power to make decisions about pharmaceuticals. Pacificare is not a provider of healthcare. It holds no license to "practice" medicine. As an HMO, it only brokers dollars. But, because these companies have this data, we, as a society, have allowed them to dictate care.

Further, the fact that our healthcare system is more concerned about claims collection than the integrity of the data, the entire country has been reprogrammed into a "cost cutting" mode not a quality mode. I never thought that I would see the day when healthcare was more price elastic than a hair cut. Patients are asked to choose health plans and physicians from a list based on a variety of data points. Again, the data points are meaningless. HealthNet does not "do" more mammograms than Pacificare. Blue Cross does not give more vaccinations than Blue Shield. Physicians order these tests. The rationale for doing a test or providing a vaccination is clinical data and those facts are not made available to the public because they don't exist. I just cringe when I get a notice from an insurance company that a patient hasn't had a certain test or exam, and it isn't true. What a waste of my time to fax a copy of my clinical record to an insurance copy so that it maintains a high score from the National Council on Quality Assurance. The insurer may not have received a claim for a procedure but that is not an indication that the procedure was not done or was neglected.

The integrity of my profession is a direct function of the integrity of the data. Our profession is based in science, not in codes. You cannot code anger, distress, or fear. A colon cancer may code as a generic colon cancer but there are specific reasons why one patient may do better than another. We are guided by relatively small studies often funded by pharmaceuticals. The study results are typically just barely statistically

significant. Yet patient care will change as a result of one study, only to be changed again when another similar study with borderline significance is published.

A clear example is the issue of hormone replacement therapy in menopausal women. For years, observational studies clearly showed support for hormone therapy as a preventive treatment. Now, after the publication of some new studies, we aren't so sure. So.... What's the right answer? Quite frankly, we don't know. Physicians and patients will spend money trying a variety of treatments for the symptoms common to menopausal woman. If we allow the science to guide our recommendations, we will be able to come to help patients more directly and at lower cost. As it is, many treatment plans are based on anecdotal data, and payment for the treatment is based on plausible fallacy, a code founded on erroneous supposition.

One of the problems with the system as it exists is that neither the consumer (patient) nor the physician really understands the product. What is for sale, really? Healthcare? A good day? Long life? Life eternal? How is our product defined? What is its value in the marketplace? These questions cannot be answered without accurate clinical data.

The current system actually detracts from the truth. It generates a prevarication. The system is the fabricator, not the physician or the hospital or the home health agency. The government has by virtue of our mutual history chosen to communicate with the healthcare industry by means of claims. We come to you only for reimbursement.

The government is not a healthcare delivery system. Government workers, excepting physicians, do not deliver health care. The government should not ... cannot direct the science of healthcare. In fact, another misguided effort was the government's determination that mammograms should be done every other year in women aged 40-50. It took "an act of Congress" to allow for a 40+ year-old woman to get a screening mammogram yearly. It has since becomes the standard, and we have saved many lives. I will confess, however, that we still don't know specifically when a mammogram has the greatest value to our patients. Is a mammogram after age 70 appropriate screening or just an added cost? That data is not available on a scale necessary to make general treatment decisions.

Benchmarks are established almost blindly. When should a patient undergo surgery for prostatic hypertrophy? It depends upon the patient, the extent of the process, and the inconveniences or other complications that the process dictates for any individual. When HCFA measures outcome, it measures mortality. When did a benign large prostate gland kill someone? Not in my medical experience. Outcomes for those receiving medical or surgical treatment may have differed if the question were "how was your day made better?" Further, other medical considerations are such a large part of the decision, but are not at all a part of the "code". The misrepresentation that we call a reimbursement code surmises facts that don't exist, or are assumed. Don't assume. It's particularly dangerous to make assumptions in a clinical setting.

The physician community needs to be at the heart of a clinically oriented database. This database would be available to all insurance companies, patients, physicians, and anyone interested. It would provide a means by which we could honestly tell a patient what the "real" risk of a specific surgery might be. We might be able to legitimately recommend one specific medication over another. We would be able to adjust treatments for our patients with far more confidence and much less cost. Fewer redundant tests would be ordered.

I cannot tell you the number of times tests are reordered because the clinical data is not available for the physician. A patient had a x-ray in Montana. We only know that a x-ray was done. The patient may have received an explanation of benefits. But, we don't know why it was ordered or what the results were. So, we repeat the study. How wasteful. Even in our own communities, we have no means to communicate with each other except through laborious dictation systems. Do you know that we may dictate the "same" history and physical exam on a patient hundreds of time over his or her lifetime? How many times must we document a patient's birthplace? Is that really the means by which you want to monitor healthcare? Did I ask all the right questions already asked by someone else simply to justify my claim? The honest answer is yes.

The system is plagued with redundancy, superimposed upon a game of telephone tag. Medical charts are handwritten, usually in the midst of a complex hospitalization or office visit. We attempt to gather all relevant information, and we document pieces of information to remind ourselves of treatment plans and objectives, and to communicate with other physicians clinically. It is not intended to describe a pattern of care for the purpose of reimbursement. The issues are truly mutually exclusive.

Charting for the purpose of reimbursement requires "pigeon holing" a complex of symptoms rather than a running documentary of the patient's care and progress.

The subject of privacy is always raised when we debate the issue of computers and medicine. It is common practice to fax, e-mail, and Fed-Ex patient confidential information. Charts lay open on hospital wards to be read by any passer-by. The system is not secure.

Moreover, it is particularly dangerous to pass on distortions about our patients' care. Our patients are labeled with diagnoses that are not accurate representations of their clinical condition. But, by necessity of reimbursement, we are forced to impose a code that could keep them from getting a job, purchasing insurance or getting future care.
For example, a patient who has an insurance rider for their back pain may see a physician about that pain, but the codes transmitted to the insurance carrier will not allude to back pain. After all, the purpose of submitting a claim is for reimbursement. Why would we purposely submit a suggestion that we should not be paid? As physicians, we have been regarded as bad business people. However, our common sense remains acute.

Reimbursement should be about value. There is nothing in the current system that helps us evaluate value. We need clinical, scientific data in order to determine the legitimate value of a treatment or a recommendation.

While many physicians have conceded to using protocols, I find them potentially dangerous. Healthcare should not be delivered like a burger and fries. Americans deserve better than "drive-through" care. We are not McDonalds.

As physicians, we do not just follow a recipe. Personally, I've spent years and years and years practicing and perfecting my craft. I have years and years of academic training. My observations are very valuable. But, they are never collected in a claims-based system. I would go so far as to say that my acumen is often wasted in superfluous and nonproductive paper work.

Personally, I want to go to work every day to take care of patients. The challenge is in the selection of a specific treatment for each individual patient. The value of my predecessor's thoughts and experience, however, has been lost in a system of coding that often obscures fact. Expanding the current system only intensifies the mistakes and the misstatements made every day. Americans deserve medical treatment based on a legitimate information base.

Philosophically, as a nation we should seek truth. Perceptions of quality should be based on fact. Our patients should choose physicians and treatment options based on real medical science not actuarial equivocation. We must encourage the public to seek quality over cost. Data systems based solely on dollars will not save dollars, improve quality of life, or decrease morbidity. On the contrary, if we don't fix the current system, we are destined to perpetuate only a game of meaningless codes. My life and the lives of my patients should not be reduced to a simple number, unless of course, it's a winning lottery ticket.

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

Mr. HORN. Thank you very much. We appreciate your testimony.

Next is David Sparks, the senior vice president for finance of Providence Hospital, the oldest hospital in Washington, DC, speaking on behalf of the American Hospital Association. Mr. Sparks.

Mr. SPARKS. Thank you, Mr. Chairman. I'm David Sparks. I am the senior vice president of Providence Hospital. I do represent the American Hospital Association's membership of nearly 5,000 hospitals, health systems, networks and other health care providers. On behalf of AHA, I'd like to thank you for inviting us to comment on H.R. 4401, the Health Care Infrastructure Investment Act of 2000.

Providence Hospital is a 380-bed facility located in Northeast Washington. We have a 240-bed nursing home and several outpatient clinics that we operate. We complete and bill for more than 108,000 encounters every year, of which only 14,000 of those are inpatient. At any point in time, we are managing approximately 36,000 accounts, and we bill both Part A Medicare and Part B for the hospital.

In addition, we also bill approximately 50,000 physician bills every year, and those all get billed to the Part B carrier. We also participate in the Medicaid program, Blue Cross and Blue Shield programs and over 111 managed care programs. Each of these programs has their own requirements for billing, payments, eligibility, medical reviews, but Medicare is by far the most prolific with over 135,000 pages of rules.

The rules by which we must play have become very complex. They result in reams of procedures and require extensive standardization, but Medicare is by far the fastest and best payer that we have today. Yet there can be improvements made in the Medicare system.

Mr. Chairman, we commend the legislation's intent to reduce improper payments. This legislation, however, proposes a wholesale change of the Medicare billing and payment system which may result in unintended or adverse consequences.

As a hospital administrator that deals with Medicare, its fiscal intermediaries, I know increased standardization and improved automation not only would ease the paperwork burden of hospitals but reduce billing errors. Proposed systemic technology change of a program that serves almost 40 million Americans, however, will be incredibly complex. It will be fraught with challenges and it will be difficult to execute.

There are incremental solutions to reducing erroneous claims and assisting providers with the myriad of rules with which we must adhere. We could greatly enhance our ability to submit clean, concise claims to the intermediaries if we had access to the logic for Medicare edits or to a common working file and were able to run electronic claims checks on our bills prior to submission for payment. Currently, the fiscal intermediary returns the bills to us if a discrepancy is found during electronic claims checks, resulting in many more man-hours spent in determining the error and then resubmitting the claim correctly.

We've also found that incremental solutions to some of these problems are more beneficial than full-scale system redesigns. In 1991, the Health Care Financing Administration launched a pro-

gram to do just that, the Medicare Transaction System. Unfortunately, after several years of time and money, the effort has failed. HCFA discovered that wholesale change is extremely difficult, at best, for a system with more than 40 million beneficiaries in a diverse care setting around the country and where rules and system requirements change periodically.

Standardizing practices around the country would also enhance the ability to reduce erroneous claims. Many hospitals, health systems and providers must constantly be aware of the rules under which care can be administered. Even so, some providers, who even follow the rules to the best of their ability, are penalized for events out of their control and for information which they do not have access to.

The Health Information Portability and Accountability Act of 1996 [HIPAA], addresses several of these items in the proposed legislation. It requires the development of standards not only for confidentiality of patient information, but also for a number of common health care transactions involving electronic billing and payments not only to Medicare, but to many of the commercial payers. One of the outcomes we would expect to see as a result of some of these HIPAA standards is fewer improper payments.

AHA is working closely with the Department of Health and Human Services, HCFA and Congress to address concerns about privacy and safeguarding personal information regarding a patient's medical record information. The administrative simplification standards replace the numerous nonstandard formats currently used for certain transactions with a single uniform set of electronic formats.

In conclusion, we understand and agree with the need to reduce erroneous bills and claims, and AHA stands ready to assist. However, wholesale replacement of the Medicare billing system would only add levels of confusion to an already complex situation.

The goals of this legislation of processing claims correctly and accurately and timely is one that we all want to attain. For us, it would mean less manual intervention and time chasing claims, approved efficiency and timelier payments. For the government, it would mean paying an accurate bill in a timely manner and being good stewards of the public's funds.

We can do this by continuing to work with HCFA in assisting in their efforts to streamline the system in a manner that makes sense for patients, hospitals and Medicare.

Thank you very much.

[The prepared statement of Mr. Sparks follows:]

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**Testimony**
**of the**
**American Hospital Association**
**before the**
**Subcommittee on Government Management, Information and Technology**
**of the**
**Committee on Government Reform**
**of the**
**United States House of Representatives**
**on**
**The Health Care Infrastructure Investment Act of 2000**

**July 11, 2000**

Mr. Chairman, I am David Sparks, senior vice president for finance at Providence Hospital in Washington, D.C. I am here today representing the American Hospital Association's (AHA) nearly 5,000 hospitals, health systems, networks and other providers of care. We appreciate this opportunity to present our views on H.R. 4401, the Health Care Infrastructure Investment Act of 2000.

**BACKGROUND**

Providence Hospital is the oldest continuously operating hospital in our nation's capital. We are a 380-bed acute care community-based hospital with a 240-bed nursing home and several primary care clinics. We provide a broad range of services including obstetrics, surgery in many specialties, wellness programs, substance abuse treatment, psychiatry,

radiology, laboratory, physical therapy and cardiology. In many cases we provide both technical and professional (physician) services.

We complete and bill over 108,000 encounters each year, of which 14,000 are inpatient. At any point in time we manage approximately 36,000 accounts. We bill hospital inpatient and outpatient services to the fiscal intermediary for both Medicare Part A and Part B hospital services

We also bill for approximately 70 physicians in many specialties including emergency medicine, anesthesia, primary care, obstetrics and gynecology, surgical assistants and geriatrics. We handle over 50,000 billings annually for physician services, all of which are billed to the Medicare Part B carrier.

For both hospital and physician services we participate in Medicare, Medicaid, and 12 Blue Cross/Blue Shield plans, and have contracts with more than 111 managed care programs. Each program has separate filing requirements to facilitate reimbursement. Many but not all want us to use the standard bill forms, UB92 and 1500. Each payer provides us with manuals and instructions for billing, but Medicare is by far the most prolific with over 130,000 pages of rules. Most payer instruction sets are very extensive, covering topics like eligibility, covered services, medical necessity, certification requirements, and appeal and billing procedures. The rules by which we must play have become extremely complex, engendering reams of procedures and requiring extensive standardization.

The massive tasks for billing for such a high volume of services could not be done without our automated systems. Beginning with registration through the service and charge data collection process and continuing through the coding and billing process, automation is a must. Medicare, Medicaid and Blue Cross have had electronic billing and payment systems for years. They may not always be the best, but improvements can be, and are, made periodically.

Mr. Chairman, this legislation proposes a wholesale change of the Medicare billing and payment system, in an effort to cease improper payments. As a hospital administrator who deals with Medicare, its fiscal intermediaries, and other insurance companies, I know that increased standardization and improved automation of our existing systems would not only ease the paperwork burden on hospital staff, but also reduce billing errors. The proposed systemic technological change of a program that serves almost 40 million Americans, however, will be incredibly complex, fraught with challenges and difficult to properly execute. I'd like to address several factors related to the proposed legislation and its intent within the overall Medicare program.

**MAZE OF REGULATIONS**

Because hospitals and health systems are entrusted with the lives and health of people, we are among the most regulated fields in America. Every day hospitals and health systems submit about 200,000 Medicare claims – that's roughly 72 million per year. In 1997, close to 12 million Medicare beneficiaries received acute care services. For

hospitals to be reimbursed for the care we provide to our nation's seniors we must follow the maze known as the "Medicare Inpatient Hospital Billing System."

Complying with the Medicare billing maze is no small task. In fact, some rural hospitals have almost as many billing clerks as they do beds. In Gonzales, Tex., Memorial Hospital has 25 beds and a billing staff of 20 employees. At Northwestern Memorial in Chicago, the financial services department spends more than 3,200 man hours per month, or 38,400 man hours per year, sorting through Medicare billing requirements alone.

This volume of staff time is necessary because hospitals, health systems and other health care providers must comply with instructions from 43 different Medicare Part A fiscal intermediaries and 28 Medicare Part B fiscal intermediaries.

Hospitals and health systems across the country would like nothing better than to submit clean, concise bills to the intermediaries. There are several reasons why this may not occur, including inadvertent clerical errors during invoice preparation and submission. But, the intermediaries are sometimes part of the difficulty. Our intermediaries perform electronic checks on submitted claims, to ensure that the bills meet all their requirements. If the bills do not comply with the electronic claims check software, the claims are returned to us for corrections. This involves time and effort on the part of our billing clerks who must review the medical record to discover the source of the error. We could greatly improve the accuracy of this provider billing if we had access to the logic for the Medicare edits.

**COMPLEXITY OF THE MEDICARE PAYMENT SYSTEM**

In 1991, the Health Care Financing Administration (HCFA) launched a systems acquisition initiative to replace Medicare's multiple, contractor-operated claims processing systems with a single and more technologically advanced system – the Medicare Transaction System (MTS). The goal of the modernized, single system was to save administrative dollars and simplify implementation of legislative and regulatory changes; enhance HCFA's ability to manage the Medicare contractors by obtaining uniformly formatted, comparable data; and greatly improve the ability to spot, both on-line and after payment, improper billings. While undoubtedly a worthy endeavor, the MTS failed operationally through a series of planning and implementation missteps. At the same time that the agency was attempting to modernize its payment system, its attention was diverted to the year 2000 problems and conversions.

In 1997, estimates from HCFA and GAO put the price tag on the MTS at nearly $1 billion over 10 years. HCFA discovered that wholesale change is extremely difficult at best for a system with more than 39 million beneficiaries in diverse care settings around the country.

**STANDARDIZATION OF POLICY**

In addition to being mindful of Medicare's coding and billing complexities, hospitals, health systems and other health care providers must also be aware of the rules under

which care can be administered. Many of these rules penalize hospitals for events that are not under their control.

For example, a fragile diabetic, having his blood glucose level monitored by his physician, receives all the blood glucose tests allowed under Medicare policy. He then goes to the emergency room with angina. The emergency room physician, noticing that the patient is a diabetic, orders a blood glucose screen. But, because he has already received all the blood glucose tests allowed under Medicare policy, Medicare rejects the bill. First, the emergency physician exercises appropriate judgment when ordering the blood glucose test for the patient. Second, the emergency physician could not have known that the patient already received the allowed number of tests under Medicare policy. He has no system or source with whom to check and thus ensure that he is adhering to Medicare policy.

This hypothetical situation illustrates the rules under which health care providers must operate, and an instance in which an improper bill is submitted. In many instances the left hand does not know what the right is doing - HCFA has rules with which providers cannot comply because they do not have all the information they need. In this instance, the hospital is penalized for an event that is out of its control.

Most information technology systems work better with standardization, resulting in better accuracy, and therefore better service for the beneficiary, the fiscal intermediary and the health care provider. As an example, Local Medical Review Policy (LMRP) of Medicare

can result in a beneficiary in Virginia having a laboratory test considered covered by Medicare if billed to the Virginia intermediary, but not covered if billed to the Maryland intermediary.

**HIPAA ADMINISTRATIVE SIMPLIFICATION STANDARDS**

Requiring managed care payers to follow standard eligibility, billing and payment guidelines would alleviate some problems. The Health Information Portability and Accountability Act of 1996 (HIPAA) addresses part of this by requiring the development of standards not only for confidentiality of patient information but also for a number of common health care transaction involved in electronic billing and payments. When HIPAA is fully implemented, health care providers and insurers will be submitting and processing claims using the same electronic standards.

Hospitals and health care systems spend an inordinate amount of time and resources customizing information for many different payers with different requirements for the form and content of claims. Uniform definitions and standards can make our health care system more efficient. The law mandates:

- Standardization of the software and data elements for claims, claims attachment, remittance transactions and other transactions;
- Standardization of diagnostic, therapeutic and treatment code sets across providers and payers (i.e., ICD and CPT codes);
- Establishment of unique identifiers for health care providers, health plans, employers and individuals;

- Establishment of privacy policies and procedures to control all uses and disclosures of individually identifiable health information; and
- Security safeguards to ensure the integrity and confidentiality of health information, including administrative processes, physical safeguards and technical security services and mechanisms.

In mandating these regulations, Congress sought to reduce the administrative costs and burden associated with health care by standardizing data and facilitating electronic transmission of many administrative and financial transactions. HIPAA's privacy and security standards will have the most significant effect on hospitals, as they require technical and procedural changes for every use and disclosure of individually identifiable health information. The AHA is working closely with the Department of Health and Human Services, HCFA and Congress to address concerns about privacy and safeguarding personal information regarding a patient's medical condition. The administrative simplification standards replace the numerous non-standard formats currently used for certain transactions with a single uniform set of electronic formats.

These information systems regulations apply to all health plans, all health care "clearinghouses" and those health care providers who transmit any health information electronically in connection with the transactions listed in the statute.

**ESTABLISHMENT OF A COMMISSION**

Within your legislation, you also set forth the establishment of a commission to oversee the implementation of the information technology system, and prescribe the various agencies represented on the board. If such a board is to exist, it may be beneficial to have representatives appointed from the health care community – physicians, hospitals and health systems. In fact, rather than having an oversight board for such a complex process, an advisory panel might be established with representatives from the appropriate agencies and industries, including the health care community.

**CONCLUSION**

We understand and agree with the need to reduce erroneous bills and claims, and the AHA stands ready to assist. However, wholesale replacement of the Medicare billing system would only add levels of confusion to an already complex situation. The goal of processing claims correctly and accurately is one that we all want to attain. For us it would mean less manual intervention and time chasing claims, improved efficiency and timelier payments. For the government it would mean paying an accurate bill in a timely manner and being good stewards of the public's funds.

We can do this by continuing to work with HCFA and assisting in their efforts to streamline the system in a manner that makes sense for patients, hospitals and Medicare.

Mr. HORN. Thank you and next is Donald Kovatch, the comptroller of Potomac Home Health Care in Rockville, MD, on behalf of the National Association for Home Care.

Mr. KOVATCH. First, I'd like to thank you for the opportunity to testify related to this bill.

My name is Don Kovatch. I'm currently the comptroller for Potomac Home Health in Rockville, MD. Previously, I worked for a midsized church-affiliated—church and hospital-affiliated home health agency, and prior to that, with a large chain of home health agencies. I'm also a member of the National Association for Home Care's Financial Manager's Forum, the national association of the Nation's largest home health organization, with nearly 6,000 home health Medicare providers.

Home health Medicare claims processing is highly complex, with many technical rules subject to rapid change. Since the majority of home health agencies are small businesses, many are unable to keep up with these changes. I feel that changes can be made to the Medicare system to facilitate more accurate claims submission, allowing home health agencies to continue to provide the stellar care that beneficiaries are accustomed to receiving.

The amount of paperwork required by a Medicare program to submit a claim for a home health agency is enormous. Upon admission to the agency, the home health agency must complete an OASIS assessment of the patient, which often consists of over 120 questions.

Next, the home health agency must complete a HCFA Form 485, which duplicates much of the information on the OASIS assessment. Additionally, all visits to a patient must be tracked, not only by discipline, but also in 15-minute increments and compiled onto a UB–92 bill.

The home health agency is also responsible for obtaining physician signatures, signed on patient orders, prior to submitting a claim to a fiscal intermediary.

Finally, the Medicare bill is submitted. However, it is subjected to medical review by the fiscal intermediary.

The medical review process is often a complex task which seldom results in more than—in additional work for both the home health agency and the fiscal intermediary. In my experience, the most common problems found in the medical review process are bills being sent prior to having an actual doctor's orders received and written. That is not to say that the doctor has not ordered the visits or that the visits not be done, but just the logistics problem with getting the orders back in.

The second issue has been improper notation of end of care on the 485 itself, which again is a logistics problem.

Many of these issues and errors can actually be easily avoided with the following recommendations. If these recommendations are adopted the Medicare claims submissions process will become significantly more effective and streamlined.

First and foremost is capital support for electronic recordkeeping. Under the current Medicare payment system for home health, technology such as point-of-care assessment, electronic billing and care planning are out of the reach of many agencies. This funding would

not only improve the effectiveness of the home health agency, it would also greatly improve patient care.

Second, we'd like to establish a standard for electronic submission of doctors' orders and establish timetables for medical review of claims. This is especially an issue with my agency when it affects our cash-flow and our ability to meet payroll.

Fourth and fifth, we would like to allow for resubmission of technical error claims. A benchmark has already been set for this in the physician arena, where physicians are allowed to resubmit claims that are denied on a technical basis; that's not the case in home health.

And finally, we'd like to be able to directly appeal technical denials instead of troubling the beneficiary with their authorization to do so.

We applaud the chairman and Senator Lugar for putting forth the Health Care Information Investment Act of 2000. Also, we feel the following changes would make the legislation more effective in improving Medicare payment process and patient care: financial assistance to providers to implement electronic capabilities. The systems that home health agencies would require under this bill require often very expensive and at times are out of reach for many agencies. These anticipated costs should be made a part of Medicare reimbursement.

Second, provider representation should be included on the Health Care Infrastructure Commission. We feel that in order for the Commission to be exposed to hands-on experience provider representation should be included on this board.

Again, I'd like to thank you for the opportunity and for your support in home health and for the opportunity to address this legislation. We stand ready to assist you and your staff in all of your efforts, and at this time, I'd be glad to take any questions you may have.

Mr. HORN. Thank you very much.

[The prepared statement of Mr. Kovatch follows:]

**DRAFT**

**TESTIMONY BEFORE THE**

**GOVERNMENT REFORM SUBCOMMITTEE ON GOVERNMENT MANAGEMENT INFORMATION AND TECHNOLOGY U.S. HOUSE OF REPRESENTATIVES**

**July 11, 2000**
**10:00 a.m.**

**Presented by:**

**DONALD KOVATCH**
**Comptroller**
**Potomac Home Health Care**
**Rockville, Maryland**

**on behalf of**

**THE NATIONAL ASSOCIATION FOR HOME CARE**
**228 7TH STREET, S.E.**
**WASHINGTON, D.C. 20003**
**(202) 547-7424**

Thank you the opportunity to testify on issues related to Medicare Claims Processing and inappropriate payments that are due to the complex operation of the Medicare program. The National Association for Home Care appreciates the opportunity to present our recommendations to streamline and integrate Medicare's claims processing system. The National Association for Home Care (NAHC) is the nation's largest home care organization, representing nearly 6000 Medicare participating home health agencies (HHAs), including not for profit providers like the Visiting Nurse Associations, for profit chains, hospital-based agencies, government based home care programs, and freestanding providers.

NAHC has serious concerns with the Medicare claims processing system. With constant changes combined with extraordinarily complex and technical rules, home health agencies rarely have sufficient resources or access to capital that can provide the capability to operate within 100 percent compliance while meeting their obligations to employees, contractors, as well as the Medicare program. The issues presented as a result of the complexity of the Medicare program may not be fully solvable, but adjustments can be made as to accuracy of the claims submissions and processing systems.

Overwhelming Paperwork Complexity and Burdens

The process of developing and submitting claim for payment under the Medicare home health benefit is essentially a Herculean task that must be undertaken by providers of care subject to Medicare reimbursement standards generally provide less than cost payment for care. In order to initiate a claim for payment under the Medicare home health benefit, a home health agency must not only comply with the conditions of participation which are intended to secure quality of care, but also paperwork intensive forms completion. That claim process begins with a patient assessment using a tool entitled the "Outcome and Assessment Information Set" ("OASIS") which involves the completion of a set of blank questions for each patient. The OASIS assessment form must be completed at the time of admission, whenever there is a significant change in the patient's condition, and prior to rectification of continuing care every 60 days.

In addition to the OASIS form, a home health agency must complete an HCFA Form 485 which contains some of the same information that is set out in the OASIS questionnaire, but also represents the plan of care for the patient. This form involves blank fields of information.

Once care is initiated, a home health agency must track not only the visits of staff to the patient, but also the length of each visit in a 15-minute time increment. The visits and the increments of time, on a per discipline basis, must be included on the uniform billing

instrument, UB-92, the document which is considered the claim for payment to the Medicare program.

Under existing Medicare rules, no claim can be submitted to the Medicare program until the home health agency has obtained signed and dated written orders from the prescribing physician. With these orders, the physician must certify that the patient meets the standards for Medicare coverage and that the patient is confined to the home and in need of skilled nursing care on an intermittent basis or some form of therapy. Where care is required on a daily basis for some term, the physician must set out that the daily care is required for a finite and predictable end point, setting out that end point on the HCFA Form-485. A home health agency has no control over when a physician actually commits a signature and date to the written order thereby causing endless delays in the billing process.

Once a claim is received by the Medicare program, it is often subject to medical review by the Medicare contractor. Medical review requires a home health agency to submit copies of the full care record, including the aforementioned documents, daily clinical charts, and any other documentation related to the care of the patient. When a claim is subject to medical review, there are no time frames with which the Medicare contractor is obligated to complete review and processing.

Home Health Care Claim Errors are Limited and Preventable

The recent analysis of Medicare claims processing performed by the HCFA Office of Inspector General concludes that the small percentage of home health care claims that are paid in error are those which relate generally to one of the many paperwork oriented technicalities in the conditions for coverage. Specifically, HCFA analyzed those home health claims reviewed by OIG and found that the vast majority of the erroneous payments related to two technical areas of Medicare coverage. First, claims may have been erroneously paid because a home health agency submitted a bill prior to a receipt of signed and dated orders for all service rendered during the billing period. With these claims, there was no dispute that the care was ordered by a physician, received by a patient, and that the care was consistent with the needs of the patient's condition. Instead, the claims were flawed in that they were submitted either prior to a receipt of signed and dated orders by the physician or submitted with some level of technical error related to the signature or dating of that order. Home health agencies have experienced claim denials where the date stamp utilized by a physician's office did not indicate that the stamp originated out of the physician's office. Generally, these technical claim denials are successfully appealed within the Medicare administrative appeals process at a tremendous cost of time and financial resources for both Medicare and the provider of services.

The second area of error in Medicare home health claims is the absence of a finite and predicable end point for daily care properly noted on the HCFA Form-485. Even in circumstances where the care rendered is clearly time limited, the technical requirements

for Medicare claims leads to the issuance of a coverage denial because the particular box on Form-485 has not been completed with the entry of an end point for daily care.

Most of the errors noted in the review of Medicare claims of payment are avoidable and preventable with adequate support and some administrative changes as listed below.

RECOMMENDATION: NAHC recommends that this committee support the following changes to the administration of the Medicare home health benefit. If adopted, these recommendations will help streamline the Medicare claims submission process and achieve significant efficiencies for the Medicare program and its participants.

1. Provide Capital Support for Electronic Recordkeeping.

   With the severe restrictions on Medicare reimbursement, Medicare home health agencies have gradually stumbled into the electronic age. It is well within technical capabilities for a home health agency to operate with electronic point of service patient assessment, care planning, claims development, and billing submission. However, home health care needs financial support to make this leap. With a heightened electronic operation, the technical based errors in claims submission can be immediately noted at the contractor's claim editing level and corrected with relative ease. With an electronic linkage between the home health agency, the patient's physician, and the Medicare contractor, the efficiencies of claim development processes can be demonstrably improved.

2. Establish Clear Standards for Electronic Authorizations by Physicians.

   While HCFA does recognize the validity of electronic physician authorizations, Medicare contractors impose varying standards and non-uniform acceptance.

3. Establish Timetables for Medical Review of Claims.

   Medicare contractors are not obligated to complete the medical review of a pending claim within any specific timetable. As a result, home health agencies are often forced to rely on expensive lines of credit to meet payroll and other expenses, if those lines of credit are even available. Where no lines of credit are available, home health agencies continue to operate only with the good graces of their staff who are willing to wait for their paychecks.

4. Allow Resubmission of Technically Erroneous Claims.

   Current HCFA standards provide that a technically erroneous claim for home health services results in a claim denial that can be reviewed only through a formal administrative appeal. HCFA allows a resubmission of technically flawed claim for some types of health care providers, including physicians.

Allowing the resubmission of a corrective claim can avoid the unnecessary expense of a formal appeal.

5. Provide Authorization for Direct Provider Appeals.

The technical claim denials discussed herein are not subject, under current law, to a direct appeal by the affected provider of services. Instead, the provider of services must secure authorization from the Medicare beneficiary involved, allowing that provider to represent a provider in an appeal of that claim denial. Only a beneficiary has a right of appeal despite the fact that beneficiaries may have no actual financial liability for the claim denied on a technicality.

## II. HR 4401, the "Health Care Infrastructure Investment Act of 2000"

NAHC and its affiliates applaud the efforts of Senator Richard Lugar (R-IN) and Chairman Horn (R-CA) for proposing the Health care Infrastructure Act. Such legislation would have a profound impact on HHA's ability to determine coverage eligibility, ensure proper payment, and allow for point of service dispute resolution that will safeguard a beneficiaries ability to receive needed services. NAHC, however, has identified several concerns with the legislation that we hope can be addressed prior to its passage.

### A. Financial Assistance to Providers to Implement Electronic Capabilities

H.R. 4401 encourages the use electronic capabilities to pay claims, transfer data and ensure coverage eligibility. While home health agencies have substantially moved to electronic transactions, continued changes in documentation responsibilities and advancements in technology challenge the ability of home health agencies to maintain up-to-date systems. In addition, the transition of Medicare home health services to a prospective payment system in October 200 will require wholesale revisions in billing, documentation, data needs, and data analysis.

The purchase of multi-purpose integrated clinical and financial systems with multiple capabilities require a significant capital investment. Traditionally, small business loans have not been available to most HHAs because they are not viewed as good credit risks. Many are dependent on Medicare for a majority of their revenue. With Medicare reimbursement covering less than the actual cost of services, keeping pace with technology needs is beyond the financial capabilities of many HHAs.

Any recommendations made under H.R. 4401 should include an analysis that determines the cost of such recommendations to providers. These costs should be made part of any Medicare reimbursement to ensure compliance with the new proposals. At a minimum, financial support and incentives such as small business loans, tax incentives, grants from the Medicare program, and other support to encourage and facilitate the implementation of newly mandated electronic capabilities.

B. Provider Representation on the Health Care Infrastructure Commission

The centerpiece of H.R. 4401 is the establishment of a Health Care Infrastructure Commission that will design and implement an advanced informational infrastructure for the administration of federal health care programs. Under the bill, the seven member Commission will be made up of appointees from various governmental agencies and to be chaired by the Secretary of Health and Human Services. Despite being charged with making dramatic and far-reaching changes to Medicare reimbursement and financial management, not one Medicare provider will be represented on the Commission. If the Commission hopes to succeed, the inclusion of a health care provider who can provide "real life" experience with the Medicare claims processing system, is essential.

Mr. HORN. Our next presenter is Arthur Lehrer, the senior vice president, VIPS, Inc. You might explain what V-I-P-S means in this context.

Mr. LEHRER. V-I-P-S is simply the name of our company. It no longer has an acronym meaning behind it.

Mr. Chairman and members of the committee, I'm pleased to be here on behalf of my company and to comment on the proposed bill, H.R. 4401. I will summarize my written statement in some fairly brief comments.

The processing of Medicare Part B claims is faster and much more efficient than 30 years ago. In fact, the cost of processing a Medicare Part B claim 30 years ago averaged approximately $3 per claim. Today, after 30 years of inflation, most carriers process a Part B claim for less than $1.

The current environment supports electronic and paper receipt of claims. Services are audited, services are edited. Medicare coverage provisions are automatically checked. More than 80 percent of all of the Part B claims are received electronically, as Dr. Christoph noted. The overwhelming majority of these claims are processed from start to finish without human intervention. In fact, approximately 85 percent are adjudicated within 2 to 3 days. After that time, the claims are intentionally held for approximately 12 more days before payment is issued. This waiting period is commonly referred to as the "payment floor."

The question that gets asked most frequently is, were the claims processed correctly, and it's where I want to spend some of my time. The best I think we can say is that based upon the information presented on that Medicare claim, the claims were technically paid correctly.

We in the claims technology business have built complex editing and auditing modules. Those who are involved in provider practice management systems have spent the same time building systems that edit those claims prior to submission, designed to pass those edits of claims systems.

A clean claim as defined by HCFA and by Congress is not necessarily a legitimate claim. The rules to create a clean claim are well-known and documented. The challenge for the health care industry in general and Medicare Part B program specifically is to determine if, in fact, the services represented on the bill were actually performed as stated for the reasons indicated to the beneficiary identified. If everything on the claim is filled out properly, a system that makes payment decisions, as the one being proposed, with split-second speed may have less chance of detecting attempts to defraud it. The cost of recovering improper payments is far greater than the cost of preventing the payment in the first place.

My company has developed technology that takes advantage of the time that claims wait on the payment floor to statistically review aberrant payment patterns and prompt human review where appropriate.

My remaining comments will be divided into three areas: improper payments, the deploying of technology and confidentiality, and a couple of general comments on the actual Commission organization.

As proposed, the system would be designed in such a way as to provide real-time claim processing. I suggest that, as presented, it brings technical innovation that is desperately needed to the Medicare community, and it would provide for much more rapid disbursement of payment to providers. If the goal of the bill is to reduce improper payments, we would recommend that the Commission consider during its study designing or selecting prepayment audit and antifraud technology to guard against improper payments. We would also recommend mechanisms to prequalify providers and suppliers, based upon prior experience with those providers and suppliers.

If, on the other hand, the goal of the bill is simply to reduce the time to payment, then we would recommend that the payment floor be suspended.

Patient confidentiality is a critical topic. It has been the subject of many discussions regarding use of the Internet and other standard identifiers. At the same time, technological solutions must be developed to allow the split-second processing of these claims transactions while protecting the integrity of the Medicare program. These are not necessarily compatible objectives.

If the Commission is to proceed as proposed, we would recommend representation from HCFA's technology group. We would believe that this bill could develop and complete the activities intended, it can be accomplished technically; our concern is that if we spend 3 years designing it and 7 more implementing it, we will have an outdated solution when we're finished.

We should be equally concerned that we have the right objectives and we've crafted the right solution to meet those objectives.

I'd be pleased to continue to work along with you and your committee, Mr. Chairman, in providing information as you proceed. Thank you.

Mr. HORN. We thank you.

[The prepared statement of Mr. Lehrer follows:]

***Testimony of Arthur Lehrer, Senior Vice President, VIPS, Inc.***

Before the Subcommittee on Government Management, Information, and Technology

Mr. Chairman and Members of the Committee:

I am pleased to be here to comment on your proposed bill, which seeks to eliminate the ongoing problem of improper payments in the Medicare system by deploying an innovative, fully integrated information technology system. There have been significant changes during the thirty years in which I have been involved with the Medicare Program. The processing of Medicare Part B claims is faster and much more efficient than thirty years ago. In fact, the costs of processing a Medicare Part B claim thirty years ago averaged $3.00 per claim in most carrier operations. Today, after thirty years of inflation, the actual cost of processing a Medicare Part B claim is less than $1.00 in most carrier sites.

However, based on my experience, I cannot state as emphatically that the accuracy and quality of Medicare Part B claims processed today is even modestly better than it was years ago.

The current Medicare claims processing environment supports the electronic or paper receipt of claims. Claims are then edited for face validity. Beneficiary and provider eligibility are verified. Services are audited to prevent duplicate payments. Medicare coverage provisions are automatically checked. Clinical rules are applied to ensure the appropriateness and extent of care being billed. Based on these edits and audits, the services are either paid or denied. The provider and beneficiary are notified, and the claim is considered completed.

More than 80 percent of all Part B claims are received electronically today. The overwhelming majority of these claims are processed from start to finish without human intervention. In fact, approximately 85 percent are adjudicated within 2 to 3 days. After that time, the claims are intentionally held for approximately twelve more days before payment is issued. This waiting period is commonly referred to as the Payment Floor.

The question that gets asked most frequently is: were the claims processed correctly? I suggest that the best we can say is that, based upon the information presented to the Medicare claims systems, the claims were *technically* paid correctly. We in the claims technology business have built complex editing and auditing modules, systems, and infrastructures. Those responsible for provider practice management systems have spent the same time building the capability to submit healthcare claims that will pass all of the edits and most, if not all, of the audits.

A "clean" claim is not necessarily a legitimate claim. The rules to create a clean, processable claim are well known and documented. The valid places of service, acceptable procedure codes for appropriate diagnosis codes, medical conditions that warrant use of durable medical equipment — the clinical and administrative rules are well documented.

The challenge for the healthcare industry in general, and for the Medicare Part B program specifically, is to determine if, in fact, the services represented on the bill were actually performed as stated, for the reasons indicated, to the beneficiary identified. If everything on the claim is filled out "properly," a system that makes payment decisions with split-second speed may have less chance of detecting attempts to defraud it. In fact, my company has developed technology that takes advantage of the time that claims wait on the Payment Floor to look for

statistically aberrant payment patterns, and prompt human review before allowing a check or electronic payment to be issued.

My comments regarding the proposed legislation will be divided into three areas. First, issues related to reducing improper payments. Second, issues directly related to deploying technology while protecting the confidentiality of personally identifiable health insurance data. Finally, potential recommendations related to the proposed organization and timetables.

### *Reducing Improper Payments*

As proposed, the "system" would be designed in such a way as to provide real-time claim processing and payment. I suggest that the bill as currently presented would bring technical innovation to the Part B Medicare claims process and, because the bill places a moratorium on delayed payments, it would also provide for much more rapid disbursement of payments to providers.

If the goal of this bill is to reduce improper payments, then some specific additional protections should be considered for inclusion in its language. For instance, we recommend the following:

- Require the Commission, during its study, to design and/or select multi-faceted pre-payment audit and anti-fraud technology to guard against improper billings.
- Register and pre-qualify providers and suppliers for participation in this program.
- Require that providers and suppliers must submit to thorough post-payment audits on a random or focused basis.

- Require that providers and suppliers first demonstrate the integrity and accuracy of their billing patterns for a period of time prior to being admitted into this real-time payment program.

On the other hand, if the goal of this bill is to reduce the time to payment, then perhaps the moratorium on delayed payments (the Payment Floor) is all that is needed.

### *Enabling Technology while Ensuring Protections*

The "system" must protect patient confidentiality. This issue has been at the heart of many current discussions regarding use of the Internet and standard identifiers. At the same time, technological solutions must be developed that allow split-second processing of claim transactions while protecting the integrity of the Medicare Program. I believe that for this bill and its resulting "system" to be successful, the following should be considered:

- Develop a separate unique beneficiary identifier — not tied to a Social Security Number — that can be cross-referenced once the carrier has received the claim transaction. Medicare beneficiaries currently have Health Insurance Claim Numbers (HICNs) as their personal identifier. For most beneficiaries, the HICN is comprised of their Social Security Number (or their spouse's) and a suffix. Use of the Social Security Number potentially puts the beneficiary's privacy at risk in an all-electronic networked environment.
- Implement the National Provider Identifiers (NPI) and National Payer Identifiers (Payer ID), both previously required as part of the HIPAA legislation.
- Enable real-time access to HCFA's master file of patient history records for duplicate payment checking and medical review audits. This requirement will be part of an overall design strategy for enabling immediate claim processing.

It will include direct access to a full patient history, including both Part A and Part B services, so that a claim transaction may be reviewed in the complete context of the patient's claim history.

### *Proposed Commission and Timetables*

As proposed, the bill provides for a Commission with new and diversified points of view. I certainly can see the benefit and wisdom of this approach to mitigate "Inside-Out" thinking. I am concerned, however, that the Commission ensure that sufficient knowledge of the current policies, practices and requirements exists within the Commission such that change is embraced for the right reasons.

- I would like to see representation from HCFA's Technology Group.
- If the Commission were opened beyond Government, I would like to see representation from the provider community.
- I think this new system could be rolled out faster than planned in the bill. One concern related to timing is an issue of technical environments. To design a solution over a three-year period, and then allow up to seven more years for implementation, is to guarantee that our solution will be technologically outdated when we finish.

In my opinion, the current Medicare Program is not that far away from the desired capability. Given the direction and responsibility, HCFA could work towards the accomplishment of this objective. The agency could potentially support immediate claim processing through a demonstration project in a focused area of the country, or in a specific carrier jurisdiction. While it would require some modifications to existing infrastructures and networks, it could be very useful in assessing the value proposition of immediate claim processing.

### *Conclusions*

The Medicare Program is a critical pillar of our complex national healthcare structure. It is imperative that it continue to serve the needs of the beneficiaries it insures and the providers and suppliers responsible for the care of those beneficiaries. Eliminating improper payments in the Medicare system through the development and implementation of a fully integrated immediate claims processing information technology system is a goal that should not be compromised.

It is imperative, however, that we recognize the inherent conflict between making claims easier and cleaner for processing, while equally protecting the system from fraudulent access. Finally, we must also ensure that we build and plan for flexibility and scalability. Today's technology allows for much more rapid development and deployment of systems; we should be prepared to take full advantage of this reality. I would be pleased to continue to work along with you and your Committee in providing information as you proceed.

Mr. Chairman, this concludes my prepared statement. I would be happy to answer any questions you or the Committee members may have.

Mr. HORN. And our last presenter is Mr. Robert Hicks, the chairman and chief executive officer of RealMed, based in Indiana.

Mr. HICKS. Thank you, Mr. Chairman. Good morning.

My name Robert Hicks. I'm chairman and CEO of RealMed Corp. We're an Internet-based, business-to-business health care technology company located in Indianapolis, IN. I greatly appreciate the opportunity to speak to the distinguished members of the House of Representatives Subcommittee on Government Management, Information, and Technology.

I also have submitted our remarks. I will not just read them. I will probably highlight them for you and then explain the testimony.

I'd also like to thank Senator Lugar and Congressman Horn for their leadership in exploring ways to deploy new technology to create efficiencies and cost savings for the Federal Government through H.R. 4401, which we've been discussing today.

RealMed is a company which was founded with the idea of fixing something that was broken. We evaluated first the private health care claims industry in the United States and decided that the disparate steps that are required to process health care claims was basically a broken system. Parts of it were improving, parts of it were not.

Our company today has about 200 FTEs, 160 employees and 40 contractors, working full time on implementing our solution on a nationwide basis. When we founded the company back in 1996, there were a number of questions we posed to look at and say: How can we make this system better?

We asked, What if the resolution of a health care claim occurred in seconds at the point of care and was painless due to its simplicity; wouldn't that benefit the payer, the provider and the member?

What if the burdensome cost of health care claims administration could actually be reduced by 50 percent without requiring any replacement of existing systems or significant infrastructure technology investments by a payer and/or provider?

What if you could deliver an EOB, or explanation of benefits, to a patient in seconds at the point of care while they were still standing in the office and could remember the services which were actually performed?

What if providers could be told when they would be paid, and receive their money in less than a week, much like a merchant does today when they sell a shirt out of their store and they receive their reimbursement for a credit card payment?

What if we could actually help reduce fraud and completely eliminate errors in submitted claims, based on the system?

RealMed set about to trying to solve that issue, first for the private sector, and is now looking at doing this in the Federal Government sector. In 1999, we went live with our first—or what we believe to be the Nation's first Internet-based electronic claims resolution aired platform. What that means is we do four basic things in our system today.

We do real-time claims eligibility, which means we access the payer's data bases with up-to-the-minute information and that takes about 5 seconds. We actually submit the claim from the provider's office, the provider does, and sends it against the claims en-

gine of the payer system. So it does not replace or replicate their claims engine; it actually utilizes their existing infrastructure.

A message is then sent back to the provider, which enables the provider to know whether the claim is going to be resolved, whether it's going to be pended on the payer's system for further review or whether it will be rejected. Then an explanation of benefits appears which can be delivered to the patient so the doctor can actually collect from the patient, or at a minimum, it allows them to tell the patient how much is owed on behalf of that bill.

We have five major clients today which include Anthem Insurance Co.'s, which is the dominant payer in about 8 States; CareFirst, which is right here in the District of Columbia, Maryland, northern Virginia and Delaware; Healthcare Services Corp., which includes Blue Cross-Blue Shield of Illinois and Texas; North Carolina Blue Cross; and importantly, Mr. Horn, WellPoint out in California.

We are rolling our system out in major cities across the country on a private basis first and are intending to look at a pilot program with HCFA to prove that this could work. We do not believe we will be a sole source provider. We believe there are several others working on similar solutions that will be competition for us.

Our system effectively allows the physician's office to work directly with the payers, in this case, potentially a fiscal intermediaries system, and allows them to correct claims before they're submitted. It does not allow them to gain the system. It does ensure confidentiality, and that would have to be further detected and studied in the committee, but it effectively allows the provider to input the claim and fix it, correct any errors and submit it online. It also allows the payer to send messages back to the provider to tell them what's wrong with the claim and also to send other messages, i.e., sending them a real-time message which also is intended to help improve the claims resolution process and the delivery of messages from the payer.

Our system does not replace infrastructure. It doesn't need to. I guess the point is, we don't need to say that we will be replacing a system. Whatever HCFA would be doing could continue and this is simply an integration into that system, much like the ATM network or the Cirrus Plus network integrates with mainframe legacies systems at a bank.

We attempted to parallel our system with how the ATM network was built. We found five early adopters of the technology wanted to examine a proof-of-concept phase where we could actually go out and show that it works, which is a technology proof of concept. It's also a business model proof of concepts, i.e., will the provider use this system, will they actually invest in a computer when in many cases they don't have it today?

It is a challenge, but to get them electronically connected, a couple of things needed to happen. There needed to be an Internet revolution, which we're experiencing today. There also needed to be a technology expense reduction so that the average cost of a computer today is probably one-third of what it was 4 years ago; and that's an important thing to know, that providers will have the technology infrastructure to be able to make a system like this work. We think that's an important consideration.

We agree with every one of the panelists that Medicare claims have reduced in cost over the past several years and probably is the least expensive and potentially the quickest payer. It also tends to represent the highest number of claims in any doctor's office that we work with, and for that reason, the doctor's care greatly about reduced paperwork on that number of claims.

The fraud reduction aspects of the bill, I think, are extraordinarily important. Claims administration savings are an important component. They pale in comparison to the fraud reduction expenses that can be saved, to the extent our system could actually affect that type of problem.

How does a system which delivers an explanation of benefits or a statement of services to a provider—I'm sorry, to a member—actually help reduce member fraud—provider fraud, excuse me. Delivering an explanation of benefits to a member or a patient while they're in the office and can remember the services that were provided would potentially eliminate many claims that could be submitted by a provider that are not real.

In addition, various digital certification methodologies, identifications and the use of some form of a "smart card" or a "swipe card" can also help, much like in the credit card industry, identify that that person is actually the person who they're supposed to be. The use of a driver's license along with that card would also be a very useful verification. So we believe that this could have a major impact on the fraud reduction goals of the bill.

There are numerous studies that have occurred on how much claims cost, how much the loss of float would cost the government by paying faster. In our experience in the private sector, we find that the administrative savings are generally about three times as great as the loss of float. We don't anticipate that it would be as great of an impact for the Federal Government because they do it more efficiently. We do believe, however, the fraud reduction—because in the Federal Government it's such a greater significant issue, we think we could have a major impact, or this solution could have a major impact in the Medicare arena.

I will be available for questions, and I too would offer our support to work with the committee on any further discussions that they'd like to have.

[NOTE.—The publication entitled, "Solutions for the New Pace of Healthcare," may be found in subcommittee files.]

[The prepared statement of Mr. Hicks follows:]

Remarks by Robert J. Hicks, Chairman and CEO, RealMed Corporation

Good morning, my name is Robert Hicks. I am Chairman and CEO of RealMed Corporation, an Internet-based, business-to-business healthcare technology, connectivity and commerce provider. I greatly appreciate the opportunity to speak to the distinguished members of the House of Representatives' Subcommittee on Government Management, Information and Technology.

I would also like to thank Senator Lugar and Congressman Horn for their leadership in exploring ways to deploy new technology to create efficiencies and cost savings for the federal government through House Resolution 4401, the Health Care Infrastructure Investment Act of 2000.

RealMed Corporation was founded with the idea of repairing the claims resolution portion of the badly broken health care system in the United States. We posed a number of questions to help set the vision for creating a revolutionary technology. We asked:

What if the resolution of a health care claim occurred in seconds at the point of care and was painless due to its simplicity?

What if the burdensome cost of health care claims administration could be cut by 50 percent without requiring any replacement of existing systems or an investment by a Payer or Provider?

What if an Explanation of Benefits could be delivered to a patient in seconds at the point of care?

What if Providers could be told when they would be paid and receive their money in less than one week?

What if we could help reduce fraud and completely eliminate errors in submitted claims?

In 1999, RealMed developed the nation's first electronic claims resolution technology and payment network in the U.S., and as a result, transformed the lengthy and frustrating process of fully resolving and paying health care claims at the point of care in seconds. We then began the process of signing agreements with large Payer organizations such as: Anthem Insurance Companies, Inc. (owns BCBS organizations in eight states), Blue Cross Blue Shield of North Carolina, CareFirst (BCBS for Maryland, D.C., Delaware and northern Virginia), Healthcare Services Corporation (BCBS of Illinois and Texas) and WellPoint.

In early 2000, after completing a successful integration process, we deployed our technology with Anthem Insurance Companies. Anthem and Providers throughout Indiana (as a part of a staged roll-out over a six-to-twelve month period) have been using the RealMed product and network for three months and over 1,500 claims have gone through the RealMed Network. During the next six months we will go "live" with three more of our Payer clients, and with WellPoint in early 2001.

Our system and network allow us to streamline the ways that health care claims are currently processed, resolved and paid for private Payers. As you can see from the charts that we have provided to you, the RealMed solution cuts the number of steps in the current process by approximately two-thirds. This illustrates the fact that the technology exists and is being utilized today.

What RealMed has done in the healthcare information technology world very closely parallels the development of the ATM network. Back in the early days of development of the Cirrus and Plus network, five major banks made large investments to ensure the development of a user

friendly system that benefits the financial services institutions (through cost savings) and customer (easy to use and available 24 hours per day, 7 days per week). The ATM technology and infrastructure has helped spawn many new ways to complete electronic transactions. We believe the same thing will happen in the health care industry.

We understand many of the key issues currently impacting the Health Care Finance Administration because they are the same issues currently challenging private Payers. We have consistently heard from our Payer customers that fraud and errors in submitted claims are some of the biggest challenges.

In the book "License to Steal," author Malcolm Sparrow draws a comparison between fraud in the credit card industry and Medicare/Medicaid. The fraud rate for Visa has consistently been at .1% or less while the General Accounting Office has suggested that fraud rate in Medicare/Medicaid is 10% or higher, which is one hundred times the fraud rate on credit cards. Fraud can only be detected by what is seen. In other words, if you do not have a system that catches what might be fraud and/or an error on a submitted claim on the front-end of the process, you might never find it.

In addition, Providers utilizing our system realize that our network has fraud and error detection measures, a tracking system, and is tied into the legacy computer system of Payers. As a result, most people will be deterred from trying to commit fraud. It is important to note that the vast majority of all Providers do not engage in fraudulent business practices. With our system, Providers and patients receive an Explanation of Benefits (EOB) at the point of care which allows them to review all treatment and related charges while it is fresh in their mind. The EOB is also provided to the Payer through their computer system. Our understanding is that currently

Medicare recipients only receive an EOB if they are responsible for a co-payment or if their claim is rejected. This creates an environment where the patient is uninformed about their medical treatment and removes another "check and balance" step in the system.

In 1995, GAO recommended the adoption of technology and software to begin the process of catching errors and reducing fraud. It was estimated that a $20 million investment at that time would lead to the saving of hundreds of millions of dollars for the federal government in reduced claims processing and resolution costs, and reduction of fraudulent claims being paid. Unfortunately, these recommendations were not fully implemented resulting in lost cost savings and minimal fraud reduction for the federal government.

Reduction in errors is also vital in terms of reduced costs for the processing and resolution of claims. Based upon a number of national studies, 20-30 percent of all submitted healthcare claims have at least one error. When a claim is submitted with errors it typically gets kicked out of the system and sent back to the provider without any explanation other than saying there is an error. As a result, the Providers office has to try to figure out the error, remember the patient's visit and treatment and re-submit the claim. The costs to re-submit, process and resolve a claim are incurred again by the Provider and Payer creating more inefficiency (time and money) in the health care system.

One of the first questions posed by our Payers revolved around the loss of the "float" and the financial impact on their organization. We were able to demonstrate that the cost savings and efficiencies gained by utilizing the RealMed system through the elimination of errors, reduction of fraud, reduced paper, printing and postage costs, and less stops along the way, far exceeded

the loss of the "float." One of our Payer clients estimated that on an annual basis they would save more than three times what they would have made from the "float" derived from not paying claims as quickly.

Clearly, the federal government should eliminate the mandatory time delay in the payment of Medicare claims for three key reasons: to create a more user-friendly and efficient system for patients, to realize significant cost savings through the reduction of fraud and elimination of errors in submitted claims, and for Providers to be paid in a more timely basis. We believe this is an issue that merits study to ensure that all parties impacted by the changes brought about by new technology are appropriately considered. We also believe the technology exists today to implement a streamlined system throughout the Medicare program within five years to benefit Payers, Providers and patients. As Harvard Professor Regina Herzlinger stressed in her book "Market Driven Healthcare", it is vital to utilize technology to empower all groups impacted by the health care system in the United States.

Thank you again for the opportunity to testify today. I am happy to answer any questions you have.

Mr. HORN. Well, thank you very much. That's a very helpful presentation.

We're now going to go to questions from the Members. There will be 5 minutes for each of us and then we'll alternate between the majority and the minority. So let me start in for the first 5 minutes.

Mr. Christoph, I was particularly interested in—divisions, I don't think, between you and Senator Lugar and myself are that far apart, but your comment was particularly pertinent, I think, that replacing a computer network as large as the Health Care Financing Administration too quickly could result in another debacle; and I think that's a point well taken.

Have you prepared a master plan for your Health Care Financing Administration project that includes key tasks and milestones and timeframes?

Mr. CHRISTOPH. Yes, sir. In the sense that we have prepared an IT vision, we have laid out the broad plan of where we want to take the agency's information technology. We don't have a set of time lines or plans that are in that level of detail.

As you're aware, we've spent the last several years working very hard on Y2K, and some of these efforts have had to take a back seat to that effort, but we have laid out a 30,000-foot view. We're in the process of taking that down to a lower view. Our friends at GAO have been very careful to ask us to develop integrated project plans and to go to that level of detail.

We have engaged in a variety of incremental projects at the lower end as we start experimenting to try and achieve some of the goals, and for those, we do have timetables and plans. For example, we've developed a beneficiary data base prototype which we expect to be operational as a fully implemented system, one integrated place for all the beneficiary information, within about the next 8 to 10 months.

Pieces are on schedule to be built into this, but for an overall time line, I can't answer that because some pieces of the picture we have sketched out are only now being painted in in detail. So as we proceed, we will be finalizing that and developing more careful plans.

Mr. HORN. Well, how specific are some of your tasks or milestones?

Mr. CHRISTOPH. Some are very specific, down to, you know, what data elements will be in data bases, when those will be delivered. Eight to 10 months is to have that prototype operational, and this is a departure from the present legacy kind of data bases that we have. It relies on modern technology, relational data bases and essentially instant access to any of the utilities or applications that need to drive that data.

Mr. HORN. In terms of how you pay for the computerization and recomputerization, that needs an appropriation, doesn't it? It doesn't come out of the people's premiums for Medicare. It acts like Social Security, and that's what we modeled it on; is that correct?

Mr. CHRISTOPH. That's correct. We have an administrative budget which—the payments for the health care come out of the trust funds, and there is a separate appropriation for our administrative

budget, and that's what pays for whatever management of the current program or any improvements.

Mr. HORN. What's your estimate on what this might take to update your whole computer system?

Mr. CHRISTOPH. What we are trying to design is an architecture that is not built of—we don't want to replicate existing stovepipes either with new stovepipes or bigger stovepipes. What we're trying to design is a system which is continually evolving as technology evolves. In that sense, it's kind of hard to put an overall price tag on it. To renovate some of these very large systems certainly will cost in the hundreds of millions of dollars.

As one of the other panelists pointed out, the regulations and the rules that govern Medicare are extremely complex, and these systems are unlike any of the commercial systems that are out there that health insurance companies use. So it will be very expensive to build completely new systems; and again, as something that's being done over time and incrementally, we won't know exactly what the final outcome will be for the whole system.

Mr. HORN. When you impose new requirements on the providers and the carriers or the HMOs, does the agency ever give them updated software?

Mr. CHRISTOPH. We provide—we make available to providers free or low-cost software so that they can electronically submit claims. The main claims processing software that we use, of course, is operated by the carriers or intermediaries. We provide other information to the providers. We publish the rules and the tables and the payment, the codes; all of those things are made available. We want to facilitate as much as possible the providers' ability to submit good, clean bills.

Mr. HORN. Are there intermediaries that the Medicare administration doesn't really feel that they're doing the job they should do? And what can you do about it?

Mr. CHRISTOPH. We have—since the program's inception we've relied on carriers and fiscal intermediaries to do essentially all of our claims processing work. We've outsourced, in essence, the main line of our business, which is the claims processing.

We've been struggling within the last few years—and Y2K helped us immensely in that—to get a handle on exactly what happens at the carriers and fiscal intermediaries. I can say that we have developed a much clearer picture of how claims are processed. We have established finer grains of control.

Yes, I would say that some fiscal intermediaries and carriers are more proficient at performing their tasks than others. The larger ones certainly have more IT resources and more ability to operate, but I'd hesitate to beat up on any particular one.

I think what we need to do is to provide increased oversight, more involvement in the process. As you're well aware, the more attention you pay to an activity, the more attention the people who are performing the activity pay to it as well, and they do a better job. We've been trying to do the same thing with our carriers and fiscal intermediaries.

I think that's the answer, for us to simply pay better attention, and as a consequence, we'll manage them better.

Mr. HORN. Thank you, and I have exceeded my time so the gentleman from Texas has 7 minutes for questioning.

Mr. TURNER. Thank you, Mr. Chairman.

Dr. Christoph, you were referring to your 26 carriers or intermediaries. Are there some things that we could do to encourage those intermediaries to adopt better technology, things like Mr. Hicks is talking about? Are there some ways we could encourage that?

I mean, obviously you've alluded to the fact that there are some intermediaries that are doing a lot better job than others. You didn't want to specify which one. Is there any way we could increase the efficiency of those intermediaries or incentives that we can have that would make them more innovative in terms of making the system work a little better?

Mr. CHRISTOPH. I believe the innovation is going to have to come from our direction. The difficulty we face, we have been gradually reducing the number of standard claims payment systems and forcing carriers and intermediaries to use one of our standard systems.

When the program began, we had over 130 carriers and intermediaries, and the health claims industry was largely a paper process. As automation came along each of them automated their own, and HCFA was dealing with on the order of 100 individual systems that had been developed locally at each of those contractors.

We have been forcing them to reduce down to just a few systems, and our goal is to get down to one Part A and one Part B system. The idea there is, if we're only dealing with a few systems, we can manage them better, we can manage them more tightly; and it also would enable us to make changes that would be widespread and concurrent. So it's our direction that's going to push innovation.

One of the things that actually hurts innovation is the fact that we deal with all of these contractors as cost contracts. Title 18 specifies that we contract with insurance companies on a cost basis. In a day when most of these contractors were nonprofits, that made a great deal of sense, but many of those contractors are no longer nonprofits; and any business nowadays, if they're in there looking for profits, have to maximize the return. If we're looking at a cost contract, by definition, there's no profit in it.

So it's difficult for us to incentivize contractors to make changes. I think contract reform in a sense would help us because it would enable us to give greater incentives to the contractors.

Mr. TURNER. Mr. Willemssen, what do you think about that suggestion, that we need to have more incentives for the contractors and move away from the cost base reimbursement?

Mr. WILLEMSSEN. I think that is something that could be explored and I would agree with Dr. Christoph's comment about the gradual movement to more standardization of those systems. That's really been an instrumental element in helping achieve that.

For Part B, HCFA and its carriers are down to four standard systems and by 2003 expect to be down to that single standard system that Dr. Christoph mentioned. So I think that will also go a long ways to assisting in standardization.

Mr. TURNER. Dr. Christoph, how long do these carriers have the contract? What period of time are they awarded for?

Mr. CHRISTOPH. I'm not a contract specialist. I believe that the contracts are basically annual but renewable. Any contract term changes need to be through bilateral negotiations, but I believe every year we renew these contracts.

Mr. TURNER. You mentioned that originally there were 130 carriers or intermediaries and we're down to 26 carriers now, is that correct, or 23?

Mr. CHRISTOPH. It is on the order of the low twenties for the number of carriers. We've got something less than 60 contractors total now. Over the years many of the contractors have voluntarily, largely for their own business reasons, decided to leave the program. This results in a declining pool of contractors able to take business over from leaving contractors and presents greater difficulties for us because we're not sure what kind of excess capacity is there to accept business from a contractor that's leaving. So there are a number of areas of risk that contract reform would help us on, perhaps increasing the pool of people we could go to.

Mr. TURNER. Thank you. Thank you, Mr. Chairman.

Mr. HORN. Thank you, and I now yield 5 minutes to the gentlewoman from Illinois, Mrs. Biggert.

Mrs. BIGGERT. I don't get 7 minutes, Mr. Chairman?

Mr. HORN. Seven minutes. You're a good bargainer, Vice Chairman.

Mrs. BIGGERT. Mr. Kovatch, I appreciate all that you do for home health care. In one of my former lives I was chairman of the board of the Visiting Nurse Association of Chicago. So I spent quite a few years involved in that and in fact was the chairman when we celebrated our 100-year anniversary.

Unfortunately, shortly after that, because of mergers with Home Health Care and with other groups and particularly with hospitals, we decided to turn over the business to the University of Chicago, but the major reason was because we found that in the billing procedure, and how difficult that was, we ended up subsidizing Medicare and Medicaid to the tune of $2 million. We were very fortunate to have a high endowment, but knew that after, well, several years that we would run out of funds to do that, and I think that the problems that you have talked about in the home health care association industry were present then, and I can see that it has continued, that certainly one of the biggest problems that we had then was getting the doctor's approval and particularly now when home health care is much more prevalent because of the acute care that they have to provide and when people are coming out of the hospital so soon.

So why is it that there's this problem and isn't it—wouldn't it be that just using the letterhead or a special stamp or the doctor's name and Medicare identification number would be enough to satisfy that requirement?

Mr. KOVATCH. That is still the requirement to obtain the doctor's written approval. It isn't that the doctor hasn't given verbal approval prior to care. That's not necessarily the issue. It's more getting the doctor to physically sign off on the orders themselves, which we're currently required to do prior to billing. So, yes, that would help greatly if we could just use the doctor's verbal approval as approval to bill.

Mrs. BIGGERT. And the other problem that we had, too, and I saw really a reduction in the amount of service, and certainly one of the requirements for being on our board was to go out with the visiting nurses periodically on visits and I think once you do that you're really hooked into the system to see, going from the Robert Taylor homes in Chicago to the high scale North Side and visiting these patients. I found that, and could understand why our nurses, particularly when there was such a limitation placed on the days of service that Medicare or Medicaid would pay for, that our nurses refused to end the service, and that's how we really got into subsidizing some of this because they found the patients were in such need of such care that they could not give up going to see them and of course then we had to pay for it.

And I know that the physician fills out a form that has a definite beginning and a definite end of the service. Has there been any change of that or how complicated is it to request an extension of this service?

Mr. KOVATCH. That's actually very complicated, and with the prospective payment system coming on board it's probably going to become more of an issue. One of the things on our wish list was to increase the amount the prospective payment system was going to pay to the home health agencies by about $500 million. With PPS a lot of agencies are going to be tasked to see patients with a certain amount of reimbursement and cutoff basically at that point, and that is going to be a challenge for a lot of agencies.

Currently we're having to subsidize our home health business with our private duty business, with the profits from our private duty business.

Mrs. BIGGERT. I think there were a lot of agencies that got into this business thinking they could make a profit and found it was a difficult business to be in but one that's certainly most needed.

Mr. Christoph, I think that Mr. Kovatch in his testimony had—written statement had talked about the denial of claims for technical errors and it differs in the home health care than for physicians or hospitals, both of which can fix and resubmit, but I know when I was in this that so many claims were turned back because of technical errors and could never be paid whether the time ran out or not. Is that true?

Mr. CHRISTOPH. Actually Medicare accepts claims for a very long time. I believe it can go up to 18 months that a claim can be submitted. So I think there's quite a long time available. Also, all of our carriers and intermediaries provide a great deal of assistance to providers to try and ensure claims are submitted correctly the first time. We're engaged in a very large training effort to try and assist providers. We appreciate that that's a difficulty; 90 percent of the claims that we get electronically are paid promptly within 14, 15 days. So it's the smaller percentage that encounter these kind of technical errors. We try and build into the systems checks, edits, policy edits to ensure that the claims are paid correctly. We are very sensitive to the program integrity issues. So when something gets denied for a technical error, it's part of our program to try and make sure that the claim is well justified.

Overall, I think the program works pretty well given its complexity, but we're always trying to improve it and particularly working on provider education.

Mrs. BIGGERT. I think in the home health care though the beneficiary has to initiate the appeal rather than the provider; is that correct?

Mr. CHRISTOPH. I can't answer that. I'm not familiar with that area. We can find out and get back to you though.

Mrs. BIGGERT. Thank you. Well, I'm on the yellow so I guess I'll have to yield back, Mr. Chairman. Thank you.

Mr. HORN. Thank you very much. I see the distinguished ex-ranking member from New York and member of the subcommittee and 5 minutes to 6 minutes for questions.

Mrs. MALONEY. OK. I just want to compliment the chairman for keeping on making government work better and being more responsible, and this is one approach. I just would like to ask every member of the panel if they'd like to comment on it.

There's a lot of fraud that takes place in Medicare. We read about it all the time. I met with the IG once. We met actually together with the IG and they talked about all the money that they brought in when they did investigations, and all the time when you pick up the paper you read about another Medicare fraud. I would like to know if you have any ideas in addition to the bill before us, No. 1, whether you think this would help and, No. 2, what would you do to stop Medicare fraud? I mean this is a great program. It helps a lot of people, but every time you read about Medicare fraud it really undermines the effectiveness of the whole system and takes away the faith of people in the system. I would just like to throw that out. If you were sitting up here and you had the opportunity to write these oversight bills, what would you do to make sure that we don't have the type of the fraud that has existed in the past and which this tries to attack? Anybody have any ideas?

Dr. ZWELLING-AAMOT. I'll suggest an answer to that. The system itself is the fraudulent part. It is the fabricator of the truth. The data you collect is just not accurate data. You cannot make clinical decisions based on claims data. And what is called fraud or duplicitousness is really not that at all. It's just perhaps an error in translation in taking a clinical situation and trying to make a code out of it, remembering that the only reason to do that in the first place is for reimbursement purposes. So by its very undertaking, the system, while it's not fraud because it's not purposeful in that sense, the system just does not collect the right data. So even after investigation, when someone goes into a physician's office to look at medical records and they claim fraud, it's not fraud. It's another interpretation.

We treat patients, not codes. This system deals with codes, codes to translate into reimbursement, and that's a very dangerous precedent, and I implore the committee to look at this at its very most basic point of integrity of data.

Health care is a science. What we do is based on science and bad science is not what this country represents. The health care in this country and the good health of our patients is implicitly necessary for the increase in productivity and for good lives, and the govern-

ment as the collector of that data must bear the responsibility of the integrity of that data.

So in answer to your question, Mrs. Maloney, the first thing we need to do is to collect the right data. We need a relational data base. We need to better define the product that physicians sell and that patients purchase, and then you can development a reimbursement system based on reality.

Mr. SPARKS. I would just like to add that—I will give you an example of what might be considered fraud and yet is really not, and it deals with having all of the standards available to the providers.

There's this thing called local medical review policies which allows each intermediary around the country to establish what they believe are the appropriate diagnoses that support a clinical test, and they vary from place to place. In the last year we underwent an audit to look at our—a particular lab test and the particular lab test had—we had a book from our laboratory that had all of the diagnoses that supported that. But when we looked at it we ended up getting denied for a number of those. The test was syphilis. The diagnosis that we had used was organic brain syndrome. It was a valid diagnosis code that supported the test, but it was in Virginia. It was not from the Maryland intermediary. So all of those tests in one jurisdiction were covered under the Medicare program and in another jurisdiction were not covered.

So I think part of the problem that we face is we need to have standardization of the information that we're dealing with in order to bill.

Mr. HICKS. Mrs. Maloney, you asked whether—do we think this system actually addresses the fraud. I would comment in part to say I don't think any one system will eliminate the fraud. I think different things can help. One thing that we can—one industry we can borrow from for some learnings is the credit card industry. The credit card industry experiences a fraud rate which is substantially below what the Medicare fraud rate is projected to be. That doesn't mean we're accurately able to really track fraud. If we could really accurately track fraud we could probably eliminate it.

The one thing about this kind of a system is that it creates a point of encounter where the service provider actually delivers the equivalent of a bill or a statement of services to the recipient of the services. That recipient of the services is probably the best person to determine whether those services set forth on that bill were actually performed and to do it timely. So that is certainly one thing——

Mrs. MALONEY. Right now do they send the services back to the person who got them?

Mr. HICKS. In certain cases——

Mrs. MALONEY. Not in certain cases. In some cases they don't.

Mr. LEHRER. In almost all they do.

Mr. HICKS. But it's usually at a much later date. For example, and again I can speak to the private sector better, but in the private sector many times it's 6 or 8 weeks later, and if it's in our house that bill never gets opened or that statement of services never gets opened. Further, it doesn't necessarily say that it is a bill, so you may not pay attention to it until you've got somebody breathing down your neck to pay a bill.

So I guess the point is getting it timely, if somebody said they gave you a blood test and you received a bill onsite and it said blood test, you know——

Mrs. MALONEY. Mr. Hicks, I just want to understand it. What happens usually is someone goes to the doctor and gets the blood test and they don't get the bill then, they get it like what, 2 months later?

Mr. HICKS. Potentially 2 weeks later, potentially 8 weeks later. It depends on the timing. In Medicare it may be different and I think some of the others——

Mrs. MALONEY. Whereas with the credit card you know right then and there.

Mr. HICKS. With the credit card you know right then and there. In addition, there are other aspects of fraud that can occur. In the credit card industry, if somebody steals your card, you have the ability electronically to shut them out of the system immediately. We have all experienced being potentially shut out of a system, and I guess the concept is if through a combination of a point of encounter system, through membership IDs, through unique provider IDs and some antifraud gaming provisions that you can build into the system through the gateway, which is what our expertise potentially is here, you start eliminating and cutting back on the fraud. I don't believe you eliminate it.

I believe you also need the ability to do statistical analysis and I kind of like the idea of Mr. Lehrer, who said treat certain providers who have a track record and you've studied them statistically. The chances of that person committing fraud may be less than somebody who's done it before. So if you can evaluate patterns of activity, that's another way of whittling away at this.

Mrs. MALONEY. We're not doing that now? We're not doing patterns of activity? If I could just throw in for personal experience, I know my time is up, the red is on. I've had constituents call me or come to see me or mail me information or even forms for services that were billed to government that they never received. You know, some of them are wheelchairs or this, that and the other, and I just take it and mail it into the Medicare fraud to followup and see if there is any truth to it or whatever. That's happened to me I'd say roughly 10 times.

Then there's another issue that many of the doctors are telling me that the reimbursement rate is far lower than what the reality of the cost of their services is, which is another totally important issue that we need to look at. But I think that anytime that there is fraud like this it just destroys the whole system.

I know you had a comment, Ms. Jarmon.

Mr. CHRISTOPH. Congresswoman Maloney, I'd like to say a little bit about what Medicare is doing because we are very concerned about the issue of program integrity, making sure that claims are paid correctly, that claims are correct, and from my standpoint as Chief Information Officer I appreciate that there is a need to have the information at hand that we can mine and look for that kind of fraud. Our systems are antiquated. The purpose of H.R. 4401 is to advance the state of art in our systems that would enable us to do this kind of statistical data mining that is very difficult now-

adays because our information systems aren't built to allow the easy sharing of information.

One of the things that we're doing, our flagship data base, the national claims history file, is probably the biggest mountain of claims information in the world, but it's very difficult to get an answer out of that. We have to code up a special program to go and access it. It may take 3 months to get an answer out of that data base. We've prototyped a new version of that data base that gives us an answer in 20 minutes to an hour and that's because we can access the information more readily.

The analogy between doing health care claims and credit cards I think is a false one because the transactions are inherently very different. A credit card transaction, all you need is an amount and a payer ID and a cardholder ID and you can look at some patterns very quickly. Health care is a much more complicated program, developing the tests, trying to do these statistical analyses, much more complex problem. I have looked at this myself and it's a very complex undertaking.

Our goal is to build an infrastructure to enable us to do those kinds—ask those kind of questions and detect program integrity problems.

Mrs. MALONEY. Even with an antiquated computer system or whatever, I think the IG at the Medicare Department, in the reports that I have read, has been the most successful in correcting and bringing in revenue that was owed the government in various ways.

Mr. HORN. I think Ms. Jarmon wants to comment on that and then we go to Mr. Ose for 10 minutes.

Ms. JARMON. We at GAO have been resolved in reviewing the studies that have been done by the IG and trying to estimate—their attempts to estimate improper payments in Medicare fee for service and I just wanted to say that HCFA has several initiatives underway and you will never be able to determine of course what the total fraud rate is because like Dr. Christoph mentioned, it is complex and there are some pretty sophisticated fraud schemes, and things like kickbacks and collusion are very difficult to measure and to control, but one of the things that we think is important is that there be an analysis of these improper payments that are identified from the IG's study to determine the cause of those improper payments, determine where the risk is, where is the fraud occurring and what can be done to address it, to address it for improving internal controls and things like that, and many of the problems that they find in their study where they come up with an error rate of about 8 percent seem to relate to medical necessity and documentation not being provided. So there needs to be this additional analysis related to those issues.

Mrs. MALONEY. Thank you. My time is up.

Mr. HORN. Gentleman from California, Mr. Ose, has 10 minutes.

Mr. OSE. Thank you, Mr. Chairman. I first want to make sure I understand, Dr. Christoph. According to your resume, you came to HCFA as CIO after the MTS contract was terminated.

Mr. CHRISTOPH. That's correct.

Mr. OSE. I also want to suggest to the other members of this committee that perhaps Dr. Christoph's service at Los Alamos was ended too soon.

Mr. Willemssen, I always enjoy reading your testimony and having the opportunity to visit with you. I mean I marked this baby up, as you can see, last night reading it. The question I have relates to the current trustees of the system obviously, and maybe, Dr. Christoph, you could chime in here, have a responsibility to make sure that the system stays up to date and current. I'm still trying to find out whether or not those six individuals ever in their trustee meetings discussed updating our IT infrastructure so we can accomplish payments for processing in a timely fashion. Are you aware of any such discussion?

Mr. WILLEMSSEN. I will have to check on that, Congressman. I don't have the answer to that question at hand, but we will get the answer for you.

[The information referred to follows:]

**(Insert responding to Congressman Ose's question on page 83 of the transcript)**

According to the Social Security Act, the duties of the Boards of Trustees for the Medicare Hospital Insurance and Supplementary Medical Insurance Trust Funds center on: (1) reporting to the Congress not later than the first day of April of each year on the operation and status of the Trust Funds during the preceding fiscal year and on their expected operation and status during the current fiscal year and the next 2 fiscal years; (2) reporting immediately to the Congress whenever the Boards are of the opinion that the amounts of the Trust Funds are unduly small; and (3) reviewing the general policies for managing the Trust Funds, and recommending changes in such policies, including necessary changes in the provisions of law which govern the way in which the Trust Funds are to be managed.

The Boards reportedly met 10 times during the 5-year period 1995 through 1999. The minutes for these meetings indicate that operational issues such as the development, design, and implementation of Medicare systems were not discussed.

Mr. OSE. Let me ask Dr. Christoph then since he's kind of had that job. Have you ever sat with those six individuals, the purpose of which was to have this very discussion we're having here today?

Mr. CHRISTOPH. The short answer is no, but my belief is that the trustees are focused mostly on the financial health of the Medicare system and have not been involved in the details of payment operations. So I believe that—I have only been there 3 years. I don't know the history and we will have to check and see if they have been involved, but my expectation is that their focus is in the other more policy areas about the longevity of the program and how the trust funds are performing.

Mr. OSE. I would suggest to you that management includes all of these areas, and I would hope that one of the things you might take back is any interest in having the trustees look at this as part of their managerial umbrella.

The second question I have is, as it relates to the common working file, if I understand correctly, the system exists in such a way that it is hard to divine from the common working file any epidemiological data that would allow HCFA or anybody else to analyze certain issues. Now you have got a prototype you have worked on that apparently indicates a much compacted process by which you can get epidemiological information. Correct me if I'm wrong.

Mr. CHRISTOPH. No, I don't believe I said that. The common working file—in fact, our whole Medicare claims payment operation is focused on claims payment. It was not designed to collect medical information to be used for epidemiology. It is often used for that because the other data just doesn't exist.

It is a huge repository of medical claims information; that is correct. However, people study it because it's the best data we have around. It is a proxy at best for doing epidemiological studies. There are other efforts under way in other parts of the government dealing with telemedicine, the government computerized patient records effort. These are all focused on trying to develop better health information and that is very different from claims information.

We are under numerous restrictions to collect only the data we need to perform our function. So we collect the claims information focused on trying to make sure we pay claims accurately and efficiently. The other information that is there is kept by local hospitals as part of the health records that they maintain. My understanding is Mayo Clinic has a huge repository; they computerized all their patient information, their medical records, and are able to mine that effectively for epidemiological studies.

Mr. OSE. In effect, what you're saying is, you only have the codes that come in on the claims submittal rather than the underlying symptoms, if you will, that might be the basis for the—I can't even talk today—the basis for the analysis.

Mr. CHRISTOPH. That's correct, we collect information that's relevant to a claim. It includes procedure codes, codes for diagnoses, information about who the beneficiary is, who the provider is. But the detailed medical information, there may be supplemental medical information attached to the claim to enable us—to help us to see whether it's medically necessary; but in general, no, we don't

collect that information if it's not necessary for the payment of a claim.

Mr. OSE. If I understand correctly then there are 26 or 28—there are different numbers in the different testimony, there are 26 to 28 carriers who process Part B claims on behalf of the Health Care Financing Administration.

I want to go back. I think it was either Mr. Hicks or Mr. Kovatch or Mr. Sparks who commented on the analogous situation in the credit cards. You have suggested that it's not a clean analogy. How about the securities industry where you have four, five or six major securities brokers with offices around the United States, all of whom are matching customers with stocks, some on a 24-hour settlement basis, some on a 72-hour settlement basis, varying payments, varying receiving entities such as IRAs, pension plans, individual holdings and the like? It would seem to me that the infrastructure, at least the basic infrastructure, exists that could be moved over in a successful effort to comport with the chairman's bill. Is that accurate?

Mr. CHRISTOPH. Actually, there is an accurate piece to the analogy. Everything you describe is a transaction, OK, in the sense that medical claims are transactions. There are pieces of that that, yes, apply, but the analogy breaks down when you look at what's behind the transaction, OK? If you're transferring money, Medicare has something like 1.3 million providers, huge disparity in large numbers of people that we make payments to.

Mr. OSE. Isn't that an issue for the carrier and not for Medicare or HCFA because you're only dealing with 26 or 28?

Mr. CHRISTOPH. We end up trying to oversee that program. You can think of HCFA as managing these 20-odd subsidiaries that carry out this business. There is a structure for the claims. We do it very efficiently to do the transactions. The difficulty and where the analogy breaks down is in the complexity of the program, the policies, what claims can be paid, looking behind the claims where necessary to the supporting medical information for the medical review to ensure that the service was medically necessary.

It is a transaction, yes, but a very complex transaction; and it's the claims processing—VIPS can talk about how large their system is. It's several millions lines of code, and that mostly does these policy edits looking to determine what is the proper payment.

Mr. OSE. I want to go to these policy edits then because I noticed in Mr. Sparks's testimony, and he reiterated it this morning, the desire to have access to the logic underlying the edits themselves, and I was unclear. Are you talking about the rationale that management uses to create certain edits, or are you talking about the actual software program that has the "logic," that substantiates the edits? I was unclear which of those you were addressing.

Mr. SPARKS. I think that the providers really want to get a clean bill. So in order for us to get a clean bill, we need—there are edits that are done at HCFA after we have submitted the bills, or at the intermediary, that we don't have access to; nor do we have access to the common working file, both of which would help in our ability to provide cleaner claims on a timely basis.

Mr. OSE. But is it the software processing logic that you're after, or is it the rationale that management uses to impose this or that edit?

Mr. SPARKS. The software logic.

Mr. OSE. I was unclear on that.

Mr. Chairman, I see my time has evaporated. I had a huge number of questions just from Mr. Willemssen's testimony, not even to mention the others. If I could submit the questions in writing—I regret that it will be a rather substantive number of questions, but I would appreciate the chairman's indulgence.

Mr. HORN. We would appreciate it if you would give a response. We'll put it in the record at this point.

Mr. OSE. I have them for all of you. So don't worry about it, you won't be left out.

Mr. HORN. I'm going to go back now to starting over with 5 minutes, now that everybody's had their say on some of this; and what I'd like to do on my 5 minutes—and we will just start down at this end and give Mr. Christoph a rest—if you had a wish list, what are the two top changes you would like to see made in Medicare and in the Health Care Financing Administration requirements to streamline the system or to make things easier?

Mr. Hicks, what are your top two?

Mr. HICKS. Actually, the system that is outlined sort of closely aligns with our vision of what we think the system, the HCFA system, can do long term. Two of the most important components of that, I believe, are the delivery of a settlement or an explanation of benefits to the member while they're in the doctor's office. That's first and foremost.

Second, providing the edits, etc., online to the doctor while they're using the system is what this entire concept encompasses. I mean to be able to look at that online, I agree, is a very important function in the system.

So if you ask for the most important components of what we would be advocating, it's those two things.

Mr. HORN. OK.

Mr. Lehrer.

Mr. LEHRER. I think the two things that would support reducing the inappropriate payments that the Health Care Financing Administration could act on would be an ability to combine history information, that is, the patient history.

We talked about the national claims history file. The reality that an ambulance trip that doesn't result in a hospital admission is not verifiable today, that is, the ambulance could get paid even though no one ever went anywhere is a concern. So I think having combined history, as Dr. Christoph described, in the prototype history file is a major advancement.

Innovations again to the standard processing systems that support or today support the underlying Medicare claim processing need to continue and need to be encouraged.

Mr. HORN. Mr. Kovatch, two, and if we can keep it short, I just want to get your thoughts on the record.

Mr. KOVATCH. First, to provide financial assistance to home health providers. Most home health providers are small agencies

and unable to purchase the electronic systems that would be necessary to speed payment along.

Second, to establish time lines for the fiscal intermediaries in responding to medical reviews and completing medical reviews. This is a huge problem with a lot of agencies, especially my own, because we're at times unable to meet payroll and cash-flow.

Mr. HORN. Mr. Sparks.

Mr. SPARKS. Standardization of policies, procedures, medical criteria, as well as access again to the software, so that the hospitals and nursing homes can do their own edits in submitting clean bills.

Mr. HORN. Dr. Zwelling-Aamot.

Dr. ZWELLING-AAMOT. Not surprisingly, again, my first wish would be legitimate data. I think the system must support legitimate data, and while all these comments are very well taken, when the data itself is not legitimate, the whole system breaks down.

Second, I would agree that standardization is very important, particularly in the physician's office where we don't have the financial means to address the thousands of different issues that various insurance companies and the government ask us to address.

Mr. HORN. Ms. Jarmon.

Ms. JARMON. From the financial management perspective, I would encourage HCFA to continue to analyze the result of the improper payment study, so they can understand, even on a sub-national basis, where errors are occurring—by contractor, by provider.

And then also, second, address the computer security issues and privacy issues that are related to this; and I'm sure Joel will talk more about those.

Mr. WILLEMSSEN. Mr. Chairman, from a systems perspective. First, as HCFA and its partners become increasingly automated, they must retain and actually increase their focus on computer security matters, especially if they go to a more Internet-based architecture.

Second, linking back to your question earlier, I think it's very important for Dr. Christoph and HCFA to fill in the details behind how he intends to achieve his vision from a task deliverable and milestone perspective.

Mr. HORN. Dr. Christoph, do you disagree or agree with some of the ones that have been in the hurricane heading in your direction?

Mr. CHRISTOPH. I agree with a number of them, if I can state my two wish lists.

Mr. HORN. Absolutely.

Mr. CHRISTOPH. Actually, I've interpreted them a little differently in the sense that I have some requests for help from Congress.

My two wish lists, Mr. Hicks mentioned individual identifiers as being critically important. I think one of the things that would go very far in helping us deal with program integrity issues would be a national public key infrastructure. This requires Congress' delicate hand in dealing with a number of very sensitive privacy issues, and I think that's something that if your committee can work on that, would be very helpful.

Second, a moratorium on changes in the Medicare program would give us time and ability to focus on modernization efforts

that we need to undertake in order to provide the kinds of things that many of the panelists and your committee have asked for.

Mr. HORN. This is very helpful, and since my colleague from California has a few more questions, how about if you do it in 4 minutes, and then I can wind it up.

Mr. OSE. I will attempt.

I'm sitting up here cheering on this moratorium on changes. Mr. Willemssen, you noted in your testimony—on page 13 of the draft, you noted two things about the Medicare coding system, one of which is that the coding system changes every year. I cannot imagine why you would change the coding system every year and I'm interested in being educated.

Who makes such a decision and why?

Mr. WILLEMSSEN. Well, in part, there are sometimes changes in the law, sometimes changes in regulations, sometimes changes in prevailing medical practice and what kind of techniques may be used; and it adds up to a great number of changes. But I can definitely see Dr. Christoph's point that if he had a moratorium coming out of Y2K, where all their attention was on that, then he could be in a more proactive posture to address the kinds of issues that have been discussed today.

Mr. OSE. Here's the thing that just drives me nuts, that the codes get changed—the standard in the industry evolves over time, and I recognize that; to the extent that occurs, clearly the codes have to change. But if we have a wholesale changing of codes on an annual basis, we end up with doctors and other providers who are in a position of perhaps being tired 1 day or being in a hurry 1 day, and they make a mistake on a coding.

The Department of Justice picks that up in a regular audit and says, Wait a minute, we've got waste, fraud and abuse and all of a sudden I've got people like Mr. Sparks, or others whose business is to provide service, spending millions fighting a waste, fraud and abuse action.

Now, I mean, we had—I don't remember who it was that recommended having prequalification for providers and the like, which is probably too logical for us to ever consider; but in the sense that the system is complex, I mean—Dr. Christoph, you're the expert here. How do we address this?

And I can't help but think that the codes are one area that we need to focus on. Correct me if I am wrong.

Mr. CHRISTOPH. We have been—actually, some of the codes that we use are industry standard consensus codes. And the standardization here to all use the same set of codes.

Mr. OSE. So you end up with, like category 100 is this DRG and category 200 is this DRG, and you might get 203, 204 as you differentiate among the specialties.

Mr. CHRISTOPH. Exactly. There might be 100 codes that deal just with various kinds of operations in the chest cavity.

Mr. OSE. Well, if that's the case, why don't we take the codes and change the system so that we anticipate an evolution over a 5-year period of time and make the code large enough so that based on past history, whatever might occur within a 5-year period of time, we don't have to change the basic structure of the code from a 1,000 or 10,000 code to a 20,000, 30,000, 40,000, 50,000. It just

seems to me like we're moving in inches when we can move in leaps on a 5-year basis instead of an annual basis.

Mr. CHRISTOPH. Again, those codes are industry consensus standards that Medicare uses, so—one of the sets of codes is actually maintained by the AMA, so we don't try and create new codes. We add codes if there's new procedures, OK, as new technology——

Mr. OSE. All I'm saying is that the structure of the code itself, if it is a three-digit code, you only have one basic categorization and 99 options. If it's a four-digit code, you have one basic categorization and 999 options. If it's five digits, etc.

Why don't we make that leap so that we have sufficient flexibility in the code that we don't have to change the basic architecture?

Mr. CHRISTOPH. You're talking like in area codes and ZIP codes where we have run out of room, and I believe we are—there is enough room in there for new additional codes; there are a lot of unused numbers. But I agree with your point, there needs to be room in there to handle additional codes.

Mr. OSE. So you say we're moving in that direction or we're there already, or we're moving in that direction?

Mr. CHRISTOPH. I would have to rely on the experts that maintain those codes, but I believe that there is room for additional codes.

It is like the library indexing system, Dewey decimal. You can always add books in the middle. If you have to, you can go to decimal points and add codes there.

Mr. OSE. You got my concept. So on a practitioner's side, how does it work?

Dr. ZWELLING-AAMOT. Much different.

There are a variety of different codes. There are diagnostic codes, there are billing codes, and for the hospital there are DRG codes.

I personally worked for various hospitals to try to enhance their DRG coding or make it more accurate. I started that job at—we will call it "year zero," and I educated the staff and the nursing staff to do the coding as to what they might look for.

Mr. OSE. You need to shrink. The chairman is giving me the eye here.

Dr. ZWELLING-AAMOT. The long and short of it is, there was a 30 percent error rate when I initiated the job, and 5 years later there was a 30 percent error rate. The codes do not adequately describe what it is we clinicians do for our patient; and as such, they're an unfair representation and, as I said earlier, lead to really bad conclusions.

Mr. OSE. Mr. Sparks from the hospitals.

Mr. SPARKS. We do have problems with standardization of supporting diagnosis for codes. As I indicated before, you have lab tests for which you have to provide valid diagnosis, and those are not standardized in the country. I think we need to look at standardizing those.

We also need to look at—in a 3-year period, we have three directions from the intermediary on how to submit our lab charges. One year they told us, don't bundle anything; the next year they said, bundle only this; and the next year they said, unbundle these things. Every year for a 3-year period this has changed.

Mr. OSE. This is from your carrier or from HCFA?

Mr. SPARKS. The direction is coming from HCFA to the carriers. So we need to have standardization. If we're going to do it, let's do it one way and not have a change every year.

Mr. OSE. What about that, Dr. Christoph?

Mr. CHRISTOPH. I firmly believe in standardization, and that's a direction we definitely want to go in.

Mr. OSE. Your testimony said you had been here 3 years, and Mr. Sparks is saying in that 3-year period we've had three changes—or two changes, excuse me.

Now, are you driving this or is somebody else driving this?

Mr. CHRISTOPH. The area that I think the changes come from deals largely with policy which is outside of my realm of competence. I'm an IT person who is trying to provide the infrastructure to allow operations to occur, and I can't speak to the policy areas that lead to some of those changes.

Mr. OSE. Mr. Chairman, you have been very generous with time, and I've eliminated two questions from my list, but I'm still going to give you a list.

Mr. HORN. I thank the gentleman. He always asks excellent questions.

We now have a vote on the floor. I have one more short question of Mr. Christoph.

To what degree do we have, in Medicare, prior approval of nonemergency treatments? It seems to me that might simplify some of the problem. If you had a preapproval, it just makes sense. Why we have to think of each case, I'll never know; but what is the situation?

Mr. CHRISTOPH. I believe the situation we have is that when Medicare is submitted a claim and that claim must come after the service is delivered, then Medicare begins its processing effort. We don't have, in a sense, a Medicare beneficiary because they are eligible. There are many things that they are eligible for; in a sense, they know they have Medicare in back of them, supporting them, whether a specific procedure is covered or not.

I think that's what you're looking for, is there a way of generating some kind of clearance so that a doctor would know up front whether or not this procedure will be covered. I think that is something that is possible to do. It might well be one of the targets, and we look forward to working with your committee to see if those things can be done.

Mr. HORN. Well, I agree with you, and I'm delighted.

Let me note here that we've had a number of staff that have helped with this hearing: the Professional Staff Member, Director of Communications, on my left and your right is Bonnie Heald for this hearing; the head of the whole staff is J. Russell George, staff director, chief counsel; Bryan Sisk, our clerk; Elizabeth Seong, staff assistant; Will Ackerly, intern; Chris Dollar, an intern; Davidson Hulfish, intern; and minority staff, Trey Henderson is the counsel; Jean Gosa, the minority clerk over there in the corner; and the official reporter of debates is Melinda Walker.

We thank you all for what you have done to make this a very successful hearing; and on behalf of Senator Lugar and the subcommittee and myself, I want to thank each of you for the insight and candor that you have brought to this situation. You've played

a very important role in the legislative process, and frankly, we have a lot of work to do in order to refine the bill.

I'd certainly appreciate it if you could in the next week—if driving away or on a plane, you could say, "Gee, I really wanted to do that" and send it to either Mr. George or myself. I can see that we have a lot of work to do, and I think your testimony will be taken to heart as we reconsider some of the bill's provisions.

And so thank you for coming and sharing your wisdom with us. Thank you very much. And we're adjourned.

[Whereupon, at 12:10 p.m., the subcommittee was adjourned.]

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