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H.R. 2768, THE "MEDICARE REGULATORY AND CONTRACTING REFORM ACT OF 2001"

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDRED SEVENTH CONGRESS

FIRST SESSION

SEPTEMBER 25, 2001

Serial No. 107–45

Printed for the use of the Committee on Ways and Means

U.S. GOVERNMENT PRINTING OFFICE

76–025 WASHINGTON : 2001

For sale by the Superintendent of Documents, U.S. Government Printing Office
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H.R. 2768, THE "MEDICARE REGULATORY AND CONTRACTING REFORM ACT OF 2001"

TUESDAY, SEPTEMBER 25, 2001

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The Subcommittee met, pursuant to notice, at 10:08 a.m., in room 1100 Longworth House Office Building, Hon. Nancy L. Johnson (Chairman of the Subcommittee) presiding.

[The advisory and revised advisory announcing the hearing follow:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
September 4, 2001
No. HL–10

CONTACT: (202) 225–3943

Johnson Announces Hearing on H.R. 2768, the "Medicare Regulatory and Contracting Reform Act of 2001"

Congresswoman Nancy L. Johnson (R–CT), Chairman, Subcommittee on Health of the Committee on Ways and Means, today announced that the Subcommittee will hold a hearing on H.R. 2768, the bipartisan "Medicare Regulatory and Contracting Reform Act of 2001." **The hearing will take place on Tuesday, September 11, 2001, in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 2:00 p.m.**

In view of the limited time available to hear witnesses, oral testimony at this hearing will be from invited witnesses only. Witnesses will include the Honorable Tom Scully, Administrator of the Centers for Medicare and Medicaid Services (CMS), independent program experts, and representatives of provider groups. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

BACKGROUND:

On August 2, 2001, Chairman Nancy Johnson and Ranking Member Pete Stark (D–CA), joined by every member of the Subcommittee on Health, introduced H.R. 2768, the "Medicare Regulatory and Contracting Reform Act of 2001," the first major bipartisan Medicare legislation developed in the Committee on Ways and Means in the 107th Congress. This package would extend important regulatory relief to our nation's health care providers and modernize Medicare's contracting processes, while protecting the program and taxpayers from potential fraud and abuse.

H.R. 2768 is intended to create a more collaborative relationship between the CMS and the providers who serve Medicare beneficiaries. The legislation was developed through months of bipartisan consultation with health care providers and with the officials at the U.S. Department of Health and Human Services responsible for protecting the financial integrity of the Medicare program. The bill includes provisions related to the issuance of regulations and compliance with changed policies, contracting reform, provider education and technical assistance, a small provider technical assistance demonstration program, the appeals system, recovery of overpayments and prepayment review, a beneficiary assistance demonstration, and evaluation and management guidelines.

In announcing the hearing, Chairman Johnson stated, "Health care providers have been overwhelmed by paperwork requirements that have nothing to do with taking care of patients. Good, responsible professionals are frustrated by a system that seemingly emphasizes policing providers rather than helping them comply with Medicare's rules and regulations. Our bill is designed to change all of that. We want health care providers to spend their time with patients, rather than paperwork, and we want to make Medicare simpler. Program integrity must be protected—and so must provider time."

FOCUS OF THE HEARING:

The hearing will give the Administration and other witnesses an opportunity to comment on H.R. 2768. We will hear from independent program experts as well as health care providers who would be directly impacted by the bill's reforms.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Any person or organization wishing to submit a written statement for the printed record of the hearing should *submit six (6) single-spaced copies of their statement, along with an IBM compatible 3.5-inch diskette in WordPerfect or MS Word format, with their name, address, and hearing date noted on a label*, by the close of business, Tuesday, September 25, 2001, to Allison Giles, Chief of Staff, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. If those filing written statements wish to have their statements distributed to the press and interested public at the hearing, they may deliver 200 additional copies for this purpose to the Subcommittee on Health office, room 1136 Longworth House Office Building, by close of business the day before the hearing.

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be submitted on an IBM compatible 3.5-inch diskette in WordPerfect or MS Word format, typed in single space and may not exceed a total of 10 pages including attachments. **Witnesses are advised that the Committee will rely on electronic submissions for printing the official hearing record.**

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. A witness appearing at a public hearing, or submitting a statement for the record of a public hearing, or submitting written comments in response to a published request for comments by the Committee, must include on his statement or submission a list of all clients, persons, or organizations on whose behalf the witness appears.

4. A supplemental sheet must accompany each statement listing the name, company, address, telephone and fax numbers where the witness or the designated representative may be reached. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press, and the public during the course of a public hearing may be submitted in other forms.

Note: All Committee advisories and news releases are available on the World Wide Web at "http://waysandmeans.house.gov/".

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202–225–1721 or 202–226–3411 TTD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

*** * * NOTICE—HEARING RESCHEDULED * * ***

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
September 17, 2001
No. HL–10–Revised

CONTACT: (202) 225–3943

Hearing Rescheduled for Subcommittee Hearing on H.R. 2768, "the "Medicare Regulatory and Contracting Reform Act of 2001" Tuesday, September 25, 2001

Congresswoman Nancy L. Johnson, Chairman of the Subcommittee on Health of the Committee on Ways and Means, today announced that the Subcommittee hearing on H.R. 2768, the "Medicare Regulatory and Contracting Reform Act of 2001," previously scheduled for Tuesday, September 11, 2001, **will now be held on Tuesday, September 25, 2001, at 10:00 a.m., in the main Committee hearing room, 1100 Longworth House Office Building.**

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Any person or organization wishing to submit a written statement for the printed record of the hearing should *submit six (6) single-spaced copies of their statement, along with an IBM compatible 3.5-inch diskette in WordPerfect or MS Word format, with their name, address, and hearing date noted on a label*, by the close of business, Tuesday, October 9, 2001, to Allison Giles, Chief of Staff, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. If those filing written statements wish to have their statements distributed to the press and interested public at the hearing, they may deliver 200 additional copies for this purpose to the Subcommittee on Health office, room 1136, Longworth House Office Building, by close of business the day before the hearing.

All other details for the hearing remain the same. (See Subcommittee press release No. HL–10, dated September 4, 2001.)

Chairman JOHNSON. The hearing will come to order.

The Democratic Caucus is not quite over, and they will be along shortly, so I will start with my opening statement and provide Pete a chance when he arrives.

Before we start, it is important to acknowledge that today's hearing on regulatory relief was supposed to have taken place 2 weeks ago today. As we all know, on that day, our country suffered an extraordinary tragedy, disrupting not only the business of governing, but so much more importantly, the lives of so many Americans—those tragically killed by terrorists, their bereft families and friends, and all Americans.

While we continue to grieve and prepare to respond to the evils of terrorism, it is a sign of the strength of this great Nation that we can also move forward with the work of governing. I want to thank our witnesses for coming back today to give us the benefit of their expertise.

Over the past several months, members of this Subcommittee have been working together closely to better understand the challenges facing providers who serve Medicare beneficiaries, and on March 15, we held a hearing on the need to extend relief from burdensome regulations to Medicare providers.

At that hearing, we heard from doctors and hospitals, from home health agencies and nursing homes. Although examples differed, the basic message from each group was the same—providers are overwhelmed with paperwork. Instead of caring for patients, health care providers are spending too much time filling out forms.

These are good people; yet they are inundated with paperwork, second-guessing, and heavy-handed oversight. If we do not act, we risk losing the providers we need to ensure that seniors have access to high-quality care.

Indeed, the U.S. General Accounting Office (GAO) study documents the loud cries for help that we have been hearing. Medicare is now such a complicated program that endless directives and long explanations and articles are necessary to explain facet after facet. Not only does the GAO report document the volume of paper doctors and hospitals must digest monthly, but the complexities are so great that even the government cannot give clear answers.

In GAO's sample, only 15 percent of the answers to physicians' questions were complete and accurate—15 percent. Thirty-two percent were entirely incorrect. Having chaired the Subcommittee that led the reform of the Internal Revenue Service (IRS), I can tell you this is an absolutely shocking, abominable, and unacceptable record of performance, although just as the IRS problems did, it has its fundamental base in the complexity of the law we passed and the rapidity with which we have imposed changes on the system.

Nonetheless we must do better than providing only 15 percent accurate answers to physician questions.

So the challenge is great to those of us in the Congress, to Administrator Scully, and to Secretary Thompson. We have, however, as you well know, been working hard. Pete and I wrote the Secretary, making a number of suggestions regarding regulatory improvements the Department could make using existing administrative authority, and many of those changes they have made.

At the same time, we began developing a legislative package which is the underlying substance of this hearing, and we will have a chance to examine its provisions this morning and look forward to your comments on how it can be altered or improved to be made stronger or to serve better.

In addition, the Secretary has given the tools to manage the Medicare Program operations more efficiently. For the first time, the Centers for Medicare & Medicaid Services (CMS) will be able to competitively contract with the best entities available to process claims, make payments, and answer questions. The Secretary will be free to promote quality through incentives for Medicare adminis-

trative contractors to provide outstanding services to seniors and health care providers.

It is a pleasure to welcome Tom Scully here, the Administrator of CMS. Mr. Scully will set forth the administration's view on H.R. 2768 and talk to us about the Department's current efforts to extend regulatory relief to providers.

This is Mr. Scully's first appearance before the Subcommittee in his capacity as administrator, and Tom, we welcome you and look forward to working with you in the months ahead. Mr. Stark.

[The opening statement of Chairman Johnson follows:]

Opening Statement of the Hon. Nancy L. Johnson, a Representative in Congress from the State of Connecticut, and Chairman, Subcommittee on Health

Before we start today, it seems important to me to acknowledge that today's hearing on regulatory relief actually was supposed to have taken place two weeks ago today. As we all know, history intervened, in the form of unspeakable tragedy, disrupting not only our hearing but, so much more importantly, the lives of so many American heroes. While we continue to mourn, and to grieve, and to respond to the evils of terrorism, it is a sign of the strength of this great nation of ours that we can also move forward with the business of governing. I want to thank our witnesses for coming back today to give us the benefit of their expertise.

Over the past several months, members of this Subcommittee have been working together closely to better understand the challenges facing providers who serve Medicare beneficiaries. On March 15, we held a hearing on the need to extend relief from burdensome regulations to Medicare's providers.

At that hearing, we heard from doctors and hospitals, from home health agencies and nursing homes. Although examples differed, the basic message from each group was the same. Providers are overwhelmed. Instead of caring for patients, health care providers are spending too much time filling out forms. These are good people. And yet they are inundated by paperwork, second-guessing, and heavy handed oversight. If we do not act, we risk losing the providers we need to ensure that seniors have access to high quality care.

After that hearing, we got to work. In May, Pete Stark and I wrote Secretary Thompson making a number of suggestions regarding regulatory improvements the Department could make using existing administrative authority. Many of those changes have already been accepted.

At the same time, we began developing a legislative package to address problems that could not be corrected administratively. We examined the proposals set forth by Representatives Toomey and Berkley in their bill, H.R. 868. They make important suggestions—many of which we adopted. But we also were sensitive to objections raised by the Office of Inspector General to provisions in H.R. 868 that put program integrity at risk. We tried to assemble a bill that extends relief to providers but protects taxpayers from waste, fraud, and abuse.

On August 2, Pete Stark and I introduced our bill, the Medicare Regulatory and Contracting Reform Act of 2001. I am extremely pleased that every member of the Health Subcommittee has joined us in cosponsoring H.R. 2768, along with many of our colleagues from the full committee.

The basic goal of H.R. 2768 is to create a more collaborative, less confrontational relationship between providers and the Centers for Medicare and Medicaid Services. Our bill will diminish the paperwork load required to meet complex and technical regulatory requirements and immediately free up for patient care time that providers now spend completing and filing federal forms. H.R. 2768 streamlines the regulatory process, enhances education and technical assistance for doctors and other health care providers, and protects the rights of providers in the audit and recovery process to ensure that the repayment process is fair and open.

In addition, the Secretary is given the tools to manage Medicare program operations efficiently. For the first time, the Centers for Medicare and Medicaid Services will be able to competitively contract with the best entities available to process claims, make payments and answer questions. The Secretary will be free to promote quality through incentives for the Medicare Administrative Contractors to provide outstanding service to seniors and health care providers. Contractor reform initiatives will eliminate artificial distinctions between Medicare's Part A and Part B with regard to contracting practices.

Since introducing H.R. 2768, we have received useful input and technical suggestions from a range of interested groups, and we will be carefully evaluating those suggestions to see what good ideas we can incorporate into our bill as we move to markup. In particular, I continue to be interested in finding ways to allow providers to challenge audit findings and the validity of probe samples before they have to formally pursue an appeal.

Today, we will hear from Tom Scully, Administrator of CMS. Mr. Scully will set forth the Administration's views on H.R. 2768 and talk to us about the Department's efforts to extend regulatory relief to providers. This will be Mr. Scully's first appearance before our subcommittee in his capacity as Administrator. Tom, we look forward to working with you at CMS.

On our second panel, providers will comment on the bill, and we will hear from the General Accounting Office about its recent work on physician documentation requirements. Again, I thank you all for being here today.

Mr. STARK. Madam Chairman, thank you for calling the hearing today on H.R. 2768, the Medicare Regulatory and Contracting Reform Act of 2001 (MRCRA).

As I know you have said, this legislation shows that when we do work together, we can accomplish some legislation. There are, of course, other areas on which we disagree—Medicare reform, payment to Health Maintenance Organizations, the Bush discount card program, known as the "rocket ranger prescription card"—but when there is some agreement, we can improve Medicare for beneficiaries, taxpayers, and providers.

As I understand it, this bill was written to address two problems in Medicare—first, to improve outreach and assistance to beneficiaries and to respond to certain other concerns raised by physicians and other providers; second, some long overdue contracting reforms that should improve beneficiary and provider services and permit the consolidation of Medicare claims processing.

I emphasize that because our legislation does not compromise the government's ability to protect taxpayer dollars from being inappropriately spent. Let me say that I am concerned about several issues, however, raised by the Office of Inspector General (OIG) concerning our bill, and I hope we can resolve those before we proceed.

I do not think that CMS needs additional legislative authority to improve its education and information for providers. Instead, I think the agency needs additional administrative resources. The GAO will testify today on serious contractor oversight problems. These management problems need to be addressed regardless of whether we enact this legislation or provide additional resources.

While this legislation would reform Medicare administrative contracting, permitting Part A and Part B contractors to be combined, I want to emphasize that we in no way would agree that this would imply any support for combining the Part A and Part B trust funds or any other efforts to combine Medicare Part A and Part B. And I am sure this side of the aisle strongly opposes such consolidation.

To improve services to Medicare beneficiaries, we have proposed that Medicare staff be stationed in Social Security field offices.

The demonstration program will allow us to examine the value of placing Medicare staff in all of those field offices, and I hope it can be expanded; I hope it will work and can be made permanent. Thank you.

[The opening statement of Mr. Stark follows:]

Opening Statement of the Hon. Fortney Pete Stark, a Representative in Congress from the State of California

Madam Chairman, thank you for calling the hearing today on the Medicare Regulatory and Contracting Reform Act of 2001 (H.R. 2768). I look forward to hearing what the witnesses have to tell us about our bill and ways to improve it.

Madam Chairman, as you know, you and I and other Members of the Subcommittee introduced this bill to address two problems in Medicare. First, the bill takes important steps to improve outreach and assistance to beneficiaries and providers, and to respond to certain other legitimate concerns raised by physicians and other providers. And second, it includes long overdue contracting reforms that will improve beneficiary and provider services and permit the consolidation of Medicare claims processing.

Importantly, our legislation does not compromise the government's ability to protect taxpayer dollars from being inappropriately spent under Medicare. On this point, however, let me say that I am concerned about several issues raised by the Office of Inspector General concerning our bill, and I hope we can resolve those issues before we proceed.

Madam Chairman, we need to improve the education and information processes for providers. It is hard for even the most seasoned Medicare analyst to keep track of all the payment and policy changes that have occurred in Medicare in the last few years. We need to do a much better job of educating and assisting physicians and other providers about these changes.

But, Madam Chairman, CMS does not need additional legislative authority to improve its education and information for providers. Instead, CMS needs *additional administrative resources*. Two years ago, in the January/February 1999 issue of *Health Affairs*, 14 of our nation's leading Medicare policy analysts—ranging from conservative to liberal—published an open letter titled, "Crisis Facing HCFA & Millions of Americans." The crisis they spoke about was the lack of resources to administer Medicare. Their letter is even more relevant today. As its administrative workload has increased, CMS (formerly, HCFA) resources have not kept pace. The changes that we propose in our legislation are important, but by themselves, they are not sufficient. We simply must get more resources into Medicare administration.

Madam Chairman, important reforms of the Medicare appeals processes were included in legislation enacted last year. However, our bill includes additional improvements that are needed. Our bill would provide an expedited review process similar to the one now used for Provider Reimbursement Review Board (PRRB) decisions to permit providers to seek judicial review when a review panel does not have legal authority to make a decision. Our bill would also transfer administrative law judges (ALJs) from the Social Security Administration to the Department of Health and Human Services in order to improve their expertise on Medicare issues. However, lengthy delays in appeals will not be curtailed unless additional resources are provided to hire more ALJs.

Madam Chairman, Medicare *contracting* processes have become outdated in the face of all of the changes that have occurred in Medicare and in information technology. Every President since President Carter has proposed reforms to the administrative contracting provisions in Medicare, yet they have never been enacted. I hope we succeed this time.

Our bill reforms the Medicare contracting processes by consolidating the contracting functions for Part A and Part B of Medicare, permitting the Secretary to contract with separate Medicare Administrative Contractors to perform discrete functions, making use of the Federal Acquisition Rules (FAR) in Medicare contracting, eliminating the requirements for cost contracting, and expanding the kinds of entities eligible for contracting. Our bill would permit consolidation of claims processing with fewer contractors, and it would permit separate contracting along functional lines—for beneficiary services, provider services, and claims processing.

But let me be clear, my support for combining the administrative contracting functions of Part A and Part B in no way implies my support for combining the Part A and Part B trust funds, or other efforts to combine the Part A and Part B. In fact, I strongly oppose such a consolidation.

Last, Madam Chairman, to improve services to Medicare beneficiaries, we have proposed that Medicare staff be stationed in Social Security field offices to help answer questions and provide assistance for Medicare beneficiaries. There are 1291 SSA field offices around the world, and I would like to see Medicare staff in most, if not all, of them. I am pleased that the legislation we are introducing today authorizes a demonstration program to examine the value of placing Medicare staff in

SSA field offices, and I hope it will be expanded and made permanent if it is found to aid beneficiaries.

Chairman JOHNSON. Thank you, Mr. Stark. Mr. Scully.

STATEMENT OF THE HON. THOMAS SCULLY, ADMINISTRATOR, CENTERS FOR MEDICARE & MEDICAID SERVICES

Mr. SCULLY. Thank you, Madam Chairman and Mr. Stark.

Thank you for having me here today. First, going back to the subject of New York, since I have the opportunity, I would like to thank all the health care providers in New York City, especially Lower Manhattan. In the last couple of weeks, I think a lot of people were unaware of the fact that in the disabled community, people did not get home health services; there were a lot of problems in Lower Manhattan beyond the obvious ones from the World Trade Centers. I think the providers there did a tremendous job of making sure that seniors who did not have home health below 14th Street, disabled folks who did not have their home health aides, and a lot of other people got wonderful services. I think the hospitals did a great job, and in particular the Visiting Nurse Association of New York City. So I just want to publicly thank them for doing a terrific job.

Thank you for inviting me here today. I have just one other issue before I jump into regulatory streamlining, which I want to flag for the Committee, because I am going to start putting it at the front of all my speeches for the next year and all my Committee appearances, and that is the Health Insurance Portability and Accountability Act 1996 (HIPAA).

In my first 3 months on the job, I probably was not focused as much on HIPAA as I should have been; in the last couple of weeks, I have become totally aware that as of next October, we have to have a standard billing and coding system nationwide between all private and public insurers. And I have not seen a lot of evidence that Congress is interested in changing the law, so I have the responsibility to get it done by next October.

The agency needs to step up to the plate; we need to focus on it a lot more. We are creating a HIPAA Task Force in CMS. And we are determined that absent other legislative guidance, we will do our best to have the entire insurer and provider world ready for HIPAA next fall. So I just wanted to flag that as an issue of increased importance and increased focus for the agency.

That said, let me turn to MRCRA. I want to thank you, Mrs. Johnson and Mr. Stark, for introducing this legislation. I would also like to thank your staff, who spent an awful lot of time working with us to make sure it was drafted effectively and worked out well. In particular, Jennifer Baxendell, Cybele Bjorklund and Deb Williams spent a lot of time on this and I think produced a terrific work product. And as Mr. Stark said, when we work on these things in a bipartisan way, we frequently get good results, and I think that generally this is a very, very good bill. We have a couple of minor concerns that I will express later, but they are very minor.

Clearly we have to balance at CMS the impact of Medicare's laws and regulations on physicians and other providers with the ac-

countability that we have for $240 billion in Medicare payments. In many areas, we can be a lot less intrusive to providers, a lot more responsive to beneficiaries, and in many cases, we can make these changes administratively. I will go through some of those that we have tried to do.

However, there are a lot of important areas where we cannot change things without your help. The Medicare contracting system, which I think is antiquated and has been screaming for reform for the last 20 years, is one, and we are very appreciative of your efforts in this bill to fix it.

We have to fundamentally change our relationship with Medicare's fee-for-service contractors. When I got in the first Bush administration 12 years ago, we had around 90 contractors, and everybody wanted to get those reformed and get them down to 10. We have made some progress, but 12 years later, coming back in, we still have 51. It is a unwieldy process. The reins between the agency and its contractors who are running the program are not exactly tight, and I think a major goal this year of both the Secretary and myself is to reform the contractor system.

So far this year, actually, we have been very pleased, working with the Committee and with the Blue Cross plans, who tend to be our predominant contractors, that we have actually worked out a lot of the issues that we had with the existing 51 contractors, and I think most of them are actually very supportive of your reforms and the reforms that you have in this bill, as are we.

In June, the President forwarded his proposal to Congress. The goal in that CMS reform proposal was to provide CMS with the flexibility to work with its contractors more effectively, to promote greater competition among contractors, to give us greater flexibility to negotiate contracts, with appropriate incentives to reward our contractors. And basically, when you look at your bill, I think it meets virtually all of those goals and is soundly based on the bill we sent up, with some significant improvements.

What have we done in addition to your bill to try to make our relationships with contractors and carriers and providers and beneficiaries better?

The first thing we did to improve agency responsiveness outside legislation with internal CMS efforts is that I created eight open door policy groups, two of which I chair—long-term care and nursing homes, and rural health. There are also policy groups for physicians, hospitals, health plans, nurses and allied health professionals, home health and hospice, and End-Stage Renal Disease and dialysis centers.

These groups basically meet with all the outside interested groups once a month in person and once a month through a nationwide conference call to find out what the problems are around the country with beneficiary groups and providers and try to do the best we can to work them out.

For example, in the nursing home group, which I chair because I have a particular interest in fixing some of our problems in long-term care, we have the for-profit and non-profit nursing homes. It is co-chaired with me by the executive director of the National Governors' Association; the Service Employees International Union is involved—there are many parties who do not always agree on

things, but I think we have found that there are a lot of common, nuts-and-bolts, day-to-day problems in the program, and that if we focus on them, we can fix them, and we are determined to do that.

The goal of these groups is not to overhaul Medicare. The goal is to find a way to make our program work better on a day-to-day basis and to solve the day-to-day operational problems that we have.

On beneficiary education efforts and outreach, as you know, we are launching a $30 million advertising campaign this fall. We are significantly increasing the 1–800–MEDICARE number budget, and it will operate 24 hours a day, 7 days a week, with a great deal of local information. The ad campaign has been delayed a little bit, obviously, by the disaster last week, but I think you will see it up and running in mid-October.

Establishing key contacts for the States—this is more relevant to Medicaid than Medicare—but we have appointed one person in the Baltimore office and one person in each region to be responsible to the Governors, so when the States and Governors have problems with Medicaid, we have folks with direct responsibility in the States who are responsible to me and the Medicaid operation to make sure the Governors and the States get quick turnaround and quicker response in the Medicaid program.

The Secretary has also formed a new regulatory reform group to identify regulations that prevent hospitals and providers and physicians from serving Medicare beneficiaries in the most effective possible way. To support this group, I have started to go around and do public listening sessions around the country. Yesterday I was in Kentucky; I have already gone to Chicago with Mr. Crane—I hope that was a good trip—and also to Montana and Arkansas, and we are determined to go around the country and meet with more of the providers and beneficiary groups and really try to drive the agency, both in Washington and Baltimore and also in the regional offices, to be much more responsive.

In addition to these efforts, we are taking concrete steps to streamline Medicare's regulatory process. We have developed a quarterly compendium of all changes in Medicare that we will send out to all physicians and providers. As of January 1, we will have a listing of each quarter; before the quarter begins, we will put out a listing of all regulations. And our goal, at least for now, working with the Federal Register—we are trying to get them to agree to let us publish all our regs 1 day a month, so every reg coming out of CMS would come out and be in a compendium at the beginning of the quarter—if it is not on there, it will not come out—and then, once a month, you will see all the regs coming out of the agency on 1 day. The goal here is to try to make the process more predictable and manageable for the providers who perceive our regulatory process to be kind of random. We are trying to fix that as best we can.

We have a significantly enhanced effort on both physician and provider education and also on beneficiary education.

So in summary, in addition to your bill, we are doing the best we can internally to try to educate providers and beneficiaries and be more responsive all across the program.

If I could just for a second raise a couple of very minor concerns that we have with the bill that we would like to work with you on in the next couple of weeks, one is that there is a provision in the bill—and there are really only two things that I have any concerns about—there is a provision in the bill that says that after CMS promulgates a new policy, there can be no enforcement for 30 days. While I understand that from the providers' point of view, from our point of view, we are concerned that if we have no enforcement for 30 days, most providers are wonderful, honorable people, but if we cannot have any enforcement for 30 days, it is an invitation for people to take advantage of the program from a billing perspective for the first 30 days after a new policy is issued.

Second, from the point of view of the Blue Cross plans, which we have spent a lot of time working on this bill with, current liability for the Medicare carriers and Fiscal Intermediaries (FI), the standard is gross negligence, and the bill changes that to negligence, which is a much lower standard and would subject them to much greater liability.

At least in the 11th Circuit, in fact, right now, they have found that there is no liability for carriers for Medicare problems. So I think gross negligence is an appropriate standard—as I said, in the 11th Circuit, there is no liability—but lowering that to negligence would open the door to a lot more legal issues for carriers. We are trying to draw in new carriers and better carriers and FIs, and I think it would present a significant problem for us if you actually raised the level of liability for the carriers. So we would like to work with you on that as well.

In summary, Madam Chairman, we think the bill is excellent; we are very supportive of it. We would like to work with you, and we are very, very grateful that, on a bipartisan basis, the Subcommittee has moved forward on this bill.

Thank you for having me.

[The prepared statement of Mr. Scully follows:]

Statement of the Hon. Thomas Scully, Administrator, Centers for Medicare & Medicaid Services

Chairman Johnson, Representative Stark, distinguished Subcommittee members, thank you for inviting me to discuss our efforts to streamline the Medicare program. Many physicians, health plans, providers, and Members of Congress, have raised concerns about Medicare, particularly Medicare's regulatory and paperwork burden and the cost of doing business with the Medicare program. We appreciate these concerns, and are making every effort to identify and address areas where improvements can be made. *Physicians and other health care providers play a critical role in ensuring that Medicare beneficiaries receive quality health care*. We know that in order to ensure beneficiaries continue to receive the highest quality care, we must streamline Medicare's requirements, bring openness and responsiveness into the regulatory process, and make certain that regulatory and paperwork changes are sensible and predictable. In addition, we must reform the way we contract with the private entities that process and pay Medicare claims.

We also know how important these issues are to this Subcommittee. We have worked with you for months now to make Medicare a more "user-friendly" program. I especially want to commend you, Chairman Johnson and Representative Stark, as well as the other members of Subcommittee, for your leadership and dedication to improving the Medicare program. Your demonstrated commitment to the best interests of our nation's seniors and disabled is laudable, and I applaud the bipartisan manner in which you have approached modernizing Medicare's management. In particular, I appreciate your introduction of the bipartisan Medicare Regulatory and Contracting Reform Act of 2001 (H.R. 2768), which is intended to streamline the Medicare program. This Subcommittee has clearly dedicated a great deal of thought

and energy toward these issues, and this bill represents a good first step toward improving Medicare and reforming the way Medicare contracts with entities to process and pay claims. I look forward to continuing to work with you to achieve this critical goal. As we discuss legislative efforts to improve Medicare, I also appreciate the chance to discuss the aggressive administrative actions that we have already begun taking to improve the program. As we work to reduce Medicare's regulatory and paperwork burden and further improve our provider education efforts, we look forward to our continued partnership with Congress and the physician and provider community.

BACKGROUND

This year, Medicare will pay approximately $240 billion for the health care of nearly 40 million beneficiaries, involving nearly one billion Medicare claims from more than one million physicians, hospitals, and other health care providers. CMS strives to ensure that Medicare pays only for the services allowed by law, while making it as easy as possible for qualified health care providers to treat Medicare beneficiaries. We have to carefully balance the impact of Medicare's laws and regulations on physicians and other providers with our accountability for billions of dollars of Medicare payments.

Medicare's requirements, as outlined in the law, generate many of the concerns that our constituents bring to your attention and to mine. Of course, there is a genuine need for clear rules in a program this large and complex. But rules should exist to help, not hinder, our efforts to assist seniors and the disabled, help control costs, and ensure quality, while remaining consistent with our obligation and commitment to prevent fraud and error. When regulations, mandates, and paperwork unnecessarily hinder the services providers are trying to give, those rules should be changed. And so I am working with the Secretary to reform the way Medicare works, making it simpler and easier for everyone involved. We are listening closely to Americans' concerns and learning how we can do a better job of meeting patients' and providers' needs to serve beneficiaries in the best way we can. In many areas, we can be less intrusive to the providers who participate in Medicare and more responsive to the beneficiaries who depend on Medicare. Many of these changes can be achieved administratively; however, there are other important areas, such as reforming Medicare's contracting system, where we need your help.

REFORMING MEDICARE'S CONTRACTING SYSTEM

I am pleased that the Medicare Regulatory and Contracting Reform Act of 2001 includes provisions to improve Medicare's outdated contracting requirements, which make it more difficult for providers and beneficiaries to work effectively with the Medicare program. In order to continue to manage the Medicare program efficiently and effectively and to fully implement our business strategy, we must fundamentally change our relationship with the Medicare fee-for-service contractors. I firmly believe that the Medicare fee-for-service contracting work should be awarded competitively to the best-qualified entities, using performance-based service contracts that include appropriate payment methodologies. This is something that current law does not allow.

I believe these contracts should result in contractors receiving returns that reflect their relative performance. We must be able to maximize economies of scale and improve the level of service to our beneficiaries and providers. We are working cooperatively with our existing contractors to get to this goal, but these changes still require legislative action. I know you recognize this, too, and I want to work with this Committee and the contractors, including the Blue Cross plans, who have been very responsive to our requests for reform, to reach a consensus for a better contracting system.

In June, we forwarded our contracting reform proposal to Congress. Through these legislative changes, CMS hopes to accomplish the following:

- Provide flexibility to CMS and its contractors to work together more effectively and better adapt to changes in the Medicare Program.
- Promote competition for contractors, leading to more efficiency and greater accountability.
- Establish better coordination and communication between CMS, contractors, and providers.
- Provide CMS flexibility to negotiate contracts with incentives that reward Medicare contractors that perform well.

These changes will enhance the Agency's ability to more effectively manage claims processing for the Medicare program in the future, and ensure that the future changes to the Medicare program's operating structure are free from unnecessary

constraints. The Medicare Regulatory and Contracting Reform Act of 2001 is designed to accomplish these same goals.

We are continuing to proceed with the implementation of our long-range business strategy under our current authority. To capture the benefits of integrated data processing, we have begun to consolidate our claims processing workload among our existing contractors, and are moving to consolidate and standardize contractor claims systems. Our goal is to have one system for intermediary claims, one for carrier claims, and one for durable medical equipment claims. And we will continue to establish more direct control of our data centers, which should reduce costs and improve efficiency. This consolidation will allow us to make changes efficiently and consistently, and help streamline our information technology infrastructure. As we implement this long-range plan, I look forward to continuing to work with you to achieve this important legislative goal.

IMPROVING AGENCY RESPONSIVENESS

The other major elements of the Medicare Regulatory and Contracting Reform Act of 2001, is to provide regulatory reforms to the Medicare program while ensuring accurate and timely payments to providers and preserving our ability to collect overpayments and pursue fraud. I also share this goal of regulatory reform, and I believe changes in how we time the development and publication of regulations can best be addressed through administrative flexibility. As I mentioned, we already are taking aggressive steps to improve CMS's responsiveness. In June, Secretary Thompson announced that, as a first step in reforming the Medicare program, we were changing the Agency's name to the Centers for Medicare & Medicaid Services. The name-change is only the beginning of our broader effort to raise the service level of the Medicare program and bring a culture of responsiveness to the Agency. These are not hollow words: creating a "culture of responsiveness" means ensuring high-quality medical care for beneficiaries, improving communication with providers, beneficiaries and Congress, and redoubling our education efforts. To promote improved responsiveness, the Agency is:

- Creating Open Door Policy Forums to interact directly with beneficiary groups, plans, physicians, providers, and suppliers, to strengthen communication and information sharing between stakeholders and the Agency. I recently designated senior CMS staff members as the principal points-of-contact for eight "Open Door Policy Forums," including physicians, hospitals, rural health, nursing homes, health plans, nurses and allied health care professionals, home health and hospice, and ESRD and dialysis centers. These open forums will facilitate information sharing and enhance communication between the Agency and its partners and beneficiaries. I chair two of these forums, nursing home and rural health, and they will focus on fixing obvious problems.
- Enhancing Outreach and Education to beneficiaries, providers, plans, and practitioners, by building on the current educational system with a renewed spirit of openness, mutual information sharing, and partnership. We will start by educating seniors through a $30 million advertising campaign this fall to engage seniors in the program, combined with a massive enhancement of the 1–800–MEDICARE number. The toll-free lines will be expanded to 24 hours a day, seven days a week and the information available by phone will be enhanced, so that beneficiaries can obtain specific information about the health plan choices and costs. The Agency also is developing and improving training for physicians and providers on new program requirements and payment system changes, increasing the number of satellite broadcasts available to health care industry groups, and making greater use of web-based information and learning systems across the country.
- Establishing Key Contacts for the States at the regional and central office level. Paralleling the senior staff contacts for industry and beneficiary groups, these staff members are assigned to work directly with the Governors and top State officials to help eliminate Agency obstacles in obtaining answers, feedback, and guidance. Each State now has one Medicaid staff member assigned to their region, and another in Baltimore, both of whom are accountable for each State's specific issues.
- Responding More Rapidly and Appropriately to Congress and External Partners by promptly responding to their inquiries. We are developing an intra-Agency correspondence routing system, and timeliness standards, to respond more efficiently and promptly to congressional inquiries. We also are also exploring ways to make data, information, and trend analyses more readily available to our partners and the public in a timely manner. In addition, CMS will make explicit, and widely publicize, the requirements for obtaining data and analyses from us, including protecting the confidentiality of the data.

EASING THE REGULATORY & PAPERWORK BURDEN

A culture of responsiveness alone will not alleviate the regulatory and related paperwork burdens that for too long have been associated with the Medicare program. Thus, the Secretary has formed a new regulatory reform group to identify regulations that prevent hospitals, physicians, and other health care providers from serving Medicare beneficiaries in the most effective way possible. This group will determine what rules need to be better explained, what rules need to be streamlined, and what rules need to be dropped altogether, without increasing costs or compromising quality. To support this group, we have developed a program, focusing on listening and learning, to get us on the right track. This methodical, sector-by-sector approach will enable us to administer our health care programs as effectively and efficiently as possible.

Under the first aspect of the plan, CMS will conduct public listening sessions across the country. We want to hear directly from physicians and health care providers away from Washington, DC, and away from Baltimore—out in the areas where real people live and work under the rules we produce and with people who do not have easy access to policymakers to voice their legitimate concerns. Most of you in Congress have these kinds of regular listening sessions with your constituents. We want to hear from local seniors, large and small providers, State workers, and the people who deal with Medicare and Medicaid in the real world. We want to get their input so we can run these programs in ways that make sense for real Americans in everyday life. We hear from some of these people now, but we want to get input from many, many more.

The second aspect of the plan, as I have already discussed, is to meet in open forums with the various health-sector representatives and beneficiary groups here in Washington. These forums provide us with an opportunity to hear ideas about how we can improve our interactions with physicians and providers and reduce regulatory complexity and burden. Regular input from providers can help to improve our oversight and management of Medicare, so that health care professionals can spend more time delivering the care for which they were trained, and so that beneficiaries can spend more time with their doctors and other caregivers.

Like the physicians, providers, and beneficiaries who live and work with Medicare every day, CMS staff have worked with managing the system for years, and they too have suggestions about how Medicare can operate more simply and effectively. So, the third aspect of our plan is to form a group of in-house experts from the wide array of Medicare's program areas. I have asked a full-time practicing emergency room physician to chair this group and challenge our in-house experts to suggest meaningful changes. We will ask them to think innovatively about new ways of doing business, reducing administrative burdens, and simplifying our rules and regulations, without increasing costs or compromising quality. The complexity of the program even makes it difficult for those of us who administer it to keep up. It is difficult to educate beneficiaries, providers, and our business partners when there is so much complex information to explain. This group of in-house experts will look to develop ways that we can reduce burden, eliminate complexity, and make Medicare more "user-friendly" for everyone.

This will in no way diminish our interest in fighting waste, fraud, and error in the Medicare program. The vast majority of physicians and other health care providers are honest and want only to be fairly reimbursed for the quality care they provide. But for the small percentage of those who take advantage of the system, we will continue our aggressive efforts to protect the funds that taxpayers have entrusted to our use. It is important that the provisions of this legislation remain consistent with our efforts against fraud, waste, and abuse.

These outreach efforts will allow us to hear from all types of people who deal with our programs. We are going to listen and we are going to learn. But we also are going to take action. I am committed to making common-sense changes and ensuring that the regulations governing our program not only make sense, but also are plain and understandable. This will go a long ways in alleviating providers' fears and reducing the amount of paperwork that, in the past, has all too often been an unnecessary burden on providers.

In addition to these efforts, we are taking concrete steps to streamline Medicare's regulatory processes. We have developed a quarterly compendium of all changes to Medicare that affect physicians, and other providers, to make it easier for them to understand and comply with Medicare regulations and instructions. The compendium will be a useful document for predicting changes to Medicare's instructions to physicians and providers, and will contain a list of all regulations we expect to publish in the coming quarter, as well as the actual publication dates and page references to all regulations published in the previous quarter. By publishing changes in the compendium, physicians and other providers will no longer be forced to sift

through pages and pages of the Federal Register—or pay someone to do it for them—for proposed rules, regulations, and other changes that may affect them. There will be more notice and predictability. The compendium will generally include all program memoranda, manual changes, and any other instructions that could affect providers in any way. Additionally, we are moving towards the publication of all our regulations once a month, barring statutory deadlines. This monthly publication, along with the quarterly compendium, will provide predictability and ensure that physicians and other providers are fully aware of Medicare's changes so they have time to react before new requirements are placed on them.

We also are looking into developing a system of electronic rulemaking to make the rulemaking process more efficient and to reduce the flow of paper between providers and CMS. Today, in an effort to make updated regulations more readily accessible, we routinely post them on our website, www.cms.gov.

These postings coincide with the display of these documents in the Federal Register and have been well received by providers and other interested parties. Over the next six months, we will further explore the use of emerging technologies and the electronic exchange of information, such as posting proposed rules and taking comments on-line. We will work closely with beneficiaries, physicians, providers, and plans, as well as with Congress and other parts of the executive branch, to better understand their needs as we move towards an electronic rulemaking environment.

IMPROVING PHYSICIAN AND PROVIDER EDUCATION

As part of our efforts to reinvigorate the Agency and bring a new sense of responsiveness to CMS, we are enhancing our provider education activities and improving our contractors' communications with physicians and providers. The Medicare program primarily relies on private sector contractors, who process and pay Medicare claims, to educate physicians and providers and to communicate policy changes and other helpful information to them. We have taken a number of steps to ensure the educational information our contractors share with physicians and providers is consistent, unambiguous, timely, and accurate.

We recognize that the decentralized nature of our educational efforts has, in the past, led to inconsistency in the contractors' communications with physicians and providers, and we have recently taken a number of steps to improve the process. We have centralized our educational efforts in our Division of Provider Education and Training, whose primary purpose is to educate and train the contractors and the provider community regarding Medicare policies. We also are providing contractors with in-person instruction and a standardized training manual for them to use in educating physicians and other providers. These programs help ensure consistency so that our contractors speak with one voice on national issues. For example, in coordination with the Blue Cross/Blue Shield Association, we developed train-the-trainer sessions for implementing both the Hospital Outpatient and Home Health Prospective Payment System regulations, which included a satellite broadcast that was rebroadcast several times prior to the effective date of the regulation. Following these sessions, we held weekly conference calls with regional offices and fiscal intermediaries to enable us to monitor progress in implementing these changes. We are continuing to refine our training on an on-going basis by monitoring the training sessions conducted by our contractors, and we will continue to work collaboratively to find new ways of communicating with and getting feedback from physicians and providers.

We also are working to improve the quality of our contractors' customer service to physicians and providers. Last year, our Medicare contractors received 24 million telephone calls from physicians and providers, and it is imperative that the contractors provide correct and consistent answers. Now that we have toll-free answer-centers at all Medicare contractors, the need is even more pressing. We have performance standards, quality call monitoring procedures, and contractor guidelines in place to ensure that contractors know what is expected and so that we can be satisfied that the contractors are reaching our expectations. This year, for the first time, Medicare contractors' physician and provider telephone customer service operations are being reviewed against these standards and procedures separately from our review of their beneficiary customer service. During these weeklong contractor performance evaluation reviews, we identify areas that need improvement and best practices that can be shared among our other Medicare physician and provider call centers. As a result of the reviews, performance improvement plans will be instituted when needed, and CMS staff in our Regional Offices will continue to monitor the specific contractor throughout the year.

We also want to know about the issues and misunderstandings that most affect provider satisfaction with our call centers so that we can provide our customer serv-

ice representatives with the information and guidance to make a difference. To improve our responsiveness to the millions of phone calls our call centers handle each year, we are collecting detailed information on call center operations, including frequently asked provider questions, the call centers' use of technology, and the centers' training needs. We will analyze this information so we can make improvements to the call centers and share best practices among all our contractors. We also developed a new Customer Service Training Plan to bring uniformity to contractor training and improve the accuracy and consistency of the information that contractor service representatives deliver over the phone. In addition, we are holding regular meetings and monthly conference calls with contractor call center managers to ensure Medicare's customer service practices are uniform in their look, feel, and quality.

Just as we are working with our contractors to improve their provider education efforts, we also are working directly with physicians and other health care providers to improve our own communications and ensure that CMS is responsive to their needs. We are providing free information, educational courses, and other services, through a variety of advanced technologies. We are:

- Expanding our Medicare provider education website, www.hcfa.gov/medlearn. The Medicare Learning Network homepage, medlearn, provides timely, accurate, and relevant information about Medicare coverage and payment policies, and serves as an efficient, convenient provider education tool. The MedLearn website averages over 100,000 hits per month, with the Reference Guides, Frequently Asked Questions and Computer-Based Training pages having the greatest activity. I encourage you to take a look at the website and share this resource with your physician and provider constituents. We want to hear feedback from you and from your constituents on its usefulness so we can strengthen its value. In fact, physicians and providers can email their feedback directly to the medlearn mailbox on the site.
- Providing free computer and web-based training courses to doctors, providers, practice staff, and other interested individuals can access a growing number of web-based training courses designed to improve their understanding of Medicare. Some courses focus on important administrative and coding issues, such as how to check-in new Medicare patients or correctly complete Medicare claims forms, while others explain Medicare's coverage for home health care, women's health services, and other benefits.
- Creating a more useful Agency website through a new website architecture and tailoring it to be intuitive and useful to the physician user. We want the information to be helpful to physicians and their office and billing needs. The same design is being used in creating a manual of "Medicare Basics" for physicians. We just completed field-testing the first mock-ups for the project at the recent American Medical Association House of Delegates meeting. Once this new website is successfully implemented, we will move to organize similar web navigation tools for other Medicare providers.

IMPROVING AND EXPANDING BENEFICIARY EDUCATION

As Medicare requirements frustrate plans, physicians, and providers, beneficiaries also have difficulty understanding the program's benefits and options. We know, from our research and focus groups, that far too many Medicare beneficiaries have a limited understanding of the Medicare program in general, as well as their Medigap, Medicare Select, and Medicare+Choice options. We firmly believe that we must improve and enhance existing outreach and education efforts so beneficiaries understand their health care options. In addition, we will tailor our educational information so that it more accurately reflects the health care delivery systems and choices available in beneficiaries' local areas. We know that educating beneficiaries and providing them more information is vital to improving health care and patient outcomes.

With that goal in mind and in an effort to ensure that Medicare beneficiaries are active and informed participants in their health care decisions, we will expand and improve the existing Medicare & You educational efforts with a new advertising campaign. We will launch a multimedia campaign using television, print, and other media, to reach out and share information and educational resources to all Americans who rely on Medicare, their families, and their caregivers. We are also:

- Increasing the Capacity of Medicare's Toll-Free Lines so that the new wave of callers to 1–800–MEDICARE generated by the advertising campaign receives comprehensive information about the health plan options that are available in their specific area. By October 1, 2001, the operating hours of the toll-free lines will be expanded and made available to callers 24 hours a day, seven days a

week. The information available by phone also will be significantly enhanced, so specific information about the health plan choices available to beneficiaries in their state, county, city, or town, can be obtained and questions about specific options, as well as costs associated with those options, can be answered. Call center representatives will be able to help callers walk through their health plan choices step-by-step and obtain immediate information about the choices that best meet the beneficiary's needs. For example, a caller from New Britain, Connecticut could call 1–800–MEDICARE and discuss specific Medigap options in Connecticut. Likewise, a caller from Fremont, California, could call and get options and costs for Medigap or Medicare+Choice alternatives in their areas. If requested, the call centers will follow up by mailing a copy of the information discussed after the call.

• Improving Internet Access to Comparative Information and providing a new decision making tool on the Agency's award winning website, www.medicare.gov. These enhanced electronic learning tools will allow visitors, including seniors, family members, and caregivers, to compare benefits, costs, options, and provider quality information. This expanded information is similar to comparative information already available, such as Nursing Home Compare and ESRD Compare websites. With these new tools, beneficiaries will be able to narrow down by zip code the Medicare+Choice plan options that are available in their area based on characteristics that are most important to them, such as out-of-pocket costs, whether beneficiaries can go out of network, and extra benefits. They also will be able to compare the direct out-of-pocket costs between all their health insurance options and get more detailed information on the plans that most appropriately fit their needs. In addition, the Agency will provide similar State-based comparative information on Medigap options and costs.

CONCLUSION

Physicians and other providers play a crucial role in caring for Medicare beneficiaries, and their concerns regarding the program's regulatory and paperwork burden must be addressed. We share these concerns. We have already taken some critical first steps to address these concerns and bring openness and responsiveness into the process. We also must make certain that regulatory changes and requirements are sensible and predictable. I want to commend the efforts of this Subcommittee in developing the Medicare Regulatory and Contracting Reform Act of 2001. This legislation represents a good first step in improving Medicare and reforming Medicare's contracting system. We look forward to continuing to work with Congress and we will continue to seek input from the health care community, our beneficiaries, and partners in reaching our goals. I appreciate the opportunity to discuss these issues with you today, and I am happy to answer your questions.

Chairman JOHNSON. Thank you very much, Tom.

I appreciate your concern about the 30-day no-enforcement policy. Unfortunately, we are the prisoner of our own past, and the past has seen extraordinarily complex regulatory provisions coming down very, very frequently, with very unclear information.

I was very interested in the GAO's testimony that looked at how much paper flowed into various practices, and only 12 percent of the paper is from Medicare, but it is so unclear that the providers have to rely on others to interpret it.

So while one could say that they could ignore 88 percent of the paper, they cannot, because the directives coming down are so unclear. So I am very pleased that you are moving ahead on some of the things you talked about at the very beginning, putting regulations out at a set time, and the task forces. Through those means, I think we can improve the clarity of the directives to the point where there will not have to be so many industries that spend their time clarifying and interpreting the directives.

But the 30-day delay in enforcement is specifically related to the lack of clarity in the directives and the massive numbers that are

coming down and the situation of particularly small providers in trying to integrate that material.

So I would be happy to talk about this with you and your staff further, but there is a very significant problem that is going to be pretty clearly documented in the GAO testimony that we are trying to respond to.

Mr. SCULLY. Well, I would hope that maybe we can come up with some slightly higher standard for the first 30 days, but my concern is that obviously, if everybody in the provider world knows—and as I have said repeatedly, I think 98 percent of providers are trying to be good partners to the program, but if the 2 percent who may not be are aware that for the first 30 days after a program change, there is not going to be any enforcement, it is a problem.

Chairman JOHNSON. I do appreciate that. Unfortunately, I think we have been legislating to the small number who are bad actors, and that, in my estimation in the long term, will have the effect of killing off the small providers. So we will talk about that further.

I just want to ask you one more question and then I will move on to the rest of the panel, because I am very pleased that we have almost the full Subcommittee here.

We have really struggled with the issue of trying to help physicians deal with the normal audit process. Extrapolation has been an issue, and there are many other aspects to the issue. But one way in which our bill does not go far enough, in my estimation, in reflecting upon this since we have written it, I just want to mention to you. That is, it requires that your auditor explain to the physician his evaluation of the cases.

Not so long ago, I and Jim McDermott and some of the staff had a conversation with some of your staff, and we were talking about the difference between a Level 5 office visit and a Level 3 office visit. The Level 5 office visit requires documentation of a comprehensive physical. The Level 3 office visit requires documentation of a detailed physical. No one can clearly tell you the difference between those physicals.

So this is an underlying problem, and it is the kind of problem that requires more than that the auditor just explain to the physician why he thinks their coding was off, or the mistake was there, or whatever the problem is. It really requires that the physician have some level of right of appeal at that point, because if the sample is wrong, the extrapolation is going to be very wrong, and ordinary practices simply cannot tolerate the alternative of a full review of everything. It closes down their office for a week, and so on. It is very, very difficult to bear.

So particularly small practices in rural areas simply do not have that choice. So I am looking at strengthening that provision in the bill, and I have not talked with Pete about this yet, either, so I am putting this before the whole Committee at the same time. But our goal in requiring the auditor to explain his interpretation of the chart to the physician was to allow the physician to then bring information. But the physician has to have the right to say before some neutral body, "This is a Level 5. This is not a Level 3." And this issue of down-coding has been just as bad on both sides of the issue—both the administrative people coming in and looking at things with hindsight, and physicians coding inaccurately.

So I do want to strengthen that point because it is such an important point and has so many ramifications through the rest of the system that I think physicians deserve more than simply an explanation of why they are wrong. They are sitting there saying, "Yes, but you are wrong." So that sometimes, there is going to need to be a right of appeal of that sample so the sample is agreed to at some level.

That is just something that I am thinking about and wanted to lay out to you, because I think this business of moving ahead without a good base of information is one reason why providers are getting terribly discouraged with the Medicare system.

Mr. SCULLY. I agree with you. It is a tough balance to find, and we are certainly happy to sit down and try to fine-tune that provision. We have already spent a lot of time talking to your staff about it.

Chairman JOHNSON. Yes. Pete, would you like to proceed?

Mr. STARK. I have just a couple of issues. The OIG is concerned about giving up the right to conduct random prepayment reviews. Do you share their concern?

Mr. SCULLY. I think that is tied closely to what Chairman Johnson is talking about. We agree that we need to have prepayment reviews. I think the issue is really under what circumstances, and what are the provider rights. But I think that giving up prepayment reviews altogether would be a mistake, yes.

Mr. STARK. OK. We have talked about major problems with the information and assistance provided by the contractors, and I think we will hear testimony about these monthly bulletins which are close to undecipherable or hard to understand.

Do we have any reason to believe that the contractors are providing any more clear information to the beneficiaries? And as we are looking at the information that is given to providers by these contractors, would it be in order for you to review the information given to beneficiaries, which might be equally complex and bureaucratic in its nature?

Mr. SCULLY. It is complex, and our stated goal is to get down to 20 to 22 good, solid contractors in 4 or 5 years that are reliable and that are more predictable and are giving more common information out. One of the goals there is to make sure that——

Mr. STARK. What I am talking about is that in the bulletins that we are talking about, the providers are given so much information about rule changes all the time, and the GAO is going to suggest that all of this information is sent out in complex language, poorly written. But we would anticipate that most providers can read without moving their lips and get to 20 with their shoes and socks on.

I think our experience has been that when you get to be my age, you have to simplify the language some and spell it out in one-syllable or two-syllable words. So I guess my question is should we not be looking at the clarity of information we are giving to our beneficiaries that is provided by these intermediaries at the same time that we are looking at the information given to the providers?

Mr. SCULLY. Yes, absolutely. I hope we are.

Mr. STARK. I hope so, too, and as I said, I hope that that does not get lost in the process.

On 1–800–MEDICARE, you said that you want to enhance that. We have 27 pages of phone numbers; is there any reason why we cannot just use one phone number over the country and, worst case scenario, have people type in their own phone number to get the local one so they do not have to look through a bulletin to find the right phone number?

Mr. SCULLY. Well, one of the goals of this whole fall campaign, which has been delayed a couple of weeks, is to do exactly that—to have a 1–800–MEDICARE number where all seniors could call that number. We have almost tripled the number of operators we have; as I said, it is 24 hours a day, 7 days a week. The goal basically is that, whether you are in Oakland or in Connecticut or wherever, you can call to get detailed information about your area that you cannot get now on picking a nursing home, a dialysis center, Medigap versus Medicare+Choice versus fee-for-service—much more credible localized information—and also, you can be referred to the contractor. The 27 pages of phone numbers are generally the carriers and the FI numbers, and if you want to be referred to one of those, you can certainly be transferred through that line. But the goal is—I think we get something like 35 million calls a year, so I am not sure that it is going to replace the carrier and FI phone systems, but the idea is to give one standardized access point for seniors.

Mr. STARK. Do you have the money for that?

Mr. SCULLY. Yes, thank goodness. The appropriators were very nice and gave us the money for that.

Mr. STARK. The National Association for Home Care is going to talk to us later about the 15-percent reduction in home health payments now in the law. As I recall, we anticipated when we went to the Prospective Payment System (PPS) that the level of services would drop by at least 15 percent. And we are now hearing that indeed that has happened, that they have reduced services under the PPS perhaps even more than 15 percent.

So I guess my question is can we assume that the quality of care has not been reduced and that indeed that 15-percent reduction in services has occurred? Are you aware of that, or is that something that you do not have information on?

Mr. SCULLY. I am sorry. I am a little under the weather. Did you say home health, with PPS?

Mr. STARK. This is under home health care. We anticipated when the PPS payment system was put into effect that their level of services would drop by about 15 percent. We are informed that that has happened. GAO has suggested that it has dropped by at least 15 percent and perhaps by even more.

My question is does that comport with your information, and as far as you know, has the quality been maintained at the same time this level of services has been reduced?

Mr. SCULLY. Yes, I think it has. In 1992, home health spending was $3 billion; as you know, by 1997, it went up to $18 billion. Now I think it is back at around $12 billion. We probably could have done without that spike.

I think the home health PPS system has worked reasonably well. There were obviously some significant bumps in the road. I think the OASIS data we collect—while some people do not like all the

data that we require—is a very good quality measurement, and we are hoping to use it to more effectively put together quality measurements on home health and have it do an even better job.

But I think the evidence that we have seen so far is that home health quality has actually been pretty stable.

Mr. STARK. Insofar as you know, has the evidence supported what GAO is telling us, that is, that the level of services or the number of services has been reduced by about 15 percent?

Mr. SCULLY. I am not sure, but I am sure that is probably about right.

Mr. STARK. Somebody is going to whisper in your ear.

Mr. SCULLY. We have not heard that number.

Mr. STARK. You have not?

Mr. SCULLY. Only from GAO.

Mr. STARK. OK. Well, I hope you look at it, because this is going to be an issue in the sense that, arguably, if it has been reduced, we can continue with present law, which calls for the 15-percent reduction in the payments.

Mr. SCULLY. I think the 15-percent reduction in the payments, if I remember correctly, is because of the way the baseline works. The actual reduction in payments is 15 percent, but the actual spending would still, even if you did that, go up. That is not to say we should not get rid of the 15 percent, or implement or not implement the 15-percent reduction, but I believe the 15 percent reduction, even if you did it, you would still have a 2 or 3 percent increase in home health spending. It is a reduction in the rates, but spending would still go up.

Mr. STARK. But it would still be interesting to know if the amount of services went down or up, because under PPS, that would of course be important to whether the amount we were paying was correct.

Mr. SCULLY. Yes.

Mr. STARK. Thank you.

Chairman JOHNSON. Mr. Camp.

Mr. CAMP. Thank you, Madam Chair.

Chairman JOHNSON. Excuse me. Before you start, if some of you would like to go vote, and we will rotate, so we do not have to have a break, that would be useful.

I will recognize Mr. Camp and then Ms. Thurman, and back to this side, hopefully before the last of us go vote. Mr. Camp.

Mr. CAMP. Thank you.

Mr. Scully, when this legislation was introduced, the President said that it reflected important elements of his framework for Medicare legislation, which included simplifying Medicare's regulations and administrative procedures and updating and streamlining them, and also trying to reduce the instances of fraud and abuse.

My question is this. Obviously, we take the protection of the Medicare program very seriously in this Committee. I think it is one of the most important responsibilities you have as well. But as it relates to the provider payment audit process, wouldn't it be possible to protect program spending while at the same time creating a more collaborative audit process, giving a greater opportunity for

providers to discuss findings and provide additional information where conclusions are reached?

Mr. SCULLY. I think we are trying to find that balance where we aggressively make sure that program payments are appropriate but that we work more closely with providers so that they are not—I think there has been a perception in the last couple of years that they are all scared to death of the Medicare program—we need to find that balance, and we are certainly trying to do that.

Mr. CAMP. I know that some of our witnesses that will come later will discuss some issues, and the Chairman in her opening remarks mentioned that GAO has found that of 60 phone calls recently made to call centers to test the accuracy of responses to frequently asked provider questions, 85 percent of the GAO responses were incomplete or inaccurate.

Obviously, you believe that this is unacceptable as well, and I wonder how we can correct this.

Mr. SCULLY. Well, hopefully, one of the ways that we will correct it is through contract reform. We have 51 contractors, fiscal intermediaries and carriers, and some are better than others. Right now, we do not have the ability to narrow those down. We would like to be able to identify the best, probably around 18 to 22 contractors, and work with them to have much better services.

I was in Kentucky yesterday, and I heard a lot of complaining about their fiscal intermediary and carrier. I was in Arkansas 2 weeks ago, and they were relatively happy. So I can tell you that the service with the contractors varies significantly by State and by region, and we have very little ability to really fix that until we have contract reform.

If we can find the ability to have contractors compete again every 4 to 5 years, which is what we are talking about in the bill, and have the ability to incentivize contractors appropriately with financial incentives—right now, they are cost-based contracts—there are a lot of carriers and FIs that are slowly getting out of the program anyway. We would like to speed that up and narrow it down to 20 to 22 contractors, and right now, we have very little ability to make sure that the guys who are screwing up 85 percent of the phone calls are no longer in the program.

Mr. CAMP. I appreciate your efforts here, because obviously, there have been problems with what was the Health Care Financing Administration (HCFA) and is now CMS for many years, and I know that you are trying to step in and make some needed reforms and changes there, and I look forward to working with you as we go through that process and appreciate the effort that you are already putting forward on this. Thank you.

Mr. SCULLY. Thanks. Hopefully, I will come back without the flu someday to testify and have better answers for you.

Mr. CAMP. Thank you. You are doing fine.

Chairman JOHNSON. Congresswoman Thurman.

Mrs. THURMAN. Mr. Scully, still on the same idea with Congressman Camp—because as you can imagine, we are hearing from our districts about this very issue as far as the contracting part of it—and particularly what I am hearing from my physicians is that this is probably costing them 20 to 25 percent more in their offices to

keep up with all this stuff, which is obviously going to have a direct impact on increases in health care costs.

Maybe you can clarify this or somebody can tell me why, but the physicians have actually told me that they will have their staff call their provider or contractor and say, "I do not know, because of all the changes, and what you told me today is different than what you tell me tomorrow on codings" or whatever. And they are saying, "So I will ask them, well, if it is 26(a), 26(b), whatever those numbers are, in fact, they will say, 'Well, we cannot tell you that.'"

And then they will say, "Well, could you tell me if it is—" and they will say, "Well, if you mention it, maybe we could tell you."

Why would that be?

Mr. SCULLY. I am sorry—if you mention it, then what?

Mrs. THURMAN. That if you mention the number or the coding, "maybe we could tell you," but if you do not mention it, they just do not give you any information.

Is there a reason for that?

Mr. SCULLY. I am not sure what the—I think your question is if you call a provider—most providers are worried that if they give the carrier detailed information, they will be flagged for additional audits—is that what you are saying—so they cannot give them too much information?

Mrs. THURMAN. They will not give them the information to help them work through this. And as we know, over the last couple of years, we have continued to change this whole system over and over and over again, so what was today might not be tomorrow, so they are getting frustrated because when they call these folks, they are not willing to really help them through the system; they are more like, "Well, it is not that, and it is not this," but they will not really say, "Based on the information that you are giving me, this possibly will be what the model should be" or whatever.

Mr. SCULLY. Well, that is something we clearly need to fix, because there is no question that physicians—I spent 3 hours with a physicians group in Louisville yesterday, and they were not real happy with this process. So we need to find a way to get them clear, straight answers. They might not always like the answers. Generally, people do not like the answers unless you are allowing them to bill more than they want. But I do think that providers are entitled to clear, straight answers, and we need to keep pushing the contracts so they do that.

Mrs. THURMAN. The other thing that the contractors actually mentioned to me was that over the last couple of years, because of the changes, we have also had to reduce the amount of education that has been done, both through bulletins—they used to do it once a month; now they are doing it quarterly. They used to bring together providers and their office staffs, bring them in, walk through the system, what the new issues are, what the changes have been, and that they have been dramatically cut in those areas because of some of the things that we have done.

Can you respond to that at all?

Mr. SCULLY. I do not think they have been—I am not sure of the numbers—the carriers actually asked us for $47 million last year, and I think we gave them $42 million. Could they have used more for beneficiary education? Sure. I think that overall, when you are

looking at a $240 billion program—and I think our administrative budget is about $2.3 billion, and the contractor budget is about $1.5 billion—it is run on a pretty thin budget, so it is understandable sometimes, with the volume of claims we have, that not everybody is happy with the services.

But on the provider education side—and I will have to check—but I think the amount of money they asked for last year was relatively close to what they got.

Mrs. THURMAN. The other issue on competitive bidding—and I know that GAO and others have talked about that as being something that we needed to do—but on the other side of that, is there a way to develop a system where we can review and look at what the provider or a contractor is doing versus just upsetting the whole system, based on the amount of claims that they have?

My guess is that their infrastructure, what they put in place to help, has got to be an enormous cost, and if we start switching around just because, or we go through the bidding process—is there another way that you might suggest that we could do that?

And then I have just one other question that I need an answer to, because I am going to be doing some town hall meetings on Friday on the TriCare for Life issue with our veterans. They have been raising the question to me—and I do not know if you will have the opportunity to do this or not—for many people who particularly have gone through the Veteran's Administration (VA) system, they have never signed up for Medicare, there is a penalty for them not being in Medicare. I was told that there potentially was a waiver, and are we looking at this, and are we potentially looking at giving these folks who would have been in VA did not take Medicare, a waiver of the penalty that they would have been given if they were to go into the Medicare Program now?

Mr. SCULLY. I was not aware of that. I have talked a lot with the American Legion lately about VA subvention, which is obviously billing the Medicare program for services in VA hospitals. But I have not heard anything about the waiver, to be honest with you. I would be happy to look into it before Friday and call your staff with an answer.

Mrs. THURMAN. I would appreciate it, because this is becoming a big issue for those veterans who just never signed up for Medicare because they were always in the VA system; and of course, with the VA system, part of it was to bring closer to their homes. So they are very concerned about this.

Mr. SCULLY. I will get you an answer today.

Chairman JOHNSON. If the gentlelady will yield, Ben Cardin has a bill to this effect. We have just had it analyzed by the Congressional Budget Office (CBO), and we will try to make sure that option is available to our veterans.

Mrs. THURMAN. I would appreciate it. Thank you.

Chairman JOHNSON. I am going to turn the chair over now to Mr. McCrery, but let me just make one comment in response to the dialog that has gone on with the two preceding questioners.

One of the recommendations in the Medicare Education and Regulatory Fairness Act driven by providers was that they wanted a written response to questions. This does reflect not only their frustration and anger, but liability exposure to the fact that if they fol-

low directions that they are given, and they are not in writing, and later, the government comes in and says, "Oh, no, those were not the right answers, so you are liable, and you have penalties." We did not put the written response requirement in our proposal, but you should know that it is hanging out there very hard, and if we do not do a lot to improve our ability to offer concrete, specific, and true answers, we will sometime have to get to that.

I appreciate the load that it would place on the contractors, and therefore we backed off from it. I think the simplification task forces that you have got going—and I really commend you in your testimony for all the things that you are doing to drive the system toward a new opportunity to serve in a more collaborative way with the providers—are all important. But that demand for a written response came from a very, very broad body of experience and is a very intense desire. So it is not in this bill, but we should never forget that it is hanging out there.

I am going to turn the gavel over to Mr. McCrery and go vote. Thank you.

Mr. MCCRERY. [Presiding.] Well, Mr. Scully, I understand that you are under the weather, and you have my sympathies, so I will try to be easy on you. You also have my sympathies for being in the position that you are in—although, having said that, I am very pleased that someone of your character and capability and experience has agreed to take on this job. It is a job that nobody should have, in my opinion—which leads me to my first question.

While I am cosponsoring this legislation, and I am all for regulatory reform, couldn't we negate the need for this if we went to a premium support system for Medicare that was proposed by the Medicare Commission, voted a majority vote by the Medicare Commission, and is embodied in legislation in the Senate in the form of Breaux-Frist? Couldn't we avoid a lot of this rancor about who pays what, when, where, and all that?

Mr. SCULLY. Yes, I think you probably could. As you know, philosophically, not just me, but I think the administration's general view is that Medicare is a wonderful program, and seniors love it, but having the government fix prices for $240 billion in payments a year and having us do it the way we do it is probably not as efficient as having us buy insurance and operate more like the Federal Employees Health Benefits Plan. Philosophically, some day, we would like to be there, but as it is now, I just try to be the best price-fixer I can.

Mr. MCCRERY. And I appreciate that. We are not there, and it does not appear that we are going to get there very soon, so in the meantime, we have to concern ourselves with these kinds of questions that we are dealing with in the hearing today—and for that, you do have my sympathy, but I do appreciate your willingness to take this on.

There has been a lot of discussion about the audit process. I do think it is a necessary evil. Our providers, particularly physicians, do not like it. They do not think it is fair. They have to hire extra people to staff their offices to try to deal with these things. And frankly, a lot of them yearn for a day when they do not have to practice, and they do not have to put up with all that, because of HCFA or CMS and these kinds of concerns.

I know that you, like this Committee, are very concerned about the financial integrity of Medicare, and I think most physicians are concerned about the financial integrity of Medicare. However, there has got to be a better way than this combative process that we engage in.

Have you looked at and would you provide us information on any changes to that process that you think could make life better for the providers in the system, some kind of collaborative process that would involve them more at the initial stages so they do not have to go to the hearing level and all that?

Mr. SCULLY. I think one thing that would help—and it is in your bill, and it was in our proposal—is to have a Medicare ombudsman. One of the frustrations that people have is that they are calling, trying to find out what coding problems they have, what legal problems they have, and what compliance problems they have, and usually, they have to hire some lawyer like me and pay him "x" dollars an hour to give them legal advice. I think that is frustrating.

So I think that one thing we could do is create a Medicare ombudsman as a provision of this bill to do that so that providers who have problems can call and get an answer from somebody who is working closely with the Department but is not employed by the Department and have kind of a third party information system on legal and compliance issues. I think one of the great frustrations that physician practice groups have is the expense for small practice groups of having compliance programs. I actually think that most physicians are relatively—I will not say happy—but the Resource Based Relative Value Scale (RBRVS) system works significantly better, I think, than a lot of the other reimbursement systems in Medicare. I think the hassle factor is what drives physicians crazy, and I think that getting straighter, quicker, better answers that they can rely on, because they are usually not big practices that have significant ability to pay legal fees, would be a good step forward.

Mr. MCCRERY. I appreciate the concept of the ombudsman, and I hope that they get better answers than they do from calling the contractors. The GAO is going to testify in a few minutes that they made 60 phone calls to contractor call centers, and 85 percent of the responses that GAO received were either incomplete or inaccurate. So I hope we can find a system that is a little better at providing accurate information.

Mr. SCULLY. That is a stunning number, and we can certainly improve and have to improve on that.

Mr. MCCRERY. Yes.

I have just one more question, and then I know Mr. McDermott wants to inquire. In the bill that is before the Committee, we require CMS to competitively bid for contractors and intermediaries at least every 4 years; whereas in Secretary Thompson's draft reform proposal, he would have allowed renewal of contracts of those entities which met or exceeded certain performance requirements.

Both of those provisions go to the same goal of improved service for the customers. Have you thought about which way is better? Do you have some thoughts on that you can share with us?

Mr. SCULLY. The Federal Acquisition Regulation for other Federal contracting I think has competitive bidding every 5 years. I

think 4 or 5 years, either one—we are somewhat flexible on that. I think the real issue is that we would like to have the flexibility that we can identify good contractors that we do not want to rebid. There are some carriers, some FIs, that have a long, good track record; they have a great track record. In some rural States, for example, there are some carriers who probably are not going to change. For instance, Blue Cross of Montana is probably going to be the carrier in Montana most likely. There may not be too many others there. Rather than have us, staff-wise, spend an enormous amount of time rebidding contracts and going through the process, which is a long, lengthy process, I think we would like to have the flexibility or the presumption that we have to rebid every 4 or 5 years, but have the flexibility with some high standard of service to not have to rebid certain contracts, because it is time-consuming. We are hoping to get it down, but if you start with 51 or even 30, rebidding one-quarter of those every year is obviously more than cumbersome for the staff. So I think that some people intuitively probably do not need to be recontracted.

Mr. MCCRERY. So you would recommend that we change the legislation to give CMS the flexibility to renew contracts if the intermediary or contractor has reached a high level of performance standards or——

Mr. SCULLY. Yes—they show sustained excellent performance, and there is no—under some circumstances, we may not want to recontract every time.

Mr. MCCRERY. Thank you. I hope you get well soon.

Mr. SCULLY. Thanks.

Mr. MCCRERY. Mr. McDermott.

Mr. MCDERMOTT. Thank you, Mr. Chairman. When you start your renal task force, give me a call.

Mr. SCULLY. Which one?

Mr. MCDERMOTT. The renal task force to talk about renal dialysis.

Mr. SCULLY. I think actually, it has already started; but we would be happy to get you involved.

Mr. MCDERMOTT. I would like to know about it.

Mr. SCULLY. I think the first meeting was about 2 weeks ago.

Mr. MCDERMOTT. Listening to Mr. McCrery made me think—I think it was Yogi Berra who was sent in to replace somebody who had made a bunch of fielding errors, and he immediately made another error and when asked about it, said, "Well, the last guy in here messed this position up so bad there is no way you can play it right." I suspect that may be the position that you are in.

But I find myself—and others may have already asked this question; one problem with getting it broken up this way is that you do not know what was asked before—I find it very hard to find the equity. And I think we always struggle for equity. I do not usually push the American Medical Association's side of anything, but the equity issue around extracting a payment after you have had the contractor review and having extended periods—I think with the Administrative Law Judge (ALJ), more than a year is the average time it takes; and then, more than 2 more years on the Departmental reviews—to make somebody pay up front when more than

60 percent are rejected in the end means that they have had their money out there for 3 years, and then they get it back.

The weight is all on the physician, and I am not sure that is fair. I think it ought to be the other way, and I would like to hear you talk about the equity of the provider.

Mr. SCULLY. I generally agree with you. I hope we can fix that in the bill. I have had a lot of discussions with staff, and I think there are some changes in the bill on that.

My view is that it should be more like the IRS, that is, if you lose, you pay interest. But there is no reason for us to have money up front and then people have to wait for 3 years. I think there is some version of that in the bill——

Mr. MCDERMOTT. Is that in this particular——

Mr. SCULLY. Yes, I think it is—yes, for the first level of appeal, anyway. I would be happy to talk to you about it more, but to the first level of appeal, you do not have to put the money up in the bill. That is one of the changes in the bill. So at least for your first level of appeal, you have the ability not to pay, and if you lose, you pay with interest, which is more like the IRS provision for taxes.

Mr. MCDERMOTT. Why don't you wait until the end of the appeals process and make it appeals plus interest—well, your penalty plus interest at the end?

Mr. SCULLY. If you do not prevail, yes.

Mr. MCDERMOTT. All the way to the end, not—when do you have to pay them?

Mr. SCULLY. At the end of the first appeal, if you lose, you have to pay with interest—the first-level appeal.

Mr. MCDERMOTT. That is inside the company that just put you on notice in their audit anyway; right?

Mr. SCULLY. That is right. I am sorry. I was going to read all of this last night, but I was not feeling up to it.

Mr. MCDERMOTT. OK, I will give you some slack.

Mr. SCULLY. The concern was—and to be honest with you, I kind of agree with you; I think this is significantly better than current law—the concern was the incentives for people—this is more, I think, from the IG and the Justice Department and our own lawyers—that people would have an incentive to string out the appeals and wait and wait and wait and appeal and appeal and appeal, as opposed to getting a decision at the first level. But I agree with you—I think this is the first step. As it is right now, you pay up front, and you do not get the money back until you win the appeal. So I think this is half-a-fix, from your point of view.

Mr. MCDERMOTT. So you are not against fixing it more by pushing it one more level?

Mr. SCULLY. Well, as you know, I do not get to set all the administration's policies. We have discussed this, and this is what we came up with in the administration. There is a lot of concern about creating extra incentives for extended appeals, and I share your view that in certain cases, it is not appropriate for us to have the provider pay, and then we keep their money while they appeal.

Mr. MCDERMOTT. I do not have any problem going after corrupt physicians. That is not the problem. The problem is that when we throw this net, it is clear that we catch far more fish than really—there is a lot of "by-catch" as we say in the Northwest—it is not

the ones you really want. And those people get hurt badly by having to come up with a cash amount. They have got to go out and borrow it in most cases and then continue fighting the appeal.

So it seems to me that we should move it back further, and I hope we can have an amendment to that point.

Mr. SCULLY. I think the bulk of those appeals, just looking at the numbers—5.7 million claims out of 6.7 million claims at that first level. I am not saying it is a perfect fix, but the bulk of the appeals, or a significant number of the appeals are resolved at the first level, and unlike today, they would not have put the money up front. So I think it will be of significant help.

Mr. MCDERMOTT. But not as much as we——

Mr. SCULLY. Not as much as your idea.

Mr. MCDERMOTT. OK. The other thing is the whole business of extrapolation. Explain to me why you think extrapolation is a good way to go.

Mr. SCULLY. When I was on the provider side until 4 months ago, I thought extrapolation was terrible. Then I came to the agency and talked to the people on the program integrity side about why they do it, and now I think there are two sides to it.

I think providers are angry that they get extrapolation and then get action taken based on that. Our program integrity folks' attitude is that we only check 1.5 percent of all claims, and then we have no idea what is going on for the other 98.5 percent of claims, and that the only way to really identify trends is extrapolation, and that since we check so few claims, you do not have any choice but to use extrapolations. I think there are arguments on both sides. Now that I have been inside the agency, I understand why they do it; I also understand why it drives providers crazy.

Mr. MCCRERY. Mr. Crane.

Mr. CRANE. Thank you, Mr. Chairman.

First of all, Mr. Scully, I want to congratulate you for your participation in our health care conference at Northwestern Medical School; I had nothing but compliments about your presentation. We were grateful that you were able to be there with us.

Back when this bill was introduced in early August, the President issued a statement saying that the legislation was an important step toward strengthening Medicare for seniors and for future retirees and that it reflects important elements of his framework of Medicare legislation.

I would like to ask you specifically—President Bush's principles for Medicare reform state that Medicare regulations and administrative procedures should be updated and streamlined, while the instances of fraud and abuse should be reduced.

How would you intend to try to implement the principles of President Bush's proposal?

Mr. SCULLY. I think we have done a lot already. I was in the hospital business until 4 months ago, and I was one of the angry providers, or represented angry providers, and I think we have tried in the agencies as much as we can—I think I told you this before, that when Secretary Thompson came to Washington, he was one of the great HCFA-haters of all time; as Governor of Wisconsin, he had had a lot of frustrating experience with Medicaid waivers, so he was not a big fan of the agency. Once he spent a week in Balti-

more learning more about the agency, he realized as I have that there are a lot of very smart, hardworking people up there. But for the most part, largely because they get pounded by providers, Congress, and lots of other people, they were pretty defensive and pretty insular.

So I have really tried to get people at the agency to go out and talk to the industries that they regulate and that they pay and try to understand them better. These eight working groups are a piece of that effort to try to get people to deal with home health agencies and talk more with the home health agencies; to get the people who regulate hospitals to actually spend some time in hospitals, because it is easy to get stuck in Baltimore and not do that. As much as I possibly can, I have been driving people to the agency to understand the parts of the health care system they regulate better, and so far, they have been pretty responsive. I do not think that will fix all the problems, but I think better communication will solve about 90 percent of the problem.

I had a great relationship when I was in the hospital field with the HCFA hospital staff because I went up there a couple times a week and got to know them all, and I kind of broke the code. The average Chicago hospital administrator has a tougher time doing that. So I am trying to get the regional offices, the Baltimore people and the Washington people to make a bigger effort to go out and understand the people they regulate, and so far, we have not fixed everything yet, but I hope the people in the provider community feel like we have made a big effort to turn that relationship around.

Mr. CRANE. Thank you, and we look forward to working with you.

Mr. MCCRERY. Mr. Kleczka.

Mr. KLECZKA. Thank you, Mr. Chairman.

Mr. Scully, I have a couple of quick questions. I believe that in answer to Mr. McCrery, you indicated your support for the provider ombudsman contained in the bill.

Mr. SCULLY. Yes, sir.

Mr. KLECZKA. And briefly, restate for me what you believe the functions of this person will be within the agency.

Mr. SCULLY. I think the basic idea is that they be kind of a quasi member of the agency. There are a number of ways that you could do it. I think the most likely way is for the agency to contract out with someone in the National Association of Health Lawyers or some party that would be closely connected with the agency and would have a lot of information about the agency's regulations and compliance efforts, but independent.

Mr. KLECZKA. So you do not view this person as an employee of CMA?

Mr. SCULLY. It could be an employee, it could be a contractor. My personal preference would be to hire somebody like the National Health Lawyers Association on contract, because what you do not want people to do is call from Wisconsin, ask opinions, and feel bound by—it could be an employee of the agency as long as it is clear to the person calling and asking for the guidance that no one is going to launch an enforcement action based on that phone call.

Mr. KLECZKA. I would think they would have to be an employee of the agency if they are going to have access to certain information that would respond directly to an inquiry from, say, a hospital or a doctor's office.

Along that same vein, what is your position on providing for a patient's ombudsman or ombudsperson?

Mr. SCULLY. I would be all for it. I do not think it is in this bill——

Mr. KLECZKA. No.

Mr. SCULLY. But I think that better communication with beneficiaries and providers is important. I am not sure—I cannot say that for the administration.

Mr. KLECZKA. Perhaps between now and markup, Madam Chair, we could possibly explore that. It was in legislation last year, I think, the drug legislation, and if we are going to provide sort of a quarterback, someone to run interference for providers, with 30 million-plus beneficiaries, maybe a person helping them a little bit might be in order.

Thank you very much, Mr. Scully.

Chairman JOHNSON. [Presiding.] Mr. Ramstad.

Mr. RAMSTAD. Thank you, Madam Chair, and thank you for your leadership.

Mr. Scully, I join my colleagues in expressing our gratitude that a person of your caliber is in this important position and appreciate working with you.

Let me just say that in my meetings with health care providers back home in Minnesota, every time I meet with them, I hear about the crushing paperwork burden they face. It was certainly brought home to me very vividly recently when I went to a skilled nursing facility, and they told me they had just hired two registered nurses to do nothing but paperwork.

Obviously, we cannot afford to divert those kinds of resources from care for the sick, so we need these reforms, and I appreciate my colleagues on both sides of the aisle working in a bipartisan way to craft this legislation.

One glaring concern that I have concerns local coverage flexibility, something that we have discussed before. According to a recent study with which I am sure you are familiar—and virtually every health care provider and Medicare beneficiary I speak with—the local coverage process is absolutely vital to Medicare's continued quality improvement because the local process is the way that patients can best gain access to the many innovative technologies that otherwise would encounter incredible coverage delays at the national or CMS level. We have all seen too many examples of those unconscionable delays in the past.

One example cited in this recent study, "Breakthrough Technology in Women's Health," which is used to diagnose osteoporosis—it took Medicare over 7 years—this is obviously before you came aboard—but it took Medicare over 7 years to cover this technology at the national level. But because many local Medicare contractors approved local coverage during that time, most women were able to gain access to the technology who otherwise would not have been able to receive it.

These unconscionable delays cannot stand. My question is this, Mr. Scully. If contractors are regionalized and consolidated, how can you assure us that you will maintain the necessary flexibility at the local level to allow new procedures and new technologies to be available as they are currently in selected localities? I am really concerned about this if we nationalize it.

Mr. SCULLY. Hopefully, it will be better. If you took the 51 contracts that we have now in Part A and Part B and consolidated them into a combined A and B contract, you would have about 30. And we are talking about going from 30 to probably 20 or 22, somewhere in that range.

So our goal is to find the best contractors and the best partners who are going to provide the best services and make good, sound, rational, well-thought-out local coverage decisions, among many other things.

So I would guess that the localized trends and coverage decisions would not change that much. You would have 20 contractors, roughly, instead of 30 making those decisions. And I think that probably 75 percent of coverage decisions are made locally, and about 25 percent are made nationally, and I think that kind of flexibility is a good idea and is likely to remain.

Mr. RAMSTAD. It is very reassuring that you plan to preserve the local coverage decision process. From what I understand from talking to people in your office, it is about 75 percent——

Mr. SCULLY. I hope the national coverage process is getting faster and better as well.

Mr. RAMSTAD. Well, certainly, Minnesotans appreciate the ability to work with the local medical community, so this local flexibility, I am glad to hear will continue, because if contractors are regionalized and consolidated, the fear is that it will become more nationalized, with less emphasis on local coverage decisions, which is absolutely imperative to get these breakthrough technologies especially to Medicare beneficiaries.

I am sure you share the judgment that Medicare beneficiaries should have the same access to medical technology, life-saving, life-enhancing medical technology, that every other health care consumer has. Do you share that judgment?

Mr. SCULLY. Sure, absolutely. I think that in some cases, we are faster than private insurers, and in some cases, we are slower; but absolutely.

Mr. RAMSTAD. Thank you again, Mr. Scully. I appreciate working with you and look forward to continuing that working relationship, and I yield back.

Chairman JOHNSON. Mr. English.

Mr. ENGLISH. Thank you, Madam Chair.

Mr. Scully, since you have landed in the administration, you have been a breath of fresh air at gale force, and we appreciate it.

As someone who used to be an internal auditor myself, I was wondering if you could don your green eyeshade for a moment and talk about some of the mechanics. Implicit in some of the things you have said about awarding contracts more based on performance is a very strong system of performance measurement. Also critical in addressing waste, fraud and abuse is a strong system of auditing.

I wonder if you could comment on what improvements you anticipate in the audit process and specifically, do you anticipate that audits could become more collaborative working with Medicare contractors. Specifically, do you think it is possible in audits to create more opportunities for discussion, for exploration of findings, and allowing providers to provide more information?

None of these ideas is new. They are embedded in generally accepted auditing standards. But too often in the past in your agency, I do not get the sense that these kinds of approaches were tried. Would you care to comment?

Mr. SCULLY. I certainly think we have to improve the interaction between the providers and the auditors, and I think we can certainly work on doing that.

Getting back to your core question, though, about cost-based contractors, I think the fundamental change that you are going to see in the program is that cost-based payment for anything, in my opinion, does not work. It did not work for inpatient hospital payments in the early eighties, and we switched to Diagnosis Related Groups. The 51 contractors that we have now are paid on cost. If they cannot make a margin, they have no incentive to perform better, they are reimbursed for their costs, and I have never seen a cost-based system that provides the right incentives.

So what we would like to do, basically, is give—theoretically, if you are a Blue Cross plan, Blue Cross of Pennsylvania, right now, you do not make any margin on your Medicare contracts. Now, the reality is that people like it because they can shift the costs of some of their systems and other things on the private side over, and they are kind of a good building base for the rest of your insurance business. But you are theoretically not allowed to have any margin.

We believe pretty firmly that if we actually find 20 to 22 good contractors and incentivize them appropriately and give them the right incentives, and also give the providers the ability to rate them, which we have talked about doing, give the hospitals and the physicians the ability to come and give us feedback on who we compete the contracts with, that we will have good contractors who are sensitive to the needs of the providers and who are obviously sensitive to the fraud and abuse issues, but also provide more aggressive and better services for us, because right now, their incentives are minimal.

Mr. ENGLISH. Do you anticipate any changes—going back to the other part of my question—do you anticipate any changes to make the audit process more collaborative, more interactive, giving the service providers an opportunity to respond to findings before they are made public, and provide additional information to put the audit findings into context?

Mr. SCULLY. I hope we are doing that more recently, and I spent some time talking with our program integrity people about that, and I believe the carriers and the FIs are doing that, and it sounds from the tone of your question like we need to make a better effort. But I thought we were heading in that direction and trying to make it a more cooperative and not quite as adversarial a process.

Mr. ENGLISH. Very good. As my final line of inquiry, with your emphasis on performance evaluation, how do you develop the performance standards that you use for that? You referenced the

standards in your testimony. What kind of process do you have, and if it is more appropriate, I would welcome you providing a written answer to the last part of that question rather than tie us up here this morning.

Mr. SCULLY. I would be happy to provide you with a written answer, but I think there are some guidelines in the bill we set up and our proposal for how we do evaluations, and a lot of it is through feedback from the providers and ratings from the providers. That is certainly something that providers want.

Mr. ENGLISH. Very good. Thank you. Thank you, Madam Chair.

[The following was subsequently received:]

Centers for Medicare & Medicaid Services
Washington, DC 20201

Contractors currently are evaluated through a Contractor Performance Evaluation (CPE) process, which evaluates their performance of specific responsibilities defined in the Medicare contract, law, regulations, and general instructions. The CPE process is structured into five broad criteria: claims processing, customer service, payment safeguards, fiscal responsibility, and administrative activities. Each of these criteria contains business functions that may be reviewed, such as medical review, beneficiary and provider customer service, benefit integrity, and provider enrollment.

The law requires that we formulate criteria and standards to determine whether contracts with fiscal intermediaries and carriers should be entered into, renewed, or terminated. Additionally, the law requires us to publish the CPE criteria and standards in the *Federal Register*. On September 7, 1994, in the *Federal Register* we specified all standards that are mandated by law or court decision and have provided examples of others. Some mandated standards include paying 95 percent of clean electronic claims within 14 to 30 days and 95 percent of clean paper claims must be paid within 27 to 30 days; as well as writing review determinations at an appropriate reading level.

In addition to the mandated standards, CMS expects contractors to meet performance requirements issued to them in program instructions or in connection with their annual budgets. Examples of these are requirements to:

- respond to telephone inquiries within specified timeframes;
- conduct audits or specified percentages of cost reports from specified types of providers;
- conduct quality monitoring of the telephone service provided by customer service representatives;
- increase over the prior year the amount of automated medical review conducted; and
- issue bulletins/newsletters with program and billing information to providers each quarter.

Medicare contractors perform a wide range of activities as part of each business function, and CMS evaluates contractor performance on an annual basis. Additionally, other types of reviews are performed at contractors outside of CPE, including reviews of contractors' internal controls as required by the Federal Managers Financial Integrity Act, and reviews of financial operations in connection with the annual Chief Financial Officer audit of CMS.

Chairman JOHNSON. Mr. Johnson.

Mr. JOHNSON of Texas. Thank you, ma'am.

I would not call it a "gale force"; that is what he called it. I have not seen that coming out of your agency. All I have seen is a name change, which I cannot remember to save my soul, so if I call you "HCFA," please do not worry about it.

What I would like to know is what are you doing to help the people out there, because all I see is in Dallas, Texas, two of our pro-

viders have stopped or say they are going to stop providing Medicare+Choice.

So could you tell me what you are doing to stop that?

Mr. SCULLY. Well, I think I was about as aggressive as I could be in stopping Medicare+Choice—too aggressive for some, since I——

Mr. JOHNSON of Texas. We do not want you to stop it. We want you to——

Mr. SCULLY. No, no—to stop the people dropping out.

Mr. JOHNSON of Texas. OK.

Mr. SCULLY. I have been a pretty strong advocate of Medicare+Choice for a variety of reasons, including the fact that demographics show that lower-income people like Medicare+Choice because they have lower premiums and more drug coverage. So we certainly want to keep as many people in as we possibly can. We had about 5.6 million people in last year, and it will probably be down to a little under 5.1 million for next year.

We moved the adjusted community rate filing date back, which is the date for the plans for file, from July 1 to September 17, which I was sued for, and we worked with the Gray Panthers and the other plaintiffs and the court, and I think we have worked that out. We are sending out additional mailings next month to educate seniors. But we tried to give the plans more time to decide what their finances were for last year. We tried to give them a better opportunity to make the financial decision whether they are going to stay in or not; and to be honest with you, that led to the ad campaign and understanding that we are going to have to start educating seniors later, because of the later filing date. We thought we had better bend over backward to give them a lot of information, and that is largely where the idea for the ad campaign came from, that if we were going to start September 17 instead of July 1 to educate seniors, we had better give them a lot more information about their program.

I think most of the health plans—I regret that there was one that pulled out of Dallas—but I think I spoke with almost every chief executive officer of a major plan in the country, and I personally pleaded with a bunch of them to stay in the hope that Congress would fix the program this year. I personally think and the administration feels that the Medicare+Choice funding formula is broken and is not working and that it is pure economics as to why people are dropping out, and that if we do not fix it, a lot more people will drop out before next year. At many, many, many plans that I talked to, the chief executive officers asked, "Do you think Congress is going to fix this, because I may stay in for one more year," and in many cases, I pleaded with them to stay in——

Mr. JOHNSON of Texas. If we could do one thing to fix that, what you think that should be?

Mr. SCULLY. I think that with the best intentions in 1997, the urban and suburban areas were doing very well in Medicare+Choice, and there was an effort to push money into the rural areas, and largely what has happened is that you have had 3 years in a row of 2 percent—the payments in the Medicare+Choice program have capped at 2 percent the last 3 years in a row, and cost growth has been 10, 12 percent. So when you look at it,

it is pure economics—the plans have gotten squeezed out. They have had to cut their drug benefits, raise their premiums, and the numbers just do not work.

So I think we could revisit the formula. Some would argue you should put more money back into the program. I think you could put some money back into the program and revisit the formula, and I can tell you the administration thinks that is a very top priority for this year, because we are down to a little over 13 percent of people in the Medicare+Choice Program.

I cannot imagine that I could have been any more aggressive than I was in trying to keep people in, so I regret that you lost some providers in Texas, but I talked to a lot of providers, including a couple of Mrs. Johnson's in Connecticut who dropped out as well despite my effort, and I think we did everything we could to send the signal to people that we were trying to make the program flexible. We are very big fans of the program and would like to get as many people back in as we can.

I think the people who are in for 2002 are probably in for 2002. I think the most appropriate thing to do would probably be to put some financing in and fix the formula for 2003.

Mr. JOHNSON of Texas. Thank you. I think part of the problem also is the paperwork issue that was brought up here previously. I just do not know how you can stop that.

Mr. SCULLY. In fairness, we made a number of changes that the health plans complained about to reduce their paperwork burden. I hope that if you ask them——

Mr. JOHNSON of Texas. What are you doing for the individual doc? You were in the hospitals; you know what a problem they have with paperwork.

Mr. SCULLY. Yes. Well, one thing we did—and again, it was not universally popular—we had a major risk adjustment collection mechanism—physicians do not always love managed care, but the one thing they like about it is they generally do not have to provide a lot of very detailed billing information.

Mr. JOHNSON of Texas. Have you stopped changing the Codes every month?

Mr. SCULLY. Yes. We suspended the physician requirement for risk adjustment for one year; if we do not find a better one, we are going to reinstate it next year. A lot of the things that the managed care plans and the physicians in managed care plans asked for, we did, to try to make their lives simpler this fall. I cannot think of too many stones I left unturned that I could do without getting sued, and I did get sued, although we worked that out in a reasonable way. But I think we are pretty aggressive in trying to keep people in the plans.

Mr. JOHNSON of Texas. Thank you, sir.

Chairman JOHNSON. I would rather not let your statement about 203 lie, because many of the plans are telling us that they will stay in for next year if, before December 31, it is clear to them what the terms will be, and if there are more realistic levels of reimbursement and some greater regulatory relief.

The whole goal of changing the date—and this Committee is eventually going to have to deal with this—you cannot make people make business decisions when they have no idea what they are

going to be paid for their product. And the whole system of the plans saying whether they are going to be in or out and at what price has to be better aligned with our appropriations process.

So one of the ways we got into this trouble was that they decided to stay in, thinking that we were going to help them at a higher level than 2 percent—even last year, this Committee recommended 4 percent, and in the end, it was pulled down to 3 percent, and so on and so forth. So you cannot have people trying to make economic decisions about products in the market when they do not know what they are going to get paid. We need to realign that whole system of provider bidding and consumer education so seniors can have a good chance to know what their choices are, but we maximize the continuity and stability of the program by putting the choices out there once people know what the Congress and the administration have done to address their problems.

In closing off, let me say thank you very much for being here, Tom. I know you do not feel very well today, and I appreciate your staying true to your commitment under really adverse circumstances to be with us.

I want to conclude by reading a small passage from the testimony by the American College of Physicians and the American College of Internal Medicine, because I want your staff to look at this before we get through this process, because I know Jim McDermott raised some issues here, and we just have to take more seriously the crisis that we are creating in physician offices.

This testimony says: "In internist carefully reviewed the 1997 guidelines and calculated the number of decisions that a physician must make before selecting a level of Evaluation and Management Services (EM) in billing Medicare. It includes 11 decision points and categories to consider before selecting the EM code. Each decision point requires several choices. There are 42 choices a decision must consider before selecting the proper EM service. There are 6,144 possible combinations representing the number of ways an office visit for a new patient can evolve and be classified."

It has gotten to be extraordinarily ludicrous, and we have to do something about how physicians bill and what code they select. If we do not do that, in the end, we will erode the quality of medical care in America because we will erode the quality of care that physicians are able to offer and the kind of people who go into medicine.

So this is a big issue. In this testimony, two or three important points are brought up that we had not really considered, and we need to talk about, and Pete and I need to talk about and the members of the Committee need to look at what more along that line we can do even in this bill.

Thank you very much for being here, Tom. We look forward to working with you. You have been very willing to work with us on a lot of complicated issues, and I thank you.

I also thank you for starting out your testimony by talking about HIPAA. We too are being deluged with HIPAA concerns, and we need to come to some conclusion about how best to handle that.

Thank you very much.

Mr. SCULLY. Thanks.

Chairman JOHNSON. I would now like to welcome the next and final panel. We will hear from all the experts and then open the floor for questions.

Leslie Aronovitz is from the Health Care Program Integrity division of the GAO. She will testify on behalf of two different people, so she will be allowed to go a little longer than the 5 minutes and make a 10-minute presentation.

Bill Hall is president of the American College of Physicians and the American Society of Internal Medicine; and Susan Wilson is vice president, Clinical Operations, and chief operating officer of the VNA of Central Connecticut and is speaking here on behalf of the National Association of Home Care.

Thank you all for being with us, and Ms. Aronovitz, if you could start.

STATEMENT OF LESLIE G. ARONOVITZ, DIRECTOR, HEALTH CARE PROGRAM ADMINISTRATION AND INTEGRITY ISSUES, U.S. GENERAL ACCOUNTING OFFICE

Ms. ARONOVITZ. Madam Chairman and members of the Subcommittee, I am pleased to be here today as you discuss modifications to the Medicare Program as set out in the proposed MRCRA.

This Act addresses two key problems that we have recently studied. First, physicians have expressed growing concern that Medicare is creating a blizzard of complicated, unclear, and inconsistent information about program requirements, and because the rules change frequently, they cannot stay current.

Second, observers of Medicare operations have for a long time questioned whether Medicare could be run more effectively if its claims administration contractors were selected through full and open competition and paid based on their performance.

With regard to the first problem, Medicare's communications with providers, our findings, as you noted, were quite disturbing. For example, carriers issue bulletins to physicians as a primary source of information about Medicare rules. For the 10 carriers we looked at, some bulletins were more than 80 pages long, with over 50 pages being the norm. They often contained long articles, written in dense language and printed in small type. Some of these had no table of contents while others did not identify topics by specialty.

We also found a number of instances in which the announcement of program changes came out after the changes had taken effect. Among carriers with multi-State bulletins, some developed separate State inserts; but others required that the physician read the entire article to determine if the change was apropos in his or her State.

In addition to periodic bulletins, carriers rely on their websites to provide another avenue of communication, but these also have many shortcomings. In our review of 10 carrier websites, we found that most lacked basic organization and navigation tools, like site maps and search functions that increase a site's user-friendliness. Further, five of the eight sites that had a required schedule of upcoming workshops or seminars were out-of-date. Although one site contained a potentially useful "What's New?" page, the page con-

tained a single document of regulations that went into effect in October 2000, 8 months prior to the date of our website review.

A third communication vehicle for physicians billing Medicare is the carrier call center. I want to clarify something that we have talked about in our testimony. Call centers answer two general types of questions. One type is on the status of a specific claim. The other is questions that pertain to coding and billing the program in specific instances.

We did not test the adequacy of the call centers in responding to the status of specific reimbursement questions. But we did perform a limited test of approximately 60 calls to provider inquiry lines of five carrier call centers on coding and billing issues. The three test questions, all selected from the "Frequently Asked Questions" on carriers' websites, concerned the appropriate way to bill Medicare under different circumstances.

The results of our tests, which were verified by a CMS coding expert, showed that only 15 percent of the answers were complete and accurate; 53 percent were incomplete, and 32 percent were entirely incorrect.

We found that CMS has established few standards to guide these three types of activities. While CMS requires contractors to issue bulletins at least quarterly, it requires little else in terms of content or readability.

Requirements for web-based communication generally focus on legal issues that do nothing to enhance providers' understanding of Medicare policy.

In regard to telecommunications, contractor call centers are instructed to monitor up to 10 calls per quarter for each customer service rep—but CMS' definition of what constitutes accuracy and completeness in call center responses is neither clear nor specific. Moreover, the assessment of accuracy and completeness counts for only about 25 percent of the total assessment score, with process issues like phone etiquette accounting for the rest.

CMS conducts much of its oversight of contractor communications through contractor performance evaluations—we call them CPEs. While these reviews have not focused on the quality or usefulness of contractor bulletins or websites, CMS has begun to focus on call center service to providers.

But again, the CPE reviews focus mainly on process rather than on the more difficult issues involving an assessment of response accuracy.

CMS officials noted a lack of resources for monitoring carrier activity in this area—and this is not just Mr. Scully, but everyone that we have talked to at the high levels in CMS. Their own data show that there are fewer than 26 full-time-equivalent staff assigned to oversee all carrier-provider relations efforts nationwide, and these people are typically stationed at the regional offices which provide the contractor oversight.

We have noted in the past that under its tight administrative budget, CMS runs the Medicare program on a shoestring. Provider relations activities currently have to compete with most other contractor functions in the allocation of these scarce administrative dollars.

We started this study under the premise that physicians were being inundated with paper from their carriers, CMS, and U.S. Department of Health and Human Services agencies. Actually, we found that only a small percentage, about 10 percent, of the mail the seven physician practices that participated in our study sent us were from those sources. However, given the poor performance of CMS in its communications activities, we could understand why physicians seek materials from other sources, which were primarily their medical and specialty societies and other private organizations.

Despite the scarcity of resources, we did find some bright spots, and I think Mr. Scully enumerated many of them. CMS is working to expand and consolidate training for the customer service reps. Its MedLearn website offers computer-based training, manuals, and reference materials. CMS is developing satellite broadcasts to hospitals and educational institutes. And we also applaud CMS' efforts to establish the Physicians' Regulatory Issues Team, the PRIT, which works with the physician community to address its most pressing Medicare-related problems.

But I would like to emphasize that no matter how impressive these individual initiatives are, they cannot replace the need for consistently reliable and timely information provided to physicians on a regular basis.

We believe that the provisions in section 5 of H.R. 2768, the MRCRA—which I am going to use as shorthand for your bill—square place responsibility on CMS to upgrade its provider communication activities.

For example, it calls on CMS to centrally coordinate the educational activities provided through Medicare contractors and to offer technical assistance to small providers through a demonstration program.

The bill would also channel additional financial resources to Medicare provider communications activities.

Although we have not determined the specific amount of additional funding needed for these purposes, we believe that the current level of funding is insufficient to effectively inform providers about Medicare rules and payment changes.

I would now like to take a minute and turn to our findings related to Medicare's contracting for administrative services. Several key provisions of your bill address elements of Medicare contracting that have limited CMS' options for selecting claims administration contractors and that frustrate efforts to manage Medicare effectively.

First, MRCRA would establish a full and open procurement process that would provide CMS with express authority to contract with any qualified entity for claims administration, including entities that are not health insurers.

Second, the bill would provide for CMS to use incentive payments. For example, a cost-plus incentive contract adjusts the level of payment based on performance.

Finally, MRCRA would modify longstanding practice to specifically allow for contracts limited to one component of claims administration process, such as processing and paying claims or providing provider education and technical assistance activities.

To summarize, the scope and complexity of the Medicare Program makes complete, accurate, and timely information of program information vital to providers who need to be kept up-to-date on Medicare's rules. While CMS acknowledges that improvements are needed, we believe it needs to do so through establishing a more skilled, standardized and centralized approach. It is also clear that more resources need to be devoted to these activities. The backers of this bill clearly recognize this need, and we believe that the funding provisions will go a long way toward ensuring that more attention is paid to provider relations activities.

The bill also contains provisions that would provide a statutory framework for Medicare contracting reform. We believe that CMS can benefit from this increased flexibility and that many of the reform provisions will assist the agency in providing for more effective program management.

Madam Chairman, this concludes my prepared statement. I will be happy to answer any questions that you or the other Subcommittee members have.

[The prepared statement of Ms. Aronovitz follows:]

Statement of Leslie G. Aronovitz, Director, Health Care Program Administration and Integrity Issues, U.S. General Accounting Office

Madam Chairman and Members of the Subcommittee:

I am pleased to be here today as you discuss modifications to the Medicare program proposed in the Medicare Regulatory and Contracting Reform Act (MRCRA) of 2001.[1] Providers have raised concerns that while the Medicare program has become increasingly complex, the education and outreach services needed to comply with Medicare coverage and billing policies are inadequate. Others have raised questions about whether the program could benefit from changes to the way Medicare's claims processing contractors are selected and paid for the functions they perform.[2] To address some of these issues, Members of this Subcommittee and others in the Congress have introduced legislation, and the Administration has proposed several new initiatives.

We are currently conducting, or have recently completed, work on several operational and structural elements of the Medicare program that frustrate providers and hamper effective management. Specifically, we are reviewing how the Centers for Medicare and Medicaid Services (CMS) works with its contractors to facilitate communications with Medicare providers.[3] We have also evaluated ways in which CMS contracting for claims payment and provider and beneficiary service activities could be modified to promote better performance. Accordingly, you asked us to focus our remarks today on our findings related to (1) Medicare provider education and communications, and (2) Medicare contracting for claims administration services. Several of the reforms outlined in the MRCRA proposal address aspects of both issues.

In summary, our ongoing work for the Subcommittee shows that physicians often do not receive complete, accurate, clear, and timely guidance on Medicare billing and payment policies. We found shortcomings in print, electronic, and telephone communications that Medicare contractors use to provide information to physicians and respond to their questions. To substantially improve Medicare contractors' provider communications, we believe that CMS needs to develop a more centralized and coordinated approach. This is consistent with several provisions in MRCRA, which require CMS to centrally coordinate contractors' provider education activities, establish communications performance standards, appoint a Medicare Provider Ombudsman, and create a demonstration program to offer technical assistance to small pro-

[1] H.R. 2768, sponsored by Reps. Nancy Johnson, Pete Stark, and others, was introduced on August 2, 2001.

[2] Medicare claims are processed by private organizations that contract to serve as the fiscal agent between providers and the federal government.

[3] In June of this year, the Secretary of Health and Human Services (HHS) announced that the agency's name would be changed from the Health Care Financing Administration (HCFA) to CMS. Our statement will continue to refer to HCFA where our findings apply to the organizational structure and operations associated with that name.

viders. MRCRA would also require contractors to monitor the accuracy, consistency, and timeliness of the information they provide.

Further, our analysis of Medicare contracting reform issues has found that the rules governing CMS contracts with its claims processors lack incentives for efficient operations. Medicare contractors are chosen without full and open competition from among health insurance companies, rather than from a broad universe of potentially qualified entities. In addition, CMS almost always uses cost-only contracts, which pay contractors for costs incurred but generally do not offer any type of performance incentives. MRCRA would broaden CMS authority so that entities of various types would be able to compete for claims administration contracts and their payment would reflect the quality of the services they provide.

Background

The operation of the Medicare program is extremely complex and requires close coordination between CMS and its contractors. CMS is an agency within HHS but has responsibilities for expenditures that are larger than those of most other federal departments.[4] Under Medicare's fee-for-service system—which accounts for over 80 percent of program beneficiaries—physicians, hospitals, and other providers submit claims to receive reimbursement for services they provide to Medicare beneficiaries. In fiscal year 2000, fee-for-service Medicare made payments of $176 billion to hundreds of thousands of providers who delivered services to over 32 million beneficiaries.

About 50 Medicare claims administration contractors carry out the day-to-day operations of the program and are responsible not only for paying claims but also for providing information and education to providers and beneficiaries that participate in Medicare. Contractors that process and pay part A claims (i.e., for inpatient hospital, skilled nursing facility, hospice care, and certain home health services) are known as fiscal intermediaries and those that administer part B claims (i.e., for physician, outpatient hospital services, laboratory, and other services) are known as carriers.

Contractors periodically issue bulletins that outline changes in national and local Medicare policy, inform providers of billing system changes, and address frequently asked questions. To enhance communications with providers, the agency recently required contractors to maintain toll-free telephone lines to respond to provider inquiries. It also directed them to develop Internet sites to provide another reference source. While providers look to CMS' contractors for help in interpreting Medicare rules, they remain responsible for properly billing the program.

In congressional hearings held earlier this year, representatives of physician groups testified that they felt overwhelmed by the volume of instructional materials sent to them by CMS and its contractors. Following up on these remarks, we contacted 7 group practices served by 3 carriers in different parts of the country to determine the volume of Medicare-related documents they receive from the CMS central office, carriers, other HHS agencies, and private organizations. Together, these physician practices reported that, during a 3-month period, they received about 950 documents concerned with health care regulations and billing procedures. However, a relatively small amount—about 10 percent—was sent by CMS or its contractors. The majority of the mail reportedly received by these physician practices was obtained from sources such as consulting firms and medical specialty or professional societies.

Congress has also held hearings on management challenges facing the Medicare program. We recently testified that HHS contracts for claims administration services in ways that differ from procedures for most federal contracts.[5] Specifically:

- there is no full and open competition for these contracts,
- contracts generally must cover the full range of claims processing and related activities,
- contracts are generally limited to reimbursement of costs without consideration of performance, and
- CMS has limited ability to terminate these contracts.

Since 1993, HCFA has repeatedly proposed legislation that would increase competition for these contracts and provide more flexibility in how they are structured. In June 2001, the Secretary of HHS again submitted a legislative proposal that would modify Medicare's claims administration contracting authority.

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[4] Medicare ranks second only to Social Security in federal expenditures for a single program.

[5] Medicare Contracting Reform: Opportunities and Challenges in Contracting for Claims Administration Services, (June 28, 2001, GAO–01–918T).

Substantial Improvement Needed in Medicare Provider Communications

CMS relies on its 20 carriers to convey accurate and timely information about Medicare rules and program changes to providers who bill the program. However, our ongoing review of the quality of CMS' communications with physicians participating in the Medicare program shows that the information given to providers is often incomplete, confusing, out of date, or even incorrect.[6] MRCRA provisions establish new requirements and funding for CMS and its contractors that could enhance the quality of provider communication.

CMS Information Was Confusing and Often Inaccurate

We found that carriers' bulletins and Web sites did not contain clear or timely enough information to solely rely on those sources. Further, the responses to phone inquiries by carrier customer service representatives were often inaccurate, inconsistent with other information they received, or not sufficiently instructive to properly bill the program.

Our review of the quarterly bulletins recently issued by 10 carriers found that they were often unclear and difficult to use. Bulletins over 50 pages in length were the norm, and some were 80 or more pages long. They often contained long articles, written in dense language and printed in small type. Many of the bulletins were also poorly organized, making it difficult for a physician to identify relevant or new information. For example, they did not always present information delineated by specialty or clearly identify the states where the policies applied. Moreover, information in these bulletins about program changes was not always communicated in a timely fashion, so that physicians sometimes had little or no advance notice prior to a program change taking effect. In a few instances, notice of the program change had not yet appeared in the carriers' bulletin by its effective date.

To provide another avenue for communication, carriers are required to develop Internet Web sites. However, our review of 10 carrier Web sites found that only 2 complied with all 11 content requirements that CMS has established. Also, most did not contain features that would allow physicians and others to readily obtain the information they need. For example, we found that the carrier Web sites often lacked logical organization, navigation tools (such as search functions), and timely information—all of which increase a site's usability and value. Five of the nine sites that had the required schedule of upcoming workshops or seminars were out of date.

Call centers supplement the information provided by bulletins and Web sites by responding to the specific questions posed by individual physicians. To assess the accuracy of information provided, we placed approximately 60 calls to the provider inquiry lines of 5 carriers' call centers. The three test questions, all selected from the "frequently asked questions" on the carriers' Web sites, concerned the appropriate way to bill Medicare under different circumstances. The results of our test, which were verified by a CMS coding expert, showed that only 15 percent of the answers were complete and accurate, while 53 percent were incomplete and 32 percent were entirely incorrect.

We found that CMS has established few standards to guide the contractors' communication activities. While CMS requires contractors to issue bulletins at least quarterly, they require little else in terms of content or readability. Similarly, CMS requirements for web-based communication do little to promote the clarity or timeliness of information. Instead, they generally focus on legal issues—such as measures to protect copyrighted material—that do nothing to enhance providers' understanding of, or ability to correctly implement, Medicare policy. In regard to telecommunications, contractor call centers are instructed to monitor up to 10 calls per quarter for each of their customer service representatives, but CMS' definition of what constitutes accuracy and completeness in call center responses is neither clear nor specific. Moreover, the assessment of accuracy and completeness counts for only 35 percent of the total assessment score, with the representative's attitude and helpfulness accounting for the rest.

CMS conducts much of its oversight of contractor performance through Contractor Performance Evaluations (CPEs). These reviews focus on contractors that have been determined to be "at risk" in certain program areas. To date, CMS has not conducted CPE reviews focusing on the quality or usefulness of contractors' bulletins

[6] In our study, we reviewed selected contractors' bulletins and Web sites and evaluated them for consistency, timeliness, clarity, and completeness. In addition, we visited three contractors to observe their call center operations and examined their approaches to monitoring the performance of customer service representatives. To test the quality of contractors' responses to physicians' phone inquiries, we posed "frequently asked questions" that appeared on contractor Web sites to customer service representatives and assessed the accuracy and completeness of the responses.

or Web sites, but has begun to focus on call center service to providers. Again, the CPE reviews of call centers focus mainly on process—such as phone etiquette—rather than on an assessment of response accuracy.

CMS is Making Efforts to Improve Provider Communications

CMS officials, in acknowledging that provider communications have received less support and oversight than other contractor operations, noted the lack of resources for monitoring carrier activity in this area and providing them with technical assistance. Under its tight administrative budget, the agency spends less than 2 percent of Medicare benefit payments for administrative expenses. Provider communication and education activities currently have to compete with most other contractor functions in the allocation of these scarce Medicare administrative dollars. CMS data show that there are less than 26 full-time equivalent CMS staff assigned to oversee all carrier provider relations efforts nationwide, representing a just over 1 full-time equivalent staff for each Medicare carrier. This low level of support for provider communications leads to poorly informed providers who are therefore less likely to correctly bill the Medicare program for the services they provide.

Despite the scarcity of resources, CMS has begun work to expand and consolidate some provider education efforts, develop venues to obtain provider feedback, and improve the way some information is delivered. These initiatives—many in the early stages of planning or implementation—are largely national in scope, and are not strategically integrated with similar activities by contractors. Nevertheless, we believe that these outreach and education activities will enhance some physicians' ability to obtain timely and important information, and improve their relationships with CMS.

For example, CMS is working to expand and consolidate training for providers and contractor customer service representatives. Its Medlearn Web site offers providers computer-based training, manual, and reference materials, and a schedule of upcoming CMS meetings and training opportunities. CMS has produced curriculum packets and conducted in-person instruction to the contractor provider education staff to ensure contractors present more consistent training to providers. CMS has also arranged several satellite broadcasts on Medicare topics every year to hospitals and educational institutions. In addition, CMS established the Physicians' Regulatory Issues Team to work with the physician community to address its most pressing problems with Medicare. Contractors are also required to form Provider Education and Training Advisory groups to obtain feedback on their education and communication activities.

MRCRA Provides Needed Statutory and Financial Support

We believe that the provisions in Section 5 of MRCRA can help develop a system of information dissemination and technical assistance. MRCRA's emphasis on contractor performance measures and the identification of best practices squarely places responsibility on CMS to upgrade its provider communications activities. For example, it calls on CMS to centrally coordinate the educational activities provided through Medicare contractors, to appoint a Medicare Provider Ombudsman, and to offer technical assistance to small providers through a demonstration program. We believe it would be prudent for CMS to implement these and related MRCRA provisions by assigning responsibility for them to a single entity within the agency dedicated to issues of provider communication.

Further, MRCRA would channel additional financial resources to Medicare provider communications activities. It authorizes additional expenditures for provider education and training by Medicare contractors ($20 million over fiscal years 2003 and 2004), the small provider technical assistance demonstration program ($7 million over fiscal years 2003 and 2004), and the Medicare Provider Ombudsman ($25 million over fiscal years 2003 and 2004). This would expand specific functions within CMS' central office, which would help to address the lack of administrative infrastructure and resources targeted to provider communications at the national level. Although we have not determined the specific amount of additional funding needed for these purposes, our work has shown that the current level of funding is insufficient to effectively inform providers about Medicare payment rules and program changes.

MRCRA also establishes contractor responsibility criteria to enhance the quality of their responses to provider inquiries. Specifically, contractors must maintain a toll-free telephone number and put a system in place to identify who on their staff provides the information. They must also monitor the accuracy, consistency, and timeliness of the information provided.

Contracting Reform Could Improve Program Management

Current law and long-standing practice in Medicare contracting limit CMS' options for selecting claims administration contractors and frustrate efforts to manage Medicare more effectively. We have previously identified several approaches to contracting reform that would give the program additional flexibility necessary to promote better performance and accountability among claims administration contractors.

Current Contracting Law and Practice Limit CMS' Management Options

CMS faces multiple constraints in its options for selecting claims administration contractors. Under these constraints, the agency may not be able to select the best performers to carry out Medicare's claims administration and customer service functions. Because the Medicare statute exempts CMS from competitive contracting requirements, the agency does not use full and open competition for awarding fiscal intermediary and carrier contracts. Rather, participation has been limited to entities with experience processing these types of claims, which have generally been health insurance companies. Provider associations, such as the American Hospital Association, select fiscal intermediaries in a process called "nomination" and the Secretary of HHS chooses carriers from a pool of qualified health insurers.

CMS program management options are also limited by the agency's reliance on cost-based reimbursement contracts.[7] This type of contract reimburses contractors for necessary and proper costs of carrying out Medicare activities, but does not specifically provide for contractor profit or other incentives. As a result, CMS generally has not offered contractors the fee incentives for performance that are used in other federal contract arrangements.

Medicare Could Benefit From Open Competition and Increased Flexibility

Medicare could benefit from various contracting reforms. Perhaps most importantly, directing the program to select contractors on a competitive basis from a broader array of entities would allow Medicare to benefit from efficiency and performance improvements related to competition. A full and open contracting process will hopefully result in the selection of stronger contractors at better value. Broadening the pool of entities allowed to hold Medicare contracts beyond health insurance companies will give CMS more contracting options. Also, authorizing Medicare to pay contractors based on how well they perform rather than simply reimbursing them for their costs could result in better contractor performance.

We also believe that the program could benefit from efficiencies by having contractors perform specific functions, called functional contracting. The traditional practice of expecting a single Medicare contractor in each region to perform all claims administration functions has effectively ruled out the establishment of specialized contracts with multiple entities that have substantial expertise in certain areas.[8] Moving to specialized contracts for the different elements of claims administration processing would allow the agency to more efficiently use its limited resources by taking advantage of the economies of scale that are inherent in some tasks. An additional benefit of centralizing carrier functioning in each area is the opportunity for CMS to more effectively oversee carrier operations. Functional contracting would also result in more consistency for Medicare-participating providers.

Several key provisions of MRCRA would address these elements of contracting reform. MRCRA would establish a full and open procurement process that would provide CMS with express authority to contract with any qualified entity for claims administration, including entities that are not health insurers. MRCRA would also encourage CMS to use incentive payments to encourage quality service and efficiency. For example, a cost-plus-incentive-fee contract adjusts the level of payment based on the contractor's performance. Finally, MRCRA would modify long-standing practice by specifically allowing for contracts limited to one component of the claims administration process, such as processing and paying claims, or conducting provider education and technical assistance activities.

Concluding Observations

The scope and complexity of the Medicare program make complete, accurate, and timely communication of program information necessary to help providers comply with Medicare requirements and appropriately bill for their services. The backers

[7] According to CMS, requirements of the Social Security Act that call for the use of cost-based reimbursement contracts preclude the program from offering financial incentives to contractors for high-quality performance.

[8] This has recently started to change in response to new contracting authorities granted by the Health Insurance Portability and Accountability Act of 1996, which resulted in the selection of 12 Program Safeguard Contractors that perform specific payment safeguard activities.

of MRCRA recognize the need for more resources devoted to provider communications and outreach activities, and we believe the funding provisions in the bill will help assure that more attention is paid to these areas. MRCRA also contains provisions that would provide a statutory framework for Medicare contracting reform. We believe that CMS can benefit from this increased flexibility, and that many of these reform provisions will assist the agency in providing for more effective program management.

Madam Chairman, this concludes my prepared statement. I would be happy to answer any questions that you or other Subcommittee Members may have.

GAO Contact and Staff Acknowledgments

For further information regarding this testimony, please contact me at (312) 220–7767. Jenny Grover, Rosamond Katz, and Eric Peterson also made key contributions to this statement.

Related GAO Products

Medicare Management: CMS Faces Challenges in Safeguarding Payments While Addressing Provider Needs (GAO–01–1014T, July 26, 2001).

Medicare: Successful Reform Requires Meeting Key Management Challenges (GAO–01–1006T, July 25, 2001).

Medicare Contracting Reform: Opportunities and Challenges in Contracting for Claims Administration Services (GAO–01–918T, June 28, 2001).

Medicare Management: Current and Future Challenges (GAO–01–878T, June 19, 2001).

Medicare: Opportunities and Challenges in Contracting for Program Safeguards (GAO–01–616, May 18, 2001).

Major Management Challenges and Program Risks: Department of Health and Human Services (GAO–01–247, Jan. 2001).

High Risk: An Update (GAO–01–263, Jan. 2001).

Medicare: 21st Century Challenges Prompt Fresh Thinking About Program's Administrative Structure (GAO/T–HEHS-00–108, May 4, 2000).

Medicare Contractors: Further Improvement Needed in Headquarters and Regional Office Oversight (GAO/HEHS–00–46, Mar. 23, 2000).

Chairman JOHNSON. Thank you very much for your testimony and for the work that GAO has done on this issue. Dr. Hall.

STATEMENT OF WILLIAM J. HALL, M.D., PRESIDENT, AMERICAN COLLEGE OF PHYSICIANS—AMERICAN SOCIETY OF INTERNAL MEDICINE

Dr. HALL. Thank you very much, Chairwoman Johnson, and other members of the Subcommittee for holding this important hearing to discuss MRCRA.

My name is William Hall. I am a practicing internist and geriatrician in Rochester, New York, and currently, I serve as president of the American College of Physicians—American Society of Internal Medicine (ACP–ASIM), representing 115,000 physicians, the largest medical specialty society and the second-largest medical organization in the country, and also a group of members who supply a major proportion of all EM to Medicare recipients throughout the country.

In the course of my travels this year, the most frequent complaint by far that I hear from my colleagues is that internists are subject to excessive paperwork and as a result do not have enough time to devote to patients.

In our work, time is by far the most valuable resource in diagnosing and caring for older adults, but it is also in the shortest

supply, largely due to a growth of unnecessary paperwork. Fortunately, this bipartisan legislation has been introduced to address paperwork hassles.

ACP–ASIM appreciates the opportunity to comment on H.R. 2768. This is a very good start, but more needs to be done. I would like to briefly touch on a few specific points in the bill, actually, all of which have been mentioned in prior testimony, but I would invite the Subcommittee to review our written testimony which contains more detailed comments, such as you already mentioned, Congresswoman.

First, the issue of extrapolation. As you know, auditors use extrapolation to look at a very small sample of Medicare claims and apply the results to a broader universe of claims that the auditors did not review. This process is simply unfair. Congress would certainly not allow the Internal Revenue Service to extrapolate a calculation error in a taxpayer's tax return from 1 year to other years without actually reviewing the returns in those years. And Congress should not allow the broad use of extrapolation either.

In order to strengthen H.R. 2768, we strongly encourage the Subcommittee to develop report language to define a "high level of payment error" to justify extrapolation. Without such a definition, problems with extrapolation could potentially continue.

We also recommend that carriers conduct a documented educational effort before a provider receives an overpayment demand letter.

Now a word about appeals. ACP–ASIM is pleased that H.R. 2768 precludes carriers from requiring physicians and other health care providers to repay an alleged overpayment until after the first level of appeal. However, ACP–ASIM believes that repayment should not occur until the administrative appeals have been exhausted. It simply is unfair that Medicare providers are compelled to repay money to Medicare contractors when the dispute has not even been settled. We would quickly add, however, that any appropriate interest and penalties should accrue if the provider is unsuccessful in his or her appeal.

Next, on evaluation and management documentation guidelines, ACP–ASIM strongly supports H.R. 2768's provision that requires the Department of Health and Human Services to initiate three or four pilot projects to test EM documentation guidelines. We are particularly interested in the peer review pilot method. Another pilot that ACP–ASIM believes should be explored is documentation of encounter time with patients and a simpler, one-page document as an alternative to more lengthy documentation requirements such as the 1997 guidelines. These are more than 40 pages long and lead to, as you already mentioned, thousands of individual decision points.

ACP–ASIM strongly agrees that pilot project participants should not be targeted for post-payment audits or overpayment demands. This stipulation should actually enhance the viability of these pilot tests.

It is our understanding that the Department of Health and Human Services Office of the Inspector General in the previous administration had some concerns regarding recommendations to improve the Medicare audit and appeal process. Essentially, the OIG

was concerned that changes in the audit process could unintentionally allow unscrupulous health care providers to submit false claims to Medicare. The suggestions that we have outlined were developed in consideration of this concern.

ACP–ASIM believes that it is time for Congress to introduce more due process rights and fairness into the Medicare claims payment review system. The overwhelming majority of physicians and other health care providers are honest and law-abiding and should no longer have to suffer from onerous and unfair Medicare rules.

In conclusion, ACP–ASIM is pleased that the Subcommittee is addressing the serious problems that the Medicare regulatory burden poses for physicians. We strongly urge the Subcommittee to report H.R. 2768 to the full House Ways and Means Committee with some of the enhancements that we have presented. We would also ask the Subcommittee to consider provisions from other pending regulatory relief legislation such as H.R. 868, MERFA, which we have endorsed.

I thank you very much, and I would be happy to answer any questions that you might have.

[The prepared statement of Dr. Hall follows:]

Statement of William J. Hall, M.D., President, American College of Physicians—American Society of Internal Medicine

I am Dr. William J. Hall, president of the American College of Physicians—American Society of Internal Medicine (ACP–ASIM). ACP–ASIM, representing 115,000 physicians and medical students, the largest medical specialty society and the second largest medical organization in the United States, congratulates the Subcommittee for holding this hearing. Internists provide care for more Medicare patients than any other medical specialty. The most frequent complaint received by ACP–ASIM is that internists are subject to excessive paperwork and, as a result, do not have enough time to devote to patients. ACP–ASIM thanks Congresswoman Nancy L. Johnson (R–CT), Chair of the Subcommittee on Health of the Committee on Ways and Means, for holding this important hearing to discuss H.R. 2768, the "Medicare Regulatory and Contracting Reform Act of 2001."

Impact of Medicare Paperwork on Clinical Practice

Time is the most valuable resource in diagnosing and caring for older adults, but it's in short supply due to unnecessary paperwork. Research breakthroughs, new pharmaceuticals and improved diagnostic equipment are of limited value if doctors lack the time to spend with patients.

Visits from Medicare patients typically begin a surprisingly complex and time-consuming paperwork process. Medicare requires that the physicians and their staffs complete a claim form with diagnosis and service codes, as well as authorizations for necessary equipment such as wheelchairs and services such as home health care. The Medicare program assumes physicians know what it will and will not cover. There is no single place to find Medicare's rules, however. The regulations are more than 100,000 pages long and different carriers, who process paperwork for Medicare across the country, have their own rules.

Once a claim is filed, Medicare might delay payment because it tripped some random criteria. If Medicare finally pays the claim, carriers have four years to change their minds and demand that the physician repay it. Appeals require more paperwork and more importantly staff and physician time to present the case.

Medicare can also sample physician's records to determine if certain services, such as office visits, were paid incorrectly. If a certain percentage were paid wrong, the carrier will demand repayment for similar claims—without looking at the records.

To keep their practices running, many internists simply repay these claims. Opening their practices to a post-payment audit can tie the physicians' practices up for days—essentially shutting down patient care activities. One physician tells of spending over $50,000 challenging an audit and in the final determination owing the government a mere $400.

Medicare patients are the ones who suffer when physicians and their office staff are diverted from patient care activities to unnecessary paperwork. The result can

be longer waiting time before being seen by the physician, because he or she is busy answering a demand from Medicare for more information at a time that could have been spent with patients. It can result in the physician seeing fewer patients each day—meaning a longer time for a patient to get an appointment. It can mean having less time to assess elderly patients and less time to answer questions and discuss new treatments with them. And in the worst cases, it can literally shut down a practice for days.

H.R. 2768—A Good Start, but More Should Be Done

Fortunately, bipartisan legislation, H.R. 2768, the "Medicare Regulatory and Contracting Reform Act of 2001 has been introduced into the House of Representatives and we are waiting for a similar measure in the Senate. ACP–ASIM appreciates the opportunity to comment on this bill.

Extrapolation

Although ACP–ASIM requests the elimination of extrapolation of alleged overpayment amounts to other non-audited claims the first time a physician or other health care provider is assessed an alleged overpayment, unless fraud is suspected, the H.R. 2768 provision on extrapolation is a step in the right direction. H.R. 2768 indicates that in either consent settlements or larger audits, carriers cannot recoup or offset payments based on extrapolation unless it is sustained by a high level of payment error, as defined by the Secretary of Health and Human Services, or documented educational intervention has failed to correct the payment error (as determined by the Secretary). ACP–ASIM strongly encourages the Subcommittee to develop report language to define a high level of payment error. Without such a definition, problems with extrapolation could potentially continue. ACP–ASIM also recommends that carriers should conduct a documented education effort before a provider receives an overpayment demand letter.

Physicians have always been concerned about the extrapolation process because it is a mechanism that auditors use to look at a small sample of Medicare claims and apply those results to a broader universe of claims that the auditors did not review. Under the extrapolation process, auditors have the ability to take a small sample of 15 claims, determine that the Medicare contractor made an overpayment of several dollars per claim, then extrapolate that finding to hundreds of claims per year over several years and demand repayment of tens of thousands of dollars without following the due diligence of looking at those other claims. This process is simply unfair. Congress wouldn't allow the Internal Revenue Service to extrapolate a calculation error in a taxpayer's tax return from one year to other years without actually reviewing the returns from those years. Congress shouldn't allow the broad use of extrapolation either.

Appeals

ACP–ASIM is pleased that H. R. 2768 precludes carriers from requiring physicians and other health care providers to repay an "alleged" overpayment until after the first level of appeal. However, ACP–ASIM believes that repayment should not occur until the administrative appeals have been exhausted. It simply is unfair that Medicare providers are compelled to repay money to Medicare contractors when the dispute has not been settled. We agree that interest should accrue if the provider is unsuccessful in appealing.

Repayment plan

ACP–ASIM suggests that Medicare carriers and fiscal intermediaries give physicians who have received overpayments the option of either a three year repayment plan or offsetting overpayment recoupments against a percentage of the physicians' future Medicare claims reimbursements. ACP–ASIM is pleased that H.R. 2768 stipulates that the Secretary of Health and Human Services must promulgate regulations that would allow physicians and other health care providers to enter into a repayment plan of no more than 3 years, however we are concerned that as written this provision gives the Secretary the latitude to keep the 30–60 day repayment process intact without making any change to the program at all. ACP–ASIM urges the Subcommittee to change this provision to a period of not less than 3 years if the aggregate amount of overpayments exceeds 10 percent of Medicare revenues for the previous calendar year.

The current repayment process is particularly onerous to physicians and other health care providers with small practices. A large repayment requirement over a short period of time could potentially bankrupt a physician practice and force it to close. This in turn would deny Medicare beneficiaries access to medical care from that practice. For practices in rural and underserved areas where patients have lit-

tle or no choice of provider, such a repayment request could literally devastate access to health care in a community.

ACP–ASIM agrees with the provision that would prohibit repayment plans in cases where the Secretary suspects that the provider would file for bankruptcy to avoid repayment, cease to do business, or has committed fraud. ACP–ASIM also agrees that if a provider fails to make a payment installment, there should be an acceleration in the repayment plan or immediate offsets.

Consent Settlement Process

ACP–ASIM believes that H.R. 2768 should afford physicians the ability to appeal a probe sample of claims without having to undergo a "statistically valid random sample" (SVRS). A probe sample is a sample of a small number of claims. H.R. 2768 indicates that when a provider appeals this probe, they must agree to a larger, time consuming, onerous audit (the SVRS). This process encourages physicians to settle, even when they believe the probe sample findings are inaccurate, because in many cases the hassle involved with complying with the SVRS audits are more costly to the physicians practice than the cost of settling with a probe sample. The current consent settlement process is ironic in that there is no true incentive for the auditors conducting the probe sample to perform the audit accurately because the penalty of appealing in many cases is more than the penalty of settling.

Limit on Random Prepayment Audits

ACP–ASIM believes H.R. 2768 would be improved if the bill were changed to state that Medicare carriers could not demand additional records or documentation prior to paying a claim absent cause except when developing contractor-wide or program-wide claims payment error rates. Random prepayment audits are troublesome to health care providers because they can disrupt cash flow in the practice and hinder the delivery of medical services to patients if the practice does not have the cash on hand to order supplies and equipment or pay its staff. Random prepayment audits are particularly irksome to physician practices because it has long been recognized that the overwhelming majority of Medicare providers are honest and therefore these audits will randomly delay payment for legitimate services provided to Medicare beneficiaries.

In addition, prepayment review should no longer potentially occur indefinitely after physicians and providers have submitted properly coded claims. ACP–ASIM agrees with the H.R. 2768 provision that limits contractors to using random prepayment audits for developing contractor-wide or program-wide claims payment error rates.

Evaluation and Management (E/M) Documentation Guidelines

ACP–ASIM strongly supports the H.R. 2768 provision that requires the Department of Health and Human Services initiate three or four pilot projects to test E/M documentation guidelines. ACP–ASIM is particularly interested in the peer-review pilot method. Another pilot that ACP–ASIM believes should be explored is documenting encounter time with the patient and the "CPT basics/General Principles of Medical Record Documentation" (a one page document) as an alternative to other onerous documentation requirements (such as the 1997 guidelines which are more than 40 pages long). ACP–ASIM is encouraged by the stipulation that pilot participants cannot be targeted for post-payment audits or overpayment demands. This stipulation should enhance the viability of the pilot tests.

Although ACP–ASIM is encouraged that the Centers for Medicare and Medicaid Services (CMS) is attempting to work with medical societies to improve the documentation guidelines for evaluation and management (E/M) services, the guidelines that were released in 1997 and currently in place dramatically increase the administrative burden for physicians. The guidelines require physicians to spend a significant amount of time selecting which code to bill and documenting extensively to satisfy the comprehensive guidelines. An internist who carefully reviewed the 1997 guidelines calculated the number of decisions that a physician must make before selecting a level of E/M service and billing Medicare include 11 decision points in categories to consider before selecting an E/M code. Each decision point requires several choices. There are 42 choices a physician must consider before selecting the proper level of E/M service. There are 6,144 possible combinations representing the number of ways an office visit for a new patient can evolve and be classified. A physician must spend time documenting in the patient's record in addition to spending time deciding what is the appropriate level of service to bill. The guidelines put an undue excessive documentation burden on physicians for the sole purpose of billing, not for quality medical care. The guidelines force physicians to spend less time with their patients and more time with the patients' charts.

Carrier Responsiveness

ACP–ASIM is pleased that H.R. 2768 requires Medicare contractors to: (1) respond in a clear concise and accurate manner to specific billing and coding and cost report questions; (2) maintain a toll-free telephone number which provides information regarding billing, coding and other appropriate information; (3) maintain a system for identifying who provides referred information; and (4) monitor accuracy, consistency and timeliness of the information provided. ACP–ASIM suggests that these provisions be further strengthened by requiring a written response within 30 days from the contractor to physicians and other providers who submit billing, documentation, coding and cost reporting questions to carriers or fiscal intermediaries. Additionally, these written responses from the carrier must be adhered to during provider audits; health care providers should be held harmless from having claims denied by carriers in subsequent audits when the provider is simply following the original advice of the Medicare carrier. It is unfair and unreasonable for physicians and other health care providers to be held accountable for mistakes made by Medicare contractors.

Ombudsmen Program

ACP–ASIM understands that the H.R. 2768 ombudsman program is designed to "provide assistance on a confidential basis to physicians (and others) about complaints, grievances, and requests for information about Medicare, resolve unclear or conflicting guidance given by the Secretary and Medicare contractors to physicians." The program would also recommend to the Secretary how to respond to "recurring patterns of confusion including suspending sanctions in these areas, and would recommend how to provide appropriate and consistent responses including not providing for audits where the self identified overpayment is returned." This provision will be helpful in resolving conflicting statements and may be an outlet for confidential complaints about carriers.

Effective Balance Between Appropriate Claims Payment and Burdensome Paperwork

It is our understanding that the Department of Health and Human Services Office of Inspector General (OIG) in the previous administration had some concerns regarding recommendations to improve the Medicare audit and appeal process. Essentially, the OIG was concerned that changes in the audit process could unintentionally allow unscrupulous health care providers to submit false claims to Medicare. The suggestions above were developed in consideration of this concern. ACP–ASIM believes that it is time for Congress to introduce more due process rights and fairness into the Medicare claims payment review system so that the overwhelming majority of physicians and other health care providers, who are honest and law abiding, no longer have to suffer from onerous and unfair Medicare rules.

Conclusion

ACP–ASIM is pleased that the Subcommittee is addressing the serious problems that the Medicare regulatory burden poses for physicians and others attempting to care for Medicare beneficiaries. We strongly urge the Subcommittee to report H.R. 2768 to the full Ways and Means Committee with the enhancements we have presented. We also ask the Subcommittee to consider provisions from other pending regulatory relief legislation, such as H.R. 868, the Medicare Education and Regulatory Fairness Act (MERFA), which ACP–ASIM has enthusiastically endorsed.

Chairman JOHNSON. Thank you very much, Dr. Hall.

Ms. Wilson, it is a special pleasure to welcome you here to this hearing. I have worked with Ms. Wilson extensively in my hometown of New Britain, and her leadership at the State level as well as the national level in solving some of the difficult problems we have been facing in the home care reimbursement area have really been appreciated. Welcome.

STATEMENT OF SUSAN WILSON, VICE PRESIDENT, CLINICAL OPERATIONS, AND CHIEF OPERATING OFFICER, VNA OF CENTRAL CONNECTICUT, INC., NEW BRITAIN, CONNECTICUT; PRESIDENT, BOARD OF DIRECTORS, CONNECTICUT ASSOCIATION FOR HOME CARE, WALLINGFORD, CONNECTICUT; AND MEMBER, NATIONAL ASSOCIATION FOR HOME CARE

Ms. WILSON. Thank you, Madam Chairman and members of the Subcommittee, for allowing me to testify regarding MRCRA.

I am Susan Wilson, vice president and chief operating officer of VNA of Central Connecticut, president of the board of directors of the Connecticut Association for Home Care, and a member of the National Association for Home Care.

In March of this year, I had the honor of addressing this panel regarding regulations and policies that impact a provider's ability to deliver efficient, high-quality care. I am pleased to be here today to personally extend my deepest appreciation for the many efforts by you, your staff, and many others to ease these burdens. You are to be commended in particular for the development of H.R. 2768 which, if enacted, will ease the impact of some of the most troublesome policies.

It has been proposed that any final regulation that is not a logical outgrowth of proposed regulation cannot take effect until there has been an opportunity for public comment. Your bill generally prohibits retroactive application and extends protection against compliance actions for 30 days. Home care has suffered greatly by the retroactive impact of issued policies, and this provision should help to prevent a recurrence of this.

Your bill also protects providers against sanctions when they have followed the guidance of a Medicare contractor. Further clarification is needed, however, regarding what constitutes a sanction. Does it relate to possible fines, or does it extend to other obligations that may result from the faulty guidance of the contractor?

Home health agencies have reported that despite adherence to written guidance from intermediaries specifically regarding cost reports, the intermediary has later rejected its own approval, which has led to unfounded allegations of overpayment. We hope that these circumstances are included in the provision.

Also, your proposal provides for education through technical assistance and program information, and certainly this will help to create a better understanding of the Medicare Program.

A similar provision applicable to Medicare's contractors for survey and certification would further secure this intent.

Providers are delighted, Madam Chairman, that your bill prohibits recoupment of a perceived overpayment until after a decision has been made on an appeal that is under reconsideration. Denied claims are frequently reversed on appeal, and nearly all denials taken to the ALJ are overturned. Please consider taking this provision one step further so that providers are protected until their appeals are exhausted.

It appears to limit, however, the postponement of overpayment recovery to circumstances in which the provider has initiated the appeal. I might say that the provider frequently does not have the right of direct appeal and must act on the beneficiary's behalf. Lan-

guage of this provision must be modified to provide pre-recovery protection in all instances.

Also, a majority of denied home health and hospice claims are rejected because they do not meet one or more technical requirements. The agency's only recourse is to undergo a costly appeal, and this delays final payment and unnecessarily burdens providers and intermediaries. Your legislation provides an opportunity to correct any errors or omissions in a most efficient manner.

I would be remiss in my testimony if I did not touch upon the 15 percent cut scheduled for October of 2002. The CBO estimated that an additional 15 percent cut would be needed to meet the targeted $16 billion savings from home health care. It has become increasingly clear that these calculations are dangerously inaccurate.

According to the latest figures, the 5-year total in reductions will exceed $70 billion. Home care providers have met the challenge of Interim Payment Services and PPS; however, we continue to struggle under the financial burden of other related issues. The proposed technical panel regarding the mandated Outcomes Assessment Information System (OASIS) assessment has not yet been convened, so I would like to take this opportunity to state that this process alone, the OASIS assessment, has cost my agency well over $100,000. Only a minuscule percentage of that will ever be compensated.

A letter recently written by a home care nurse in Connecticut stated: "I am disheartened by the paperwork burden which is stealing time away from needed patient care." She goes on to say: "My supervisor is also diverted from helping me with patient care by the third-party liability paperwork, copying, and the review of records going back 3 years."

Several States, Connecticut in particular, are struggling to maintain viability under the burden of the Third Party Liability initiative. Records are requested for retrospective review for payment of duly eligible clients, and current interpretations are applied to past care. My agency soon must begin the duplication of over 15,000 pages of records which must be sent to the FI, and this only accounts for a very small portion of the review year. One large Connecticut agency reported that their costs will exceed $1 million just for the review process.

H.R. 2768 addresses the burden of the escalating request for documentation. It is my hope that the provision will limit their request to what is necessary rather than reaffirm their current practices.

While Home Care is well aware of the Nation's dwindling surplus, in light of the savings to date, the additional financial burdens home care faces, as well as a growing staffing shortage, we urge you to eliminate the 15 percent cut.

Madam Chairman, the issues addressed by H.R. 2768 may seem quite technical in nature, but they will make a tremendous difference in the day-to-day operations. We in home health and hospice will work diligently to work with you for their enactment.

I thank you for your longstanding efforts on behalf of the Nation's home health providers and the patients and families they serve. On behalf of the National and Connecticut Associations of

Home Care, I thank you and the members of this Committee for the bipartisan action that you have taken.

Thank you.

[The prepared statement of Ms. Wilson follows:]

Statement of Susan Wilson, Vice President, Clinical Operations, and Chief Operating Officer, VNA of Central Connecticut, Inc., New Britain, Connecticut; President, Board of Directors, Connecticut Association for Home Care, Wallingford, Connecticut; and Member, National Association for Home Care

Thank you, Madame Chairman, Representative Stark, and Subcommittee members, for inviting me to present testimony on ways to bring regulatory relief to beneficiaries and providers, and specifically to discuss the many benefits that would result from enactment of HR 2768, the "Medicare Regulatory and Contracting Reform Act of 2001." My name is Susan Wilson. I am Vice President of Clinical Operations and Chief Operating Officer of the Visiting Nurse Association (VNA) of Central Connecticut. I am also the President of the Board of Directors of the Connecticut Association for Home Care (CAHC), the voice of home care in Connecticut, and a member of the National Association for Home Care (NAHC).

NAHC is the largest national organization representing home health care providers, hospices, and home care aide organizations. Among the nearly 6,000 organizations NAHC represents are every type of home care agency, including nonprofit agencies like the VNA, for-profit chains, public and hospital-based agencies, and free-standing agencies. CAHC represents 61 providers that collectively deliver more than 75 percent of all home health and hospice services provided in the state.

In March I had the honor of being called before this panel to provide testimony on a number of the regulations and policies that impact a provider's ability to deliver high-quality patient care in an efficient manner. I am pleased to be back here today to personally extend my most sincere thanks for the many efforts that you, members of this Subcommittee, your staff, and others have made to ease burdens on home care and other providers.

Madame Chairman, you and all of the members of the Subcommittee, particularly, are to be commended for developing HR 2768, the "Medicare Regulatory and Contracting Reform Act of 2001." This legislation will go a long way toward easing the impact of some of the most troublesome policies of the Medicare program. You have included a number of provisions that address specific problems that hospices and home health agencies have struggled with in recent years, including:

New Requirements for Regulatory and Policy Issuances

Among the changes that would be enacted as part of HR 2768, you have included several provisions related to regulatory or policy issuances that will be of tremendous help to providers. First, the legislation prohibits any provision published in a final regulation that is not a logical outgrowth of the proposed regulation from taking effect until after appropriate opportunity for public comment. Additionally, your bill generally prohibits retroactive application of substantive changes in regulations or other policies, and extends protection against compliance actions relative to the change until 30 days after issuance of the change. Home care has faced great difficulties in the past with policy issued with retroactive impact, such as the revision in standards for allowable branch offices. The bill should prevent this in the future.

The bill also protects providers against sanction in cases where they have followed written guidance from one of Medicare's contractors. NAHC believes that it would be helpful if, with respect to this particular provision, the Subcommittee could provide clarification regarding what would constitute a "sanction"—does this mean that a provider would not be subject to fines for wrongdoing, or would the protections extend to other obligations that resulted from the faulty guidance of the contractor? Home health agencies have followed written guidance from intermediaries on cost reporting only to find the intermediary later rejecting its own approval. This led to unfounded allegations of overpayments. We hope that these circumstances are included under this provision.

Contractor Accountability

NAHC applauds your efforts as part of HR 2768 to improve Medicare contractor compliance and accountability through development of specific performance measures. We also believe that the emphasis you have placed on provider education is a sound foundation for improved provider relations with the contractors and greater understanding of the Medicare program. Of particular note is the bill's establishment of provision of technical assistance and program information to providers as

one of the contractors' key functions. The availability of program information is so vital to the ability of providers to operate in compliance with the program that NAHC recommends inclusion of a similar provision applicable to Medicare's contractors for survey and certification, the state survey offices. An educational role for state survey offices is a key way to secure quality of care for patients.

Section 6 of HR 2768 establishes a Small Provider Technical Assistance Demonstration Program. We believe that this is an excellent approach for evaluating billing and other practices of small providers to ensure compliance with Medicare law. As you know, Madame Chairman and members of the Subcommittee, the vast majority of home health agencies and hospices are small businesses that could greatly benefit from participation in such a demonstration. We support this effort wholeheartedly. We also would ask that the definition of "small providers of services or suppliers" be clarified to be certain that it would include providers of care such as hospices and home health agencies as it currently references "institutional" providers.

Medicare Provider Ombudsman

Your establishment, under Section 7, of a Medicare Provider Ombudsman is a concept that NAHC has long advocated, and is very much in keeping with the spirit of your efforts and those of others who are working to ease regulatory burdens.

Recovery of Overpayments and Prepayment Review; Enrollment of Providers

We have several comments and questions regarding the provisions in HR 2768 that relate to overpayments. As you are well aware, Madame Chairman, the Balanced Budget Act of 1997 (BBA) imposed deep and swift cuts on Medicare home health providers. Many providers operated for as much as one full year without knowing what the limits on their payments would be. As a result, a great number of agencies throughout the country found themselves in situations where they owed such significant amounts of money to the Medicare program that even a 36-month payment plan was too short a time. In such cases it was not unusual for the provider, contractor, and Medicare to establish a 60-month repayment schedule. We would urge that your legislation create sufficient flexibility so that repayment schedules of more than 36 months might be allowed under such special circumstances.

Similarly, your establishment of a "bright-line" test for "hardship" for overpayment obligations at 10 percent of the provider's Medicare income is understandable. However, and particularly in the case of home health agencies and hospices that are not heavily capitalized, "hardship" may occur with overpayment obligations at less than 10 percent. We would, once again, urge that some discretionary authority be extended so that special circumstances are considered for exceptions to the rule.

We are delighted, Madame Chairman, that your bill would prohibit any recoupment of an overpayment until after a decision on a reconsideration has been rendered. Under the home health and hospice programs, significant numbers of denied claims are reversed on appeal, and nearly all denials taken to the administrative law judge level are overturned. We would encourage you to consider taking this particular provision one step further so that providers would be protected from overpayment recoupment until after their appeals are exhausted.

The bill also appears to limit the postponement of the overpayment recovery to circumstances where the provider has initiated the appeal. In many of the appeals, the provider does not have a direct appeal right and must proceed as the beneficiary's representative in order to have the dispute reviewed. For example, a claim denial based on an alleged failure to submit a document can only be appealed by the beneficiary even though the provider suffers the financial consequences. We would suggest that the language of this provision be modified to provide the prerecovery protection in all instances where the issue in dispute is under appeal.

Under the Subcommittee's bill, Medicare contractors would be permitted to request the periodic production of records or supporting documentation for a limited sample of submitted claims to ensure that the previous practice is not continuing. As I have discussed with you and your staff, Madame Chairman, the duplication of records can be costly and time consuming. It is my hope that this particular provision was designed to encourage contractors to limit their requests to what is absolutely necessary, rather than to affirm some of the contractors' current practices.

Use of statistical sampling by Medicare's contractors has been a significant problem for home health agencies at times, and we applaud your efforts to limit its use only to cases in which there is a sustained or high level of payment error or where documented educational interventions have failed to correct the payment error. This should ensure that sampling is used only in appropriate circumstances.

Ability to Correct Minor Errors and Omissions on Claims

The vast majority of home health and hospice claims that are denied are rejected because they do not meet one or more of the technical requirements set out by the Medicare program. Under current practice, if an agency fails to meet a technical requirement in developing and filing claims—examples of which are failure to record the verbal order date on the plan of care, secure physicians' signatures on all verbal orders prior to billing (including minor treatment changes), or date the receipt of signed orders if the physician has not dated his or her signature—the claim is denied and the agency's only recourse is to undergo a costly and lengthy appeals process. This can delay payment to the agency for up to a year and a half, and unnecessarily burden providers and intermediaries. Your legislation would address this long-standing problem by establishing a process under which health care providers would be given an opportunity to correct these minor errors or omissions without having to initiate an appeal. We consider this change in the law as a significant advance for providers, patients, and the Medicare program that will achieve great savings while providing Medicare payment for necessary care.

Additional Action to Shore Up the Home Health Program

Madame Chairman and members of the Subcommittee, the issues addressed by your legislation may seem quite technical in nature, but they will make a tremendous difference in day-to-day operations of all types of providers. We in the home health and hospice world have sought a number of these solutions for many years and will work diligently for their enactment.

I would be remiss in my testimony if I did not at least touch upon one additional issue that weighs heavily on home health providers nationwide-—that of the 15 percent cut currently scheduled for October 2002. As you will recall, the Congress included the additional 15 percent cut in home health payments as part of a series of cuts under the Balanced Budget Amendment at the recommendation of the Congressional Budget Office (CBO). At the time, CBO estimated that the additional 15 percent cut would be needed in order to meet the targeted $16 billion in savings from home health for fiscal years 1998 through 2002. With each passing year since BBA's enactment, it has become increasingly clear that those calculations were dangerously off the mark. According to the latest numbers from CBO, the five-year total in reductions for home health will exceed $70 billion—a far cry from the $16 billion goal.

We in home care are painfully aware of the state of the nation's dwindling surplus. However, we respectfully urge that you take steps this year to eliminate the 15 percent "Sword of Damocles" that has hung over our heads these past few years.

In closing, I cannot thank you enough, Madame Chairman, for your long-standing efforts on behalf of our nation's home health providers and the patients and families they serve. On a more personal note, it is a source of great pride for me to be able to call you "my Representative" in the Congress. Many thanks, again, for your exemplary advocacy.

This concludes my formal remarks but I would be happy to answer any questions that any members of the panel might have.

Chairman JOHNSON. I thank the panel for their extensive testimony and for your detailed suggestions. We will review all of them carefully.

Let me just say for the education of my colleagues on the Subcommittee that this third party liability problem that we have in Connecticut and in a few other States is going to spread like a disease. It is a way that States can maximize Medicare reimbursement, move people from Medicaid onto Medicare, reduce the States' costs and increase our costs. What it results in is the State or some contracted agency requiring review of documentation on every, single patient.

We had one agency in Connecticut, just a very small agency, who wrote that it was going to cost them $37,000 just to xerox the first round of requests. That is unconscionable, and any government

that allows that kind of squandering of national resources is irresponsible and derelict in their duty.

So we have made a lot of progress in negotiating an agreement on this, but we may need to include some language in this bill or another to ratify the resolution of that problem before it truly destroys particularly the small providers.

But the provider that Ms. Wilson referred to that says it is going to cost them $1 million, it is $1 million for that one agency, just this first set of reviews, and it is big because they are the last agency that now serves inner-city folks needing home care. So it would be catastrophic if we wiped them out through utterly irrational regulatory requirements.

Mr. Crane, would you like to question the panel?

Mr. CRANE. Thank you, Madam Chairman.

Ms. Wilson, in your testimony, you urge us to amend H.R. 2768 to postpone recovery of alleged overpayments until all provider appeals are exhausted. As you know, the OIG strongly opposes that proposal, arguing that the likelihood of successful recovery diminishes dramatically the longer the process is drawn out.

H.R. 2768 tries to find a compromise by permitting recovery only after the first level of appeal is exhausted, which would filter out the majority of denials that will be overturned on appeal.

I understand that you would like us to go further. How can we do so and still be sensitive to the real concerns outlined by the Inspector General?

Ms. WILSON. I believe that what needs to be done is to take a look at what has happened historically. The recoupment does take place after the first round of appeals; however, the continued look at the particular issue by going through additional appeals is lengthy, extremely costly, and I believe the history has been that a great many of those have been overturned in the long run.

Essentially what has happened is that the agency has been paid a certain amount of money for service. It may be recouped at a certain time. However, the appeal process needs to continue. We are talking about many agencies, whether not-for-profit or for-profit, that at this point are working under very tight constraints regarding costs. So that essentially, we are removing moneys from the agency necessary in order for them to continue the care that they are providing. Agencies are extremely hard-pressed to be able to do that.

Mr. CRANE. Thank you.

Ms. Aronovitz, I would like to ask you to expand on some very important statements that you made in your testimony. Don't you think that competition will improve the operations of the Medicare contractors, and specifically, will it improve services for seniors and for health care providers?

Ms. ARONOVITZ. Absolutely. The Federal Acquisition Regulation, which requires full and open competition, we think is essential; it is a real foundation to the way that most government entities contract for most goods and services. We think this is a very important principle even with claims administration contractors. I know there is some discussion of developing a system where CMS could be excused from ever conducting full and open competition where a contractor is performing very, very well.

I personally have a lot of skepticism about that, because we have found that CMS has a lot of work to do before they develop the kind of performance system for claims administration contractors that could justify that kind of flexibility.

Clearly, this is an extraordinarily large endeavor, and we do not expect that CMS would be able to do this in record time. It takes time to develop statements of work and to develop this type of contracting. But we think that CMS should develop these contracts, and there should be some time definite where all these contracts would be competed.

Mr. CRANE. Thank you. Thank you, Madam Chairman.

Chairman JOHNSON. Mr. McDermott.

Mr. MCDERMOTT. Thank you, Madam Chair.

Dr. Hall, since you are the designated hitter for the medical profession, I want to ask you a couple of questions. I was just thinking about the fact that this country is going through an awful experience, and it is my view that there will be a national epidemic of post-traumatic stress disorder in this country. So I was just thinking, well, now, all those doctors are out there, and they are going to have to document this, and they have to find sleep disturbance, and they have to find irritability, and they have to find that it has lasted for more than 90 days. All of those are parts of the diagnostic criteria for making that diagnosis.

And I was having some trouble remembering exactly what the diagnostic indicators were, so I was thinking to myself, what is it about this scheme that is out there of coding and documentation that, if you could change a couple more things in this bill to make it work better, what would you do—because I think physicians are overwhelmed with a lot of stuff coming at them, and I do not start with the premise that they are doing it on purpose, but on the other hand, we do need some documentation.

So if you were looking at this, what else would you change?

Dr. HALL. Thank you, Congressman McDermott.

If I were czar of the universe—and I certainly recognize that I am not—I guess there are a couple of things I would change.

As internists and particularly with evaluation and management services, which are the bulk of our business, particularly where older adults covered by Medicare are concerned, often our ability to tell you what you do not have is more important than our ability to tell you what you do have. I have very few patients, if I spent adequate time after a work-up sitting with them and saying, "I have to tell you that we did not find that you have life-threatening cancer," very few of them say, "Aw, shucks, I am not going to pay your bill because you did not make that diagnosis."

On the other hand, that is what I deal with constantly when I deal with CMS. If I go through the same, identical, exhaustive work-up, but it turns out that I have not diagnosed a more classic disease, I am very likely to have my payment rejected or at least down-coded. This is one of the problems that we face in a very complex system which, I agree with you, is going to get increasingly complex as the population ages, bringing with it a baby boomer level of demand, intellectual inquiry and access to the Internet.

Internists are more and more going to be providing services to say to patients, "I understand where you are coming from. This is

not what you have. Here is how we can get your life back into a certain amount of order," which is really what the post-traumatic stress syndrome is. Add to that the fear of bio-terrorism, and we are facing an amazing and I think formidable challenge in the next couple of years in our own country.

So, what would I change? Well, I think the things that I hear the most include, first of all, the appeals process. This is felt to be inherently quite unfair to internists. More importantly, it has some very serious practical implications.

We know that after the first appeal, very, very few of these claims turn out to be anything, as has already been mentioned, individual fraud is extremely rare, but some overpayment is unfortunately going to occur, just like underpayment. Then, let us get it right the first time. Let us put our resources at CMS into first of all being much more open and forthright in telling physicians and their staffs what they have to do right. Let us not have a situation where, if we call for advice, the person giving us the advice refuses to give us his or her name. Let us not have a process where, if we send our staff to various intermediary or regional carrier orientation sessions and they ask the wrong question, they are going to be targeted for review. This is not a healthy environment.

I graduated from medical school the same year that Medicare was enacted, and I have never known anything else throughout my 30-plus-year career. I happen to like it. I think it is a good system. But I think we have now reached the point where we are discouraging physicians.

So what happens with this appeal process? Physicians toward the latter half of their careers are the people who are dropping out. They just do not want to have to deal with this problem and be considered guilty until proven innocent. If we then look at rural communities and what is happening in terms of physicians moving out, I am very much panicked about how we are going to take care of this bulge in the demographics without getting on top of it.

Do it right. Set up a system that creates much more of a partnership between CMS and physicians, and let us not have physicians have to settle claims that they know are absolutely wrong just in order to stay in business, which is what is happening in a lot of places.

Second, I guess I would take a very careful look, as you already have and as other people have testified to, at the whole extrapolation process. This just does not make any sense. It is all re-work. Let us do it right the first time. Let us get the educational guidelines set up.

I file one income tax return a year—in fact, I file it for two of us, because my wife and I file together. I understand the need for some kind of random audit there, because I only do it once a year. But if I take care of 2,000 frail elderly people, I am submitting 6,000 claims a year. Wouldn't it be better to look at the claims that are being submitted already and say, "Dr. Hall, compared to your peers in the community, your billing practices are not very right, and we think that we had better take a look at that." Why would we just pick a random audit sample out of those 6,000? It just does not make sense in terms of getting at the real problems. Thank you.

Mr. MCDERMOTT. Would you let me have a little extension on that, Madam Chair?

Chairman JOHNSON. Is that all right with you, Mr. Johnson?

Mr. JOHNSON of Texas. Yes.

Chairman JOHNSON. Yes, that would be fine, Jim.

Mr. MCDERMOTT. We use the term in our bill "a high level of payment error." I would like to know how you would define that. That triggers a bunch of bad things for a doc. So how would you define "a high level of payment error" for HCFA, or whatever that agency is called now?

Dr. HALL. CMS. Well, I would be the wrong person to ask that, because whatever I said could be subject to some bias. But if someone were to ask my opinion on how it should be set up, I would say that within every region, there are standard, acceptable practices and there are frequencies of coding that are very much keyed to the specific population that is being taken care of.

If I am practicing in Sun City, Arizona, my distribution of billing codes and my levels of care are going to be very different than if I am practicing in some other area where there is not such a high concentration of retirees.

I think that the definition should be based on some kind of statistical cut point that says you should be within 95 percent of the spread of diagnostic codes and of billing codes, or whatever is the right number, but let us decide on that number that makes some sort of sense in the context of practice—and I agree there has to be some kind of accountability here. The last thing we are asking for is decreased accountability.

Mr. MCDERMOTT. Thank you.

Chairman JOHNSON. Thank you.

I would note that Gail Wilensky testified to this point at our very first hearing, that the whole system needs to move to that kind of oversight so you can identify patterns early and can use that pattern process to get at providers who are either making errors or exploiting the system. I do not know that we can move that into this specific bill, but we are going to have to get into that much more deeply.

I just want to clarify something before I go to Mr. Johnson. Did you say that if you do not diagnose a serious illness, the visit is then down-coded? We have heard this many times.

Dr. HALL. The likelihood is that with an EM service, if we do not have a piece of paper that has a lab test attached to it that says a certain disease was diagnosed, that claim has a much higher probability of being down-coded.

Chairman JOHNSON. Are your people having trouble with Level 5, which says "comprehensive physical," versus Level 3, which says "detailed physical"?

Dr. HALL. There are problems there, but I think it runs through the entire spectrum of the coding levels.

Chairman JOHNSON. Thank you.

Mr. Johnson.

Mr. JOHNSON of Texas. Thank you.

Ms. Aronovitz, would you talk to me about how you have said, I believe, that there is a lack of accuracy in the information that

Medicare contractors make available? Are the pressures of the system forcing that on them, or were your questions trick questions?

Ms. ARONOVITZ. They were clearly not trick questions, and we were very disturbed by our findings. We did not expect to have such a high error rate.

Our questions were actually taken from contractors' websites under their "Frequently Asked Questions" section, so these are questions that should have been answered correctly.

We think that there is a lot of pressure for customer service representatives to answer questions quickly and well, and there is no excuse for having such a high error rate. We think that the training and the oversight that is given to customer service representatives and other activities that are conducted at the contractor level need to be more standardized, and they need to be increased.

Mr. JOHNSON of Texas. Is it the fault of the system that makes the paperwork level almost extreme? Most of the doctors, I think, have to hire one or two people just to keep track of what is going on. Is that part of the problem?

Ms. ARONOVITZ. Well, there is some concern that the program is so complicated that customer service representatives have trouble figuring out the correct answers. But in this case, these three questions were ones that had been asked so many times that the answers were very straightforward and very clear and had been discussed with customer service representatives several times.

So we do not think that our questions in any way indicate the kind of complexity where the expectation is that they should not have been able to answer correctly. They clearly should have been able to answer these questions.

Mr. JOHNSON of Texas. Do you think that they are answering truthfully in their own minds and just did not get the question right, or what?

Ms. ARONOVITZ. Yes, I really do. I think maybe it could have something to do with training or oversight or monitoring or feedback. There are lots of things they have to worry about—not just answering the question correctly, but there are a lot of process questions. They need to make sure that they ask a follow-up. There is a lot of phone etiquette that they also have to engage in. And to their credit, they also answer a lot of questions that pertain to reimbursements on specific claims. We have not tested those, but we do not hear complaints from physicians when they call up about those kinds of things.

So we think they need a lot more training, and they need to have more feedback in terms of how their performance is measured.

Mr. JOHNSON of Texas. Did I just hear you say that physicians are not griping about their reimbursements?

Ms. ARONOVITZ. No, no, no. I did not say they are not griping about their reimbursement at all. What I said was that we have not heard the same level of concern when a physician calls one of these call centers and asks, "What is the status of my reimbursement?" In other words, when is it coming? They seem to be satisfied that they get an answer; whether they are happy with that——

Mr. JOHNSON of Texas. OK. Did you pursue HCFA at all as to why they do not trust the providers and the docs when they are

giving them information? That has been my experience in dealing with them. Did you pursue that at all?

Ms. ARONOVITZ. Why the physicians do not trust the answers?

Mr. JOHNSON of Texas. Why HCFA will not take information from the hospitals, docs, and associations as real; they have to go out and do their own studies, which are always about 10 years late. Did you pursue that at all?

Ms. ARONOVITZ. We did not really pursue that, but it is an interesting point. I think that CMS is starting to reach out more, and we are very encouraged by their interactions with physicians, trying to get feedback on their concerns. But you are right, they do a lot of their independent studies, and they feel they really need to to get the kind of evidence they need to make program changes.

Mr. JOHNSON of Texas. Well, I think it is a waste of time and money on their part, frankly. Thank you, Madam Chairman.

Chairman JOHNSON. I just want to pursue one brief question with Dr. Hall and one with Ms. Aronovitz.

Dr. Hall, it was very helpful to hear you follow up on Dr. McDermott's questions, but in your testimony, you said something about instead of all this documentation, a one-pager. Have you thought through what that one-pager would be, or would you be interested in having your people begin thinking through what is—because this is something that actually I have proposed and we have in our bill, sort of a demonstration possibility for people outside the government, without any background or without any attachment to the bureaucracy and the IG, to come up with what they think in the real world is sensible documentation, and then we can go through the process of rectifying it.

But right now, we are trying to rectify a process that is extraordinarily detailed and intrusive with a generalized payment system and with an IG who has the right to require things that even the IRS does not have the right to require.

So there are other steps beyond this bill, but I wonder if you would be interested in sort of giving body to that comment that you made in the course of your testimony.

Dr. HALL. Congresswoman Johnson, I thought you would never ask. I think there is a start. Within the Current Procedural Terminology documentation, there is such a document that is much more contracted than what we have had before. One of the proposals for a pilot study would be to combine that with the element of time, the actual commodity that we are really talking about in an office setting. We could supply some of that information to the Subcommittee. We would be able to get that to you right away, right from our own Washington office.

Chairman JOHNSON. We would appreciate your getting that to us right way, and then we can flesh out that particular pilot idea, because in the long run, I personally believe that we will not be able to continue to attract the quality of mind or heart to medicine if we do not do something about the fact that they are paid on the basis of an RBRVS formula which is so extraordinarily complex, and nobody understands it, not even the people who implement it, a coding system that now is almost unworkable, and a practice expense formula that is also controversial, complex, and in my estimation, unworkable.

So when you look at the three systems supporting physician reimbursement, frankly, it is not the future, and we have to find radical ways to break through and find another basis on which to restore an honest and responsive relationship to a medical community that has to increasingly deal with complex illnesses, complex methods of diagnosis and treatment. This is also true in the home health area and in many other areas, but if you will get that to us, we will work on that.

Dr. HALL. We will do that. Could I just make one comment in relationship to that?

Chairman JOHNSON. Yes.

Dr. HALL. The medical chart for most physicians is more than a legal document. It is really the record of the clinical transaction that goes on behind closed doors with the patient. It often contains, if it is a proper chart, information that maybe some people would not even share with their spouses. It is very, very important to the continuity of care.

What we have now done is taken that record and used it as the sole basis for determining the quality and quantity of the interaction that occurred behind those closed doors. It was never meant for that, so what we are finding is that I personally and all the people we work with spend an inordinate amount of time recording what is quite frankly nonsense—it has nothing to do with what is important for that patient—in order to justify and provide the documentation that is necessary.

To be sure, there has to be some metric for that documentation that is understandable and allowable, but I think the bureaucracy has just gotten away from us. We need to reestablish this dialog between the medical profession and CMS and just come up with a better way.

Chairman JOHNSON. Thank you. We invite your participation in that dialog, and we hope to push that dialog ahead very aggressively from this Subcommittee.

Ms. Aronovitz, I was surprised at your response to Mr. Johnson's comment—or another of my colleagues; I am not quite sure—about giving CMS the flexibility to renew contracts without a bid process. This business of setting standards is not rocket science. Just because the government has not bothered to do it does not mean it is not quite regularly done throughout the private sector and is not a process that we know a lot about.

I would like to preserve that right, because the bidding process is very expensive, and it is going to take a while to get this first round, and I think there needs to be some flexibility to recognize high performance. So one possibility might be to require a report to the Committee on the standards once they have been set so we can have a dialog about that; we could even have hearings on it if we think the standards are too low or not well enough developed, and then a report when the decision is made by the government not to go to bid, so that we can follow this.

But I think that at the time we are giving flexibility, we need to give broad flexibility, because we are going to make really radical changes in the system. Do you have any comment on that?

Ms. ARONOVITZ. Sure, I do. First of all, I totally agree with you. We believe that performance standards is one of the most impor-

tant principles in any type of contract. Setting up expectations and then providing oversight and monitoring and feedback is essential to understanding whether you are getting your money's worth for any goods or services you would have.

So we definitely believe that that is critical. It is just that CMS does not have really strong performance measures. I think they are getting there, and in their program safeguard contractor efforts, it is coming along.

In terms of the expense involved in doing full and open competition, we agree that this could be very expensive, but we think the expense really comes in the first round. CMS really does not have experience on claims administration contracts, in writing statements of work, in developing this process. We believe, though, that once it does that for several contractors, it could use the same approach or the same statement of work for competing in future years or even competing with other contractors or doing one big competition.

So we think that the expense that they are going to incur up front is going to be a fixed cost that could apply across the board. We do not think there would be that much saved in exempting one contractor down the road from having full and open competition, and there are some real benefits to it down the road. That is, no matter how well you are performing, it forces you to look around and make sure that you are improving because you know you do have competition.

The last thing I want to say is that we agree that we would not want to push CMS into doing this in a time frame that would be unreasonable. I think that if all competition would have to be completed by 2006 or 2007 or 2008, or whatever amount of time would be reasonable to give CMS a chance to do this well and to do it in a phased approach, we are not in any way opposed to that. It is just that ultimately, these contracts should be completed because there are a lot of benefits that could be derived.

Chairman JOHNSON. Thank you very much. Mr. McDermott.

Mr. MCDERMOTT. Madam Chair, I wonder if it would be possible—I keep thinking about the IRS, and they do not make you pay in advance; what they do is they charge interest when you finally settle up—I wonder if we could not consider an amendment to move it up a layer in the appeals process before people have to pay, knowing that they would have to pay interest. Is there some compromise that we could work out in there to make it a little less onerous to hit somebody right up front and make them pay for what then takes sometimes as much as 3 years to pay—and you may not in fact wind up paying at the end of the 3 years. That seems unfair to me.

Chairman JOHNSON. I certainly would be happy to look at it with you. First of all, I take the interests of the Subcommittee members very seriously, and in addition, there are some data that say that particularly for physicians on that second level of review, 60 percent—on the first level of review, 40 percent have changed, and on the second level of review, the remaining 60 percent are reviewed.

We have found that there is some disagreement about those figures and whether they really hold up, but I think we would be

happy to look at it with you and see if we can—I know that for all of you, that second level of review is important.

Mr. MCDERMOTT. When do you anticipate having a markup?

Chairman JOHNSON. We anticipate resolving these kinds of issues this week, so we will be talking about this directly this week, and hopefully will be able to have a Subcommittee markup in 2 weeks.

Mr. MCDERMOTT. Two weeks?

Chairman JOHNSON. Yes.

Mr. MCDERMOTT. OK.

Chairman JOHNSON. Unless there are other time frames that are beyond our control that require us to move it up more rapidly.

Mr. MCDERMOTT. Thank you.

Chairman JOHNSON. Thank you.

Thank you very much, members of the panel. I so appreciate your joining us and giving such serious consideration to the proposal that we put out a month and a half ago.

Thank you very much.

[Whereupon, at 12:22 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

Statement of the Advanced Medical Technology Association

AdvaMed is pleased to provide this testimony on behalf of our member companies and the patients and health care systems we serve around the world. AdvaMed is the largest medical technology trade association in the world, representing more than 1100 medical device, diagnostic products, and health information systems manufacturers of all sizes. AdvaMed member firms provide nearly 90 percent of the $68 billion of health care technology products purchased annually in the U.S. and nearly 50 percent of the $159 billion purchased annually around the world.

AdvaMed would like to thank Chairwoman Johnson, Ranking Member Stark, and the members of the Subcommittee for their bipartisan effort to make the Medicare program more efficient and effective for providers and Medicare beneficiaries. Medicare is a critical program for some 40 million Americans, and we greatly appreciate the way that the Committee has reached out to the health care community to develop legislation to make the program easier to understand, comply with, and participate in.

Contracting Reform

While some reforms to the contracting process are warranted, AdvaMed strongly believes that any reforms that would result in changes in local carriers or consolidated areas for carriers should maintain a process for making coverage decisions locally, and for securing input from the local medical community.

AdvaMed strongly supports Medicare's local coverage process as a vital route for timely patient access to the vast majority of innovative medical technologies. The local coverage process offers an important alternative to national coverage decision-making by the Centers for Medicare and Medicaid Services (CMS), which runs Medicare and oversees local contractors. Currently, Medicare patients face delays of 15 months to five years or more in gaining access to technologies at the national level.

Consolidation of the number of local Medicare contractors that make coverage decisions would severely constrict or eliminate the local coverage route and create significant new delays in patient access to important new medical technologies and services. AdvaMed appreciates the work of Congress and CMS to examine Medicare contractor operations in areas such as accountability and performance incentives. However, as Congress addresses this issue, we urge it to avoid steps that would undermine the local coverage process as a route to early patient access to new medical technologies.

The local coverage process provides the flexibility and timeliness needed to keep pace with rapid advances in medical technology. Current flexibility at the local level very efficiently incorporates the majority of new procedures and technologies into the existing Medicare payment systems. This flexibility includes:

- timely access to local contractor decision-makers

- an active relationship with the local medical community and understanding of local medical practice, and
- the ability to make case-by-case determinations.

Local decision-making authority provides Medicare beneficiaries access to new procedures and technologies without having to wait until these innovations have been disseminated nationally.

A recent report by the Lewin Group, a prominent health care policy research firm, also highlighted the value of the current local Medicare coverage process. According to the Lewin Group, "the local coverage process remains a critical avenue for obtaining coverage" for the vast majority (90%) of new technologies and services.

Preservation of the local coverage process is particularly important, the Lewin Group found, because it offers a way for patients to gain access to many innovative technologies that otherwise would encounter significant coverage delays at the national (CMS) level. Lewin cites the example of a breakthrough technology in women's health, dual x-ray absiorptiometry, which is used to diagnose osteoporosis. It took Medicare more than seven years to cover this technology at the national level. However, coverage decisions by local Medicare contractors during that time enabled many women to gain access to this technology who otherwise would not have been able to receive it.

Recommendations

AdvaMed strongly believes that, despite any contracting reforms, a process for making coverage decisions locally, and for securing input from the local medical community (through the local coverage advisory committee) should be maintained.

- Local authority to make decisions. One approach to maintaining local decision-making is to require contractors to grant local physicians (such as state medical directors) direct authority to make coverage decisions, in consultation with their peers in the local medical community. This includes the authority to make claims-level case-by-case decisions in a timely manner.
- Local carrier advisory committees (CACs). Local CACs should be continued in each state to assure that local medical review policy reflects the consensus of the local physician community. Changes in local coverage decisions should be subjected to the normal review and comment process with the local CAC.
- Local codes. Occasionally, to implement a local decision, it may be necessary to issue a new temporary local code, and so we recommend that contractors continue to have the authority to issue and recognize local codes.
- Accessibility and Responsiveness. Contractors should require their medical directors to be readily accessible and responsive to local physicians, providers, beneficiaries, and manufacturers, and to continue to respond and render decisions in a timely manner.
- Open Participation in Decision-making. Last November, CMS issued a program memo instructing contractors to post their draft coverage decisions on their websites for comment. We suggest extending this to include additional information earlier in the process, similar to the national level, where the local medical director would post to the website the intent to make a coverage decision, what information will be reviewed, the names of the members of the coverage advisory committees who will be reviewing the information, and acceptance of input from interested parties during the various stages of this process. This would apply to any changes in local coverage policy, including those that may result from a change or consolidation of contractors.

Conclusion

AdvaMed thanks the Subcommittee members again for their collaborative efforts to improve and strengthen the Medicare program. We look forward to working with this Committee, the Congress and the Administration on this important legislation, as well as additional ways to improve the quality of care available to seniors through Medicare and foster the delivery of innovative therapies for patients.

Statement of the Alliance to Improve Medicare

The Alliance to Improve Medicare (AIM) is the only organization focused solely on fundamental, non-partisan modernization of the Medicare program to ensure more health care coverage choices, better benefits (including prescription drug benefits), and access to the latest in innovative medical practices, treatments and technologies through the Medicare system. AIM coalition members include organizations

representing seniors, hospitals, small and large employers, insurance plans and providers, doctors, medical researchers and innovators, and others.

AIM recently released the attached report outlining regulatory burdens on both Medicare beneficiaries and providers and recommending administrative remedies. The report, "Improving Medicare Management for Everyone", identified areas of complexity for both senior citizens and providers including health plans, hospitals, and medical technology innovators. AIM identified beneficiary concerns including the lack of clear information on benefits and eligibility, access to prescription drug benefits, and difficulties understanding Medicare paperwork. The report also outlined provider regulatory burdens including inconsistent Medicare program policies, slow responses to provider concerns and inquiries, and an inflexible Medicare bureaucracy.

Complexity in Medicare's rules governing beneficiary and provider participation has resulted in increasingly bipartisan support to improve the fairness of the system for all participants. AIM applauds Subcommittee Chairwoman Nancy Johnson and ranking member Pete Stark for their bipartisan efforts in the discussion of necessary regulatory reforms to the Medicare program. We hope the Subcommittee will consider the recommendations in the attached report as they continue their discussions on this issue.

Improving Medicare Management for Everyone

Improving Medicare Management Through Reducing Regulatory Burdens on Both Providers and Beneficiaries

A Report by the Alliance to Improve Medicare

June 2001

The Alliance to Improve Medicare (AIM) is a coalition of organizations representing seniors, doctors, hospitals, patients, medical researchers and innovators, insurance plans and providers, small and large businesses and others who believe that Americans need and deserve a better Medicare program. AIM is the only organization focused solely on fundamental, non-partisan reform of the Medicare program to ensure more coverage choices, better benefits (including prescription drug benefits), and access to the latest in innovative medical practices and treatments though the Medicare system.

The structure of the traditional Medicare program has changed little in more than three decades, and, consequently, has not kept pace with many of the dramatic improvements in the delivery of health care. AIM is dedicated to comprehensive modernization of the traditional Medicare program. By focusing on benefits and services rather than excessive government regulation, and injecting competition and choice into the program, AIM believes we can have a better Medicare program and one that will be financially healthy well into the 21st century.

AIM is working to achieve Medicare modernization through policy research and educational programs for Members of Congress and staff, the media, and the American public.

Key AIM Principles

- Improve coverage through better coordination of care and health promotion and disease prevention efforts.
- Improve coverage choices by providing Medicare beneficiaries with the power to choose from a range of coverage options similar to those available to Member of Congress, federal employees and million of working Americans under age 65 who are covered by private plans.
- Improve coverage through increasing market competition and availability of basic, affordable coverage to Medicare beneficiaries.
- Provide access to prescription drug coverage as part of comprehensive, market-based modernization and improvement.
- Improve traditional Medicare's basic benefit package and provide the flexibility to make new health care innovations more accessible.
- Reduce Medicare's excessive complexity and rigid bureaucracy.
- Establish a solid foundation upon which to improve Medicare by ensuring appropriate and timely payments to health plans and providers.

ALLIANCE TO IMPROVE MEDICARE

COALITION MEMBERS

60 PLUS ASSOCIATION
AdvaMed—ADVANCED MEDICAL TECHNOLOGY ASSOCIATION
AETNA U.S. HEALTHCARE
ALZHEIMER AID SOCIETY OF NORTHERN CALIFORNIA
AMERICAN BENEFITS COALITION
AMERICAN HOSPITAL ASSOCIATION (AHA)
AMERICAN MEDICAL GROUP ASSOCIATION (AMGA)
AMERICAN ASSOCIATION OF HEALTH PLANS (AAHP)
AMERICAN SMALL BUSINESSES ASSOCIATION
BELL SOUTH CORPORATION
BLUE CROSS BLUE SHIELD ASSOCIATION
CITIZENS AGAINST GOVERNMENT WASTE
COMMUNICATING FOR AGRICULTURE
COUNCIL FOR AFFORDABLE HEALTH INSURANCE (CAHI)
COUNCIL FOR GOVERNMENT REFORM
COUNCIL ON RADIONUCLIDES AND RADIOPHARMACEUTICALS
THE ERISA INDUSTRY COMMITTEE
FEDERATION OF AMERICAN HOSPITALS
FOOD MARKETING INSTITUTE
HEALTHCARE DISTRIBUTION MANAGEMENT ASSOCIATION
HEALTHCARE LEADERSHIP COUNCIL (HLC)
HEALTH POLICY ANALYSTS
HISPANIC BUSINESS ROUNDTABLE
KIDNEY CANCER ASSOCIATION
MEDICAL IMAGING CONTRAST AGENT ASSOCIATION (MICAA)
NATIONAL ASSOCIATION OF HEALTH UNDERWRITERS (NAHU)
NATIONAL ASSOCIATION OF MANUFACTURERS (NAM)
NATIONAL RESTAURANT ASSOCIATION (NRA)
NATIONAL RETAIL FEDERATION
NATIONAL FEDERATION OF INDEPENDENT BUSINESS (NFIB)
PHARMACEUTICAL CARE MANAGEMENT ASSOCIATION (PCMA)
PHARMACEUTICAL RESEARCH AND MANUFACTURERS ASSOCIATION (PhRMA)
PREMIER
SENIORS COALITION
THIRD MILLENNIUM
UNITED SENIORS ASSOCIATION
US CHAMBER OF COMMERCE
VHA INC

IMPROVING MEDICARE MANAGEMENT FOR EVERYONE

Improving Medicare Management Through Reducing Regulatory Burdens on Providers and Beneficiaries

Background

Medicare, the world's largest health insurance program, serves approximately 40 million beneficiaries today and is projected to serve nearly double that number when the baby boom generation fully enters the program. Increasing dissatisfaction, however, from both beneficiaries and providers has forced policy makers to consider whether Medicare can survive for these future beneficiaries. AIM members applaud the Administration and Congress for their work to strengthen and improve the Medicare program for today's beneficiaries and for future generations but urge a continued focus on a solid administrative infrastructure geared toward beneficiary interests.

Most important is the vision that Medicare was created to serve senior citizens and disabled individuals, to ensure that these individuals are provided with quality, appropriate health benefits. Since the program's creation, however, Medicare benefits have not kept pace with private health coverage. In addition, both Medicare beneficiaries and providers have been subjected to more and greater regulatory and administrative requirements for participation. These requirements have harmed providers and caused some health plans to leave the program entirely while others have been forced to reduce benefits in order to maintain financial solvency. Beneficiaries have also suffered through a scarcity of information and confusing coverage issues.

Complexity in Medicare's rules governing beneficiary and provider participation has resulted in increasingly bipartisan support to improve the fairness of the system for all participants. AIM applauds the bipartisan efforts of House Ways & Means Committee members to develop and recommend changes to the current program. Like the recommendations contained in the May 14, 2001 letter from House Ways & Means Health Subcommittee Chairman Nancy Johnson (R–CT) and Ranking Minority Member Pete Stark (D–CA) to U.S. Department of Health and Human Services (HHS) Secretary Tommy Thompson, many of the recommendations contained in this report can be achieved through administrative actions.

AIM urges Congress and the Administration to work together to achieve these regulatory reform goals this year and to strengthen and improve the Medicare program for both beneficiaries and providers.

Report

This report identifies primary beneficiary concerns as well as some of the major administrative problems and regulatory burdens facing health care plans and providers in the Medicare program. Further, the report makes recommendations to improve Medicare coverage through reduction of regulatory burdens on both beneficiaries and plans and providers.

The beneficiary recommendations are based on surveys of Medicare caseworkers in Congressional District offices conducted in May 2001. The surveys, sent to field offices of all Member of the U.S. House of Representatives and U.S. Senate, requested input on the most common concerns raised by beneficiaries in their attempts to understand and comply with Medicare paperwork. AIM received completed surveys from over 100 Congressional district offices in 40 states.

The health plan and provider regulatory burden relief recommendations are based upon responses from a variety of AIM member organizations representing a range of industries.

SECTION ONE:

Medicare Modernization: Beneficiary Regulatory Concerns

AIM surveyed Medicare caseworkers in Congressional district offices to compile the recommendations included in this section. Generally, the caseworkers reported that constituents' Medicare concerns rank second or third in sheer volume of inquiries to their offices. Caseworkers overwhelmingly reported that the biggest concern raised by constituents is obtaining information about Medicare eligibility and benefits and understanding that information. Caseworkers specifically cited difficulty obtaining basic information on Medicare eligibility and understanding enrollment opportunities. Further, beneficiaries appear to have great difficulties understanding Medicare claims and appeals procedures. Ranking second among beneficiaries, according to caseworkers, is obtaining coverage for prescription drugs and assistance in paying for prescription drugs. Understanding and responding to Medicare paperwork, particularly for beneficiaries with supplemental coverage, ranked third among beneficiary inquiries to Congressional offices.

Beneficiary Benefit and Compliance Concerns

Recommendation: *Provide Better Information on Beneficiary Eligibility and Covered Services including Claims and Appeals Procedures* (Administrative)

Medicare beneficiaries are often confused about basic eligibility and benefits requirements despite efforts by the Centers for Medicare and Medicaid Services (CMS—formerly known as the Health Care Financing Administration) to improve and expand communications. Many Medicare beneficiaries continue to have trouble obtaining clear explanations of their benefits. Beneficiaries appear to lack clearly identified customer service representatives who can provide assistance by explaining coverage and benefit information and options.

Beneficiaries also appear to need additional assistance understanding Medicare claims and appeals procedures. Beneficiaries contacting Congressional offices frequently raise concerns about denial of payment for services previously covered. For example, coverage for ambulance services and chiropractic care were specifically cited on nearly 10% of all responses. Beneficiaries are confused about what is covered and report to Congressional caseworkers they have been told by their physician that a service is covered but they are later informed that Medicare has denied coverage for that particular service. (Medicare makes coverage determinations only after services are provided.)

Caseworkers responded that many beneficiaries are unaware of existing opportunities for assistance from such organizations as State Health Insurance Assistance

Programs and other medical hotlines or simply lack access to opportunities such as the Internet and the www.Medicare.gov web site. Beneficiaries clearly need such information to be more easily accessible.

AIM applauds the Medicare Patrol Project grants recently announced by HHS Secretary Thompson. The grants will fund programs to train senior volunteers help other seniors learn to read Medicare notices and how to obtain answers about billing and claims questions. HCFA should expand such efforts to provide better and more easily accessible information to beneficiaries and their family members to outline basic eligibility and benefits. Separately, more detailed information to clearly explain claims and appeals procedures should be provided to beneficiaries and providers. HCFA should also consider greatly expanding Medicare customer service operations through additional hotlines and marketing efforts.

Recommendation: *Provide Prescription Drug Coverage* (Statutory)

Beneficiaries contacting Medicare caseworkers report the lack of prescription drug coverage to be a significant concern.

AIM members believe all Medicare beneficiaries should have basic prescription drug coverage and encourages Congress and the Administration to work toward a bipartisan solution. AIM supports efforts to strengthen and improve the existing Medicare benefit package through inclusion of prescription drug benefits.

AIM believes an integrated benefit is necessary to ensure the long-term viability of the Medicare program. Congress should not simply layer a new, stand-alone drug program onto the traditional Medicare program without addressing the program's outdated and inadequate financial and structural systems.

Recommendation: *Reduce Paperwork Burden on Beneficiaries* (Administrative)

Beneficiaries report enormous difficulties understanding Medicare and its paperwork. Further, beneficiaries with supplemental coverage receive, and must respond to, paperwork and information from multiple coverage sources. Specifically, beneficiaries contacting Congressional caseworkers cite the monthly Medicare Summary Notice as a source of great confusion.

SECTION TWO

Improving Medicare Management: Provider Regulatory and Compliance Concerns

This section illustrates outdated or burdensome regulatory business practices which the Center for Medicare and Medicaid Services (CMS—formerly known as the Health Care Financing Administration) should eliminate or streamline to improve the delivery of health care through the Medicare program. All of the recommendations could be achieved through administrative action.

This report shows that CMS does not currently operate as a good business partner with private sector providers. AIM members believe that CMS must refocus its goals to emphasize cooperative relationships with providers including health plans, hospitals, doctors, technology innovators and other private sector partners. AIM believes CMS must replace the current rigid and outdated bureaucracy with the flexibility to make new health care innovations more accessible and to reduce excessive complexity of federal rules, regulations, and guidelines.

Further, CMS should seek health plan and provider input prior to making or changing policies, and should establish a process for the responsible department within CMS to certify to the Administrator its readiness before changing over to a new system or policy. Because plans and providers are on the front line of health care, they are best positioned to gauge the administrative burden of proposed policy changes, as well as the likely impact on patient care. In addition, plans and providers often can propose potentially less burdensome and more effective alternatives. Thus, by consulting health plans and providers before changing policies, CMS can increase efficiency, limit or reduce regulatory burdens, and potentially improve health care quality and patient outcomes. Similarly, requiring CMS to certify its readiness to implement a change before doing so potentially saves the enormous time, effort and expense that result when plans and providers are required to follow a new policy before CMS, itself, is prepared for the policy.

Additionally, advanced medical technology is playing an increasingly important role in the delivery of quality health care. However, Medicare has not kept pace with advances in medicine. In fact, many of the policies and procedures CMS uses to incorporate new technologies into Medicare reflect the science and health care system of 1965, when the program was created.

Today, advances in areas such as DNA-based testing, microelectronics, tissue engineering and molecular imaging are transforming health care—and patients' lives.

Frequently, cutting-edge medical technologies are supplanted by new breakthroughs in two years or less, yet Medicare can take 15 months to five years or more to make these advances available to seniors and people with disabilities. The recommendations below will help make timely patient access to 21st century medical technology a part of CMS's new mission.

AIM supports CMS Administrator Thomas Scully's recently stated goals to improve the Medicare+Choice (M+C) program by improving and increasing information about M+C options to eligible beneficiaries and by examining administrative simplification of the program. Mr. Scully stated his goal to increase the enrollment of beneficiaries in Medicare+Choice plans and we look forward to working with his agency to achieve this goal.

AIM also looks forward to working with HHS Assistant Secretary for Planning and Evaluation Bobby Jindal and the Task Force on Regulatory Reform to review these and other recommendations for relief.

Provider Regulatory Relief Recommendations

Recommendation: *Publish Guidelines for Beneficiary Materials* (Administrative)

CMS should halt efforts to standardize written materials for Medicare beneficiaries. The current requirement for CMS approval of all documents and CMS's long term objective for standardizing many more communications is problematic. Health plans need to tailor their communications to their own programs. CMS's current review of communications creates constant revisions and delays for plans and there is inconsistency among reviewers. Even implementation of the standardization of the document called the "Summary of Benefits" has resulted in approvals of inaccurate documents, as the "standard" may not allow for specific plan benefit designs.

CMS should provide a checklist for plans of the information required to send to beneficiaries. CMS should also develop marketing and communications guidelines and require compliance with such guidelines on the contents of beneficiary communications. Violations could then be determined from on-site reviews similar to state market conduct audits when a plan is reviewed for compliance with state regulations.

Recommendation: *Improve and Consolidate CMS Oversight of M+C Program* (Administrative)

CMS's fragmented approach to policy making has been a major barrier to success of the M+C program. Authority for the M+C program is currently divided among three CMS Centers: the Center for Health Plans and Providers; the Center for Beneficiary Services; and the Office of Clinical Standards and Quality. The result is a complex and inefficient policy making process.

For example, issuance of the Quality Improvement System for Managed Care (QISMC), developed by the Office of Clinical Standards and Quality, created further confusion about CMS's standards, because it overlapped with and differed from regulatory requirements developed by the Center for Health Plans and Providers and the Center for Beneficiary Services.

AIM members are pleased that CMS Administrator Scully has announced the creation of the new Center for Beneficiary Choices to focus on Medicare beneficiaries in private plans. We urge CMS to designate an official who reports to the CMS Administrator and has responsibility for overall program oversight. This will allow for greater efficiencies and streamline requirements that now may be developed within different offices.

Recommendation: *Coordinate Release of Federal Regulations* (Administrative)

The duties of the Office of Information and Regulatory Management (OIRA) at the Office of Management and Budget should be enhanced to allow for the orderly release of regulations from federal agencies. Such coordination should recognize the tremendous burden placed on providers who must simultaneously implement multiple, complex regulations from agencies like CMS, HHS, OSHA and EPA. For example, in the last two years, even though CMS delayed implementation of some statutory provisions to address potential Y2K system problems, hospitals have still had to make significant changes to their patient data collection, coding and billing systems to implement prospective payment systems for Medicare skilled nursing care, home health care, outpatient care, and transfers of inpatients. This is in addition to other regulations hospitals are currently in the midst of implementing, such as uniform electronic transactions standards, privacy standards, ergonomics standards, and prospective payment for rehabilitation services. The implementation of regulations should be better coordinated so that providers' administrative and information systems are not overwhelmed.

Recommendation: *Create a Medicare Office of Technology and Innovation to Improve CMS Accountability, Openness and Coordination in Making Timely Decisions* (Administrative)

Many important new medical technologies and services must go through three sequential stages of Medicare decision-making—the initial coverage decision, assignment of a procedure code, and determination of a payment amount—before they are widely available to patients. This process has suffered from a lack of coordination and long delays in patient access to new treatment options.

Congress should create a new Office of Technology and Innovation at CMS to improve coordination among the agency's offices involved in this process and facilitate a shift in CMS's culture to one that supports the development and dissemination of beneficial new technologies.

Recommendation: *Develop Consistent Policies Throughout the Program* (Administrative)

- M+C organizations across the country frequently receive different instructions and policy interpretations from the 10 CMS Regional Offices and the CMS Central Office. Regional Office Administrators and CMS Center Directors report directly to the CMS Administrator. Regional offices and centers are not required to maintain program-wide consistency for instructions or policies.

  For example, the CMS Central Office has issued model language for beneficiary communications and stated that use of the language by plans is discretionary: if a plan chooses to use the language as issued, it will not be subject to change by the Regional Offices and will receive expedited review. Contrary to Central Office instructions, however, some Regional Offices have *required* rather than permitted use of the model language and required plans to make changes in the Central Office model language in order to obtain Regional Office approval.
- CMS should adopt consistent policies for Part A and Part B. Examples of inconsistency include: advanced beneficiary notices (ABNs) and medical necessity determinations for Part A and Part B; Medicare secondary coverage determinations for Part A and Part B, including reference labs, etc.

  Requiring consistency in administration of Part A and Part B will simplify and streamline compliance both for providers of Part A services and providers of Part B services (and especially for providers of both types of services), as well as promoting fairness by leveling the health care playing field.

Recommendation: *Reduce CMS Decision Making Delays* (Administrative)

CMS's decision making process typically involves many different parties at varying levels of seniority and in different Centers. Despite creation of cross-Center task forces, the complexity of this process and the lack of clear decision making authority below the level of the Administrator's office results in delays that are frequently costly to plans and disadvantageous to beneficiaries.

For example, the Medicare+Choice payment rates for 2001 were issued as required on March 1, 2000. However, the instructions for filing 2001 plan rate and benefit proposals were issued in early June only a short time before the July 1 submission deadline. Plans were required to submit by July 15, 2000 proposed Summaries of Benefits using previously issued mandated CMS language in order to assure timely approval. However, in some cases the mandated language did not accurately describe plan benefits. To address these and other problems, changes in the mandated language began shortly after the July deadline and were still being made in early September.

Recommendation: *Establish Decision Deadlines to Improve CMS Accountability* (Administrative)

CMS took steps to improve the timeliness and openness of its national coverage process in April 1999. However, for technologies subject to national coverage decisions, the agency has no deadlines for total "time to patient access"—the amount of time the agency takes to set coverage, coding and payment policy on a new technology and make it available to beneficiaries.

To ensure timely patient access, CMS should take action on a timeline similar to those in place for FDA review decisions. Patients should not have to wait more than six months for CMS to make coverage decisions, assign codes and implement reimbursement for technologies that do not have to be referred to outside experts. In cases where CMS must seek advice from external advisory bodies, patients should wait no more than 12 months.

Recommendation: *Stop Extensive Data Collection Efforts* (Administrative)

• CMS issues requirements that fail to take into consideration the practical steps necessary for implementation of regulations, rather than working with health plans to determine the most efficient way to achieve the desired result.

For example, implementation of CMS's risk adjustment approach is making excessive demands on health plan resources that are not necessary to achieve the initiative's purpose. The approach is based on collection of 100% encounter data from inpatient and outpatient settings and requires plans to develop all of the systems and staffing necessary to process claims in the same way as the fee-for-service Medicare program. An alternative approach that meets the goals of risk adjustment by building on the existing data systems capabilities of plans can achieve the same results.

Plans currently must submit claims and data encounter reports for hospital, physician and outpatient medical services for Medicare+Choice beneficiaries even if the services are not covered under Medicare. Extensive data collection is burdensome and costly and greatly impacts on plan administrative costs as well as plan relationships with providers. HHS Secretary Thompson recently suspended through July 2001 the burdensome collection of outpatient physician and hospital data. AIM members urge Secretary Thompson to permanently end this burdensome data requirement.

• With fewer and fewer hospital services being reimbursed on the basis of costs, the Medicare program should adopt a simplified cost-reporting program to reflect the reduced importance of these reports. The cost-reporting system was designed and developed during an era of cost-based reimbursement. Medicare should adopt a single, streamlined cost reporting system based upon generally accepted accounting principles, and eliminate the voluminous regulations dealing with cost-based reporting, such as related party transactions, depreciation expense, interest expense, interest income offsets, change of cost finding, etc., where Medicare payment is no longer based upon costs.

The complex and burdensome hospital cost-reporting process developed over decades, at a time when Medicare payments were, to a significant degree, based on their costs. Now that Medicare has largely eliminated cost-based payments for hospital services, the primary purpose of hospital cost reporting has disappeared, and thus the process should be correspondingly reduced and simplified. By comparison, the cost reporting process for skilled nursing facilities was recently substantially simplified in the wake of their conversion from cost-based reimbursement to prospective payments. Hospitals are entitled to similar regulatory relief.

• CMS should ease the paperwork burden placed on beneficiaries and providers by revising the Medicare Secondary Payor (MSP) Provisions. The MSP form is intended to identify other insurance coverage a beneficiary might have. Currently, hospitals must fill out an MSP form every time a patient comes to the hospital for a procedure. Beneficiaries are annoyed at being asked the same questions each time they return for services. For example, a patient taking the anti-coagulant drug Coumadin (warfarin) may require weekly or daily monitoring due to internal bleeding risks. The hospital must fill out the form each and every time. In addition, hospitals that act as reference laboratories (to which doctors' offices forward specimens for analysis) are being told to track down a beneficiary whose specimen might have been sent in, and collect information about possible other insurance coverage. Independent labs are not subject to these requirements. Hospitals should not have to collect MSP information more than once per month for patients that require recurring services, and should not be responsible for MSP information for non-patients.

• Since June 1998, CMS has required skilled nursing facilities (SNFs) to collect and submit patient assessment data in a standard format known as the Minimum Data Set (MDS). The assessment instrument that serves as the basis for collecting MDS data was originally developed as a comprehensive care planning tool, but the information it generates is now also used to classify patients into SNF payment categories, and to measure the quality of long-term nursing home care. Providers are required to collect the data elements as many as five separate times during a patient's Medicare-covered stay. The current version of the MDS includes some 300 elements, but only 108 of them are needed by CMS to pay providers. These requirements are overly burdensome for providers. The MDS should be scaled back to require only data that can be justified on the basis of payment and quality.

Recommendation: *Select a Sound Methodology for Risk Adjustment* (Administrative)

CMS implemented on a limited basis in January 2000 a risk adjusted payment methodology for Medicare+Choice plans containing practical and methodological problems resulting in payments that are neither equitable nor valid. Further, the risk adjustment payment methodology substantially reduces aggregate payments to plans while adding additional administrative requirements and expense.

In order to improve efficiencies in payment, CMS needs to select a methodology for risk adjustment with a public comment period of no less than 18 months prior to implementation. The methodology must be financially sound and provide for an efficient system for data collection. Risk adjustment, in turn, needs to be phased in over a 10-year period, beginning in 2004, in order to stabilize payments to plans. Current law calls for risk adjustment to have an 8-year phase-in, with 100% of payments risk adjusted in 2007. This schedule is not adequate to preserve stability in plan payments.

The Principal In-Patient Diagnostic Cost Group (PIP–DCG) risk adjuster should remain at this year's level of 10% until a more appropriate and less burdensome methodology is agreed upon.

Recommendation: *Compare Diagnosis Codes to Verify PIP–DCG Risk Adjuster Assignment* (Administrative)

Medical record review is one Medicare+Choice encounter data validation activity used to validate the accuracy of the encounter data submitted by plans to CMS. Encounter data can more easily be validated by merely comparing the diagnosis code submitted by the hospital to the plan with the diagnosis code submitted by the plan to CMS. Medical record review requiring retrieval of inpatient medical records is costly and of questionable value. Further, there are no standards for inpatient medical record review in the Medicare fee-for-service program.

In the Medicare fee-for-service environment, hospital medical record review is the responsibility of the CMS contractors and the Peer Review Organizations (PROs). The costs of medical record review are covered in the contract that CMS has with the PRO.

Recommendation: *Simplify Accreditation Procedures* (Administrative)

CMS should revise its rules to accept a plan's accreditation by a nationally recognized accreditation organization as meeting quality assurance and quality requirements in Medicare+Choice. This would allow for "deeming" of a Medicare+Choice organization in accord with Congressional intent. CMS's requirements for deeming status should match and not exceed accreditation standards.

Recommendation: *Allow Plans to Select Quality Improvement Projects and Rewards Plans for Quality Improvements* (Administrative)

CMS should permit plans to select and implement their own quality improvement projects. Plans may already have existing quality improvement activities designed to best serve their specific populations and meet requirements for accreditation.

Further, CMS should reward plans that demonstrate continual quality improvement and report higher than average performance, when compared with fee-for-service performance, in their HEDIS reports. CMS should reward plans with additional compensation to encourage maintenance of high levels of performance.

Plans that also wish to participate in quality improvement activities generated by the Professional Review Organizations (PROs) in their area should be compensated on an individual plan basis for any work that enhances the objectives of a PRO-initiated quality improvement project. Implementation of this recommendation would allow plans to recover expenditures for their efforts and strengthen cooperation between plans and the PROs in achieving national quality improvement objectives.

Recommendation: *Formalize the CMS Advisory Opinion Process* (Administrative)

CMS should offer a more formal process for providers to obtain answers to Medicare questions. Typically, providers are unable to obtain timely, clear and final answers to their questions, in part because answers require certain level of authority and may cut across departments within CMS, or draw interest from OIG and DOJ, FDA or other agencies.

It is often impossible to obtain clear, timely and final answers from CMS on complex billing issues. Thus, providers must take a best guess at the answer, which leaves them vulnerable to second-guessing and charges of incorrect billing. Creating a formal process for obtaining answers to these types of questions would provide greater certainty and consistency, and reduce billing and payment errors. Receiving a written advisory opinion would also permit the provider to rely on the advice re-

ceived. Many other Federal agencies have similar programs (e.g., the SEC, the IRS, the DHHS OIG) and they are enormously helpful.

Recommendation: *Incorporate Regulatory Cost Estimate into the Medicare Update* (Administrative)

The cost of caring for patients continues to increase as a result of complex regulations such as the Health Insurance Portability and Accountability Act (HIPAA) and greater technological advances in such areas as pharmaceuticals and blood products. MedPAC should be required to aggregate, on an annual basis, the estimated impact of a regulation on the provider community's payments and costs. MedPAC should incorporate this aggregated impact into the Medicare inflationary market basket update.

Recommendation: *Treat All DRG Corrections Equally* (Administrative)

There should be equal treatment for correcting DRGs, whether the correction results in higher or lower reimbursement. Appropriate adjustments to DRGs should be allowed in all cases. This is a matter of simple fairness. CMS's goal should be to pay providers, correctly and accurately, the amount they have earned for the services that they have provided to beneficiaries. CMS should not seek to pay less than what is due by setting a shorter timeframe for correcting underpayments than for correcting overpayments.

Recommendation: *Fix the PRRB Process and Denial of Cost Report Reopenings* (Administrative)

There are significant problems with the Provider Reimbursement Review Board (PRRB) process that need to be addressed, including inordinate delays caused by an enormous backlog of cases. The Supreme Court issued a ruling in *Your Home Visiting Nurse Services, Inc. v. Shalala*, which involved interpreting statutory and regulatory provisions regarding PRRB review of a fiscal intermediary's decision to deny reopening of a cost report at the request of the provider. In the decision, the Court held that the statutory and regulatory provisions do not require the intermediary's decision to be subject to review, even if clearly erroneous. The PRRB should have full authority to review intermediary decisions to deny reopening of cost reports.

The process must be streamlined and accelerated. Alternative resolution methods should be considered. This is a matter of simple fairness. Erroneous intermediary decisions should be subject to review and correction.

Recommendation: *Interpret and Enforce EMTALA According to Legislative Intent* (Administrative)

The current interpretation and enforcement of the Emergency Medical Treatment and Labor Act (EMTALA) far exceed legislative intent. This has had two significant adverse results: (1) it is seriously disrupting the provision of good care in hospitals; and (2) it is making the burden of uncompensated emergency care unsustainable. Note: There are a number of changes with regard to EMTALA that could be done administratively.

The law should be interpreted and enforced in accordance with its legislative intent to prevent the current disruptions and financial burdens arising from the regulatory and administrative expansion of EMTALA.

Statement of the American Academy of Physician Assistants, Alexandria, Virginia

On behalf of the more than 41,000 clinically practicing physician assistants (PAs) in the United States, the American Academy of Physician Assistants (AAPA) is pleased to submit comments on H.R. 2768, the Medicare Regulatory and Contracting Reform Act of 2001. The AAPA commends Chairman Nancy Johnson, Ranking Member Pete Stark, and the entire Subcommittee for their efforts to create a more collaborative relationship between the Centers for Medicare and Medicaid Services (CMS) and the health care professionals who provide services to Medicare beneficiaries. We are particularly appreciative of the Subcommittee's interest in reducing Medicare's regulatory and paperwork burden.

The operation of the Medicare program is extremely complex, and H.R. 2768 goes a long way to assist health care professionals in complying with Medicare's rules and regulations. Although not addressed through H.R. 2768, the AAPA regards Medicare coverage policy, particularly as it relates to medical services provided by

PAs, as unnecessarily complex and ultimately limiting to Medicare beneficiaries' access to care. We ask that the Subcommittee also consider this issue in the context of H.R. 2768.

The AAPA is the only national organization representing PAs in all medical specialties. The Academy educates the general public about the PA profession, assures competency of PAs through active involvement in the development of educational curricula and accreditation of PA programs, provides continuing education, and conducts PA-related research. PAs conduct an estimated 150 million patient visits per year; many of these encounters are with Medicare beneficiaries.

The AAPA believes that H.R. 2768 provides a unique opportunity to improve the Medicare program and substantially benefit beneficiaries and the health care professionals who serve them. Problems in the administration of Medicare that lead to overly burdensome requirements for participating health professionals, as well as overly restrictive coverage policy, affect access to care for all Medicare beneficiaries; however, they disproportionately affect access to care in medically underserved communities because there are fewer health care resources. Unless these problems are addressed, they may create even greater access to care challenges in the coming months as rural and other medically underserved communities lose PAs and other health care professionals who are called to serve in the National Guard and Reserves.

Medicare's Regulatory and Paperwork Burden

PAs, like other health care professionals who provide covered services to Medicare beneficiaries, would prefer to spend their time delivering medical care, not mired in paperwork that is often confusing and viewed as unnecessary. The paperwork requirements' impact on clinical practice is even more keenly felt in medically underserved communities where staffing resources are scarce. Similarly, other problematic administrative requirements disproportionately affect the ability of practitioners in underserved communities, including PAs, to provide care to Medicare beneficiaries. Some of these problems include excessive costs incurred by practices for random prepayment audits, onerous documentation requirements for Evaluation and Management, and required repayment of purported overpayments before the appeals process is complete.

The AAPA is very pleased that the H.R. 2768 attempts to address the impact of Medicare regulations and paperwork requirements on the delivery of care to Medicare beneficiaries. We are particularly concerned with the increased impact of burdensome requirements on the delivery of care in medically underserved communities.

Full Coverage of Medicare Services Provided by Physician Assistants

As Members of the Subcommittee are aware, Medicare coverage was originally extended to physician assistants (PAs) through the 1977 Rural Health Clinic Services Act. Congress acknowledged the educational preparation of PAs to provide a wide range of primary care services to Medicare beneficiaries living in areas experiencing a shortage of physicians. Congress' aim was to extend medical services to Medicare beneficiaries, and subsequent Congresses steadily expanded Medicare coverage for services provided by PAs. In 1997, the 105th Congress passed the Balanced Budget Act (BBA). The BBA expanded the ability of PAs to provide medical and surgical services that would otherwise be provided by physicians, if allowed by applicable state law.

Unfortunately, the former Health Care Financing Administration determined that the BBA's Medicare provisions regarding coverage of services provided by PAs did not apply to ordering home health care, hospice care, or skilled nursing facility care following hospitalization. Other medically necessary services that the Medicare program arbitrarily prohibits PAs from performing are screening colonoscopies and supervising diagnostic testing. PAs are not optimally utilized by the program. The restrictions on PAs' ability to order care limit beneficiaries' access to care, particularly in medically underserved communities where a PA may be the only on site provider.

The American Academy of Physician Assistants recommends that Congress direct the Centers for Medicare and Medicaid Services to revise national Medicare coverage policy to fully recognize the ability of PAs to provide medical care in accordance with state law. The CMS' role in administering the Medicare program is most certainly a sizeable one. However, the AAPA does not believe that CMS' administrative responsibilities legitimately extend to determining physician assistants' scope of practice. That responsibility rests with the states, and the Medicare statute wisely defers to state law in determining which physician medical services may be provided by PAs. We ask that Congress address this problem H.R. 2768.

The AAPA is very appreciative of the Subcommittee's efforts to relieve Medicare's regulatory and paperwork burdens for the physician-PA team and other health care professionals who provide services to Medicare beneficiaries. We look forward to an improved Medicare program, which is more responsive to the beneficiaries and the health professionals who serve them.

Thank you for the opportunity to present the AAPA's views.

Statement of the American Clinical Laboratory Association

The American Clinical Laboratory Association ("ACLA") is pleased to have this opportunity to present its views to the Subcommittee on Health of the House Ways and Means Committee in connection with the Subcommittee's hearings on H.R. 2768, the Medicare Regulatory and Contracting Reform Act of 2001.

ACLA is an association of federally regulated, independent clinical laboratories and represents national, regional, and local laboratories throughout the United States. All ACLA members furnish services reimbursed by the Medicare program and interact regularly with CMS and its Medicare contractors. As a result, ACLA has had the opportunity to observe CMS's performance and that of its carriers.

ACLA is pleased that in recent years, in particular, the industry's relationship with CMS has improved significantly. The agency has developed greater expertise in laboratory issues and has attempted to respond to issues that the industry has raised. Nonetheless, like all health care providers, laboratories face a complex web of confusing—and often inconsistent—rules and regulations, many of which result from the way the laboratory payment system is currently structured.

In our testimony, ACLA would like to focus particularly on ways that the administration of the Medicare Program could be improved, through greater uniformity and simplification. Laboratories face payment and coverage policies that differ from carrier to carrier. As a result, ACLA believes that it is imperative to develop more uniform policies that apply consistently, regardless of carrier jurisdiction. Congress began that task in the Balanced Budget Act of 1997 ("BBA '97"), when, as discussed below, it required CMS to reduce the number of carriers processing lab claims to no more than five and to convene a negotiated rulemaking to develop uniform national policies. That work is still uncompleted. A recent study by the Institute of Medicine ("IOM"), which was mandated by Congress, also recommended greater uniformity in payment for laboratory services. ACLA believes that the implementation of the IOM study and the completion of the BBA '97 mandates should be a top priority for CMS and Congress.

In our statement today, ACLA would like to present an overview of the testing process. We would then like to review particular areas where the lack of uniformity and increasing complexity create payment and coverage issues for laboratory services. Finally, we discuss some specific ways that the system could be improved. In addition, we are attaching a summary of legislative issues affecting laboratories that we hope this Congress will address.

I. Overview of Reference Laboratory Testing

Clinical laboratory testing is an important, cost-effective and life saving health care tool, which provides physicians objective information about a patient's medical condition. It permits the early detection, treatment and monitoring of a variety of diseases and conditions. Appropriate testing ultimately enhances health, saves lives and reduces health care costs. Independent clinical laboratories are an important participant in that process.

For independent laboratories, the testing process usually begins in the physician's office or at a hospital, when a physician examines a patient and determines what laboratory testing is necessary. The specimens for this testing may be obtained by the physician or by a nurse in the physician's office, or the patient may sometimes take the test requisition to a "Patient Service Center" operated by the laboratory, where a laboratory employee obtains the specimen. In the vast majority of cases, however, the blood for testing is drawn in the physician's office. Thus, laboratory testing is unique among medical procedures, in that the entity furnishing the service often does not see, or have any direct contact with, the actual patient.

Most clinical laboratories have extensive courier networks that are designed to quickly and efficiently transport the specimen from the physician's office to the laboratory. The laboratory courier will usually go the physician's office in the late afternoon or early evening to pick up the specimens that the physician has left for testing. The courier may take the specimens directly back to the laboratory, or he may transport them to a central processing facility, where they are packaged for further

shipment, by air or ground, to the laboratory. The laboratory may be hundreds or thousands of miles away from the physician and the patient, and often is located in a different state.

Test specimens usually arrive at the laboratory late at night or early in the morning, at which time they are entered into the laboratory's computer system and the testing begins. It is not unusual for an independent laboratory to receive 10,000 specimens a night, on which 30,000 to 40,000 tests may be run during the night and early evening. For most routine specimens, the laboratory completes the testing overnight and reports the results back to the physician by the next morning. Often, some tests are performed at the facility that initially received the specimens, but then the specimen is sent to another facility for additional testing. Thus, laboratory testing takes place in a national marketplace, but the payment and coverage system is still linked to the specific location where the testing occurs. As a result, differences in payment and coverage decisions arise, a situation that creates inefficiencies, duplication, and increased costs.

II. Issues Arising Under the Clinical Lab Fee Schedule

Laboratory services are reimbursed based on the lesser of the laboratory's actual charge, the fee schedule amount applicable to the location of the testing laboratory, or the national limitation amount ("NLA"). CMS has established fee schedules on a carrier by carrier basis; therefore, in most instances, each state has its own fee schedule for clinical laboratory testing. Some states have more than one carrier and in those areas there may also be more than one fee schedule for the state. The NLA, which is set at 74% of the fee schedule medians for each test, acts as a ceiling on reimbursement and limits the amount that each carrier can pay under its fee schedule.

Thus, there are actually 56 different laboratory fee schedules—one for each carrier jurisdiction. However, because of consistent reductions in the NLA, today it is the NLA, rather than the carrier fee schedule, that usually governs payment. This has created a *de facto* national fee schedule, although there continue to be some outliers in particular jurisdictions, where the test is paid at slightly less than the NLA amount. However, in those cases, the difference is usually very small, and is often no more than a few cents. Thus, although we almost have a national fee schedule, Medicare continues to operate as if it has 56 different fee schedules, a circumstance that creates unnecessary complexity and leads to operational difficulties.

For example, laboratories routinely refer testing from one laboratory to another, usually because the initial laboratory does not perform a particular test. Under the Medicare statute, the referring laboratory is permitted to bill its carrier for all of the testing furnished, even what it referred to another laboratory for analysis; however, the carrier processing the claim is to pay for the testing based on the fee schedule applicable to the *testing* laboratory. This means that for claims involving lab-to-lab referrals, two different fee schedules may apply to different tests on the same claim. Because the carrier processing the claim may not maintain the other carrier's information in its computer files, the laboratory may actually be required to *resubmit* the claim to the second carrier, the one with jurisdiction over the laboratory that performed the referred tests.

This solution requires laboratories to "split" their claims and to bill tests that were all part of the same patient encounter to multiple carriers. This is confusing to the laboratories and to carriers because the same laboratory may be required to enroll with several different carriers, a situation that the carriers themselves often object to because it creates additional paperwork for them. Even if the laboratory is able to enroll with, and forward claims to, the different carriers, the Program incurs the cost of processing multiple claims, and the beneficiary may receive Explanation of Medicare Benefit ("EOMB") forms from multiple carriers for the same specimen, which can be very confusing. The wastefulness of this process is especially apparent because under current payment rules, there may be little or no difference between the actual amounts paid by each carrier.

The recently completed study of the laboratory industry by the Institute of Medicine ("IOM"), *Medicare Laboratory Payment Policy: Now and in the Future*—a study mandated by Congress in BBA '97—concluded that the Medicare laboratory payment system, incorporating 56 different fee schedules, is unnecessarily complex and inefficient. The IOM found that for a sample of 20 high-volume Medicare services, payment was set at the NLA in at least 80% of carriers; for three other services, all payments were at the NLA.

As a result, the IOM urged Congress to adopt a single, national, rational fee schedule for clinical laboratory services based, at least initially, on the NLAs. H.R. 1798, the "Medicare Patient Access to Prevention and Diagnostic Tests Act," includes a provision implementing the IOM recommendation. ACLA supports this pro-

posal and believes that the development of a single national fee schedule for laboratory services should be a top priority that will greatly streamline the payment of laboratory claims.

III. Issues Related to Medical Documentation Rules

In 1994, many carriers began to implement new medical necessity requirements applicable to clinical laboratory testing. These requirements took the form of Local Medical Review Policies ("LMRP"), which often specified particular ICD–9 diagnosis codes that the carrier believed would demonstrate the medical necessity of a particular test. If the laboratory did not submit a diagnosis code that the carrier deemed acceptable, then the laboratory would not be paid for the testing. In some instances, the policy would also limit how frequently the carrier would pay for the testing for an individual beneficiary.

The growth in these carrier policies for laboratory testing had a direct impact on the cost of laboratory testing. Because the ICD–9 code had to be supplied by the physician—it is a violation of fraud and abuse laws for the laboratory to supply the code itself—laboratories had to put more resources into educating physicians about the need to supply diagnosis coding information and into obtaining the information from physicians when they failed to supply it. As a result, laboratories were forced to invest large amounts in billing system refinements and added personnel, just so they could bill and be paid for the testing that they performed. However, in many instances, laboratories still do not obtain the necessary information from the physicians ordering the tests, and thus are forced to write off the costs of testing that they have performed.

The growth of these policies also led to confusion concerning payment policies. Each carrier developed its own LMRPs for the laboratories within its jurisdiction. However, carriers did not usually agree on the particular tests that were subject to LMRPs. Thus, the list of tests for which a laboratory had to submit diagnosis codes would differ depending on where the laboratory was located. In instances where two carriers had LMRPs for the same test, they often did not agree on the particular diagnosis codes that they found acceptable as demonstrating the medical necessity of the testing. This led to confusion, because physicians could not easily determine which tests required diagnosis coding information or which diagnosis codes were considered acceptable.

These differences in policy also led to differences in coverage. For example, if a physician used a laboratory in one state, he might know that the laboratory's carrier had certain LMRPs, which required him to submit ICD–9 codes for specified tests. If he complied with those requirements, and sent in acceptable diagnosis codes, the patient's testing would usually be paid for. If the patient went to a physician across the hall, who used a laboratory in another state, the physician could order the same tests and submit all the same information to the laboratory. However, the patient could find that the testing was not paid for, because the carrier with jurisdiction over the second laboratory did not accept the same diagnosis codes as the other carrier. These differences have real implications for patients because, if it is clear that the testing is going to be denied as not medically necessary, the patient might be asked to sign an Advance Beneficiary Notice, which permits the laboratory to bill the patient for denied testing. Thus, Medicare might pay for one patient's testing, while the other patient would have to pay for it himself. The result is that Medicare beneficiaries inadvertently have different coverage for laboratory testing services.

As a result of concerns about these issues, Congress directed CMS, in BBA '97, to convene a negotiated rulemaking committee whose purpose was to develop uniform payment policies for clinical laboratory testing. The negotiated rulemaking, in which ACLA participated, began meeting in July 1998 and completed its deliberations in August 1999. The Committee developed over 23 uniform documentation policies and recommended additional payment policies. A proposed rule was issued in March 2000, 65 *Fed. Reg.* 13082 (Mar. 10, 2000); however, a final rule is not expected to be issued until the fall of this year, at the earliest.

To further reduce differences among carriers, as part of BBA '97, Congress also directed CMS to designate a maximum of five regional carriers that would be responsible for paying for clinical laboratory testing. In its recent study, the IOM also concluded that regional carriers should be established to process clinical laboratory claims in order to reduce inefficiency and waste. However, up to now, CMS has taken no action to implement the regional carrier system, which was to be in place by *July 1, 1999*.

ACLA strongly urges the adoption and implementation of the negotiated rulemaking policies, which were mandated by BBA '97, and which, by statute, were to be in place by January 1, 1999. In addition, we urge the implementation of the regional carrier requirements that were also mandated by BBA '97. Both the regional

carrier and negotiated rulemaking provisions of the BBA were designed to achieve greater uniformity in the process of clinical laboratory testing—a goal that would ultimately be to the benefit of laboratories, physicians and most of all, beneficiaries. Such a result would reduce the costs of claims processing, increase predictability concerning what tests would be paid for, and eliminate unnecessary regulatory burdens.[1]

IV. Issues Created by New Laboratory Testing

Because the laboratory fee schedule was originally developed almost 20 years ago, based on 1983 pricing data, it does not address the tremendous technological advances that have taken place since that time. The law establishing the payment methodology did not specify a process for dealing with new technologies so CMS has had to create one.

For new tests that are not already covered by the fee schedule, CMS uses two different methodologies to arrive at a price. For some tests, CMS directs carriers to develop their own prices, based on "gap filling." Presumably, carriers are to determine the price that is applicable in their individual area, but CMS has provided little guidance to carriers concerning what information they are to review to develop the new gap-filled prices. As a result, "gap filling" often results in widely divergent pricing levels for the same test.

In other instances, CMS "cross-walks" a new CPT code to an existing code, and prices the new code at the same level as the old code. However, there may be little relationship between the test represented by the new CPT code and the test represented by the old one; therefore the decision to price them at the same level may result in a payment level that is inappropriate.

Further, when CMS issues a proposal concerning how it will pay for other types of services, the agency usually issues a notice in the Federal Register for comment, and subsequently responds to these comments when issuing a final rule. Thus, interested parties have an opportunity to present their views on how particular services will be paid for. For the laboratory fee schedule, this process is not followed. CMS makes a unilateral determination concerning how new technologies will be handled; whether they will be gap filled or cross-walked; and what fee will be set—without any opportunity for public comment. CMS's determinations are not known until the agency issues a Program Memorandum late in the year, which specifies how the new codes will be treated.

Again, the IOM recognized the difficulty in obtaining coverage for new tests and technology. ACLA agrees with the IOM's conclusion that new tests and technologies must be incorporated into the fee schedules in an open, timely and accessible manner that is subject to challenge. The current coverage process, according to the IOM, is lengthy, costly and not open to meaningful challenge.

ACLA believes that it is vital to address the problem of payment for new technologies. CMS needs to develop a process, *in consultation with the industry*, that sets reimbursement levels for new technologies that reflect their fair market value. CMS should develop clearer standards concerning how carriers develop payment levels in their jurisdictions, so that carriers have direction in how to set these prices. Congress solved one, albeit small, part of this problem last year in the Benefits Improvement and Protection Act ("BIPA") by ensuring that the NLA, for new tests that were gap filled, would be set at 100% of the median price, rather than at 74% as is done for other services. However, the other problems discussed above, related to disparity in pricing, and the lack of input into the process, remain. The aforementioned H.R. 1798, the "Medicare Patient Access to Prevention and Diagnostic Tests Act," addresses this concern by establishing specific procedures for determining payment amounts for new clinical laboratory tests.

ACLA is pleased to have the opportunity to testify on these matters. We believe greater uniformity and simplicity in lab payment policies will lead to greater benefits for labs, Medicare and patients. We look forward to working with the Committee in its deliberations.

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[1] ACLA also believes a single, separate carrier for laboratory services furnished to End Stage Renal Disease ("ESRD") beneficiaries would introduce additional cost savings for the Medicare program and support overall claims processing simplification. Because ESRD testing is usually a small part of each carrier's claims, carriers do not usually develop the expertise necessary to apply the very complex set of rules that pertain to ESRD testing. As a result, laboratories performing this testing often encounter great difficulty with claims processing issues. Therefore, we also believe it is reasonable to ensure that a single carrier handles all the claims processing for laboratory services dedicated to performing ESRD testing.

Statement of the American Medical Association, Chicago, Illinois

The American Medical Association (AMA) would like to thank the Ways and Means Health Subcommittee, Chairwoman Johnson, and Ranking Member Stark for holding this hearing on H.R. 2768, the "Medicare Regulatory and Contracting Reform Act of 2001."

We also appreciate Chairwoman Johnson and Ranking Member Stark's substantial efforts to work with the Centers for Medicare and Medicaid Services (CMS) in its efforts to accomplish additional reforms on an administrative level.

The AMA believes that H.R. 2768 is a solid, first step in addressing many of physicians' concerns regarding CMS contractors' activities for the following reasons:

We laud the legislation's commitment to and funding of education programs for physicians, providers of services, and suppliers. Although we have some technical suggestions in these sections, we believe that the education provisions in the bill would vastly improve the resources available to physicians, providers of services, and suppliers. In particular, the section requiring contractors to work with organizations representing physicians, providers of services, and suppliers when a widespread billing problem exists would be extremely helpful in ensuring that the problem is explained to the larger community sooner rather than later. This broad dissemination of information would lead to a quicker and better resolution of the issues involved.

The AMA is generally pleased with H.R. 2768's provisions related to repayment plans. This provision, if clarified to ensure that repayment plans would be for a minimum of three years, would permit physicians, providers of services, and suppliers to enter into reasonable repayment plans with their CMS contractors if the alleged overpayments exceed a certain proportion of their Medicare revenues. Currently, CMS contractors require repayment of alleged overpayments within 30–60 days. When alleged overpayments represent a high proportion of practice revenues, this requirement can present a major economic hardship to the practice. Carrier overpayment demands for almost immediate repayment can also restrict the financial ability of physicians to provide an adequate level of service to their patients and can make physicians less eager to care for Medicare patients in the future.

The AMA greatly appreciates that the legislation would establish pilot projects to test the viability of proposed evaluation and management documentation guidelines. Although CMS has recently withdrawn proposed documentation requirements, as this process progresses, it is clear that any new proposed guidelines must be tested to ensure their accuracy prior to national implementation. H.R. 2768 would also ensure that a sufficient number of physicians participate in the pilot projects by prohibiting audits for documentation that occurred as part of the pilot project.

The legislation's proposed standardization of random prepayment audits is a very positive development that would ensure that the Secretary would establish standards for random prepayment audits. Contractors would no longer have unlimited discretion as to the circumstances that would trigger random prepayment audits. Another serious problem with prepayment audits is that they often have no defined endpoints. This places an enormous strain on practices' cash flow as claims are held up for payment while audit continue. H.R. 2768 would ensure that procedures are put in place to remove physicians from prepayment review once their billing practices are sufficiently compliant with Medicare policies.

The AMA also appreciates the additional resources that this bill would direct towards administrative law judges. This funding would increase the number of administrative law judges and improve education and training opportunities for the judges and their staffs.

The AMA is also gratified that the Committee has recognized that contractors' use of "extrapolation" is a serious problem, and that it has acknowledged the inequity of demanding that overpayments be repaid before appeals are heard. These and several other provisions of the bill must be strengthened, however, if they are to remedy the problems they are intended to address. In particular:

Contractors use "extrapolation" to magnify the alleged overpayments found in a very small probe sample of claims to all of these type of claims submitted by a physician or provider of services over a one-to-two year period. This technique lacks any semblance of statistical validity, but it can lead to overpayment demands in the hundreds of thousands of dollars. Even more egregious, the letter demanding repayment of these huge sums is often the first indication a physician has that there is a problem with his/her billing practices. For this reason, the provision of H.R. 2768 that would allow CMS contractors to use extrapolation to project an overpayment in instances where there is a high error rate OR where documented education efforts have failed should be strengthened. For example, this extrapolation provision would have a very limited impact on physician practices such as the critical care

practice that testified before the House Budget Committee. This particular practice had a high error rate, but there was no documented educational effort. Thus, the provisions in H.R. 2768 would still subject this and other physician practices to enormous overpayment allegations, even if it were the first time the practice had heard that it had a billing problem. The AMA strongly believes that contractors should be prohibited from using extrapolation to calculate overpayment amounts unless documented educational efforts have been employed first and have failed to correct the billing problem.

Although the education provisions in H.R. 2768 are a vast improvement over existing education efforts by CMS contractors, the AMA is concerned that the legislation gives contractors discretion as to whether they wish to supply physicians, providers of services, and suppliers with written advice upon which they could rely. Under H.R. 2768, the aforementioned groups would not be entitled to any additional information or guidance regarding complex and confusing carrier policies and regulations to use if they are later audited by their contractor.

The ability to rely on written guidance is especially important in light of the recent report by the General Accounting Office (GAO), which found that when GAO called contractors (callers identified themselves as calling from the GAO), contractor employees gave incorrect answers to questions 85% of the time. GAO further reported that these questions had been identified by the contractors as "frequently asked questions." The carriers will not give physicians written answers to their billing and coding questions, and as the GAO study shows, answers given via the telephone are often incorrect. Physicians should be able to submit their written questions to contractors, and in turn, receive correct and consistent written responses from contractors upon which they can rely.

The consent settlement process, as detailed in H.R. 2768, would still not permit physicians, providers of services, and suppliers to contest the validity of a probe sample without being forced to submit to a statistically valid random sample (SVRS) of 200–400 claims, which is very disruptive to a physician practice. The AMA believes that a physician should not be forced to agree to an SVRS in order to maintain his or her appeal rights. Physicians should be permitted a 60-day time period to decide whether to appeal the probe sample finding. If the physician decides not to appeal the probe sample, then he or she would either have to pay the alleged projected overpayment or agree to an SVRS. This ability to appeal the probe sample is an essential due process right that should be afforded to physicians, providers of services, and suppliers—especially in light of the probe sample's use in determining projected overpayments.

H.R. 2768 would permit physicians, providers of services, and suppliers to repay an alleged overpayment after the first level of *internal* appeal has occurred. This internal appeal usually occurs within 45 days. Under H.R. 2768, repayment would be required at this point. Physicians, providers of services, and suppliers who opt for further administrative appeals would still be forced to repay alleged overpayments while their appeals are pending. In contrast to the 45 days for internal appeals, administrative law judge (ALJ) decisions took an average of 389 days in the first quarter of 2001 and departmental appeals board decisions (DAB) took an average of 661 days to complete. If the physician, provider of services, or supplier is successful at the DAB level, it is likely that three years have elapsed since the physician's payment of an alleged overpayment to the CMS contractor. This is especially egregious since the most recent figures from 2000 show that 60% of contractor decisions were reversed by an ALJ. The provisions of H.R. 2768 would not assist physician practices such as the West Coast practice that received its overpayment demand letter in 1996, paid the alleged overpayment amount six weeks later and received a favorable ALJ ruling in 1999. The carrier had held the practice's funds (approaching $100,000) for nearly three years.

While the AMA greatly appreciates H.R. 2768's provision that would require contractors to repay the funds held with interest, we agree with Administrator Scully that physicians, providers of services, and suppliers should have the same rights that taxpayers have when they are audited by the IRS; that is, as long as interest accrues, taxpayers do not have to repay alleged overpayments while administrative appeals are pending.

We strongly urge the Subcommittee to amend the repayment provision to mirror the "Access to Judicial Review—Interest on Amounts in Controversy" provisions in Section 8 of H.R. 2768. This would ensure that interest would begin to accrue 60 days after the date of the contractor's determination. The overpayment amount plus any interest would be payable when all administrative appeals are exhausted. (Section 8 states that such amounts become payable when they are awarded to the prevailing party).

The AMA is very concerned about the provisions in H.R. 2768 related to a physician, provider of services, or supplier's right to appeal a contractor's decision to deny or revoke a Medicare provider number. For most health care practitioners, the denial or revocation of a provider number is an extremely serious occurrence that prohibits them from submitting any claims for reimbursement to the Medicare program. Currently, physicians have very limited recourse if their provider enrollment application has been denied. They can request that the carrier reconsider their application, and then can request a hearing by an entity or person appointed by the Secretary of the Department of Health and Human Services. The provision in H.R. 2768 would not establish any additional rights for physicians, providers of services, and suppliers whose applications have been denied. In fact, the legislative language appears to codify existing and proposed CMS practices. We strongly urge the Subcommittee to consider a denial or revocation as an initial determination and accord physicians full administrative appeal rights under Section 1869 of the Social Security Act.

The provision of H.R. 2768 addressing voluntary repayments also should be strengthened. The legislation proposes that an ombudsman would make recommendations to the Secretary about how to respond to physicians and providers of services who identify overpayments themselves that they have mistakenly received and voluntarily repay Medicare. We note that CMS has previously issued instructions to its contractors on handling these voluntary repayments and that the contractors are instructed to investigate and consider auditing those who make the repayments. These kinds of policies are more likely to intimidate than encourage honest professionals to develop compliance plans. H.R. 2768 should offer real protections, not leave the matter for the Administration to resolve in the future.

Finally, the AMA is uncertain as to why H.R. 2768 seeks to limit the ability to present additional information during the appeal process. We are not aware of any indication that physicians, providers of services, and suppliers are inundating the system with new evidence, and creating a sizeable backlog. Many physicians may not hire attorneys or experts immediately to contest a contractor's audit finding. When these attorneys or experts are hired, they may suggest additional evidence or information that the physician had not thought to disclose. We believe that this section is not needed and urge its deletion.

In closing, the AMA has also been very interested in the issue of contractor reform. A coalition letter signed by the AMA and other leading national medical organizations and specialty societies, as well as every state medical society, was sent to Chairman Johnson and Ranking Member Stark on August 30, 2001, and is attached to this statement. On the whole, the reforms to the contractor reform language appear to be reasonably geared towards improving the efficiency of the program and towards sharpening the responsiveness of contractors to beneficiaries and physicians. As an overarching comment, the AMA does believe that contractors should be required to maintain local carrier advisory committees and local carrier medical directors. In addition, a transparent contracting and budgeting process should be set forth in the Federal Register for public notice and comment. We also have some technical suggestions regarding these sections which we will be happy to share with the Subcommittee at the earliest possible date.

We appreciate the Subcommittee's consideration of the AMA's concerns. We value all of the Subcommittee's work on H.R. 2768, and we believe that we can work together to ensure that physicians obtain more complete due process rights and extremely effective education tools that can be relied upon by the physician. We thank you for the time that your Subcommittee, and particularly, the Subcommittee staff has devoted to this issue, and are pleased that it is a high priority for the Subcommittee.

August 30, 2001

Letter Sent to all members of the House Ways and Means Subcommittee on Health

The Honorable Nancy Johnson
Committee on Ways Means
U.S. House of Representatives
1136 Longworth House Office Building
Washington, DC 20515

Dear Chairwoman Johnson:

As your Committee continues its work on the "Medicare Regulatory and Contracting Reform Act of 2001," H.R. 2768, please know that the medical organizations listed below endorse the need for regulatory relief in the administration of the Medicare program. For that reason we strongly support the provisions of the "Medicare

Education and Regulatory Fairness Act of 2001" (MERFA), H.R. 868. One aspect of that relief that is not addressed in MERFA is the need for contractor reform. The Medicare program is a continual source of frustration, complexity, and paperwork for virtually all physicians treating Medicare patients. The contractor community plays a key role in administering the program. We believe that Congress should incorporate the following principles in any Medicare contractor reform efforts:

- Physicians and other providers must have a single point of contact who will be responsible and accountable for program administration. Even if contractor services are themselves fragmented (e.g., claims processing performed by one contractor, medical review by another contractor, and correspondence/appeals to another), physicians and providers should not have to deal with a whole new contractor bureaucracy where each contractor tries to shift responsibility to others. There should be a single point of contact in each state that can, if necessary, serve as a liaison between physicians/providers and the various contractors.
- Local carrier advisory committees (CACs) should be continued in each state to assure that local medical review policy reflects the consensus of the local physician community. All changes in local coverage decisions (whether through a change in contractor or through the consolidation of existing contractors) should be subjected to the normal review and comment process with the local CAC. It would be unacceptable for a new contractor to simply transport a new policy from one geographic region to another without subjecting that policy to CAC review in the new geographic area.
- Given the significant transition problems experienced with establishing regional durable medical equipment carriers, the medical community believes it is imperative that the Center for Medicare and Medicaid Services (CMS) establish contingency plans to assure that there are no delays in claims processing/payment capabilities. Such contingencies should include provisions for advanced payments for covered services based on the previous year's submissions.
- CMS should establish and enforce the highest possible standards in determining which organizations are most qualified to serve as contractors in the program. Formal physician/provider feedback should be solicited regarding the establishment of performance criteria for contractors and whether the contractors' actions have actually met those standards.
- Physician/provider outreach, education, and service should be considered a priority for each contractor in the program.

We believe these basic principles should be incorporated into any Medicare contractor reform legislation agreed to by the Congress.

Sincerely,

Alaska State Medical Association
Arizona Medical Association
Arkansas Medical Society
California Medical Association
Colorado Medical Society
Connecticut State Medical Society
Florida Medical Association
Hawaii Medical Association
Idaho Medical Association
Illinois State Medical Society
Indiana State Medical Association
Iowa Medical Society
Kansas Medical Society
Kentucky Medical Association
Louisiana State Medical Society
Maine Medical Association
Massachusetts Medical Society
MedChi, The Maryland State Medical Society
Medical Association of Georgia
Medical Association of the State of Alabama
Medical Society of Delaware
Medical Society of the District of Columbia
Medical Society of New Jersey
Medical Society of the State of New York
Medical Society of Virginia
Michigan State Medical Society
Minnesota Medical Association
Mississippi State Medical Association

Missouri State Medical Association
Montana Medical Association
Nebraska Medical Association
Nevada State Medical Association
New Hampshire Medical Society
New Mexico Medical Society
North Carolina Medical Society
North Dakota Medical Association
Ohio State Medical Association
Oklahoma State Medical Association
Oregon Medical Association
Pennsylvania Medical Society
Rhode Island Medical Society
South Carolina Medical Association
South Dakota State Medical Association
State Medical Society of Wisconsin
Tennessee Medical Association
Texas Medical Association
Utah Medical Association
Vermont Medical Society
Virgin Islands Medical Society
Washington State Medical Association
West Virginia State Medical Association
Wyoming Medical Society
American Academy of Allergy, Asthma and Immunology
American Academy of Dermatology Association
American Academy of Facial Plastic and Reconstructive Surgery
American Academy of Family Physicians
American Academy of Neurology
American Academy of Ophthalmology
American Academy of Otolaryngic Allergy
American Academy of Otolaryngology—Head and Neck Surgery
American Academy of Physical Medicine and Rehabilitation
American Association of Clinical Endocrinologists
American Association of Neurological Surgeons
American Association of Orthopaedic Surgeons
American College of Allergy, Asthma and Immunology
American College of Cardiology
American College of Chest Physicians
American College of Emergency Physicians
American College of Obstetricians and Gynecologists
American College of Osteopathic Family Physicians
American College of Osteopathic Surgeons
American College of Physicians—American Society of Internal Medicine
American College of Radiology
American College of Surgeons
American Gastroenterological Association
American Geriatrics Society
American Medical Association
American Osteopathic Association
American Psychiatric Association
American Society for Gastrointestinal Endoscopy
American Society for Therapeutic Radiology and Oncology
American Society of Anesthesiologists
American Society of Cataract and Refractive Surgery
American Society of Clinical Pathologists
American Society of General Surgeons
American Society of Hematology
American Society of Plastic Surgeons
American Thoracic Society
American Urological Association
Association of American Medical Colleges
College of American Pathologists
Congress of Neurological Surgeons
Joint Council of Allergy, Asthma and Immunology
Medical Group Management Association
National Medical Association
North American Society of Pacing and Electrophysiology

Renal Physicians Association
Society of Critical Care Medicine

Statement of the American Osteopathic Association, Chicago, Illinois

The American Osteopathic Association (AOA) thanks Chairwoman Nancy Johnson and Ranking Member Fortney "Pete" Stark for introducing the "Medicare Regulatory and Contracting Reform Act of 2001" (H.R. 2768). We appreciate your holding this timely hearing.

Our members increasingly are frustrated with the complexities of Medicare policies and regulations. It is well documented that there are now over 100,000 pages of Medicare rules, policies and regulations. Physicians are forced to spend a growing amount of time completing paperwork and meeting administrative requirements set forth by Medicare and managed care organizations. Time spent completing these tasks is time spent not doing what they were trained to do, providing care to patients.

We thank you for making this issue a priority for the Committee and for introducing legislation to reform the regulatory and contracting process at the Centers for Medicare and Medicaid Services (CMS). Your legislation addresses the major concerns that the AOA has raised and establishes a system that will focus more on educating and assisting physicians and not on punishing them. We especially support provisions you included on provider education and technical assistance and the inclusion of specific educational programs and technical assistance for rural providers. As you know, rural practices often consist of less than ten employees and simply do not have the manpower to dedicate an individual(s) to Medicare compliance. Your proposal recognizes and creates ways to assist these physicians.

We continue to be concerned about the use of extrapolation in post-payment audits. It is our desire that the committee carefully evaluate the use of this practice. Your legislation addresses this issue, but we request that you consider requiring documented educational intervention before extrapolation can be used. This supports our desire to move from a system that assumes guilt to a system that offers compliance assistance.

Our priorities for regulatory and contracting reform legislation include:

Provider Education and Technical Assistance

The AOA strongly endorses a "change in attitude" at the CMS. The AOA does not support fraud or those who defraud the government, but we are convinced that an overwhelming majority of the mistakes made are inadvertent. It is our opinion that CMS generally operates with an assumption of guilt when dealing with providers. This attitude is counterproductive and creates an environment of distrust between providers and CMS. We believe that CMS should focus more effort on educating providers, especially those in rural and frontier areas. One of the most important services CMS can provide is timely and accurate feedback on how to comply with policies and procedures.

The AOA believes that CMS and its Medicare contractors should:

- Create a national standard for provider education.
- Establish incentives for contractors who improve their provider education programs.
- Establish education programs exclusively for rural providers.
- Maintain a 24 hour toll-free phone line staffed by individuals capable of answering questions regarding the Medicare system.
- Maintain a web page dedicated to compliance with Medicare policies and procedures. We recognize that addressing every potential question on the web page is impossible, but material addressing the most frequently asked questions could be maintained.
- Medicare contractors should respond to all requests in writing. This would provide a written record that providers and contractors could rely upon if there is a future audit.
- Create a system that accurately documents each question or inquiry received, who handled the request and the information provided. This will allow CMS and its contractors to create a valid database of frequently asked questions and points of confusions within the program. Additionally, it will provide both the Medicare contractor and the provider with documentation of the inquiry.

Provider Appeals

The AOA believes that every provider should have an equitable and unbiased opportunity to appeal any decision handed down by CMS or a Medicare contractor when facing a post-payment audit. Appeals should be conducted in a timely manner and governed by legal experts independent of both the provider and the Medicare contractor. It must be emphasized that the purpose of the audit is to recover alleged overpayment, not to proceed against suspected fraudulent behavior, and that physicians and providers in these situations should not be "presumed guilty." The AOA supports the permanent inclusion of Administrative Law Judges (ALJs) in the Department of Health and Human Services (HHS). We believe that their existence within HHS will speed up the appeal process and create consistency within the appeal process.

Recovery of Overpayments

Physicians/providers should not be forced to pay contractors for alleged overpayments before they have exhausted their administrative appeals. The time it takes to complete the appeals and the high percentage of reversals of contractors' overpayment allegations illustrate the inequity of these repayment demands. If a physician or provider chooses to appeal and is unsuccessful in that effort, then the provider should pay interest on the amount in question. We strongly believe that physicians and providers should have the opportunity to exercise their due process rights before assuming financial liability.

Physicians should be entitled to repayment plans if their overpayments exceed a certain threshold that would severely impact the financial well-being of their practice. Contractors currently give physicians and providers 30 days to repay overpayments in full. We understand that there is concern that some providers may file for bankruptcy without repaying the overpayment amount. Unless there is legitimate concern that this may occur or the provider has demonstrated in some manner that he or she is not a reliable source of repayment, all providers should be given flexibility in repaying overpayment amounts.

The AOA is concerned about extrapolation from probe samples. Medicare contractors conduct these samples on 15–20 claims over a one to two year period and then use the alleged overpayment to extrapolate to all claims submitted during that one to two year period.

Using 15–20 claims in a probe sample over such a long time period is not a valid method to determine an alleged overpayment for the rest of the claims. Contractor errors regarding payment in the probe sample, which are often overturned through administrative appeal, can result in enormous extrapolated overpayment allegations. Even more egregious, often the first notice that physicians and providers receive regarding alleged overpayments is a letter demanding this extrapolated overpayment amount. We strongly urge the Committee to ensure that extrapolation does not occur unless the contractor has provided prior, documented education to the physician or provider. We would even go so far as to suggest that extrapolation not be used in first time audits against a provider.

Voluntary Repayment

Physicians and providers receiving mistaken overpayments should be allowed to return the money voluntarily without fear that they will be audited by contractors. These repayments, if they occur before they are noticed by the contractors, should be encouraged. Physicians and providers should not have to fear that they will be audited for acting in good faith.

Pre-payment Reviews

We strongly urge the Committee to direct the Secretary to establish uniform standards for random prepayment audits. Currently, contractors have complete discretion regarding how to structure and implement random audits. We believe that physicians and providers should be provided guidelines with the general conditions under which these audits may occur.

Issuance of New Regulations

The AOA supports the concept of establishing stricter and more regimented time frames for the release of proposed, interim final and final rules. Additionally, we believe failure to meet published deadlines should require the Secretary to publish an explanation as to why deadlines were not met and establish new deadlines. This

will prevent the Secretary from issuing continuations for interim final rules and thus avoiding a final decision on a proposed rule.

Compliance With Changes in Regulations and Policies

Providers should be given, at minimum, 30 days to comply with new regulations. The 30 days should begin upon receipt of direct notification of policy changes from the Medicare contractors, not upon finalization of the rule. Additionally, we believe that new policies impacting providers should not be applied retroactively, unless it benefits the provider or is necessary due to statutory requirements.

Contractor Accountability

CMS must address carrier fraud. The Office of the Inspector General (OIG) released several reports concerning carrier misconduct in Illinois, Connecticut, New Mexico, Colorado, Florida, Michigan, Pennsylvania, Massachusetts and California. CMS must be just as vigilant about preventing fraud and abuse among its contractors as it is with its providers.

The General Accounting Office recently reviewed contractor bulletins from 10 carriers. The GAO found that the bulletins contained lengthy discussions with overly technical and legalistic language that providers may find difficult to understand. The bulletins also omitted important information about mandatory billing procedures.

The GAO found that in 85% of its phone calls, the answers were incomplete or inaccurate. In addition, carrier Internet sites rarely met all CMS requirements and lacked user-friendly features such as site maps and search functions. We frequently hear of such complaints from our membership. Our members also find that carriers at times are unwilling to put their communications with physician practices in writing. This behavior is unacceptable.

For contractor reform to succeed, physicians and other providers must have a single point of contact who will be responsible and accountable for program administration. Local carrier advisory committees (CACs) should be continued in each state to assure that local medical review policy reflects the consensus of the local physician community.

CMS should establish the highest possible standards to determine which organizations are most qualified to become new contractors in the program. Formal physician/provider feedback should be solicited regarding the establishment of performance criteria for contractors and whether the contractors' actions have actually met those standards. Physician/provider outreach, education, and service should be considered a priority for each contractor in the program.

In addition, CMS regional offices must be well versed in Medicare rules and regulations because their errors can have disastrous results. A case in point:

In the mid 1990s, three osteopathic physicians in Oklahoma wanted to establish rural health clinics in the towns of Morrison (population 900), Yale (population 1200), Pawnee (population 2500) and Fairfax (population 1800). They contacted HCFA's regional office in Dallas, which guided them in establishing the federally designated rural health clinics. The regional office approved the clinics. Three years later, HCFA headquarters in Baltimore contacted the doctors and told them they were over paid. HCFA requested a repayment of $980,000 and in its effort to recover the money, all Part A Medicare payments were stopped. It was ultimately determined that the regional office provided the wrong information. The rural health clinics were forced into bankruptcy. One clinic was shut down and the others are open on a part time basis—approximately one half to two half days a week.

The error caused by the Federal government's regional office has had devastating effects in these rural low-income towns. Access to medical care has been severely limited and the doctors and their patients are paying the price.

Limited English Proficiency

The AOA supports H.R. 969 that would rescind Executive Order 13166 "Improving Access to Services for Persons with Limited English Proficiency." The financial implications of compliance with this rule potentially could be devastating to providers, especially those in rural areas. Fees for a professional interpreter average $40 per hour with a two hour minimum. At this rate, providers will be forced to pay more for a mandated interpreter than they are reimbursed for the health care they provided. Additionally, confusion still exists to whether this rule applies to written materials. This rule, and the cost of compliance, would have an adverse effect upon access to care.

Evaluation and Management (E&M) Documentation Guidelines

E&M documentation guidelines have an extremely broad impact on physicians as they govern how physicians must document for office visits in order to receive Medicare reimbursement. To date, CMS has been unable to set forth E&M guidelines that accurately reflect the services provided during a physician office visit. HHS Secretary Tommy Thompson stopped work on the E&M guidelines in order to address the many concerns within the physician community. We support efforts to address physicians' concerns about burdens caused by documentation requirements. The AOA asks that CMS not be allowed to implement any new E&M guidelines prior to the completion of at least four pilot programs, one of which should be focused on rural providers. Until documentation guidelines are finalized, CMS should suspend all pre- and post-payment audits of E&M services, since the agency has not arrived at the requirements that ultimately will be used.

Emergency Medical Treatment and Labor Act (EMTALA)

The extension of EMTALA to cover ambulances, free standing clinics and off campus facilities goes beyond the original intent of the law. EMTALA requirements strain the ability of the medical profession to provide the quality of care that patients deserve. Hospitals and physicians face overcrowded emergency departments, a lack of access to critical specialty emergency care, and the significant compliance costs associated with EMTALA that provide little, if any, added value to patient care. EMTALA discourages emergency departments from referring non-urgent patients back to their primary care provider. The CMS should not penalize or prevent hospitals from referring patients to continuity care clinics on the hospital grounds. There are varying interpretations of the EMTALA requirements among the regional carriers, making it all the more difficult to comply. Regional carriers should have some degree of uniformity in the interpretation and enforcement of EMTALA.

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On behalf of the 47,000 osteopathic physicians (D.O.s) in the United States, we thank you for the opportunity to submit a statement on the important issue of Medicare reform. The AOA stands ready to assist you in facilitating the enactment of H.R. 2768.

The American Osteopathic Association promotes public health, encourages scientific research, serves as the certifying body for D.O.s and is the accrediting agency for all osteopathic medical schools and health care facilities.

Statement of Patricia L. Scheifler, Association for Ambulatory Behavioral Healthcare, Alexandria, Virginia

I am Patricia L. Scheifler MSW, PIP, Board Member and Co-Chair of the Public Policy Committee of the Association for Ambulatory Behavioral Healthcare (AABH), and I am submitting this testimony for the hearing record. AABH is a national behavioral healthcare trade and professional association active in professional training, advocacy, research, publishing, best practice development, and technical assistance. Originally established in the early 1960s by clinicians involved in the relatively new treatment approach of "day hospitalization," the association now embraces the full range of behavioral health interventions with a powerful interdisciplinary approach to ambulatory care and integrated medical and psychosocial methods. We currently represent over 5,000 professionals and more than 70 systems of care, one of the largest interdisciplinary behavioral healthcare associations.

We strongly commend Congresswoman Nancy L. Johnson (R–CT), Chair of the Subcommittee on Health of the Committee on Ways and Means, and the other members of the Subcommittee for holding this hearing. The topic of this hearing, H.R. 2768, the "Medicare Regulatory and Contracting Reform Act of 2001" and Medicare regulatory relief and modernization are long overdue for action by Congress. Our members provide care for some of the most vulnerable Medicare patients and we hear grave concerns daily that providers and the patients they serve feel under siege by a Medicare administrative operation that is too-often unresponsive, insensitive and adversarial.

Overview of Our Medicare Concerns

To respond to behavioral health providers' very serious problems with Medicare, AABH recently testified before MedPAC and presented a strong case for fundamental change in Medicare payment policy. Some problems in particular AABH would like to draw to the Committee's attention in the administration of the current mental health benefit, these include:

- **Variable Interpretation**
  Medicare Reviewers and Hearing Officers have enormous latitude in interpreting and applying Local Medical Review Policies. What they do is highly subjective except in the unusual circumstance of missing documentation. Their determinations are often inconsistent and frequently lack any justification or clarification beyond use of the well-worn phrase "not medically necessary."
- **Lack of Accountability**
  Reviewers and Hearing Officers can make obvious errors in interpretation or erratically apply written rules without any real accountability or possibility of effective redress. Even when denials are overturned on appeal, Reviewers are under no obligation to make future determinations comply with the determination made on appeal. A comment heard from Fiscal Intermediaries is: "Denials are over turned because the Hearing Officers and Administrative Law Judges don't understand the rules." There is no precedent set by overturned denials. The Fiscal Intermediary is under no obligation to alter their review practices.
- **Protracted Appeal Process**
  It often takes a year or more to complete the appeal process on even a single claim. This is an enormous problem because it restricts providers' cash flow and because the Fiscal Intermediary and Medicare expect providers to learn and change their practices as a result of the review process. Often months after services are delivered and documented, providers discover their Fiscal Intermediary is denying claims based on an idiosyncratic interpretation that challenges the validity of a critical piece of documentation. This is far too late to solve the problem. The Fiscal Intermediary can then (and some do) reopen all paid claims a year or longer retroactively and demand repayment because the provider "knew or should have known" that the documentation did not meet requirements. If the provider decides to appeal the denials, they must appeal each claim individually over the course of the next year (or longer). Often providers can't sustain program operation due to restricted cash flow, the enormous investment of time and resources needed to sustain the appeal process and the very real risk that the Fiscal Intermediary will reopen paid claims and render a large payback determination. If they continue to bill Medicare, even when the provider is right and the decision to deny the claims was wrong, it is very costly to dig out of intensive review once it has started.
- **Switch to Prior Approval**
  Prior approval is the industry standard practice long employed effectively by private insurance and managed care, its adoption by Medicare would greatly simplify the burdens of behavioral health providers. Under this well-established process, a provider knows up front if treatment will be covered, and if not, why not. If key documents are determined to be unacceptable, they can be immediately revised to satisfy requirements and future documentation can be written to comply with the payer's expectations. If a patient does not, in the payer's opinion, require that level of care, alternate treatment arrangements can be made at that time. Even more importantly, if coverage is denied up front, it eliminates a substantial portion the Medicare Program's risk of fraud and abuse. CMS would not be put in the position of paying millions of dollars for non-covered services and then trying to recoup the payments. Providers would not be put in the position of providing treatment in good faith and then being denied payment after the fact, or worse, having paid claims reopened and being told to pay back a million dollars for services that were rendered.

H.R. 2768—A Good Start, but More Should Be Done

Madame Chairman and members of the Subcommittee, the issues addressed by your legislation may seem technical in nature, but they will make a substantial difference in the day-to-day operations of all types of Medicare providers. Members of our association are gratified that the Committee is considering the impact of current regulatory procedures and burdens on providers. We particularly appreciate the opportunity to comment on this bill and hope that you will act to address the concerns we have raised in this testimony so that an even better bill will emerge from your deliberations. Following are our recommendations on what we view as the key provisions of the bill.

1. No Retroactive Application of Substantive Changes

AABH supports this provision because it would prohibit the unfair practice of publishing changes in rules and regulations and then applying those rules/regulations to services that have already been rendered and documented.

2. Reliance on Guidance

This is a very important provision because it would mean that providers could rely on written clarification from Carriers and Fiscal Intermediaries. This is especially critical when there is a change in Carrier or Fiscal Intermediary and this provision should be broadened to specifically address Fiscal Intermediary transitions. Medicare coverage policy for psychiatric services is complex and ambiguous and Fiscal Intermediaries often develop highly unique interpretations of payment policies. In a number of instances, our provider members have experienced a very high level of erroneous denials when a Fiscal Intermediary transition occurs. That is, where one Fiscal Intermediary takes over for another and the second holds providers to its standards rather than the ones in effect during the tenure of the first. Broadening this provision to cover such transitions will help alleviate these problems.

3. Methodology to Measure Contractor Error Rates

AABH finds this a potentially helpful provision. If the intent is to correlate good provider education & outreach with low claims denial rates, this would be extremely helpful. It would give Carriers and Fiscal Intermediaries some incentive to bring denial rates down and to ensure that provider education is both available and effective.

4. Response to Inquiries: (1) Contractor Responsibility & (2) Evaluation

These are important provisions that AABH supports. Some Fiscal Intermediaries and Carriers are less responsive to provider questions than others. These provisions hold the Medicare administrative contractor accountable for responding to provider questions. AABH recommends one important change: that CMS be required to respond in a timely manner to specific billing and cost reporting questions of providers of services and suppliers. CMS responses that are not timely are of little help to providers.

5. Encouragement of Participation in Education Program

AABH supports this provision because to benefit from education, providers must be shielded from being targeted with review simply because of attending or asking questions during an educational program. Without this provision, providers are likely to avoid asking specific questions out of fear that such questions might reveal problems that could put them at risk for review and repayment.

6. Avoidance of Recovery Action for Problems Identified as Corrected

AABH supports this provision because it is critical if any type of technical assistance is going to be offered. Few if any providers would open their system to technical assistance if there is a potential for recovery action as a result of problems identified during the technical assistance process.

7. Financial Participation by Providers

Since the technical assistance envisioned in this section is specifically designed for small providers, it will be important for the section to specify that the cost must be stated in advance, in writing, and can't be exceeded without the prior written agreement of the provider.

8. Medicare Provider Ombusdman

AABH finds this a helpful provision, especially since it includes "resolution of unclear or conflicting guidance."

9. Medicare Administrative Law Judges

AABH members sometimes wait up to a year to get an ALJ Hearing plus a written decision; this provision will be a helpful if it speeds up the process.

10. Requiring Full and Early Presentation of Evidence by Providers

AABH takes strong exception to this provision and urges that it be deleted. Under this section, a provider of services or supplier would not be permitted to introduce evidence in any appeal that was not presented at the first external hearing or ap-

peal at which it could be introduced. Although there is an exception for a good cause, this provision is extremely problematic.

Each level of the appeal process allows Reviewers, Hearing Officers, and Administrative Law Judges to conduct a "new and independent review" of the claims. This means that they can (and often do) give new reasons for denial at each point in the appeal process. Thus, if a provider successfully defends the claim against one reason for denial, a new reason for denial is given at the next level of appeal. This can be (and typically is) repeated over and over up through each level of appeal. Responding to a moving target of changing reasons for denial often necessitates submission of new evidence to address the new reasons for denial. The clause "unless there is good cause which precluded the introduction of such evidence at a previous hearing or appeal" is extremely inadequate and too subjective to protect providers. This whole provision must be stricken in its entirety or providers will be tremendously and unfairly disadvantaged in defending their claims against ever shifting reasons for denial.

11. Limitation on Recoupment Until Reconsideration Exercised

AABH recommends a change in this provision for the case of a provider of services, physician, practitioner, or supplier that is alleged to have received an overpayment under this title and that seeks a reconsideration of that determination. As proposed, the provision could be interpreted to mean that the provider can be required to pay a recoupment after the first level of appeal is completed. Providers should not be required to begin repayment until all levels of appeal have been exhausted, not just after the first level of appeal. AABH urges that providers should not be required to payback alleged overpayments until such time as it has been clearly established that an overpayment has in fact been made.

12. Limitation on Use of Extrapolation

AABH members have received intensive claims and audit reviews inspired by criticism of Medicare mental health claims from the Office of the Inspector General. Therefore, our experience with extrapolation is much greater than other provider groups. We recommend that Medicare contractors be prohibited from using extrapolation to determine overpayment amounts to be recovered by recoupment, offset, or otherwise unless there is a sustained and high level of payment error. Since many Fiscal Intermediaries have a propensity for high rates of denials, simply having a "high payment error rate" should not justify extrapolation unless it is sustained in spite of documented efforts to educate the provider. This section should read "sustained high level of payment error" not "sustained or high level of payment error."

In addition, the payment error rate should (1) exclude denials that are currently under appeal and (2) be adjusted to reflect denied claims that have already been overturned on appeal. Unfortunately, Fiscal Intermediaries calculate error rates based on initial denials regardless of the number of claims (or dollar amount of claims) that are being appealed or have already been over turned on appeal. Thus, a provider could have 100% of reviewed claims denied during the first review, appeal the denials, win all the appeals, and still be accused of having a 100% payment error rate! This can and does happen. Error rates should be calculated based solely on claims that have been denied, which are not pending in appeal and have not been overturned on appeal.

Furthermore, CMS must be required to show documented evidence that educational interventions, *over and above the Review process itself*, have been provided and failed. This will protect providers from receiving denials for a short period of time and then having those denials used to extrapolate to the universe of claims without any attempt to educate the provider. The provider should have a genuine and valid opportunity to identify problems and make required changes. Since the Review process itself is considered an educational intervention, additional educational interventions should be required before extrapolation is permitted. This is important because the reasons given for denial are often vague (e.g., "not medically necessary") and do not provide sufficient information to allow the provider to identify specific problems and make required changes.

13. Limitations on Non-Random Prepayment Review

AABH recommends a change so that a Medicare contractor cannot initiate non-random prepayment review of a provider or supplier based on the initial identification of that provider for improper billing practice unless there is both a sustained and high level of payment error.

Lastly, we strongly recommend the legislation include a tight timeline for CMS promulgation of regulations that would implement these provisions. Many do not

appear to be self-implementing and providers therefore will not be protected under these reforms until CMS promulgates regulations—particularly with respect to appeals.

Conclusion

AABH is pleased that the Subcommittee is addressing the serious problems of the Medicare regulatory burden on behavioral health and other providers. We strongly urge the Subcommittee to report H.R. 2768 to the full Ways and Means Committee with the enhancements we have presented. Lastly, on behalf of our members, I cannot thank you enough, Madame Chairman, for your long-standing efforts on behalf of consumers of behavioral health services, their family members, and the providers that serve them. I would be happy to respond to any questions that members of the panel may have.

Statement of the Blue Cross and Blue Shield Association

The Blue Cross and Blue Shield Association (BCBSA), which represents 44 independent, locally operated Blue Cross and Blue Shield Plans throughout the nation, is pleased to submit written testimony to the subcommittee on H.R. 2678, the Medicare Regulatory and Contracting Reform Act of 2001.

Blue Cross and Blue Shield Plans play a leading role in administering the Medicare program. Many Plans contract with the federal government to handle much of the day-to-day work of paying Medicare claims accurately and in a timely manner. Blue Cross and Blue Shield Plans serve as Part A Fiscal Intermediaries (FIs) and/or Part B carriers and collectively process most Medicare claims.

Blue Cross and Blue Shield Medicare contractors are proud of their role as Medicare administrators. While workloads have soared, operating costs—on a unit cost basis—have declined about two-thirds from 1975 to 2001. In fact, contractors' administrative costs represent less than 1 percent of total Medicare benefits. Few government expenditures produce the documented, tangible savings of taxpayers' dollars generated by Medicare anti-fraud and abuse activities. **For every $1 spent fighting fraud and abuse, Medicare contractors save the government $16.**

Blue Cross and Blue Shield Medicare contractors are committed to achieving outstanding performance. We support efforts to improve the ability of both contractors and the Centers for Medicare and Medicaid Services (CMS), formerly known as the Health Care Financing Administration, to cost-effectively provide the highest service levels to Medicare beneficiaries and providers.

This testimony focuses on three areas:

I. Background, including a description of Medicare contractor functions;

II. Current challenges facing Medicare contractors; and

III. BCBSA recommendations for improving contractor operations and comments on contractor reform provisions included in H.R. 2678

I. Background

Medicare contractors have four major areas of responsibility:

1. **Paying Claims:** Medicare contractors process all the bills for the traditional Medicare fee-for-service program. In FY 2001, it is estimated that contractors will process over 900 million claims, more than 3.5 million every working day.

2. **Providing Beneficiary and Provider Customer Services:** Contractors are the main points of routine contact with Medicare for both beneficiaries and providers. Contractors educate beneficiaries and providers about Medicare and respond to approximately 40 million inquiries annually.

3. **Handling Hearings and Appeals:** Beneficiaries and providers are entitled by law to appeal the initial payment determination made by carriers and FIs. These contractors handle over 7.4 million annual hearings and appeals.

4. **Special Initiatives to Fight Medicare Fraud, Waste, and Abuse:** All contractors have separate fraud and abuse departments dedicated to assuring that Medicare payments are made properly. According to the Department of Health and Human Services (HHS), these activities saved the government $9 billion in 1998.

Medicare contractors operate under detailed instructions from CMS. As government contractors, Medicare contractors must comply with numerous federal statutes, regulations, and Executive Orders. In addition, contractors must follow extensive CMS-issued program guidelines and manual instructions. To monitor compli-

ance with these guidelines, contractors are visited several times each year by their local CMS regional office staff for an assessment of their performance against CMS' requirements. These reviews, termed Contractor Performance Evaluations, are conducted across all aspects of contractor operations—claims processing timeliness and accuracy, customer service, fraud and abuse detection efforts—and culminate in a formal annual report called the Report of Contractor Performance. Also, CMS routinely contracts with private companies to review various critical aspects of contractors operations.

II. Challenges Facing Contractors

There are four key challenges currently facing Medicare contractors:
1. Inadequate funding levels with rising workloads;
2. Increased complexity of Medicare rules;
3. Frequent changes in program direction; and
4. Legislative mandates not accompanied by additional funding.

Inadequate funding levels: Of utmost importance to attaining outstanding performance is an adequate budget.

However, Medicare contractors have been severely underfunded since the early 1990's and are facing poor prospects of receiving adequate funding next year. During the early to mid-1990's, reductions in funding concurrent with increases in workload seriously eroded contractors' ability to fight fraud and abuse. Between 1989 and 2000, the number of Medicare claims climbed almost 70 percent to over 800 million, while payment review resources grew less than 11 percent. As a result, the amount allocated to contractors to review claims shrank from 74 cents to 48 cents per claim. Because of the significant cost of reviewing claims, this decline in funding resulted in CMS directing contractors to reduce the percentage of claims that were scrutinized and investigated. Similarly, the percentage of cost reports audited declined—between 1991 and 1996, the chances that any institutional provider's cost report would be reviewed in detail fell from about 1 in 6 to about 1 in 13.

Throughout this period, contractors identified to CMS additional anti-fraud efforts they could undertake if awarded additional resources. BCBSA and Blue Plans urged both Congress and the Administration to allocate significantly more funds for critical anti-fraud and abuse efforts. Finally, in 1996, Congress created the Medicare Integrity Program (MIP) in the Health Insurance Portability and Accountability Act (HIPAA). MIP provided a permanent, stable funding authority for the portion of the Medicare contractor budget that is explicitly designated as fraud and abuse detection activities. MIP funding was set at $500 million in 1998 and is authorized to rise to $720 million in 2002. After 2002, the permanent authorization is capped at $720 million despite continuing projected increases in claims volume.

Thanks to this new funding mechanism, Medicare contractors have been able to improve their efforts to reduce the amount of fraud, waste, and abuse in the Medicare program. Contractors' enhanced anti-fraud and abuse efforts due to MIP funding contributed to the significant decline in improper claims and documentation submission by providers. The OIG audit of FY 2000 claims estimated that improper Medicare payments had dropped to $11.9 billion, or about 6.8 percent of the $173.6 billion in Medicare payments. The improper payment rate declined by over 50 percent or $11 billion in five years.

But, the creation of MIP did not solve the budget problems for the remainder of the contractor budget. The largest portion of the contractor budget— program management—is subject to the annual appropriations process and continues to face severe funding pressures. Program management activities include claims processing, beneficiary and provider communications, and hearings and appeals of claims initially denied. Under the appropriations process, contractors must compete for funding with high priority programs such as the National Institutes of Health and education.

For example, between 1989 and 1998, funding for program management activities (adjusted for inflation) declined by 18 percent. During this period, the volume of Medicare claims increased by 84 percent; Medicare outlays (in real dollars), by 65 percent. Whenever possible, contractors responded to reduced funding by achieving significant efficiencies in claims processing, lowering program management costs per claim by 56 percent in real dollars over this period. But even these efficiencies have not been enough to keep pace with rising Medicare claims volume and diminishing funding levels. For example, this year, contractors have been instructed to cut back on customer service plans, responding to inquiries, provider training and other provider services in order to live within the 2001 budget. It should be noted that Medicare contractors have had to cut back on these important provider and beneficiary

services in past years as well due to funding shortfalls, even though these services were critically important and contractors had wanted to enhance these programs.

Inadequate budgets for program management also impact Medicare's fight against fraud and abuse. While many think of program management activities as simply paying claims, these activities are Medicare's first line of defense against fraud and abuse and are critically linked to MIP activities. As an example, many of the front-end computer edits (e.g., preventing duplicate payments and detecting suspicious claims) are funded through program management. Inadequate funding impacts different functions at different times, but always disrupts the integration of all the functional components needed to "get things right the first time." It thus results in inefficiency and higher costs.

We are pleased that Secretary Thompson and many Members of this subcommittee have recognized the need for additional administrative resources at CMS. We are concerned the Administration's FY 2002 budget relies on a proposal for $115 million in new user fees from providers. Congress has consistently rejected user fees and BCBSA recommends they be rejected again. We also strongly recommend Medicare contractor funding be increased to $1.567 billion in FY 2002 to ensure adequate resources are available to provide the high quality services beneficiaries and providers deserve. If funding for the Departments of Labor, Health and Human Services (HHS) and Education are subject to a Continuing Resolution (CR) at the start of FY 2002, BCBSA would recommend the CR include an increase in appropriations for Medicare contractor program management based upon the expected increase in claims volume. This will prevent any disruptions in paying claims and providing beneficiary and provider services while the final budget is being negotiated.

Increased Coomplexity of Medicare Rules: The Medicare program continues to grow more and more complex. It takes a great deal of time and resources to educate providers and beneficiaries about new laws and rules as well as answer questions and without appropriate time and resources, it is difficult for the contractors to do an adequate job. Contractors have been challenged over the years with enormous program changes such as:

- New payment mechanisms for outpatient departments, home health agencies, and skilled nursing facilities.
- Changes to Medicare coverage rules: Balanced Budget Act (BBA), Balanced Budget Refinement Act (BBRA), and the Beneficiary Improvement and Protection Act (BIPA).
- Implementation of the HIPAA administrative simplification provisions.

Just as Members of Congress are hearing from providers about the program's complexities, so too are contractors who must answer their questions and concerns.

Frequent Changes in Direction: Medicare contractors are challenged by the very nature of the business. At last count, Medicare contractors, received on average a new instruction from CMS every five hours of every day of the year. This constant state of change requires contractors to be extremely flexible—both in terms of operations and budget. It has not been uncommon in the past for contractors to be forced to abandon projects or reallocate staff mid-year in order to adapt to CMS' suddenly revised priorities or modified funding levels.

Medicare contractors operate under cost contracts, and CMS places budget caps, or limits, on the unit costs paid to contractors to process claims. By law, Medicare contractors are not allowed any profit. Under these contracts, Medicare contractors essentially do whatever work CMS requests, without "change orders." There is not a clear statement of work at the beginning of the year, and contractors generally must comply with constant change orders from CMS without additional reimbursement. These demands make the Medicare contractor business extremely challenging.

Legislative Mandates Without Funding: Legislative changes to Medicare are rarely accompanied by administrative funding or appropriate transition time for proper implementation. For example, Medicare contractors had to implement the new prospective payment systems and the many changes stemming from the BBA, BBRA and BIPA without new funding. This is extremely cumbersome for contractors that are already strapped for resources.

III. BCBSA Recommendations to Improve Medicare Contractors and Comments on Contractor Reforms included in H.R. 2678

BCBSA agrees that revisions to the Medicare contractor program would strengthen contractors' ability to effectively and efficiently handle day-to-day administration of the Medicare program. Blue Cross and Blue Shield Medicare contractors are com-

mitted to achieving outstanding performance levels and providing superior service to Medicare beneficiaries and providers. We want to work with this subcommittee, the Congress and CMS to attain this objective.

BCBSA supports many of the reforms proposed in H.R. 2678, including contracting with any entity, not just health insurers; modernizing the way contractors are paid; adopting a more business-like environment; enhancing competition; and restoring critical provider education activities. We do, however, have two key concerns. First, while BCBSA supports increased competition in the program, requiring CMS to competitively bid all contractors every four years would likely be extremely problematic for beneficiaries, providers and CMS—as well as both potential new and existing contractors. Second, while we applaud the committee for mandating enhanced provider education, which has been severely cut back in recent years because of funding shortfalls, the ability to conduct these activities must depend on the appropriation of additional funding. Our specific comments follow.

Competitive Contracting: BCBSA supports introducing more competitive bidding into the program in an orderly manner to minimize the risk of disruptions to beneficiaries and providers. To ensure stability of the Medicare program, BCBSA recommends that—rather than requiring bidding every four years for all contracts—CMS only put to competitive bid poor performing contractors and contracts from entities voluntarily exiting the program. This would allow the government to maintain those contractors that are providing quality services and meeting CMS' performance expectations, while encouraging new entities to compete for a stable program.

BCBSA also supports provisions of H.R. 2678 that would enhance competition by giving HHS the authority to contract with any entity, not just health insurers, that are able to provide the full range of Medicare administrative services.

BCBSA believes the provision in H.R. 2678 to require CMS to competitively bid all Medicare contracts every four years would:

1. **Reduce Flexibility for CMS:** CMS would have less flexibility in managing competitive bids than other government agencies. Other agencies generally bid contracts on a five to seven year basis, and are able to provide longer terms. It is important to note that there is a trend to provide longer-term government contracts because of the cost and complexity of frequent competitions.

2. **Divert Already Scarce CMS Resources:** Given the consensus that CMS is already underfunded, mandated competition every four years would divert resources away from other important CMS responsibilities.

A four-year competitive bid process would place an enormous financial burden on CMS and require additional resources, including a new cadre of staff to manage what is likely to be a continuous process. Procurement for each contract could take up to three years; it can take up to a year to prepare the request for proposals, a year to run the competition, and another year to resolve any protests regarding the award of a contract (which are common in contracts of this size). Staff needs would be considerable as CMS would be taking on significant new duties:

With respect to bidding, assuring all contractors are qualified and have the capacity to perform all assigned functions, assure all bidders address all functions with realistic and adequate resources, overseeing the competition and protests.

With respect to the transition, managing change orders, assuring implementation matches what was provided in the bid, assuring problems—for beneficiaries and providers—are averted, responding to and addressing the inevitable problems that will arise.

In addition, CMS administrative budgets will also have to take into account the increased contractor funds necessary to cover the very considerable costs of bidding for these contracts.

3. **Likely to Result in Beneficiary and Provider Service Disruptions:** Providers would be faced with potential upheaval every four years. Past experience shows that transitions to new contractors are very challenging. They must be carefully managed to prevent service problems which has plagued previous transitions: incorrect payments, a backlog in claims processing, and lack of responsiveness to beneficiary and provider inquiries. Mandating CMS to competitively bid all contracts every four years—a massive undertaking—would be extremely high risk for providers and beneficiaries.

4. **Deter the Most Qualified Medicare Contractors:** Current contractors, as well as potential new entities, would face significant disincentives to bid, knowing their investment is at risk every four years. Both current and new contractors are likely to be concerned about the huge business risk of losing the contract after four years and the subsequent loss of hundreds and even thousands of local jobs. In par-

ticular, potential new Medicare contractors must make significant investments in buildings, sophisticated computer systems and large numbers of trained staff. Many of the best contractors may decide that a 4-year contract is too high risk and not bid.

5. **Require an Increase in Overall Medicare Contractor Funds:** Medicare contractor funds would have to be increased to cover the additional costs of competitive bidding. Currently, contractors live with CMS-set caps on costs per claim basis. When funding is inadequate—because of lower than requested appropriations or increased workloads (such as when new Medicare legislation is passed or unexpected increase in claims volumes)—contractors must still perform their functions, often without corresponding decreases in performance expectations.

Under a mandated competitive bidding process, there is a significant potential for a mismatch between competitive bids and available funding. If the competitive bids exceed the total funding available, CMS would be required to scale back the proposed scope of work and recompete the contracts. This would be extremely time consuming and even more costly and could result in an inadequate coverage of important functions.

Unlike most other government contracting, Medicare is an entitlement program and the function of paying claims must continue. An entire contract just cannot be cancelled or postponed, like most other government contracts in the event of funding cutbacks.

For these reasons, BCBSA believes that competitive contracting should be expanded in the Medicare contractor program carefully, with considerable planning. In our view, the best way to accomplish this is by focusing competitive contracting on poor performers and exiting contractors.

Additional Funding is Necessary to Restore and Enhance Provider Education: Blue Cross and Blue Shield Medicare contractors agree that provider education services should be restored and expanded. One of our primary messages to appropriators in recent years is that adequate funding is critical to support provider and beneficiary services. Since paying claims is the program's highest priority, provider and beneficiary services often fall victim to insufficient funding levels.

BCBSA supports the provider education and technical assistance provisions included in H.R. 2678; however, implementation of these provisions should be dependent upon adequate funding.

In the past, Medicare contractors provided many more services to beneficiaries and providers than are offered today, as budget pressures forced CMS to curtail these activities. Blue Cross and Blue Shield Medicare contractors are committed to providing the highest level of services to beneficiaries and providers. However, the services cannot be provided unless adequate funding is available. Therefore, we would ask that the provider education and technical assistance provisions be made contingent upon funding.

CMS authority to award other than cost reimbursement contracts: BCBSA agrees with the provisions in H.R. 2678 to modernize the current cost-based contracting system. Currently, most contractors are paid costs up to a cap set by CMS; there is virtually no opportunity for profit. We believe CMS should be allowed to use other payment options, such as cost plus contracts.

Funding recommendations: We have two specific recommendations that are not included in HR 2678:

- First, we urge Congress and the Administration to assure Medicare administrative funds keep pace with workload increases and new legislative/regulatory requirements.
- Second, we urge the Committee to increase the permanent MIP appropriation, which is currently capped at $720 million in 2002 and beyond. If fraud and abuse efforts are to be effective, MIP funding must keep pace with workload increases. Therefore, BCBSA recommends indexing the MIP authorization by the projected increase in workloads and medical inflation.

BCBSA would like to work with this subcommittee to assure adequate funding is available each year for paying claims promptly and providing high quality provider and beneficiary services.

CONCLUSION

Blue Cross and Blue Shield Medicare contractors are committed to achieving outstanding performance. We believe more can and should be done to improve Medicare contractor operations. Success in Medicare claims administration requires that CMS and the contractors work together toward their mutual goal of providing high qual-

ity services to beneficiaries and providers, including accurate and timely claims payment.

BCBSA look forward to working with this subcommittee and CMS to make these needed improvements.

Statement of the Medicare Administration Committee, Silver Spring, Maryland

CIGNA Health Insurance Corporation. Cooperativa de Seguros de Vida de Puerto Rico Group Health Incorporated. Mutual of Omaha Insurance Company National Heritage Insurance Company. Nationwide Mutual Insurance Company Wisconsin Physicians Service Insurance Corporation

The member companies of the Medicare Administration Committee are substantially involved in the administration of the Medicare program as carriers and intermediaries. During Fiscal Year 2001, we processed 256 million Part B claims and 16 million Part A claims. We appreciate this opportunity to comment on the Medicare contracting reform provisions of H.R. 2768, the proposed "Medicare Regulatory and Contracting Reform Act of 2001"

For several years, the Administration has been recommending that Congress enact its "contractor reform" proposal, which would allow the Center for Medicare and Medicaid Services (CMS) to restructure its contracting process and drastically reconfigure the administrative structure of the Medicare program. The General Accounting Office and the Office of Inspector General of the Department of Health and Human Services have endorsed the concepts put forth by the Administration.

H.R. 2768 is aimed in part at modernizing Medicare's contracting for the processing and payment of Medicare claims as well as education and services provided to providers of care and beneficiaries. Section 4 of the bill embodies many of the contracting changes being sought by the Administration. It would:

- Create a new class of contracting entities, "Medicare Administrative Contractors", (MACs) replacing the current Medicare Part A intermediaries and Part B carriers.
- Eliminate the current law requirement for cost-reimbursement contracts, allow contracting in any manner allowed by the Federal Acquisition Regulation (FAR), and require that contractors be provided with financial incentives for quality and efficiency.
- Eliminate the current Part A right of hospitals to select their fiscal intermediaries and the Part B requirement that carriers be insurance companies.
- Allow CMS to contract for specified Program Management functions individually or in any combination it wishes with any entity it deems qualified.
- Require competition in the procurement of MAC services, with some exceptions.
- Eliminate current law provisions that protect carriers and intermediaries when their contracts are terminated by either the government or themselves.
- Increase the liabilities that contractors may incur in the performance of their responsibilities.

CMS believes that revisions in its contracting authority will enable it to reduce overall Medicare program management costs through price competition and by reducing the number of Medicare fee-for-service contractors, to achieve further economies of scale. It also hopes to achieve greater efficiency through the use of specialized, "functional" contractors. However, the agency has not indicated with any degree of specificity how it would employ the broader contracting authority it seeks.

COMMENTS

We believe that appropriate changes should be made in the way the government contracts for the services provided by carriers and intermediaries. For example, our companies would welcome the opportunity to earn a reasonable profit as MACs. Nor do we oppose competitive contracting—provided the entities involved are clearly qualified to perform the complex operations involved in processing Medicare fee-for-service claims and related activities. But, we doubt that the mandatory 4-year competitive procurement cycle envisioned by H.R. 2768 would be the best way to implement competition—given the immense scale and complexity of the Medicare program. The cost and disruption of conducting four or five major competitive procurements each year would be a major expense and disruption for CMS and contractors

to deal with and would probably not yield the results that could be achieved by a more targeted approach.

Functional Contracting—We are also concerned about the feasibility of "functional contracting." Dividing the activities that go into processing a single Medicare claim among several specialized contractors may have theoretical benefits, but the potential problems involved in coordinating all of these functions deserve careful analysis. Thorough planning, extensive pilot testing and cautious implementation will be needed to make functional contracting effective.

Funding of Medicare Contractor Operations—During the past decade the annual funding of Medicare contractor operations has eroded to the point where it is inadequate to meet the demands of an efficiently run, high output program. The workload of claims to be processed has increased more than 70 percent, while the funding of contractor operations has risen less than 15 percent. In addition, Congress has enacted literally hundreds of substantive changes in the program without providing CMS or Medicare contractors the resources for the complex processes involved in implementing them.

While contracting reform may produce some further economies of scale, they may not be sufficient to keep up with the growth in claims workload or general inflation in the economy. As the General Accounting Office has frequently pointed out, Medicare administrative costs are extremely low in comparison to similar government programs or private health insurance.

Further, in reconfiguring contractor operations, CMS will incur substantial additional transition costs. Unless the funding of contractor operations is increased by 10 percent or more it will be impossible to maintain the current levels of quality and efficiency in the ongoing processing of 900 million annual Medicare claims while, at the same time, implementing contracting reform.

CMS Capacity to Manage a FAR Contracting Environment—The current form of Medicare "cost-reimbursement" contracting has been in place for over three decades. It is an environment in which contractors are assigned tight annual budgets with no discretion to address shifting requirements by transferring resources among the various budget categories dictated by CMS. There is no detailed statement of work in the contracts. Instead, contractors receive hundreds of instructions from CMS, many of which are vague and subject to definition or change throughout the year. The majority of these instructions require operational changes to be carried out "within existing resources." Under the current "cost-reimbursement" business environment, all contractors have experienced situations in which CMS orders additional work to be done and then fails to make funds available to pay for it. Contractors also are frustrated by performance evaluations that judge their work on a fiscal year basis yet fail to take into account the fact that funding for new or revised work was not provided until several months after the year had begun, if it was provided at all.

Contracting in accordance with the FAR is a sound concept. However, its implementation will probably require more change by CMS itself than by its contractors. In the FAR contracting environment, CMS will be required to negotiate a highly detailed and specific statement of work with each contractor. Any new work or significant changes in the ongoing work to be performed will have to be negotiated with each contractor and price adjustments agreed upon. Further, CMS will have to develop precise, objective measurements of contractors performance. The GAO has commented that CMS already has experience with FAR contracting under the MIP program. But that experience may not prove particularly useful in dealing with the high-output and immense scale of ongoing carrier and intermediary operations.

The immense workload imposed by hundreds of legislative changes, coupled with appropriations that have been inadequate for the work required of the agency, have greatly hampered CMS in the performance of its mission. Under contracting reform, CMS will need to be funded, staffed and reorganized to deal with the transition to a very different contracting environment. It will need to improve its planning, funding and policy implementation processes as they affect Medicare administrative contractors. The FAR contracting process will not accommodate constantly shifting agency strategies and goals, or imprecise, untimely definitions of the work that contractors are to perform.

Contractor Liability—The financial risk of being a Medicare contractor is a factor that must be carefully considered by any entity interested in this business. The weighing of potential risk against potential financial reward is an important factor in making the decision to compete for Medicare administrative business. The revised standards for liability and indemnification of Medicare Administrative Contractors proposed in H.R. 2768 are inadequate for the levels of risk to which carriers and

intermediaries are exposed. They would greatly increase the business risk of being a contractor. Insuring for the added risk would also increase contractors' operating costs and thus the government's cost of administering the program.

We urge that the liability and indemnification provisions of H.R. 2768 be reexamined. The liability provisions that CMS has incorporated in the contracts that it has awarded under the Medicare Integrity Program contracting authority are not appropriate for the program management work performed for Medicare by carriers and intermediaries. We believe that, when CMS moves beyond the limited projects that have been awarded thus far under MIP, it will find itself pressured by MIP contractors to adopt contract liability language comparable to that in current intermediary and carrier contracts.

Contractor Termination Costs—Under their current contracts, carriers and intermediaries do not make a profit. They have many career employees with 20 or more years of service that must be provided severance pay if a contractor leaves the Medicare program.

At the beginning of the Medicare program, the government agreed that, under the long-term cost-reimbursement relationships envisioned, carriers and intermediaries would be entitled to recover their termination costs regardless of whether the government or a contractor decided to end the relationship. In view of this agreement, carriers and intermediaries have not been allowed to include any charge for funding termination costs as an ongoing operating cost to be reimbursed by the government. We believe that CMS intends to end this longstanding commitment when it enters into new FAR contracts with existing carriers and intermediaries. Termination costs would be allowed only if the government cancels a contract. This would be extremely unfair to existing contractors—especially so in view of the fact that, since 1965, more than 40 contractors have left the program subject to the existing termination rights.

If the Medicare program continues to contract on a cost-reimbursement or cost plus incentive fee basis, the traditional termination provisions should be retained in new contracts. If, instead, it changes from cost-reimbursement to fixed price contracting and forces contractors to give up their traditional right to termination costs, it is critically important that the change be applied prospectively.

Unless current contractors are assured that the potential severance pay and lease termination expenses accrued up to this point will continue to be covered should they decide to leave Medicare, many may quickly drop out of the program under their existing contracts, in order not to lose their right to recover termination costs. Importantly, if the accrued termination costs of existing contractors are recognized under new contracts, the potential cost to the government will eventually disappear as the contractors' current employees leave or retire and are replaced by personnel not covered by the traditional contract language. Moving forward all bidders will simply include their prospective termination costs in the prices they bid for Medicare contracts.

Statement of the Power Mobility Coalition

The following statement is respectfully submitted to the U.S. House of Representatives Committee on Ways and Means on behalf of the Power Mobility Coalition ("PMC"). The PMC is a coalition of suppliers and manufacturers who provide power mobility equipment and services, such as motorized wheelchairs and scooters, to Medicare beneficiaries nationwide. PMC members represent well over half of the nation's power mobility market and our members are located in all regions of the country.

The members of the PMC would like to thank the Subcommittee on Health of the Committee on Ways and Means for its work on Medicare reform and for holding their recent hearing concerning H.R. 2768, the "Johnson-Stark Medicare Regulatory and Contracting Reform Act of 2001." We are grateful that the Subcommittee is addressing legitimate concerns raised by suppliers and providing regarding regulatory and administrative issues in the Medicare program.

Suppliers of power mobility equipment and services spend much of their time and effort interpreting and complying with Medicare's complex regulatory and procedural requirements. In addition to dealing with Medicare laws and regulations, PMC members must also deal directly with the Durable Medical Equipment Regional Carriers ("DMERCs"), the entities that are charged with administering payment on behalf of CMS. While CMS has overall responsibility for program management, many of the responsibilities related to reimbursement and medical policy

have been delegated by the agency to the DMERCs. Unfortunately, the DMERCs have used this authority to create new policies, often in direct contrast to existing policy published by CMS. For example, the DMERCs often conduct random audits of suppliers of so-called "high utilization" items without adhering to published standards governing such audits, and use "overpayment" calculation methods such as extrapolation to recoup funds that have already been appropriately paid out by the Medicare program.

These actions have led to an erosion of the due process afforded to those who choose to provide items and services to program beneficiaries. In this context, we offer the following comments.

A. CMS/CARRIERS SHOULD BE PROHIBITED FROM RECOVERING PAST OVERPAYMENTS IF AN APPEAL IS PENDING

The PMC supports legislation that prohibits recovery of overpayments until the Administrative Law Judge ("ALJ") level of appeal is completed.

The current system requires suppliers and providers to repay the government and then undergo a lengthy appeals process to win back monies to which they are entitled. It is not unusual for a supplier/provider to wait one or two years for a claim to be completely adjudicated.

During the appeals process, a supplier continues to provide the equipment and service to the beneficiary—to do otherwise would force the supplier to forfeit its right to appeal. The appeals process typically results in payment to the supplier who provided equipment and service.

Pursuant to the order certified by the physicians in compliance with Medicare rules. According to statistics cited in the September 1999 Report issued by the Office of Inspector General of the Department of Health and Human Services, entitled "*Medicare Administrative Appeals—ALJ Hearing Process*," 78 percent of DME appeals studied were "reversed at the ALJ level" and 81 percent of home health appeals studied "were reversed at the ALJ level."

With a reversal rate of roughly 80 percent, it does not seem fair that a company would have to forfeit the right to reimbursement without having the ability to adjudicate these disputed claims prior to repayment. Further, the supplier who wins a case is, under the current law, not entitled to interest on reversed claims even though there has been no break in service, or removal of equipment from, the Medicare patient.

B. EXTRAPOLATION CREATES UNDUE HARDSHIP ON POWER MOBILITY SUPPLIERS

The current arbitrary use of the technique of extrapolation to calculate so called overpayments creates an undue hardship on suppliers and providers participating in the Medicare program. The PMC supports legislation that limits the use of extrapolation and would recommend that extrapolation not apply to customized items of equipment such as power mobility equipment.

Extrapolation works in the following manner: a carrier draws a "sample" of claims (often as few as thirty) from a universe of claims for that supplier a defined period of time. If, for example, the carrier reviewer determines that 50% of the claims should not have been paid (even though the treating physician has certified the need for the equipment), that non-payment amount is then "extrapolated" to the universe of claims. If there are a hundred claims in the universe, the company will owe repayment for 50 electric wheelchairs ($250,000) rather than 15 wheelchairs ($75,000). The overpayment amount is due within thirty days of the DMERC reviewer's determination. Even though, typically, the supplier wins most, if not all, of the overpayment back on appeal, the business is severely damaged.

The indiscriminate use of extrapolation for costly, customized items of medical equipment such as electric wheelchairs, is creating hardships for dealers and has forced many businesses to face bankruptcy. Although CMS has the discretion to allow the supplier to pay back a large overpayment in installments, such payment arrangements are usually granted only for a twelve-month period, with interest of around 14% is assessed on all outstanding "overpayments" even while they are being appealed.

The use of extrapolation saddles the supplier, who is trying to provide a service in his/her community, with a large overpayment assessment, as well as additional costs including, fees for representation and interest on any assessed "overpayment." In addition, the supplier is required to pay back the government within thirty days. The company who finds itself in this position will take little comfort in the fact that the ultimate reversal rate for these cases is, according to CMS's own figures, roughly 80 percent. That is because the business may very well not survive the next year

or two of working through this CMS/DMERC controlled process. An appeal for relief to federal court is not possible until administrative remedies are exhausted.

C. AUDIT PROCESS

Medical Review and Audits Should Be Conducted Based on Good Cause

Medicare audits and medical reviews should be conducted based on good cause and should adhere to established standards and guidelines. Toward that end, CMS developed standards for the audit process in an August 7, 2000 Program Memorandum entitled the *Medicare Review Progressive Corrective Action* plan. These standards require that intermediaries/carriers should "*subject providers only to the amount of medical review necessary to address the nature and extent of the identified problem*."

Many of the audits conducted upon suppliers are not based on an "identified problem" but rather are triggered on the use of a code for equipment for which utilization has increased. For example, the Region D DMERC, the Medicare Part B carrier overseeing 17 states spanning the entire Western part of the country, has developed a series of pie charts highlighting the top suppliers of power wheelchairs for 3 month periods. Each of the suppliers cited on these pie charts are subsequently targeted for an audit based solely on the "high utilization" of this equipment.

What is troubling is the fact that the Region D DMERC's own pie charts demonstrate that the targeted suppliers are providing only between six and eight wheelchairs a month to Medicare beneficiaries. Providing less than ten wheelchairs a month does not constitute high utilization in a Region spanning 17 states. Further, the information provided to industry by the Region D DMERC appears to be inconsistent. One chart used by the Region D DMERC cited the top supplier for the first quarter of 2000 as providing 32 wheelchairs while another chart used by the same DMERC for the same quarter of 2000 cited a company as providing 39 wheelchairs.

The Region D DMERC audit process is consistent with CMS/carrier policy of targeting companies that may specialize in a particular area and/or companies that have developed a reputation for providing quality service and care to Medicare beneficiaries. CMS's policy of targeting suppliers of a particular product creates a chilling effect on the ability of Medicare suppliers to provide equipment and services to patients who qualify for such equipment and services.

The Current Audit Process Should Not Penalize the Utilization of New Technology in the Marketplace

The current process by which companies are being audited raises a broader issue concerning CMS's inability or unwillingness to acknowledge or recognize the importance of technological advancements in the health care field. The development of new technology in the power mobility industry has made this equipment available to a larger number of disabled people. It is now possible for beneficiaries to obtain smaller, more lightweight and maneuverable motorized wheelchairs for use inside a patient's home. This new technology allows people to move about in small places (e.g., hallways, kitchens, and bathrooms) and complete their activities of daily living without being bed-bound or sent to nursing homes.

CMS's targeting of companies based strictly on utilization fails to recognize the evolving health care marketplace or changing consumer needs and fails to appreciate the rationale for a particular product or service being provided to patients throughout our country.

Carrier Audit Determinations Should Be Consistent With Medical Necessity Standards Established By Congress and CMS

The CMS Medical Review Progressive Corrective Action plan states that "after validating that claims are being billed in error, target medical review activities at providers or services that place the Medicare trust funds at the greatest risk while ensuring the level of review remains within the scope of the budget for medical review."

Unfortunately, the criteria the carriers use to determine that "claims are being billed in error" are inconsistent with criteria already established by Congress and CMS. Current Medicare policy governing the use of power mobility equipment requires that a supplier submit, on behalf of a beneficiary, a certificate of medical necessity ("CMN") form signed and completed by the patient's treating physician, with each power mobility claim. Congress passed legislation in 1994 defining a CMN in the following manner:

> A form or other document containing information required by the carrier to be submitted to show that an item is reasonable and necessary for the diagnosis or treatment of illness or injury to improve the functioning of a malformed body member.

CMS worked with the medical community on the development of the CMN for power mobility equipment (as well as CMNs for other DME items) and received approval from the Office of Management and Budget for these forms pursuant to the Paperwork Reduction Act. When submitting the CMN forms to OMB for approval, CMS explicitly declared that the CMN forms are "needed to correctly process claims and ensure that claims are properly paid" and that "these forms contain medical information necessary to make an appropriate claims determination." In fact, the treating physician (or clinician familiar with the patient's condition) is required to complete the detailed medical necessity information on the CMN and certifies that such information is true and accurate.

The CMN process has been quite effective. The PMC sampled roughly 20,000 power mobility CMNs and discovered that over 75% of the patients failed to qualify based on responses to medical necessity questions established on the CMN form. Only the 25% of patients who have met the medical necessity requirements established on the CMN form were provided with power mobility equipment that was billed to the Medicare program.

Despite the legal/medical necessity significance of the CMN form as envisioned by Congress, CMS and the OMB, the DMERCs have often disregarded the information contained on the forms, particularly when conducting audits, to determine the validity of claims. On numerous occasions, power mobility suppliers have been assessed overpayments even though the equipment was provided pursuant to a properly completed CMN form signed and certified by the patients treating physician.

One power mobility supplier, a company with revenues between 1 and 2 million a year, was assessed an overpayment of nearly $500,000. Upon making this overpayment assessment, the carrier informed the supplier in writing that the "*CMN represents nothing more than a Medicare pre-payment tool* which has been abbreviated as much as possible to reduce physician paperwork." Another small power mobility supplier was assessed an overpayment of over $600,000 and informed by the carrier in writing that "*the CMN itself does not provide sufficient documentation of medical necessity*. . . . Suppliers are not required, nor should they, sell equipment to unqualified beneficiaries merely because they have a physician's written order and a CMN."

In these cases, and in other similar cases throughout the country, the supplier had fully complied with the rules established by the Medicare program and yet were penalized based on new and arbitrary criteria developed by the carrier after the equipment had been delivered to the patient and after the claim had originally been paid. While these companies will most likely be vindicated during the appeal process, the damage to the company has taken place and the company's ability to survive has been impacted. As set forth above, the inability of CMS to effectively monitor the performance of the Part B carriers results in an unfair burden and cost to suppliers and providers who serve beneficiaries.

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