WASTE, FRAUD, ABUSE, AND MISMANAGEMENT

HEARINGS

BEFORE THE

TASK FORCE ON HEALTH

OF THE

COMMITTEE ON THE BUDGET
HOUSE OF REPRESENTATIVES

ONE HUNDRED SIXTH CONGRESS

SECOND SESSION

HEARINGS HELD IN WASHINGTON, DC: MAY 18, JUNE 14, JULY 12, AND AUGUST 9, 2000

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Medicare's Regulatory Burden on Providers (Part 1)

THURSDAY, MAY 18, 2000

HOUSE OF REPRESENTATIVES,
COMMITTEE ON THE BUDGET,
TASK FORCE ON HEALTH,
Washington, DC.

The Task Force met, pursuant to call, at 10:15 a.m. in room 210, Cannon House Office Building, Hon. Saxby Chambliss (chairman of the Task Force) presiding.

Members present: Representatives Chambliss, Fletcher, Gutknecht, Spratt, McDermott, and Lucas.

Chairman CHAMBLISS. We can come to order here and we will go ahead and begin our hearing. Let me just say that I am very pleased to see this number of folks here because there is no more important issue, in my opinion, that the Budget Committee can carry out than its function of oversight, particularly in the area of waste, fraud, and abuse in the Federal Government.

Let me also say that we are not here to throw stones and throw darts at anybody. Instead our purpose in this is going to be is, at least as far as the Health Care Task Force is concerned, is to try to find the deficiencies in the system, try to find the areas where the health care delivery system from a Federal perspective is not working the way that it was intended to work, or as Congress envisioned it to work. We also expect to find some areas that we can make recommendations either to the Appropriations Committee or to the government agencies that are responsible for the health care aspect of the Federal Government to not only improve the system but also to save money. And if we can do that, then I think we will accomplish an awful lot and I certainly hope that that goal is going to be achieved.

I have a statement for the record that I am going to submit, and I don't want to sit here and read all of that statement but let me just say that first of all, I appreciate our witnesses being here today. Dr. Robinson, Ms. Murray, Mr. Vaughan, we are very appreciative of you all for giving your time and lending your talents to the exercise that we are going to be carrying out. I can't introduce the panel without looking at my good friend, Joe Sam Robinson, who I have known for many years and who is not just an excellent individual but he is a great American, and he is somebody who cares about not just good delivery of health care but cares about the way the system operates. And I am confident that our other two witnesses feel that same way and that this is going to be a very beneficial hearing this morning.

[The prepared statement of Saxby Chambliss follows:]

PREPARED STATEMENT OF HON. SAXBY CHAMBLISS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF GEORGIA

As part of a comprehensive effort in the House of Representatives to provide increased oversight and scrutiny of how our tax dollars are spent in Washington and how those decisions effect the daily lives of all Americans, the House Budget Committee recently created six bipartisan task forces to investigate instances of waste, fraud, abuse, and mismanagement in Federal programs.

Specifically, the Health Task Force will examine issues reaching across all health-related accounts of the Federal budget. Today, we turn our attention to the waste of resources associated with the burdens that Medicare's complex regulatory system imposes on the health care community and the patients they serve. Such attention may be appropriate, as a college professor was recently quoted in the Wall Street Journal as saying that the statutes and rules governing Medicare * * * now run the risk of becoming themselves a form of waste, fraud, and abuse.

While I want to ensure this Task Force's focus remains on eliminating wasteful Federal programs or practices and identifying illegitimate and fraudulent actors stealing taxpayer dollars, it is equally important that America's program for providing seniors' healthcare does not penalize honest providers struggling to comply with and meet the frustrating bureaucratic maze of Federal health care regulations.

Currently, there is no comprehensive estimate of the regulatory burdens and costs imposed on providers by the Medicare Program, resulting from either laws passed by Congress or regulations implemented by the Health Care Financing Administration (HCFA). In an effort to determine the depth of this problem, last year in the Balanced Budget Refinement Act, Congress required the Medicare Payment Advisory Committee (MedPAC) to conduct "a study on the complexity of the Medicare Program and the levels of burdens placed on providers through Federal regulations. While the MedPAC report isn't due until December 2001, forums such as this one can offer illustrations of the impact of Medicare regulations in the real world of medicine.

Although much of the evidence of Medicare's regulatory burden on providers is anecdotal, it known that providers must comply with almost 111,000 pages of Medicare regulations and supporting documents. According to the Heritage Foundation, this is roughly six times the size of the impossibly complex Internal Revenue Service code and its Federal tax regulations.

In fact, before coming to Washington this week, one of our witnesses, Dr. Joe Sam Robinson, actually weighed the amount of HCFA regulations his practice receives every year. The result: a whopping 35 pounds of regulations arrive in his office each year!

The purpose of today's hearing is to hear firsthand testimony from individuals such as Dr. Robinson on how those 35 pounds of new regulations each year, as well as the existing ones, effect his ability to provide care to his patients. After all, if the billions of tax dollars spent each year on the worthwhile Medicare Program are not meeting the needs of the taxpayers the program was designed to benefit, a real problem exists.

We will also hear today that the problem at 'ground zero' in healthcare delivery is not isolated to the content of regulations emanating from Washington. Ms. Kathleen Murray will offer testimony regarding the morass of duplicative and counterproductive healthcare regulations that exist among 29 different Federal organizations, ranging from the Internal Revenue Service to the Occupational Safety and Health Administration (OSHA) to the Environmental Protection Agency (EPA).

While we will no doubt hear compelling testimony from the witnesses before the Health Task Force today, it has become clear that they are not the lone voices in the wilderness on the complexity and burdensome nature of Medicare. In just a few short months my office has heard from numerous providers in Georgia alone about the burden of Medicare regulations on their ability to provide care. I would like to share just a few of those examples at this time.

Before citing one specific burdensome example, I would like to share the comments of an e-mail I recently received from a constituent on this matter that seems to succinctly sum up sentiment on this issue in Georgia:

> Dear Sir:
>
> I got out of medicine recently because I couldn't take the government interference any more—and it is much worse now. My colleagues tell me I better be glad I got out when I did. How sad—we go to school for years and then cannot practice medicine and provide care for people because we spend

so much time and money complying with frustrating bureaucratic regulations. It's a crying shame.

Retired physician,
Macon, GA.

A major regulatory headache commonly cited that constantly frustrates hospital providers and annoys Medicare beneficiaries is the Medicare Secondary Payer Questionnaire (MSPQ). The purpose of the MSPQ is sound as it is to ensure that Medicare does not pay for services that another payer is responsible for (e.g. auto insurance covering injuries sustained in auto accident). However, in practice, the MSPQ has become an unnecessarily complex and unreasonable approach to determining whether or not there is another payer that should be primary.

Two examples underlie the problems of the MSPQ. One, is its duplicative and repetitive nature because HCFA requires the MSPQ to be completed on each encounter, regardless of the service provided. Given that many Medicare beneficiaries often suffer from chronic illnesses that require ongoing diagnostic monitoring and treatment, recurring patients must answer MSPQ questions on a weekly, or even a daily, basis. As one can imagine, this is quite frustrating to a beneficiary who does not understand why the hospital must ask the same questions it did only a week ago—questions that generally take anywhere from 30 to 40 minutes to process and answer. Not only is it frustrating to the beneficiary, but it is an unnecessary waste of the provider's resources to waste valuable staff time that could be better spent attending to other patients' needs.

A second problem with the MSPQ is the information it requires the provider to seek. For example, the beneficiary's retirement date must be included. According to Georgia providers, patients are often elderly, sick, and/or confused and cannot remember their retirement date. Their fiscal intermediary has instructed hospitals in Georgia that in those cases, they should get the information from a family member. If a family member isn't available, they are to contact the beneficiary's previous employer to get the retirement date. Sometimes, these beneficiaries have been retired for 25 years or more, and the employer may not even be in business, or be in another state. How nonsensical is it for hospital employees to spend their time tracking down former employers across the nation. Such a policy is not only unnecessarily time consuming, but it borders on an invasion of privacy and causes concern and potential embarrassment for all involved.

The above example is but one of many my office has received detailing the complexity and burdensome nature of Medicare. The bottom line is whether both the American taxpayer and Medicare beneficiaries are getting the best bang for their buck when it comes to Medicare and the regulations that govern its implementation.

Not only do I look forward to testimony from our witnesses who engage in the health care arena on a daily basis, but I look forward to a follow-up hearing in which various administrative agencies will have an opportunity to respond to comments made today as well as answer questions from Members of this panel on how their regulatory structure best meets the needs of beneficiaries and taxpayers.

Chairman CHAMBLISS. I want to take an opportunity to let my friend, Mr. McDermott, as well as Mr. Spratt make any opening remarks that they would like to make this morning.

Mr. MCDERMOTT. Thank you, Mr. Chairman. I want to thank you for having this hearing today to discuss Medicare's regulatory burden on providers. I look forward to really working on this issue because I am one of those people who believes that Medicare is a good program. I think it is an enormous benefit for the country and for the elderly in this country, and I will always be interested in hearing ways in which we can improve the program.

I hope that today's testimony will be more than just telling us all the problems with Medicare, but you will also have suggestions about ways in which the program can be improved. I sit on the Ways and Means Committee and I am on the Health Subcommittee that has jurisdiction over Medicare and I know a good bit about it. Also, being a physician, I have experienced lots of things as a provider and recently having been a patient, I understand a little bit about the reimbursement system that goes on in this country in the private sector.

Medicare's error rate has been cut in half over the past few years and I think we will hope to hear ways in which we can make it be even better. But one of the problems I see—and this committee hearing is interesting to me because on the one hand we want to cut waste, fraud, and abuse. Everybody agrees to that. There isn't anybody in the Congress, all 435 Members, who would say, I want there to be more waste, fraud, and abuse out there. So we always say we want to cut it. And we write bills, some of which I voted against, like the balanced budget amendments in 1997, because I knew what it would do to Medicare. And we write all kinds of regulations as an outgrowth of the bills that we pass.

These regulations don't come from God or from the sky. They come from the Congress, through the regulatory process. And sometimes we get, when Murphy's law takes over, something we did not really intend. So I hope that we can hear about that.

But what troubles me in looking at the appropriations process this year is that the 2001 budget is 6 percent less than it was last year. That is a real cut of $127 million, and $220 million below the President's request. Now, if you are serious about finding waste, fraud, and abuse you have to look for it, and you won't take away HCFA's people and money and expect it to happen. I think that that is one of the problems we really have in looking at this whole issue.

The second one is that HCFA is the largest health insurer in the Nation. We cover 74 million Americans through Medicare, Medicaid and the children's—the CHIP program, the health program for children. And we are spending $368 billion of taxpayers' money. So we have a responsibility to be sure that it is spent adequately and effectively for good health care. It is not an easy process to run something like that. We have delegated it to private insurance companies.

Having been a physician and having had to deal with private insurance companies as well as Medicare, I find it hard to see that Medicare is any worse than dealing with the private insurers. So I would like to hear in your testimony whatever you have to say about how the private sector does it better than the government does it, using private sector intermediaries.

I think that it is easy to rant and rave about the problems, but having been in the medical profession since 1968, I know enough about what goes on in the private sector to know that that is not without its problems also. I had an aortic valve replaced and I was sitting at home, and you are recovering from something like that, you have nothing to do but go and get the mail. So I get the mail and look at all these bills and here comes a bill for a consultant who saw me and they denied the payment. So I picked up the phone and called and said, "why you are denying the payment?" They said, "well, we have no record that you were in the hospital." And I said, "well, I don't know where you think they did the aortic valve replacement—in the parking lot?" They said, "well, the hospital hasn't sent in their report yet, so as soon as they send in their report we will resubmit the bill on the doctor's consultation record."

Now, the waste in the health care system is, I think, on both sides and I want to hear—because I know that some of the intermediaries are taking the regulations of HCFA and using them. And

so I see some real problems here and I am really eager to hear what people have to say about how we can improve or simplify and still guarantee to the American public that we have looked at where their money is going. Because there is certainly money in the system that is not being well spent, and I think no one who looks at the system would say that it is otherwise. It is the same in the defense industry or in a lot of other major expenditure areas of the United States Government. And I think we need to be mindful that we have to find it, but how can we do it in a less burdensome way? I think we are all open to hear. So I look forward to this testimony and I ask unanimous consent to put my whole statement in the record.

Chairman CHAMBLISS. Without objection.

[The prepared statement of Jim McDermott follows:]

PREPARED STATEMENT OF HON. JIM MCDERMOTT, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF WASHINGTON

Chairman Chambliss, thank you for having this hearing today to discuss Medicare's regulatory burden on providers. I look forward to working with you and other members of the Health Task Force to address the challenges facing Medicare, which will celebrate its 35th birthday this year. I believe we share the goals of improving the program's level of efficiency while ensuring access to high-quality and accessible services for all beneficiaries. We may not always agree on how to achieve those goals, but I do think we share the same ultimate goals.

When Chairman Kasich created these Task Forces on Fraud, Waste, and Abuse, the stated purpose for their creation was to enable Congress to have greater oversight to prevent and detect fraud, waste, and abuse. I am sympathetic to the concerns of legitimate providers who believe they are burdened by Medicare's regulations, but I am not sure how these concerns fit the purpose of the Task Forces. Medicare's error rate has been cut in half over the past few years. I hope we will hear how we can help the agency responsible for administering Medicare, the Health Care Financing Administration (HCFA), keep reducing the error rate while we diminish the burden on legitimate providers.

Because Medicare is so important to the 39 million seniors and disabled persons who rely on it to provide health care coverage, I look forward to hearing from our witnesses today. I hope they will provide us with clear examples from the private sector or other government programs for improving Medicare without jeopardizing efforts to provide quality care for seniors. I hope the models they provide will allow us to strengthen our efforts to prevent and detect fraud, waste, and abuse by unscrupulous providers without impeding the care provided by legitimate health care providers.

Medicare is an exceedingly complex program and its administration is complex. According to recent congressional testimony by the Administrator of the Health Care Financing Administration (HCFA), Nancy-Ann DeParle, HCFA "contracts with 55 private health insurers to process nearly 1 billion Medicare fee-for-service claims each year, and with 346 private health plans that provide managed care. For Medicare alone, the agency pays more than $210 billion in claims to some 700,000 physicians, 6,000 hospitals, and thousands of other providers and suppliers each year. HCFA is the largest health insurer in the nation, providing coverage for some 74 million Americans through Medicare, Medicaid, and the State Children's Health Insurance Program, and paying about $368 billion for health care services this year."

The statutory language related to all HCFA programs, not just Medicare, encompasses 900 pages. HCFA's implementing regulations encompass 1,700 pages. However, it is not the number of statutes or the number of regulations that should guide us. We want the programs to be effective and regulated effectively. Undoubtedly, there are areas that could be clarified and strengthened to make it easier for legitimate providers to document legitimate claims for timely payment. We do not want to punish the legitimate provider.

During the last 3 years, significant improvements were made in reducing Medicare's improper payment rate. Between 1996 and 1998, the error rate was cut almost in half (a 45 percent reduction). Medicare's payment error rate declined from 14 percent to 7.97 percent. However, the amount of payment errors is still too high (about $13 billion annually). HCFA is ahead of its Government Performance Review Act goal of 9 percent by 1999 and is committed to its strategy to again cut the pay-

ment error rate in about half and reduce it to 5 percent by 2002. Clearly, reduction of these payment errors, protection of the integrity of the Medicare Trust Fund, provision of appropriate coverage to beneficiaries, and provision of appropriate payment to providers are daunting tasks. I hope our witnesses can give us their insights as to how we can achieve all of the goals.

I think the testimony we receive today can give us a preview of what we might expect when MedPAC completes the study Congress required in the Balanced Budget Refinement Act (BBRA) of 1999. This comprehensive review of all providers and recommendations for simplification of many of Medicare's complexities will be available to us by December 31, 2001. In the meantime, today's testimony will shine some light on these areas for us to consider.

I look forward to hearing from all of you. Thank you, Mr. Chairman.

Chairman CHAMBLISS. Mr. Spratt.

Mr. SPRATT. Mr. Chairman, I thank you for calling the hearing and I really think that oversight is the second most important function of this committee, and I am glad to see us undertaking it particularly in this area.

I simply want to speak—to welcome one of my former constituents. When we invited him, I think he was my constituent, but he is now in your constituency, Mr. Chairman—Page Vaughan, who was with the Carolina Pines Hospital, a brand-new hospital in Hartsville, SC, and now is in Statesboro, GA. His parent firm is Health Management Associates. He comes here to bring a point of view that I think we need to hear.

We need to talk to HCFA about the administration of these programs but we also need to talk to those hospitals who are on the receiving end—and in this particular case, a hospital in small town to rural area setting—about the particular problems they face. So, Page, we are glad that you are here. We appreciate you coming.

Chairman CHAMBLISS. Thank you, Mr. Spratt. Does any other member wish to make a statement?

Mr. GUTKNECHT. I promise to be brief. I would agree that I think this is an area where we need more congressional oversight. I think every Member who spends any time in their district visiting with people in the health care delivery system recognizes that this system has become so clumsy and so burdensome that sometimes it seems as if the system consumes the participants. Using the good doctor's own numbers if they are correct, and I believe they are, we are spending approximately $5,000 per person on Medicare and Medicaid coverage. And if you talk to the providers, they are hard-pressed to see that they get that in kinds of benefits from the amount of money that we spend.

I hear from my nursing homes, I hear from my hospitals, I hear from providers of all kinds, home health care, that the paperwork and the nitpicking that goes on is just unbearable. And it seems to me that we must find a simpler system for the providers so that we continue to be able to take care of the people who need the help; but at the same time, we don't continue to reinforce what I believe is one of the unwritten rules of Washington, and that is that no good deed goes unpunished. The providers that are doing a good job should not continually be held up as criminals. While we want to stop waste, fraud, and abuse, I think that there has got to be some kind of a happy medium. So I appreciate this hearing and I look forward to the testimony.

Chairman CHAMBLISS. Thank you, sir. Mr. Lucas.

Mr. LUCAS. Mr. Chairman, I am looking forward to the hearing today to see what we might do to improve our system. I am very open and hopeful that today will be very constructive.

Chairman CHAMBLISS. Great. Just for the sake of scheduling, let me tell our members as well as our witnesses that we are going to have a series of votes beginning somewhere around 10:45. We are going to have a break at that point in time to go vote and come back and resume our hearing. I think we will have time to get through at least our opening statements. And we will ask your patience through this process as there are times when we have to go do what we get paid to do, which is to carry out the legislative business of the country.

I will tell our witnesses, also by way of schedule, that our next hearing is going to be in a couple of weeks and the witnesses at that hearing will be the folks from Medicare, from HCFA, from the payer side, who are going to come in and explain from their perspective how the system is working. And if there are things that this panel thinks that we particularly need to be on the lookout for, we need to have responsive questions or responsive answers on, it would be important to us to know that so that as we go into that next phase we are prepared for that.

We are now joined by the vice chairman of the Task Force, Dr. Fletcher. Other members have given their statements. If you have anything you want to say before we begin we will be glad to hear from you.

Mr. FLETCHER. Thank you, Mr. Chairman. I appreciate you holding these hearings. I think it is very important. You know, I met with a physician yesterday and we were discussing HCFA and some of the oversight, and one of the concerns was raised in that meeting of the fact that sometimes the way HCFA implements fraud and abuse and other regulations, certainly impairs I think sometimes a provider's ability to really provide the care and encumbers them with a great deal of bureaucracy. And sometimes I am not sure we are targeted as well on fraud and abuse.

So I think it is going to be an excellent opportunity to oversee the actions of HCFA and to make sure that we work to provide better health care for all of our constituents. Thank you, Mr. Chairman.

Chairman CHAMBLISS. Thank you, Dr. Fletcher. We will begin the testimony and, Dr. Robinson, we will go to you, go to Ms. Murray, then Mr. Vaughan.

STATEMENT OF JOE SAM ROBINSON, JR., M.D., PRESIDENT, THE NEUROLOGICAL INSTITUTE OF CENTRAL GEORGIA, MACON, GA

Dr. ROBINSON. Thank you, Mr. Chambliss. Good morning. My name is Joe Sam Robinson and I am a practicing neurosurgeon from the beautiful city of Macon, GA. And I would like to say I am honored to be here today to discuss some of these issues; more exactly, the impact that HCFA regulation has upon practicing physicians and, more importantly, upon their patients.

I think there are two general comments I would like to make before I get started. The first one is that I think practicing physicians basically respect HCFA and the task that it has been charged with

performing. It is a very complicated situation. We have an aging population. There is an increasing technology, evolving technology, that these patients need access to, and their budgetary restraints. So it is natural there is going to be some tension and conflict in this realm. So I can appreciate that.

The next issue I would like to just make reference to is the spirit of my remarks are going to be as much nonpartisan as I can make them. And I think one of the difficulties that happens, and I think physicians are upset about this, is they see issues involving health care being politicized and the differing parties attempting to gain some leverage for one reason or another. And I just think health care is too important to let this happen. So we shouldn't be in that domain.

I have five random comments I would like to make just from my point as sort of a ground zero of the health care delivery system. I don't have any special expertise in a lot of the bureaucratic issues involved here but I can make some remarks about how some of these regulations have impacted upon my patients and the health care delivery system.

My first comment is the HCFA regulations are excessively complicated, voluminous, and changeable. They are just absolutely amazing. I asked my office manager to bring in the documents we had received from HCFA in the past year or so, so I could look them over. And she came into my office, I was concerned she might get a little low back injury; might have a Workmen's Compensation problem on our hands because they were so heavy.

So rather than going through them, I had them weighed, and she reported back to me they weighed 35 pounds. So 35 pounds of regulations have come upon our small practice in Macon, GA, from HCFA in the course of a year. And as a practicing physician, I am responsible for making sure those regulations are effectuated. There are all kinds of nuances about patient care documentation, and what happens is it is just impossible for me to do that. It is just past my abilities. So I have to depend on people in my office to make sure these regulations are complied with and I am responsible for those, for the compliance with these incredible regulations.

So what that means is I am always nervous, and as far as I know all the other health care providers I know are nervous that they may not be in compliance with these regulations, and that is not a good situation.

Which brings me to my second point, which is the sense of intimidation and fear which HCFA has fostered among physicians. It is a very troubling situation. When I came to Washington, to the big city from our beautiful, bucolic town of Macon, GA, people warned me, my God, you are going up there? The black helicopter may come after you if you speak against HCFA. It is very dangerous what might happen. And this is a very, to me, upsetting situation. And I think there is—I have to say that regrettably this is part, in my opinion, of HCFA's policies.

I have got something that actually came off the HCFA Web site, it is dated March 17, 1998, and they are talking about fraud and abuse in there. And it is—one of their purposes is to encourage a fear of prosecution and punishment for unscrupulous providers. Well, I don't know any unscrupulous providers, but I do know plen-

ty of doctors that are nervous that their office staff has complied with these complicated regulations. And some of the things HCFA does or they suggest doing in this Web site are, number one, to publicize the punishments to achieve a sentinel effect. Need to create a fear of being detected. Random on-site aggressive reviews. Number three, well-focused random reviews and audits. And number four, unannounced auditor visits.

So this is sort of the spirit with which HCFA is approaching the 500,000 physicians in the country that ought to be their natural allies in administering this program. So it is not a good way to start things going.

The third comment I'd like to make is that there is a lot of evolving, changing technology out there, and it is particularly present in neurosurgery, and that it is important for the elder citizens of this country to have access to that technology. So it is particularly important that HCFA doesn't hinder their access. And I know of several examples when that basically happens. One of them involves EMG monitoring of cases where there is neurosurgical intervention around spinal nerve roots. This is an important safety precaution. It is good for patients, it is well recognized. And HCFA compensated this technology up until 1999. Then, when for what I can determine no good reason, they stopped compensation. Other third-party payers continue to compensate physicians for this technology. There is some expense in performing the test. It is a useful test. In our practice we have elected to continue giving all our patients this modality.

Basically, sort of the message that HCFA is sending out is that the compensation for our senior citizens is not going to be as great, and one could make the case their access to health care is not as great as other citizens. And I think that is not a good situation.

The fourth issue I'd like to talk about involves organ donation. And this is an example of one of the numerous regulations that are being propagated that have tremendous impacts on many parts of many, many issues. Organ donation is a big issue and there are many who need—full transplant recipients out there. They need these organs. And so as a neurosurgeon, I thought it my responsibility to have conversations with patients' families after a loved one has expired, and initiate some kind of interchange and say what many people might: Your father or your child is dead, there is an issue here about maybe letting someone else make use of his organs. It may be a kind, nice thing that your child or parents would want to have happen. And then if the family has said OK, then it has been our custom to have an organ transplant professional discuss this with the family.

It has worked out very well. Our hospital has been number one in the State of Georgia in organ donation. And I feel that that is good.

In 1999 HCFA propagated a regulation which demanded that a treating physician could not initiate this kind of conversation unless he went—he or she went to a 2-day course to learn the right way to do it. And, in general, what HCFA has done is essentially stopped that kind of communication, and I think that is awful. I think that is reprehensible. It is a violation of patient rights, free

speech, and everything else I can think of. And it is just not the kind of thing that should be going on in this country.

My fifth comment involves patients that are in our tertiary care center that have brain damage and they need to go to some kind of extended care facility. That is the best place for them. It is going to be better on their families and it also is the most—it is the best use of health care resources. The expenses won't be as great. They just don't need a tertiary care center.

What has happened is the compensation package that these extended care facilities receive is not adequate to allow them to accept the patient. So what happens is these patients—or if I could use this phrase, "shipwreck"—are in a tertiary care center for months at a time, very inappropriately. And this is not a good—this is bad. This is wasteful display of regulations. Then when the transfer is finally arranged, it is often at a great distance from the patient's family, sometimes even another State, which causes significant emotional distress and expensive commuting back and forth. This is something that Congress should check on.

Those are my five comments.

I now have three sort of general remarks. And this, the basic point I would like to make is that there should be better outcome analysis of the thousands of decisions that HCFA is making. It is a question of outcome analysis. When HCFA makes a decision, it shouldn't be a blind shot in the dark but its implications should be known and monitored.

The first of those is the impact on the patient's health. When HCFA denies an elderly patient very advanced technology, they need to be able to tell Congress what happens. If a dialysis patient can't get a nephrologist consult because of HCFA compensation policies and that is affecting that patient population, HCFA needs to be able to say, this is what happened to patients because of that.

The second general issue is that the financial impact of these decisions needs to be more broadly stated. It shouldn't be that HCFA merely saves the government $2, but it should be how much is this costing society? If $2 are saved and it costs $10 in compliance costs, patient inconveniences, how much is it costing for families to travel 250 miles, take time off from work to see their elderly relative in a distant nursing home? That is something that ought to be looked into, and HCFA needs to tell Congress what those numbers are.

The third thing that HCFA should tell Congress about or be able to answer to is the impact of their regulations on the health care professions, particularly among physicians. Physicians are growing increasingly timorous and intimidated by HCFA policies, and that is not in the best interest of the patients in this country. There needs to be a strong and independent medical profession that can stand up for their patient rights against any comer, including third-party payers of all types, the government, insurance companies. Whatever it takes to protect their patient's rights, physicians need to feel like they can do it independently and they should not be intimidated or terrorized by HCFA. Thank you.

Chairman CHAMBLISS. Thank you, Dr. Robinson.

[The prepared statement of Joe Sam Robinson follows:]

PREPARED STATEMENT OF JOE SAM ROBINSON, M.D., NEUROSURGEON FROM MACON, GA

My name is Joe Sam Robinson, and I am a practicing neurosurgeon from Macon, GA. I am pleased to have this opportunity to appear before the committee today to speak to you about the regulatory burdens that the Health Care Financing Administration (HCFA) places on physicians. From the perspective of a practicing physician, the task of HCFA seems immense. Its broad, overarching power makes it the dominant influence upon the American healthcare system. Its routine decisions and judgments touch the lives, either directly or indirectly, of nearly all Americans. Its work will not grow any easier, as budgetary restraints collide with an aging population whose health and well-being can often be preserved only by the judicious application of expensive and evolving medical technologies.

This aside, I find considerable room for improvement in the administration of HCFA. I do not wish to offer my comments in a partisan spirit, nor do I claim any special expertise in the intricacies of such a vastly complicated structure. But in the busy clinical setting in which I labor (the metaphorical "ground zero" of healthcare delivery), the actions of HCFA, despite its generally good intentions, often seem quite wrong.

Regrettably, I lack the ability to say what fully should be said, but I can offer a few random observations.

1. The sense of intimidation and fear of HCFA among physicians is widespread and troubling. Physicians of my acquaintance, though upset and concerned, recoil from any outright public criticism of HCFA. They fear that such testimony will evoke an audit by HCFA, or even worse, by the Internal Revenue Service. "Who knows," they ask, "what demons will be directed against you and your family as revenge for testimony in Washington?" I regret such fears are present, but in my opinion the agency has engendered these fears among well meaning healthcare providers in many locations all across the country.

2. HCFA regulations are so excessively complicated, voluminous, and changeable that full compliance even among the most motivated is difficult. My office, for instance, receives about 35 pounds by weight of HCFA regulations every year. I personally wish to attend to the medical needs of my patients, which is why I went to medical school. I am not a professional coder and would rather spend my time discussing neurosurgical treatment options with patients, not in coding seminars. I am forced to depend on my office personnel to respond to the extraordinary amount of government regulations that HCFA has engendered so I can continue to tend to may patients' needs. If, however, my office makes some kind of error in following these regulations, I am the one who bears the responsibility for the error. As no one can be sure such errors do not exist, every physician fears himself vulnerable to reprimand, and thus quakes at any HCFA fiat.

For example, a number of years ago when HCFA first instituted new rules for coding medical office visits—the so-called "Evaluation and Management Documentation Guidelines"—I found the rules quite confusing. Wishing to be in compliance with this regulations, our office elected to charge every patient the lowest possible level visit, thus saving the Federal Government a good deal of money. We imagined we would avoid an audit by this tactic, since we were undercharging the Medicare program. However, both advisors and fellow physicians warned us that such conduct was still actionable and would provoke an audit. We were therefore forced to increase our office charges to attempt to comply with HCFA's very complicated coding regulations. As an aside, you may be interested to know that HCFA has yet to finalize these regulations. In fact, HCFA is currently using two different versions of these draft rules, making it even more difficult for physicians to figure out what is required of them, while we remain subject to audits and sever penalties if we fail to follow these draft regulations. This is simply unfair.

3. HCFA often restrains the growth of appropriate new medical technology by refusing to compensate such procedures or compensating the technology at such a low level that effective application of such technology is difficult. For instance, there is significant evidence in the medical literature that electromyographic monitoring of neurosurgical procedures in which spinal nerves are decompressed promotes a good clinical outcome. It has been our custom for a number of years to routinely employ such technology in many operative cases. Initially, we were reimbursed by HCFA. In 1999, however, for no apparent reason, the compensation abruptly ceased. Believing it is in our patients' interest to use this technology, we have elected to bear the expense of such monitoring rather than deny it to our patients. We have been told that we can appeal HCFA's decision, but informally have received information that such appeals are almost never accepted and we should not count on a reinstatement of the charge.

Another example of such a restriction in our practice is our effort to develop a functional neurosurgical program in our area of Georgia. Such a program has the potential to help a good number of patients who suffer from movement and other disorders, by using deep brain stimulation devices. While HCFA does pay for these procedures, the compensation is at such a low level that we simply are unable to make use of this exciting new technology. Since most third party payers follow the HCFA coding and reimbursement procedures, all citizens in our part of the state have basically been denied access to this technology.

4. Organ donation regulations do not promote discussions with patients about organ donation options. As a neurosurgeon, it is has often been my responsibility to inform family members when the earthly life of a loved one has ceased. In the past, in the course of such a discussion I have mentioned the usefulness of organ donation. This is a responsibility that I take quite seriously. Indeed, I have published an article in the Georgia State Medical Journal on this very subject. Following a general discussion about the good things that organ donation can accomplish, I used to refer the affected family to a representative of an organ retrieval service where detailed questions could be answered in a kind and gentle way. The families of many of my patients generally agreed to organ donation based on this local system, which I believe functioned in a kind, beneficial and humane fashion. In 1999, however, new HCFA regulations forbade any physician who had not been through a 2-day HCFA approved course on the subject of organ donation to broach this issue with the patient's family. Such a regulation effectively curtails useful involvement of the deceased patient's treating physician and severs the role of someone who is often a trusted friend, from this important decision. In my opinion, this new HCFA regulation represents a wrongful intrusion in the doctor/patient relationship, and displays a cavalier restriction upon the rights of free American citizens. With such a scarcity of organs and long organ transplant recipient waiting lists, HCFA should be doing everything in its power to encourage, not discourage such discussions.

5. HCFA's long-term care facility compensation policies have on occasion increased healthcare costs and have initiated significant family distress. A good example is the placement of brain injury patients in appropriate long-term care facilities. As compensation is quite inadequate, long-term care facilities are often reluctant to accept patients, forcing them to remain in far more expensive tertiary care facilities for often months at a time. When discharge occurs, it is often to a location at great distance from the patient's family. This happened to me recently, when one of my patients was discharged to a facility in another state, over 250 miles from his family.

In many ways, our vast half-public, half-private healthcare system is the best in the world. Unfortunately, however, over the years HCFA has come to dominate this healthcare system. While attempting to maximize efficiency, improve outcomes, equalize treatment costs, and diminish expenses, its actions have regrettably often had contrary, unintended effects. I would therefore suggest an increased oversight and analysis of HCFA policies, rules and regulations. Those policies, which adversely impact the physician/patient relationship and patient health, should, in particular, be rigorously assessed. Additionally, the total expense of such regulations, including total compliance expenses should be more closely monitored.

Finally, there is another more general issue on this topic that should be closely monitored by Congress: the effect HCFA policies have on diminishing the independence of the medical profession. Such independence is part of a broader system of checks and balances, which ensures the use of governmental power is judicious and restrained. Retention of this independence is in the high national interest.

Once again, Mr. Chambliss, and other members of the Committee, thank you for the chance to meet with you today on this important issue. My fellow physicians and I want only to do our very best to take care of our patients. The time is right for Congress to seriously reevaluate the HCFA rules, regulations and policies that interfere with this basic goal.

I would be pleased to answer any questions that you may have.

Chairman CHAMBLISS. Ms. Murray.

STATEMENT OF KATHLEEN G. MURRAY, EXECUTIVE VICE PRESIDENT AND CHIEF OPERATING OFFICER, NORTHWESTERN MEMORIAL HOSPITAL, CHICAGO, ILLINOIS; ON BEHALF OF THE AMERICAN HOSPITAL ASSOCIATION

Ms. MURRAY. Mr. Chairman I am Kathleen Murray, the executive vice president and chief operating officer of Northwestern Memorial Hospital in Chicago. I am here today on behalf of the Amer-

ican Hospital Association's nearly 5,000 hospital, health system, and other health care provider members. We are pleased to have the opportunity to testify on the complexity and burden of Medicare's regulations on providers.

Because hospitals and health systems are entrusted with the lives and health of people, we are among the most regulated fields in America. For example, the Mayo Clinic in Rochester, Minnesota determined that hospitals are subject to 132,720 pages of Medicare rules. A breakdown of those rules, or the largest numbers of those rules, is on Chart A in front of us. This just represents some of the largest categories of the 132,000 pages.

Every day, hospitals and health systems submit about 200,000 Medicare claims. That is roughly 72 million per year. In 1997, close to 12 million Medicare beneficiaries received acute care services. For hospitals to be reimbursed for the care we provide to our Nation's seniors, we must follow the maze you see here in Chart B. I know you have a copy of this and can't see it there, but at the very top, on the right-hand side, it says that we must spend 20 minutes asking questions of patients about their secondary coverage. A new requirement is that we have to get this information every single time a patient presents.

So if you are a cancer patient and you are coming for radiation therapy three times a week, three times a week we have to ask you all of these questions and take 20 minutes of your time to refill out the Medicare secondary payer questionnaire. Complying with this Medicare billing maze is no small task. At Northwestern Memorial, the billing department alone spends more than 3,200 hours per month, or 38,400 hours per year, sorting through Medicare billing requirements.

In addition to Medicare, hospitals and health systems face laws, regulations, and instructions from Medicaid, the Occupational Safety and Health Administration, the Environmental Protection Agency, the Centers for Disease Control, the Internal Revenue Service, and numerous other regulatory agencies. Chart C demonstrates the massive web of regulators to whom hospitals must answer. As you can see, there are at least 29 other organizations issuing some type of rules, regulations, or instructions to hospitals. Hospitals' regulatory burdens are getting heavier and heavier.

Through the Balanced Budget Act of 1997, Congress sought to simplify outpatient reimbursement by requiring HCFA to implement a prospective payment system. The new system, slated to take effect this July 1, is more complex than the inpatient PPS system implemented in the early eighties, yet it will be shoehorned into place over the next few months. For us it means reviewing over 10,000 new charge codes without any vendor available to provide billing software to assist us in the over 525,000 outpatient tests we bill for every month.

Recently the AHA sent a letter to HCFA expressing our concern over inaccurate and misleading HCFA training material and a lack of detailed information that hospitals need to properly comply with their directives. It seems that every regulation HCFA issued was followed by correction notice after correction notice. This complicates and hinders our ability to implement the changes in a timely fashion and is impeding the start-up of outpatient PPS. The

outpatient PPS introduced many new complicated coding requirements that add to those already in existence.

Worse still, hospitals must continue to operate and maintain two separate coding systems; this, despite the recommendation of the National Committee on Vital Health Statistics which recommended HCFA use only one coding system.

But in order to be reimbursed, hospitals are now required to collect the old inpatient ICD9 coded diagnoses for a growing portion of our outpatient services including lab tests. The vast majority of physicians do not provide ICD9 codes, the diagnosis information when ordering tests, for the simple reason that the test itself is needed to make the diagnosis. A classic Catch-22.

The effort and costs associated with outpatient PPS is extraordinary and wrong. Hospitals are forced to choose between providing the care for the patient or delaying the test until the proper code is received. Our choice has been to provide the test and risk no reimbursement. In fact we are currently holding $3 million in Medicare laboratory billing for this reason, a sum that could destroy a smaller hospital.

On the heels of the new outpatient PPS implementation, hospitals face the overwhelming task of implementing the upcoming privacy security and administration simplification provisions of the Health Insurance Portability and Accountability Act of 1996, or HIPAA. Some experts estimate HIPAA implementation will cost $43 billion over 5 years, much of which will be borne by providers.

Yet another Federal regulation in the pipeline is OSHA's proposed ergonomics rule. We believe that OSHA's estimate of the cost of this for hospitals is grossly underestimated. In addition, there are patient care implications. Complying with this growing mountain of rules and regulations comes at a high administrative price tag.

At Northwestern Memorial we have committed a great deal of time and resources to ensure that we follow State and Federal regulations. Our culture is to do the right thing. We have a corporate compliance officer who is also an experienced health care attorney. The hospital's corporate compliance committee, which I chair, includes nine other senior officers who meet monthly to discuss regulatory changes and compliance initiatives. We have an internal audit department with a staff of six and a number of outside resources who regularly and actively focus an increasing amount of time on Medicare-related compliance issues.

The rules are the same for smaller hospitals. How can they afford this? Besides the known expense of time and resources, burdensome regulations include hidden costs, a prime example being the toll they take on employee morale. Our employees came to Northwestern to take care of patients. The current regulatory environment buries good dedicated employees in bureaucratic paperwork. In today's tight job market, we face employee exodus to jobs that involve less red tape and hold the potential for greater job satisfaction.The necessity to constantly train and educate new staff in the intricacies of these burdensome regulations is another hidden cost that hospitals must bear.

In conclusion, hospitals' first priority is to provide high-quality care to our patients. Only a small percentage of these voluminous

regulations contribute to our efforts to provide quality patient care. The rest simply drain resources away from that goal. These burdensome regulatory rules also place a financial strain on providers who are already reeling from the drastic provider cuts in the 1997 Balanced Budget Act.

Mr. Chairman, we all agree the health care industry should be regulated. There is a valid reason why HCFA, the Joint Commission, IRS, and OSHA should monitor hospitals' activities. However, the strain of 29 or more organizations issuing rules, instructions, and laws is hurting the health of our Nation's hospitals. There is no coordination among agencies that regulate providers. Rules appear to be issued in a vacuum with no regard to the fiscal or practical consequences of compliance.

Most of the examples I have given today come from Northwestern Memorial's experience. I speak, though, for hospitals across the country, as these examples apply to all hospitals whether large or small.

The AHA is ready and willing to continue our work with HCFA and other agencies to improve the way rules and regulations are promulgated and implemented. We know that the size and complexity of the Medicare program is a challenge. We pledge to do all we can to help make the regulatory system work better, not just for hospitals and health systems but also for the patients and communities we serve.

Thank you very much for this opportunity.

Chairman CHAMBLISS. Thank you very much Ms. Murray.

[The prepared statement of Kathleen G. Murray follows:]

PREPARED STATEMENT OF KATHLEEN MURRAY, MEMBER, AMERICAN HOSPITAL ASSOCIATION

Mr. Chairman, I am Kathleen Murray, executive vice president and chief operating officer of Northwestern Memorial Hospital in Chicago. I am here today on behalf of the American Hospital Association's (AHA) nearly 5,000 hospital, health system, network, and other health care provider members. We are pleased to have the opportunity to testify on the complexity and burden of Medicare's regulations on providers.

Though our history dates back to the days of the Civil War, the Northwestern Memorial of today was created in 1972 when two Chicago hospitals, Wesley Memorial and Passavant Hospital consolidated their services. It is the primary teaching hospital for the Northwestern University Medical School and enjoys a substantial national reputation. The hospital is staffed by more than 4,000 caregivers, including 1,000 physicians in 30 medical and surgical specialties, all dedicated to the organization's mission of putting "Patients First." Last year, Northwestern Memorial provided care for more than 260,000 outpatients and admitted close to 40,000 patients. The hospital has a diverse patient population in its urban locale, serving patients with many ethnic and socioeconomic backgrounds.

MAZE OF REGULATIONS

Because hospitals and health systems are entrusted with the lives and health of people, we are among the most regulated fields in America. For example, the Mayo Clinic in Rochester, Minnesota determined that hospitals are subject to 132,720 pages of Medicare rules. A break down of that overwhelming statistic is provided for you in Chart A.

CHART A.—REGULATION OVERLOAD

132,720 Pages of Medicare Rules

	No. of pages
Medicare Laws and Related Laws	706

CHART A.—REGULATION OVERLOAD—Continued

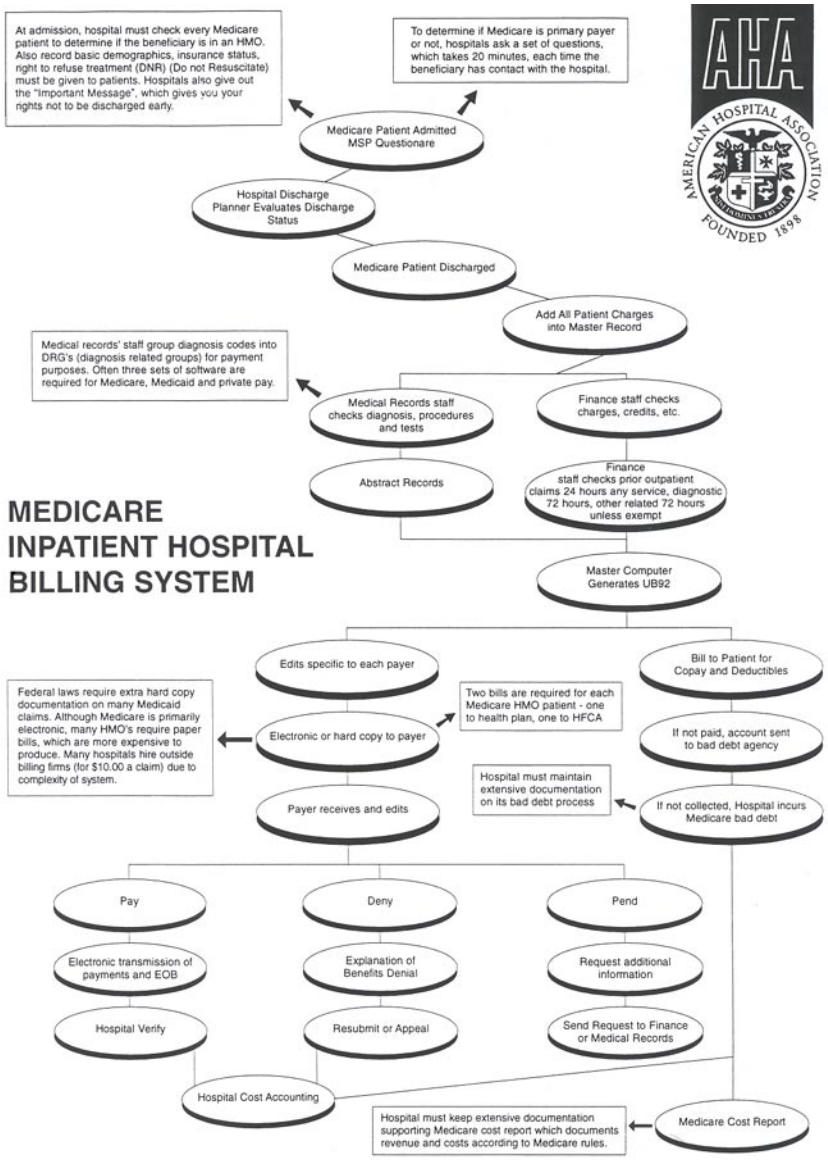
132,720 Pages of Medicare Rules

	No. of pages
Medicare Regulations (42C.F.R.)	3,574
Fraud and Abuse Regulation	14,500
HCFA Registers ('94–'98)	30,000
Carrier Newsletters	4,320
Intermediary Communicators	2,880
HCFA Administrator Decisions	2,000

Source: Mayo Clinic.

Every day hospitals and health systems submit about 200,000 Medicare claims—that's roughly 72 million per year. In 1997, close to12 million Medicare beneficiaries received acute care services. For hospitals to be reimbursed for the care we provide to our nation's seniors, we must follow the maze known as "Medicare Inpatient Hospital Billing System." If you look at Chart B, you will begin to understand the morass of regulations hospitals face.

CHART B



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

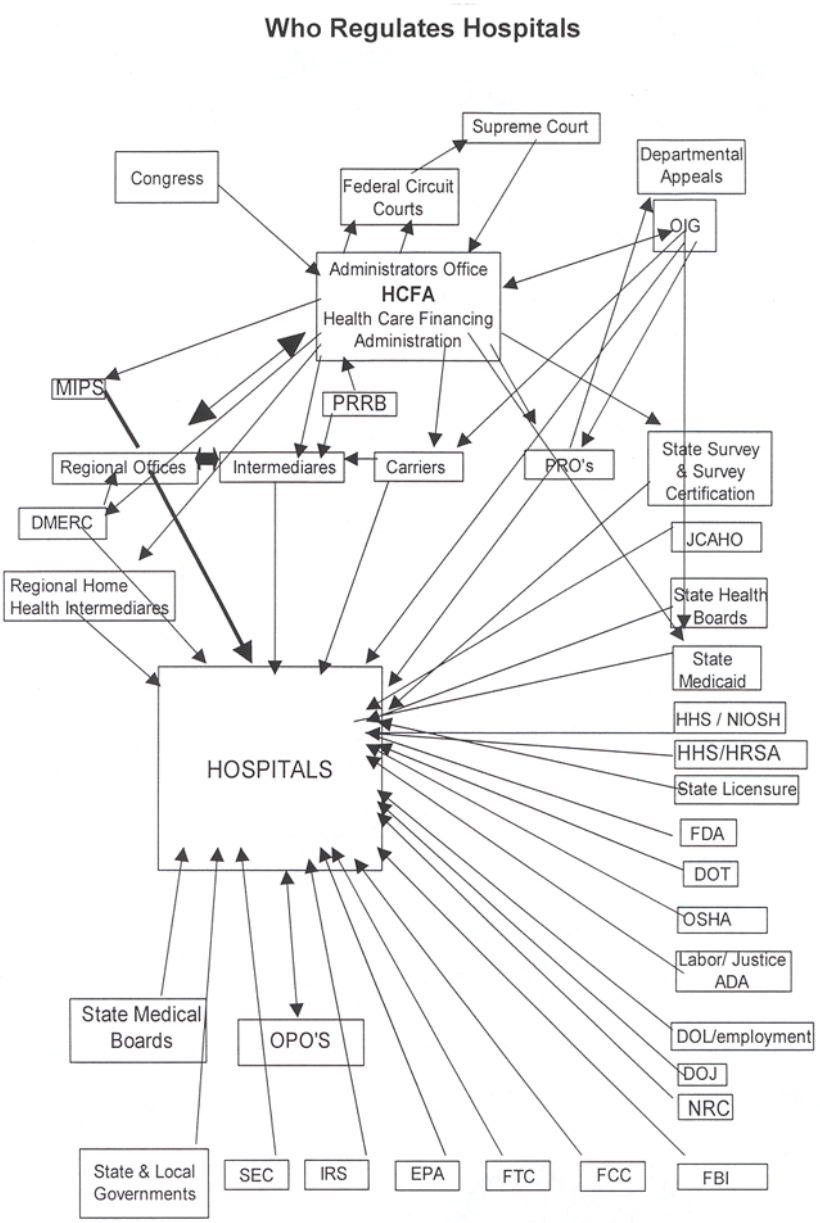
This volume of staff time is necessary because hospitals, health systems and other health care providers must comply with instructions from 43 different Medicare Part A fiscal intermediaries, and 28 Medicare Part B fiscal intermediaries. These

are private insurance companies that contract with the Health Care Financing Administration (HCFA) to process Medicare claims.

HCFA has delegated the responsibility of determining medical necessity to these local fiscal intermediaries. The vehicle for this determination is a publication called the local medical review policy (LMRP). An LMRP may be issued for diagnostic services, surgical procedures, lab tests, etc. Northwestern Memorial's fiscal intermediary, Administar, currently has 60 LMRPs, of which 35 are either new or significantly revised and reissued since January 1, 2000. Administar and Wisconsin Physician Service, the Part B fiscal intermediary, have only one LMRP in common. This indicates that physician practices, which have office-based diagnostic services, may not be subject to the same medical necessity standards as hospitals rendering the same service for the same reason. This has ramifications for patient care consistency and quality.

In addition to Medicare, hospitals and health systems face laws, regulations and instructions from Medicaid, the Occupational Safety and Health Administration (OSHA), the Environmental Protection Agency, the Centers for Disease Control, the Internal Revenue Service (IRS), and other regulatory agencies. Chart C clearly demonstrates the massive web of regulators to whom hospitals must answer. There are at least 29 organizations issuing some type of rules, regulations or instructions to hospitals. Depending on the type of facility and its location, there could be more than 29.

CHART C



To make matters more troublesome, many of our regulators issue conflicting and confusing rules. For example, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) recently issued revised standards for the use of physical restraints and patient seclusion that differ from government requirements. JCAHO requires that an in-person evaluation by a health care provider be done within 4 hours of the beginning of restraint and seclusion. HCFA, on the other hand, requires that a face-to-face evaluation must occur within 1 hour.

REGULATORY BURDEN INCREASES

Hospitals' regulatory burdens are getting heavier and heavier. Using a patchwork of 13 different payment formulas, Medicare outpatient reimbursement is complicated and administratively costly for hospitals and the Medicare program. Through the Balanced Budget Act of 1997, Congress sought to simplify outpatient reimbursement by requiring HCFA to implement a prospective payment system (PPS).

The AHA supports an outpatient prospective payment system that is simple, predictable and fair. Unfortunately, between the enactment of the law and the drafting of the regulatory language, the new system is anything but. The new system, slated to take effect July 1, is more complex than the inpatient PPS implemented in the early 1980's, yet it will be shoehorned into place over the next few months. Ten thousand existing charge codes are being reviewed for appropriateness while upwards of 1,000 new codes may need to be opened. Additional documentation and coding will be required. Coinsurance and deductible determinations will be multivariable calculations that will inevitably lead to errors for hospitals and confusion for patients. Detailed billing requirements and error reporting procedures that are not fully tested will be implemented simultaneously. Software support from vendors has not been finalized and the system will have little or no lead-time before going live.

Recently, the AHA sent a letter to HCFA expressing our concern over inaccurate and misleading HCFA training material, and a lack of detailed information that hospitals need to properly comply with their directives. It seems that every regulation HCFA issues is followed by correction notice after correction notice. This complicates and hinders our ability to implement changes in a timely fashion and is impeding the start up of the outpatient PPS.

The outpatient PPS introduced many new complicated coding requirements that augment those already in existence. Worse still, hospitals must operate and maintain two separate coding systems—this despite the recommendation of the National Committee on Vital Health Statistics, which recommended HCFA use only one coding system. In order to be reimbursed, hospitals are required to collect ICD9 coded diagnoses for a growing portion of our outpatient services, including tests. The vast majority of physicians do not provide ICD9 coded diagnosis information when ordering tests for the simple reason that the test itself is needed to make the diagnosis. Hospitals must spend inordinate amounts of time and money tracking down physicians for the appropriate ICD9 codes, or not be paid at all, as Medicare often rejects the general ICD9 code. Northwestern Memorial is holding $3 million in Medicare laboratory billing for this reason, a sum that could destroy a smaller institution.

The effort and costs associated with outpatient PPS is extraordinary—and wrong. It forces hospitals to make decisions that could negatively impact patient care. Our only options are to absorb the costs of the tests without any possibility of reimbursement or to bear the costs of resubmitting the bills multiple times with no guarantee of payment.

The prospective payment system has implications for home health agencies, too, a branch of providers already at serious financial risk. The increase in required paperwork under PPS necessitated that Northwestern Memorial's home health agency hire an additional fulltime employee. These same reporting requirements reduce field nurse productivity and increase costs by $3.03 per visit. HCFA responded by increasing reimbursement by a mere twelve cents per visit.

On the heels of the new outpatient PPS implementation, hospitals will face the monstrous task of implementing the upcoming privacy, security and administrative simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Without significant alterations, implementation of this regulation could be extremely costly in terms of both dollars and increased liability. The Health and Human Services Secretary estimated that the regulation would cost $3.8 billion over 5 years, with the bulk of the costs being borne by providers. However, that estimate includes the costs of only a few of the provisions. An earlier study based on similar policies estimated costs at $43 billion over 5 years. The AHA has not done a formal cost estimate, but we believe the costs will be significant.

Yet another Federal regulation in the pipeline is OSHA's proposed ergonomics rule. Excluding the expense of retrofitting hospitals to eliminate and minimize patient lifting, OSHA's proposal is administratively pricey. Hospitals would need at least one new management position at each hospital. They would have to create a monitoring system and launch a massive employee education campaign. The AHA estimates that OSHA's ergonomics standard would cost hospitals and health system millions of dollars to implement—all with no sound scientific evidence that employee safety would increase or that injuries would drop.

COMPLIANCE COSTS ARE HIGH

Complying with this growing mountain of rules and regulations comes with a high administrative price tag. In HCFA's most recent comparison of wages, medical records and administrative cost centers showed the largest increases between 1996 and 1997, the period for which the most recent data is available.

At Northwestern Memorial, we take corporate compliance seriously. We have committed a great deal of time and resources to ensure that we follow state and Federal regulations. We have a corporate compliance department headed by a corporate compliance officer, who is also an experienced health care attorney. The hospital's corporate compliance committee, which I chair, includes nine other senior officers who meet monthly to discuss regulatory changes and compliance initiatives. We have an internal audit department with a staff of six, who regularly and actively focus an increasing amount of their time on Medicare-related compliance issues. Northwestern employs several outside consultants to help us prepare for review by HCFA and other agencies. In addition, we have numerous internal cross-functional task forces dedicated to ensuring compliance with regulations covering the Emergency Medical Treatment and Active Labor Act (EMTALA), coding, laboratory tests, patient observation and employee education, among others.

Besides the known expense of time and resources, burdensome regulations incur hidden costs—a prime example being the toll they take on employee morale. People choose to work at hospitals because they want to help others. The current regulatory environment buries good, dedicated employees in bureaucratic paperwork. In today's tight job market, we face employee exodus to jobs that involve less red tape and hold the potential for greater job satisfaction. The necessity to constantly train and educate new staff in the intricacies of these burdensome regulations is another hidden cost that hospitals must bear.

CONCLUSION

Hospitals' first priority is to provide high quality care to our patients. Only a small percentage of these voluminous regulations contribute to our efforts to provide quality patient care. The rest simply drain resources away from that goal. These burdensome regulatory rules place a financial strain on providers, who are already reeling from the drastic provider cuts included in the 1997 Balanced Budget Act. And as I said earlier, in addition to Medicare we face laws, regulations and instructions from some 29 other regulatory agencies.

Mr. Chairman, we all agree the health care industry should be regulated. There are valid reasons why HCFA, JCAHO, the IRS and OSHA should monitor hospitals' activities. However, the strain of 29 or more organizations issuing thousands and thousands of pages of rules, instructions and laws is hurting the health of our nation's hospitals. There is no coordination among agencies that regulate providers. Rules appear to be issued in a vacuum with no regard to the fiscal consequences of compliance.

Though most of the examples I have given today come from Northwestern Memorial's experience, I speak for hospitals across the country as these examples apply to hospitals whether large or small. The AHA is ready and willing to continue our work with HCFA and other agencies to improve the way rules and regulations are promulgated and implemented. We know that the size and complexity of the Medicare program is a challenge. We pledge to do all we can to help make the regulatory system work better not just for hospitals and health systems, but also for the patients and communities we serve.

I thank the Committee again for the opportunity to describe the difficulties hospitals are facing. I welcome any questions you may have.

Chairman CHAMBLISS. Before we go to Mr. Vaughan, just so we will know as a matter of comparison, Northwestern Hospital, what is the number of beds at that facility?

Ms. MURRAY. We have 700 beds.

Chairman CHAMBLISS. Mr. Vaughan, if you will tell us how many have you as you begin your statement and we will turn it over to you.

STATEMENT OF PAGE VAUGHAN, EXECUTIVE DIRECTOR, EAST GEORGIA REGIONAL MEDICAL CENTER

Mr. VAUGHAN. Good morning Mr. Chairman and members of the House Budget Committee. I appreciate the opportunity to highlight the challenging regulatory environment hospitals are facing in these tough times. My name is Page Vaughan. For the last 5 years I have served as the executive director of Carolina Pines Regional Medical Center, a 116-bed facility. I have recently been appointed as the executive director of the East Georgia Regional Medical Center in Statesboro, GA, which is a 150-bed facility.

The negative budgetary consequences of the Balanced Budget Act, together with the industry's increased regulatory burden, have eroded the financial underpinnings of the Nation's Medicare program. Combined with the current enforcement environment, hospital CEO's fear that they are being treated as guilty until proven innocent. A specific recent regulatory change illustrates hospitals' frustration with the outpatient perspective payment system. HCFA has indicated for a year that these new changes would be effective in July 2000. The guidelines were only published several weeks ago. Clearly we understand HCFA's need to meet a deadline given. However, we are very concerned that hospitals and the Medicare contractors that actually make these payments to us will have insufficient time to implement this complex change.

The industry is working diligently with HCFA in an accelerated implementation time frame. We are very concerned that this effort will not be successful. While it is important that providers be held accountable, the constant reinterpretation of existing regulations that have been mirrored by my colleagues make it virtually impossible to always be accurate.

As a hospital CEO, I have significant staff hours, not only myself but many of my staff people, including clinical directors, invested in trying to keep up with the increasing and complex HCFA interpretations. Caregivers should focus on patients and not, again, on paperwork. And I think in a rural facility such as mine, we have less economy of scale of people and staffers to take care of these things. Quite often it does fall onto the shoulders of clinical people.

Despite the hard work of Congressman Spratt and others, the Balanced Budget Act of 1997 significantly reduced the amount of Medicaid patients' payments to disproportionate share of hospitals. For Carolina Pines, this reduction totaled approximately $1.1 million last year. This cut plus the BBA-imposed reduction in our Medicare bad debt has severely hurt our efforts to reach out to the community to meet the very complex needs of the area's indigent.

The focus in Congress should be on how to reform the Medicare program and away from persistent cutting of provider reimbursements. Bottom line, we lose money on a lot of Medicare services to Medicare patients, and no other health care provider can be expected to continue to perform quality services, again with negative reimbursement.

This country is faced with an increasingly older population with more complex needs as the years go by. We are serving these individuals with a beleaguered delivery system. The regulatory and financial burden that I must operate under as a hospital administrator is driving too many of my resources away, again, from pa-

tient care and toward paperwork and, again, the other activities involved in regulation. This, again, is not good for my patients or these people who, again, are your constituents.

I appreciate the opportunity to testify and your interest in enhancing the quality, again, of our Nation's health care system, which personally I believe, as most people in this room, is the best in the world. I welcome any questions that you may have at the appropriate time.

Chairman CHAMBLISS. Thank you very much Mr. Vaughan.

[The prepared statement of Page H. Vaughan follows:]

PREPARED STATEMENT OF PAGE H. VAUGHAN, EXECUTIVE DIRECTOR, CAROLINA PINES REGIONAL MEDICAL CENTER

Good morning, Mr. Chairman and members of the House Budget Committee, I appreciate the opportunity to highlight the challenging regulatory environment hospitals are facing in these tough financial times.

My name is Page H. Vaughan, for the last several years, I have served as the Executive Director of Carolina Pines Regional Medical Center a 116 bed facility that provided more than 45,000 outpatient visits and had more than 6,000 inpatient admissions last year. Our patient mix at Carolina Pines is approximately 40 percent Medicare, 20 percent Medicaid, 30 percent private pay or "commercial;" the remaining 10 percent are indigent care patients for whom we receive no compensation (obviously a significant fiscal issue). I have just been appointed to be Executive Director of the East Georgia Regional Medical Center in Statesboro, GA.

The community we serve at Carolina Pines Hartsville—is largely rural with some manufacturing. We have industries as diverse as the world headquarters of Sunoco, to a "Sting Ray" sports boat manufacturing facility, to South Carolina's traditional textile industry, and the highly regarded Coker College. In short, we are "middle America."

From the pending implementation of the prospective payment system for outpatient services, to the ongoing and unintended negative impact of the Balanced Budget Act of 1997, one thing is very clear to those of us delivering health care on the front line: policies and regulations appear more often than not to be coming out of Washington, DC, without serious concern for hospitals' ability to implement these changes in the time frame necessary, and seemingly without regard to how the changes may affect the quality of patient care. Washington appears to be focused only on the budgetary bottomline. The current crop of policies and regulations has shown us this in spades!

This is not to suggest that some regulations haven't succeeded in clamping down on some "waste, fraud and abuse" in the Medicare program. No one, least of all providers and beneficiaries, want to see any fraud take place. However, the unfolding negative budgetary consequences of the Balanced Budget Act, together with the industry's increased regulatory burden, have eroded the financial underpinnings of the nation's Medicare program. Combined with the current enforcement environment, hospital CEO's fear that they are being treated as "guilty until proven innocent."

Let me highlight two specific recent regulatory changes that illustrate hospitals' frustration.

The first involves the Hospital Outpatient Prospective Payment System (HOPD PPS), and the encouraged use of Advanced Beneficiary Notification (ABN) by the intermediaries. The Ambulatory Patient Groupings (APC's) are a new and unique way to reimburse hospitals for outpatient services on a prospective basis replacing the old cost-based system (A $17 billion per year system that accounts for 10–15 percent of an average hospitals' revenue). HCFA has indicated for a year that these new changes were coming and that they would be effective in July, 2000. Unfortunately, the guidelines were only published a couple of weeks ago. Clearly, we understand HCFA's need to meet a deadline. However, we are very concerned that hospitals and the Medicare contractors, that actually make payments, will not have sufficient time to implement this complex major change in the way we conduct business.

HCFA is going forward with critical implementing changes even when the Medicare fiscal intermediaries have raised concerns that they may not have their systems in place and tested given the extremely short implementation time frame. Hospitals run the risk of submitting incorrect bills due to lack of instructions and implementation time for training and systems changes. One of our concerns is that these bills, submitted in a good faith, but never the less possibly in error, could retro-

actively be classified as fraudulent by the enforcement community. The industry is working diligently with HCFA on an accelerated implementation time frame. And, HCFA to their credit are working very hard to try to make the best of a difficult situation. We are very concerned that this effort will not be successful. I would hope that Members of this Task Force will focus their attention on helping HCFA to ensure that an infrastructure is in place.

A second major change involves the encouraged use by the HCFA—through its fiscal intermediaries—of Advanced Beneficiary Notifications, as a process to inform the patient of those services provided to Medicare beneficiaries that HCFA has determined to be "Not Medically Necessary or Screening," and as such not covered under Medicare.

First, HCFA and our local fiscal intermediary will argue that nothing has changed, and in fact, the regulations haven't even been rewritten. HCFA, however, through the fiscal intermediaries (in our case, Mutual of Omaha) continually issues interpretations, advisories, alerts and local medical review policies (LMRP) that guide hospitals. And even if the regulations do not change, it is this guidance that has completely confused us and has caused hospitals to focus on a more extensive use of the ABN. It would not be an overstatement to suggest that it would take a detective to find clearly written policy from HCFA concerning ABN's, their use and recent changes. The paragraph below comes directly from existing HCFA policies.

> Providers are responsible for knowing the rules and regulations that apply to all services they are billing to the Medicare program. According to the Medicare Intermediary Manual, Section 3432.2, "Hold the provider liable for non-coverage of services if it is determined that the provider: (1) had actual knowledge of the non-coverage of services in a particular case, or (2) could reasonably have been expected to have such knowledge." In general, provider should have known a policy or rule if the policy or rule is in the Federal Regulation, Medicare Manual governing the provider type, or is made through publication from the Intermediary which includes, but are not limited to, the Part A news and mailings sent periodically to all or individual providers * * *

This statement is being used to hold providers accountable for all regulations and the reasonable interpretation of regulations contained in these more informal advisories before a hospital ever submits a bill. While it is important that providers be held accountable, the constant reinterpretation of existing regulations makes it virtually impossible to always be accurate. As a hospital CEO, I have significant staff hours invested in trying to keep up with all these HCFA interpretations. In fact, hospital staff spends increasing amounts of time dealing with this growing paperwork burden, shifting resources away from the patient care that should be our focus. Caregivers should focus on patients not paper.

As the Executive Director of Carolina Pines, two other Federal issues have had a severe negative impact on the Hartsville community.

First, the Balanced Budget Act of 1997 significantly reduced the amount of Medicaid payments to disproportionate share hospitals (DSH), and for Carolina Pines, this reduction totaled more than $1 million dollars last year—with a significant impact to our bottom line. This cut, plus the BBA imposed reduction in Medicare Bad Debt, has severely hurt our efforts to reach out into the community to meet the health care needs of the area's indigent population. And, I mentioned earlier about 10 percent of our care is indigent or unreimbursed.

Second, in the Medicare program, hospitals, nursing homes and home health agencies are all being paid on a per service basis and not a per cost of delivery. However our suppliers still require us to pay them on a cost basis, leaving us in a very precarious position.

To illustrate, Medicare pays Carolina Pines, like other hospitals, approximately $7,000 for a hip replacement. However, the joint implant costs between $3,000 and $4,000. The average number of hospital days for a normal recovery for this procedure is 3 days. So, you can see how little of the total $7,000 can be used to pay the 4-5 person surgical team that performs the procedure, to pay for the drugs and other materials used during the procedure, to pay for the associated rehabilitation of the patient, and to pay the nursing costs spent during the patient's recovery. Bottom line, we lose money on almost all Medicare patients, and no health care provider can be expected to continue to perform quality patient care with negative reimbursement.

There are several other areas where we have serious concerns about complicated regulatory requirements including: medical records privacy, filing of cost reports, provider enrollment and changes to the Medicare "Conditions of Participation." The Federation of American Health Systems or I would be happy to follow-up with you

and your staffs on the regulatory issues associated with our compliance with these Federal standards.

Health care is changing dramatically and we are living under ever changing complex regulations. This environment makes it very difficult for hospitals to function. I know we provide the best health care in the world. But hospitals lack of appropriate reimbursement has made them short on capital to invest in technology, and on staff to meet the needs of both today and tomorrow's Medicare beneficiaries. The primary reasons for this are the 1997 BBA and the aggressive regulatory intervention of the Federal Government, both in reimbursement and compliance.

The focus in Congress should be on how to reform the overall Medicare Program to bring it into the 21st Century, and away from persistent cutting of provider reimbursement for budget reasons unrelated to health policy. This country is faced with an increasingly older population that is being served by an unstable health care delivery system. Believe me, as a hospital CEO, my first responsibility is to my patients, they depend on me. The regulatory and financial burden that I must operate under is driving too many of my resources away from patient care and toward paperwork. That is not good for my patients or your constituents.

I appreciate the opportunity to testify and your interest in enhancing the quality of our nation's health care system.

Chairman CHAMBLISS. Let me just say that in going over the schedule again with staff here, I didn't realize that somebody has this room at 12 o'clock. And we have got a series of one 15-minute vote and five 5-minute votes. So we are probably looking at almost an hour before we are going to be back. So I want to take a minute to get into a couple of questions, but then come back and give those that have questions an opportunity within the limited time to try to do so. But also, as I will remind you at the end, anybody who has written questions you would like to submit to any witness, I would hope our witnesses would be willing to respond to those in writing and they will obviously go into the record. I think there will be a lot of that.

Also we have got a number of both solicited and unsolicited written testimony coming in for today's hearing and I would like to ask unanimous consent to ensure that members have up to 7 additional days from the date of this hearing to put into the record any other testimony that you wish to put in. Is there any objection? If not, so agreed to.

[The information referred to follows:]

PREPARED STATEMENT OF THE AMERICAN ASSOCIATION FOR HOMECARE

The American Association for Homecare (AAHomecare) appreciates the opportunity to submit this statement for the record of the Health Care Task Force of the Budget Committee. AAHomecare is a new national association resulting from the merger of the Home Care Section of the Health Industry Distributors Association, the Home Health Services and Staffing Association and the National Association for Medical Equipment Services. AAHomecare is the only association representing homecare providers of all types: home health agencies and home medical equipment providers, be they not-for-profit, proprietary, facility-based, freestanding or governmentally owned. As providers of all end-user home health care services, AAHomecare members are able to provide unique "ground level" insights into the impact of Medicare's regulatory burdens.

HOME HEALTH AGENCIES

Home health agencies (HHAs) provide skilled nursing care, therapy and home health aide services to individuals recovering from acute illnesses and living with chronic health care conditions. Health care services in the home setting provide a continuum of care for individuals who no longer require hospital or nursing home care, or seek to avoid hospital or nursing home admission. The range of homecare services includes skilled nursing; respiratory, occupational, speech, and physical therapy; intravenous drug therapy; enteral feedings; hospice care; assistance in the activities of daily living; skilled assessments; and educational services.

AAHomecare sincerely appreciates the efforts of this Committee and the Health Care Task Force in recognizing the importance of home health care. Your leadership in developing and supporting a recommendation to eliminate the additional 15 percent reduction in Medicare home health reimbursements was strategic and prudent. Home health reimbursements have already been reduced by much larger amounts than originally forecasted. As a result, the most frail elderly are experiencing problems with access to home health care. As you are aware, the additional 15 percent reduction will only exacerbate these problems.

The Health Care Financing Administration (HCFA) announced in January 2000 that home health services had a rate of growth of minus 4 percent, less than any other health care sector. Unfortunately, reductions this large have an inevitable impact on the availability of the homecare benefit. The George Washington University's Center for Health Services Research & Policy has released two studies reviewing the impact of the Balanced Budget Act of 1997 (BBA97) on home health patients and providers. The studies show that:

1. The number of Medicare home health patients has declined by 50 percent from 1994 levels and by 21 percent as a percentage of all patients in 1998 alone.
2. Patients who were most likely to lose access to covered services included those suffering from complex diabetes, congestive heart failure, chronic obstructive pulmonary disease, multiple sclerosis, skin ulcers, arthritis, and mental illness.
3. Physicians are increasingly hesitant to prescribe home health services even when they are medically necessary for fear of triggering a review or a penalty under the Medicare program.

Clearly, the current reimbursement environment is creating a hardship for home health agencies and threatening beneficiary access to medically necessary healthcare. This situation will only be exacerbated by a myriad of new Federal regulations imposed on homecare. These regulations represent real costs to home health providers and decreased dollars spent on patient care. The cumulative effect of these regulatory initiatives is to siphon crucial resources away from patient care.

EXPANSION OF OASIS TO NON-MEDICARE AND NON-MEDICAID PATIENTS

Medicare has required home health agencies to collect Outcome and Assessment Information Set (OASIS) survey data from Medicare beneficiaries for nearly a year. AAHomecare understands the need for a uniform data set for measuring patient outcomes in home care. We do not understand, however, why HCFA has recently determined that OASIS data must be collected from both Medicare and non-Medicare patients.

HCFA estimates that OASIS, as proposed, will impose an additional $45 million in costs in the first year and $110 million in costs over 5 years. They also concede that 70 percent of agencies will receive no Medicare reimbursement for these costs and that the new data reporting measures would require home health agencies to expend 967,600 hours of effort annually. Thus, already scarce financial and personnel resources will be further diverted from patient care.

HCFA maintains that OASIS data is needed to implement a prospective payment system (PPS) for home health agencies. However, HCFA has recently conceded that only 19 out of 79 OASIS questions are actually being used for the PPS system that will be implemented on October 1 of this year. AAHomecare believes that HCFA is already collecting information on Medicare and Medicaid patients that is more than adequate for the purposes of implementing the prospective payment system for Medicare covered services on October 1. In addition, the relevance of this information is highly questionable since the coverage and eligibility requirements for Medicare and Medicaid patients are different than those for non-Medicare and non-Medicaid patients. For example, patients must meet the complex criteria for being "homebound" as a condition of Medicare coverage, but there is no such requirement for most non-governmental insurance programs or for the many patients who pay for services privately. In fact, public harm will result if HCFA imposes an additional administrative burden on home health agencies to collect and report more information on more patients at the very time that the finances of home health agencies are being stretched to the breaking point by the startup costs of the new prospective payment system.

We also have serious questions about whether HCFA's use of the information is consistent with the notices sent to the patients. Patients who do not have Medicare and Medicaid coverage are to be given a notice which states that the OASIS questions are being asked "to make sure that you get quality health care services." (64 Fed. Reg. at 32991, June 18, 1999) The notice further states that the information will be made "anonymous" so that HCFA "cannot know that the information is about you." In reality, it would appear that HCFA as well as the state agency rou-

tinely surveying the home health agency would have access to unencoded OASIS data. Therefore, the information is not, in fact, "anonymous."

It also seems prudent to defer expanding the government's collection of OASIS data in view of recent actions by both the Administration and Congress. On November 3, 1999, the Department of Health and Human Services published proposed comprehensive medical information privacy regulations establishing new privacy standards for medical information that is transmitted electronically. (64 Fed. Reg. 59917) The collection, encoding and transmission of OASIS data would be encompassed within those standards. The Administration has indicated that it will publish the final regulations in the latter part of this year. If those standards impose new privacy protections (which is likely) home health agencies will have to incur the additional expense of changing the process for collecting and reporting the expanded OASIS data.

In the Balanced Budget Refinement Act of 1999, Congress directed the General Accounting Office (GAO) to study and report back to Congress (a) on the costs incurred by home health agencies in complying with OASIS and (b) "the effect of such data collection requirement on the privacy interests of patients." (See § 301(b)) GAO is just now in the process of assembling the research team for this project. It would seem prudent, particularly at a when the home health benefit has been so severely disrupted, to allow Congress and the Administration to consider the findings of the GAO report before expanding OASIS.

Home Health Advance Beneficiary Notices

HCFA is also in the process of approving a revised Home Health Advance Beneficiary Notice (HHABN) to be given to Medicare patients where the home health agency believes that services prescribed by the patient's physician would not qualify for coverage under the Medicare home health benefit. (65 Fed. Reg. 24217) AAHomecare supports the use of standardized notices accurately informing patients of their Medicare rights. We have several concerns with the revised notice that HCFA seeks to have approved.

The notice estimates that complying with the HHABN requirement will consume 180,000 hours annually. (65 Fed. Reg. at 24217) These hours and associated costs result in another cut in funds that are already inadequate to provide the services that beneficiaries have a statutory right to receive. None of these costs appear to have been included in the calculation of the PPS base reimbursement rates. The new notice also appears to require agencies to incur unnecessary and duplicative costs. For example, a new page has been inserted into the notice that requires HHAs to inform beneficiaries of where they can obtain "free legal services." The "patient rights" provisions of the conditions of participation do not contain a requirement of any such notice. Home health agencies should not be expected to locate legal services for their patients.

In addition, the additional page requires the HHA to inform the patient of the number for the Area Agency on Aging and the state's toll-free home health hot line. The conditions of participation already require HHAs to notify patients in writing of the state's toll-free home health hotline number "when the agency accepts the patient for treatment or care * * *" (42 C.F.R. § 484.10(f)) Thus, this notice requirement is duplicative and should be stricken in accordance with 44 U.S.C. § 3506(c)(3)(B).

The notice states that the patient may submit any additional information, including additional information from the patient's physician, to the home health agency, which will then forward it to Medicare. We question whether the additional cost of collecting and forwarding this additional information was included in the estimate of 180,00 hours annually to implement this provision. Finally, the notices do not appear to provide for the situation where some, but not all, of the services ordered by the physician may not be covered by Medicare.

Surety Bonds

AAHomecare's HHA members strongly supported the enactment of a home health surety bond at a maximum of $50,000. We supported this provision in order to ensure that only high-quality home health providers are given the opportunity to serve Medicare beneficiaries. Congress enacted the new requirement as a part of the BBA97. When HCFA implemented the new regulations in early 1998, the requirement was expanded to the greater of $50,000 or 15 percent of Medicare revenues. The HCFA requirement also permitted the use of the surety bond for Medicare recoupments. These requirements made it nearly impossible for a surety company to develop these bonds, and greatly increased the costs of the bonds that were available. The cost of securing a surety bond is not an allowable Medicare cost, which

made it very difficult for HHAs to obtain these bonds. For these reasons, we were not able to support the surety requirements enacted by HCFA.

ERGONOMICS

AAHomecare is also concerned about the proposed ergonomics program regulation recently promulgated by the Occupational Health and Safety Administration (OSHA). We believe that homecare should be exempted from the proposed ergonomics standard. OSHA's own cost estimates indicate that homecare providers would spend $51.5 million in order to comply with the proposed rule. This places homecare in the fourth highest compliance cost category as a percent of total revenue out of the 42 affected industries. As stated above, the homecare industry is ill prepared to absorb these costs at this time.

In addition, homecare providers believe an exemption is necessary due to the lack of employer control of the work site. A 1993 Seventh Circuit Court decision in HHSSA v. Martin, 984 F. 2d 823, and the recent decision by the Secretary of Labor to withdraw the work at home OSHA policy only further supports the need for a homecare exemption. In HHSSA v. Martin, the Court found that the Occupational Safety and Health Act does not authorize OSHA to impose work site related standards on home work sites that are not under the employer's control. OSHA recognized the Court's findings in their November 1999 compliance directive on bloodborne pathogens, but failed to do so in the ergonomics proposed rule.

AAHomecare also believes that home health meets the standard qualifications for an exemption. While AAHomecare recognizes the importance of preventing work place injuries, it is difficult to understand how a regulation so broad in scope, covering manufacturing jobs, manual handling jobs, and jobs in which an employee experiences an OSHA-recordable musculoskeletal disorder (MSD), would be applied to the unique homecare environment. Homecare services are provided in a patient's home, which includes a broad range of conditions that homecare employers can not possibly control.

AAHomecare further believes that the recent withdrawal of the "work at home" advisory warrants an exemption for the homecare industry. The advisory indicates that OSHA will not attempt to impose OSHA standards on private homes, unless they are being used as a part of the manufacturing process. It is the Association's understanding that no further efforts will be made by OSHA to apply these standards to the home work environment until a national dialogue on the issue takes place.

Based on these findings, AAHomecare recommends including homecare on the list of industries exempted from the requirements due to the unfeasible costs and the lack of employer control in the home work environment.

HOME MEDICAL EQUIPMENT

Home medical equipment (HME) providers supply medically necessary equipment and allied services that help beneficiaries meet their therapeutic goals. Pursuant to the physician's prescription, HME providers deliver medical equipment and supplies to a consumer's home, set it up, maintain it, educate and train the consumer and caregiver in its use, provide access to trained therapists, monitor patient compliance with a treatment regimen, and assemble and submit the considerable paperwork needed for third party reimbursement. HME providers also coordinate with physicians and other homecare providers (e.g., home health agencies and family caregivers) as an integral piece of the homecare delivery team. Specialized home infusion providers manage complex intravenous services in the home.

Medicare's durable medical equipment, prosthetic, orthotic and supply (DMEPOS) benefit is administered through four specialized regional carriers known as Durable Medical Equipment Regional Carriers (DMERCs). In addition, HCFA officials in Baltimore make national decisions regarding the administration of the DMEPOS benefit. AAHomecare's HME members consistently express their frustration with the inconsistency of the guidelines issued by the four DMERCs and unpredictable changes in national policies. All too often, these changes go into effect without any consideration of the operational impact on providers and with little or no notice. AAHomecare believes that these problems could largely be eliminated through better and more frequent communication between HCFA, the DMERCs and industry representatives.

POSSIBLE SOLUTIONS

AAHomecare believes that many of the regulatory problems associated with the Medicare DMEPOS benefit could easily be solved through increased and improved communication efforts. Specifically, we recommend that Medicare:

- Communicate with providers and provider groups prior to implementing changes in coverage policy or claims processing requirements.
- Seek comments from the industry with respect to the operational impact of proposed changes.
- Standardize policies and rules across the four DMERCs, including standardization of documentation requirements.
- Consider conducting "pilots" of certain operational changes prior to implementing them nationally.
- Improve the training of DMERC staff.
- Provide better education opportunities for the DMEPOS community.

A PARTICULAR CONCERN: CMNS

One particular regulatory burden has caused more consternation among HME providers than any other has; the certificate of medical necessity (CMN). The CMN is a form designed by Medicare to document the medical necessity of certain items of medical equipment. In addition, the CMN collects information necessary to determine whether the beneficiary meets Medicare coverage criteria for the DMEPOS item. In order to receive payment for a covered item of DMEPOS, a provider's claim (HCFA—Form 1500) must be accompanied by a CMN signed by a treating physician. The original CMN must be maintained by the supplier and must be produced upon the request of the DMERC, HCFA, or the Office of the Inspector General.

Providers often experience long delays in obtaining the completed CMNs because the provider cannot submit a claim for payment to the DMERC until the physician returns the completed and signed CMN. These delays lengthen the payment cycle for the supplier. At the same time, physicians are not penalized for failing to complete the CMN and often are unaware of the importance of this document. As a result, the DMEPOS supplier disproportionately bears the weight of physician noncompliance with CMN requirements.

The administrative burden that results from HCFA rules and DMERC policies pertaining to CMNs have been documented by industry and government studies. For example, the NAMES 1998 Industry Survey shows that the industry maintains higher than average outstanding accounts receivables because the medical necessity documentation in support of a claim often takes several weeks (and at times months) to obtain. The Industry Survey shows that median days sales outstanding for the industry ranges from a low of 81 days to a high of 108 days.[1] Likewise, the 1999 HIDA Home Care Financial Performance Survey reports that the median number of days outstanding for DMEPOS suppliers' accounts receivable has been rather steady at 84–87 days for the last 5 years.[2] In addition, the GAO included Medicare documentation requirements as one of the factors that account for a 30 percent difference in the administrative costs of serving Medicare beneficiaries when compared to individuals served by the Veterans' Administration (VA).[3]

POSSIBLE CMN REMEDIES

Physician Education: Physicians often fail to understand the legal ramifications of properly completing and signing a CMN. We continue to hear from our members that many physicians request compensation for completing the CMN. We also hear that physicians often tell our members that they will refer their business to suppliers who are willing to complete the forms. This is a continuing problem, although we acknowledge recent efforts to address this issue by the OIG. We urge HCFA to follow the lead of the OIG and develop an ongoing physician education program on medical necessity requirements. We believe that consistent and ongoing communication about the role of the physician in completing the CMN would promote compliance and improve the efficiency of the process.

Administrative Simplification: The DMEPOS supplier community has repeatedly requested permission to accept faxed CMNs from prescribing physicians to take the place of the original document. HCFA responded with a program memorandum stat-

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[1] See NAMES Industry Survey, p. 11.

[2] See HIDA 1999 Home Care Financial Performance Survey, p.18.

[3] See letter dated May 15, 1997, Re: Medicare: Comparison of Medicare and VA Payment Rates for Home Oxygen, from William J. Scanlon, Director, Health Financing and Systems Issues, GAO, to William V. Roth, Chairman, Committee on Finance, United States Senate.

ing that suppliers may submit a claim to the DMERC for DMEPOS services, if the supplier has received a completed CMN from the prescribing physician via facsimile. However, the supplier must be able to produce the original, hard copy CMN in the case of a post-payment review. The post payment review provision effectively negated the ability of the DMEPOS supplier to use the fax to transmit these documents, as very few suppliers will subject themselves to the possibility of recoupment. In practice, suppliers still must secure the original, hard copy CMN in order to avoid liabilities in an audit. AAHomecare welcomes the opportunity to work with HCFA to develop a secure and efficient means of transmitting CMNs electronically. Importantly, the Health Insurance Portability and Accountability Act requires HCFA to implement administrative simplification for claims processing and payment and we are prepared to assist HCFA in that process.

CONCLUSION

AAHomcare appreciates the interest of the Health Care Task Force in the considerable administrative burdens that the Medicare Program places on providers. We look forward to working with you and HCFA officials to support a strong homecare benefit that protects the interests of beneficiaries and preserves the integrity of the Medicare Program.

PREPARED STATEMENT OF THE AMERICAN COLLEGE OF PHYSICIANS—AMERICAN SOCIETY OF INTERNAL MEDICINE

The American College of Physicians-American Society of Internal Medicine (ACP–ASIM), representing over 115,000 physicians and medical students, appreciates the opportunity to submit a statement for the record to the Health Task Force of the Committee on the Budget on the regulatory burden the Medicare program imposes on physicians. ACP–ASIM commends the Task Force for its interest in this issue as it is imperative that the regulatory environment protect the integrity of the Medicare program without imposing an undue burden on physicians.

Medicare regulations are vast as physicians must navigate over 100,000 page of regulations pertaining to Medicare alone. A number of these regulations, such as those issued by Medicare carriers, are updated frequently. Physicians are concerned that the government's focus on fraud and abuse has increased at a time when Medicare regulations are becoming more and more complex. The government needs to ensure that billing errors are not treated as fraud and abuse. Internists frequently tell us that they will go to jail for the simplest of mistakes. Although we explain that the standard for demonstrating fraud and abuse is much higher, the government should be troubled that this perception is so widespread.

ACP–ASIM has worked with the Department of Health and Human Services Office of Inspector General (OIG) over the past year to ensure an appropriate anti fraud and abuse message. We have also attempt to allay internists' concerns about overzealous prosecution by presenting statistics showing that the government prosecutes very few physicians for fraud and abuse. We believe that we have made significant progress toward raising awareness among Medicare beneficiaries and the public regarding fraud and abuse while conveying that the vast majority of physicians are honest. We expect to continue our on-going dialogue with the OIG.

However, physicians will remain concerned that they are at risk to be investigated for fraud and abuse if the complex regulatory environment, which practically prohibits full compliance, remains unchanged. The OIG has an obligation to enforce the regulations that are in effect. We believe that the complexity of the regulatory environment is the root of the problem and that the government should commit to simplifying it.

The government can demonstrate its commitment to simplifying the current regulatory environment by:

1. Streamlining Medicare regulations;
2. Improving how regulations and regulatory updates are communicated to physicians; and
3. Improve physician education regarding Medicare regulations.

Further, we want to bring a several specific issues that are within the jurisdiction of the Health Care Financing Administration (HCFA) to the Health Task Force's attention. These issues are:

1. Documentation guidelines for evaluation and management (E/M) services;
2. Assessing Medicare carrier performance;
3. The Medicare medical review process; and
4. Proprietary, black box coding edits.

We believe these issues deserve Congressional intention as they are especially problematic for practicing physicians. We urge HCFA to adopt our recommendations and ask Congress to provide oversight.

NEED TO STREAMLINE REGULATIONS

The overall volume of Medicare regulations is tremendous. A document prepared by the majority staff of the House Committee on Budget puts the number of regulations at over 110,000 pages. This figure includes HCFA manuals, carrier Part B manuals and newsletters, fraud and abuse regulations, etc.

A significant portion of Medicare regulations are updated regularly. The experience of a physician who practices in Kansas illustrates the magnitude of the regulatory workload faced by physicians. The Kansas Medicare carrier regularly communicates policies to its physicians through: a Part B Physicians' Manual; Local Medical Review Policies (LMRPs); and Medicare communiques. These communications are not user friendly and that the sheer volume of regulatory instructions is overwhelming. The annual volume of regulations can most easily be measured by their height when stacked together. The Kansas carrier's Part B Physician's manual is approximately two and a half inches thick. The compilation of LMRPs totals about four inches. A binder containing the communiques, which are sent out once or twice a month, is about three-quarters of an inch thick.

Congress should establish a task force comprised of representatives from all agencies with Medicare jurisdiction as well as representatives from the physician community and charge it with compiling all Medicare directives into one accessible source. Overly burdensome regulations identified during this comprehensive review could be eliminated. All Medicare regulations should be contained in a single source (or as few sources as possible). A single entry could contain references to multiple laws as appropriate. However, a concentrated source of information is necessary to ensure consistency of information and to reduce the burden on physicians-reducing their costs and providing them more time to treat patients.

Streamlining regulations and compiling them into one accessible source will make it easier for physicians to adhere to Medicare directives. We believe that framework could be modeled after the HCFA Physician Regulatory Issues Team (PRIT). The PRIT is comprised of individuals from various departments within HCFA. It was formed to assess the totality of Medicare regulations and issue recommendations for improvement. However, it is our understanding that the PRIT has yet to make significant progress.

One of the few finding announced by the PRIT is that physicians view all Medicare regulations as "government" regulations; they do not associate specific regulations with the agency that promulgates them. This supports our contention that a review of Medicare regulations should be coordinated among all agencies with jurisdiction.

The congressionally established interagency task force we are proposing should be more open than the PRIT. It should seek broader physician input. We believe that the best way to assess the impact of regulations is to ask those who must adhere to those regulations. The inter-agency task force should provide frequent updates to Congress and the public regarding its progress.

NEED TO IMPROVE HOW INFORMATION IS DISSEMINATED TO PHYSICIANS

Requirements are communicated to physicians in a disjointed and ineffective way. Dissemination of LMRPs, which are policies that are specific to a particular Medicare carrier's area, are especially problematic. When LMRPs are updated, typically, only the changes are listed in the materials sent to physicians. The original policy is rarely updated and published in its entirety. The result is that individual practices have to update the original policies in their files to maintain accurate information, which makes it virtually impossible for physicians to learn LMRPs. Even the most well-informed physicians have difficulty keeping apprised of changing Medicare regulations.

Physicians find it extremely difficult to keep track of ever-changing Medicare regulations while treating patients. The problem is compounded for physicians in small group and solo practices, which make up the majority of rural practices. They do not have the staff to keep up with constantly changing rules. Although physician involvement in comprehending and applying regulations is likely to vary according to practice size, all physicians must be mindful of the universe of Medicare regulations. The magnitude and complexity of regulations is compounded for physicians that are covered by more than one carrier jurisdiction. Keeping track of the morass of Medicare regulations detracts from the time physicians have available to treat patients.

A single source for Medicare regulations that would result from an inter-agency effort will greatly enhance physicians' ability to adhere to regulations.

NEED TO IMPROVE PHYSICIAN EDUCATION

MEDICARE CARRIER PROVIDER EDUCATION AND TRAINING

Congress should allocate additional funding for Provider Education and Training to help physicians adhere to Medicare regulations. We are concerned that funding for carrier educational activities has failed to increase as regulations have become more voluminous and complex. The Administration's proposed fiscal year 2001 budget allocates $15.8 million for Provider Education and Training. The proposed Provider Education and Training 2001 funding level equals the $15.8 million that was allocated for fiscal year 2000 and represents approximately 1 percent of the 2001 $1.3 billion contractor budget request.

MEDICARE INTEGRITY PROGRAM PHYSICIAN EDUCATION CONTACT

ACP–ASIM is pleased that HCFA is addressing physician education early in its implementation of the Medicare Integrity Program (MIP), recently selecting a contractor to implement the physician education task order.

HCFA must use the physician education task order to find mechanisms to get information to physicians and other providers in a useful and manageable way. Our understanding is that the contractor plans to assess current educational efforts and then develop and implement educational tools. HCFA must maintain its commitment to this process as it evolves. HCFA must also be committed to adequately funding the physician education initiative.

Further, it is essential that HCFA coordinate its education efforts agency-wide. It would be counterproductive for a segment of the agency's program integrity group to take actions that would undermine contractor physician education. For example, it would be inappropriate for the program integrity group to instruct carriers to issue overpayment requests based on extrapolating the results of a post-payment medical review if the contractor developed an educational approach to conducting review on those who have been audited for the first time. Similarly, other departments within HCFA must avoid contradicting physician education initiatives.

SPECIFIC REGULATORY ISSUES WORTHY OF CONGRESSIONAL OVERSIGHT

DOCUMENTATION REQUIREMENTS FOR EVALUATION AND MANAGEMENT SERVICES

Although ACP–ASIM is encouraged that HCFA 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.

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. There are 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.

We expect that HCFA will soon announce at least its preliminary intent regarding the content of revised guidelines. Congress should ensure that the documentation standard selected by HCFA imposes a minimal regulatory burden. The Medicare Payment Advisory Commission's (MedPAC) agrees. MedPAC's 2000 report to Congress on Medicare Payment Policy MedPAC specifically states that "HCFA will need to consider avoiding overly complex and burdensome requirements for physicians, such as counting formulas that assign points for each element of a physician's service to determine the level at which services can be billed." It recommends that "HCFA should continue to work with the medical community in developing guidelines for evaluation and management services, minimizing their complexity, and exploring alternative approaches to promote accurate coding for these services."

HCFA has also committed to pilot testing the guidelines before they are fully implemented. The agency has yet to announce specific pilot testing approaches. ACP–ASIM recommends that any HCFA pilot test of the eventual guidelines should assess the amount of time physicians spend writing or dictating a patient's chart note to satisfy the guidelines. Guidelines that require physicians to spend too much time documenting information (beyond what is necessary for on-going care of the patient) unnecessarily interfere with patient care.

We also believe that HCFA should pilot test alternatives to the guidelines, such as allowing physicians to use time spent with the patient to determine what code to bill (while meeting a less onerous documentation standard). Academic research on this issue generally shows that time is a valid proxy for the amount of physician work involved in providing an E/M service.

In its 2000 report to Congress, MedPAC recommends that HCFA "should pilot-test documentation guidelines" and "continue to work with the medical community in developing the pilot tests, and should ensure adequate time for physician education."

Congress should also investigate as to whether more aggressive auditing of E/M services coupled with heightened fraud and abuse concerns have caused physicians to under bill for their E/M services. The MedPAC report demonstrates how past annual OIG financial audits of HCFA have led to intensified review requirements on physicians, possibly leading to undesirable changes in coding. MedPAC notes that beginning in 1998, "decreases began to occur for almost all types of E/M coding. This change occurred simultaneously with several factors, including heightened attention to the fraud and abuse issues in the Medicare program and random audits investigating documentation of E/M claims." The report notes that "results from the Chief Financial Officer's (CFO) audit of FY 1996 Medicare spending prompted HCFA to address concerns about the adequacy of documentation for services billed. Random audits grew from this impetus and the results of this and the subsequent two CFO audits further focused attention on fraud and abuse issues."

MedPAC observes that it is unclear why the change in 1998 occurred, saying that "it may reflect a return to a more appropriate level of coding" or "alternatively, the change may indicate the beginning of downcoding, that is physicians erring on the side of being overly cautious. This downcoding may be inappropriate, given that the beneficiary population is older and in poorer health and that Medicare+Choice programs generally draw low-risk individuals from the traditional program. These dynamics would predict a trend toward higher-level E/M codes."

Physician Input Into Medicare Carrier Performance

HCFA should establish a mechanism to assess valid regulatory hassles imposed by a specific policy or by carrier misinterpretation of HCFA policy identified by state and/or national medical societies. Carrier misinterpretation of national Medicare policy is problematic. Carriers are unlikely to recognize that their interpretation of a national policy is incorrect, leaving physicians no outlet to address their concerns. There are numerous instances in which a carrier(s) implemented a policy that inappropriately denied or reduced payment for services that were billed correctly.

We believe that HCFA can best identify hassles imposed by the current regulatory environment by listening to the concerns of individual physicians through their state and/or national medical society. Frustrated, rank-in-file physicians need a mechanism to address valid concerns. It is imperative that a process be established to listen and respond to these concerns so that physicians do not feel that the government is unresponsive to their legitimate concerns.

We envision that medical societies would only bring well-documented problems and/or carrier misinterpretations of national policy to the attention of the HCFA central office. We do not envision that frivolous or trivial policy matters would be brought to the attention of the HCFA central office. The HCFA central office would only become involved if a problem could not be resolved at the carrier or regional office level.

As noted above, it is our understanding that the HCFA regional offices are vital to addressing physician concerns regarding carrier policy. Individual physicians and their medical society representatives can have difficulty in locating appropriate regional office staff. The HCFA central office should designate a Medicare liaison in the each regional office to serve as a contact for medical societies and individuals. HCFA should make contact information available through its *http://www.hcfa.gov* Internet site. Providing medical societies access to central and regional office officials encourages dialogue and collaborative efforts to solve legitimate problems.

Maintaining a mechanism to collect and assess concerns about carrier actions will enable HCFA to be more informed regarding the performance of its carriers. The

General Accounting Office (GAO) recently issued reports detailing HCFA's general lack of oversight of its Medicare carriers and other contractors. HCFA cannot fully evaluate its carriers if it lacks a mechanism to collect documented inappropriate carrier actions. Also, the lack of such a mechanism unnecessarily antagonizes physicians by making it difficult for them to get relief for their valid concerns.

Further, HCFA communicates policy instructions to its Medicare carriers through Program Memoranda and other transmittals, which are then implemented by the carriers. HCFA should ensure that these instructions are clear to avoid misinterpretations. The instructions HCFA sends to its Medicare carriers should be reviewed by practicing physicians to promote clarity and to assure that the regulatory burden is minimized.

MEDICARE MEDICAL REVIEW PROCESS

The Medicare medical review process is a major concern of physicians. ACP–ASIM is encouraged that HCFA has contracted with the consulting firm of PricewaterhouseCoopers (PwC) to make recommendations to improve the effectiveness and the efficiency of medical review. We await the results of the contractor's report. However, the current medical review process denies physicians their due process. The design also coerces physicians into entering into a settlement with their carrier. Physicians often have a disincentive to prove their billing is appropriate as the legal costs involved in appealing an audit determination can rival the amount in question as the overpayment amount is often determined by extrapolating the results of a small sample.

Carriers should use detailed statistical analyses of severity-adjusted provider billing patterns to identify true outliers. Outliers who fail to exhibit egregious behavior should receive educational coding assistance before being subjected to comprehensive audits. While improved technology makes this possible, it is essential that carriers share the results of statistical analyses with providers and use them in a constructive manner.

HCFA should standardize the process for how carriers conduct medical review. The process then needs to be clearly communicated to physicians. Currently, carriers have wide latitude when conducting physician audits.

Program integrity entails paying claims appropriately in addition to detecting and preventing fraud and abuse. Carrier-initiated medical review should be furnished by a physician licensed in the same specialty as the physician whose claim(s) is under review. Also, appeal of overpayment requests over a certain monetary threshold should be conducted by an independent organization, such as the state Peer Review Organization. These steps would inject fairness and give physicians more confidence in the Medicare medical review process. HCFA should use the stable source of funding provided by Congress for the Medicare Integrity Program to assure fairness in medical review activities.

Physicians should be able to retain their appeal rights without opening themselves up to a more comprehensive audit. Currently, physicians must open themselves up to a review of the patient records pertaining to all claims for the identified service(s) over an open-ended period of time simply to maintain their appeal rights. In addition to opening oneself up to such a practice-disrupting audit, physician can accumulate substantial legal costs.

Physicians should not have to repay carrier-determined overpayment amounts until they exhaust all appeal rights and an accurate overpayment amount has been established. Currently, physicians must repay overpayments within 30 days even if the case is under appeal.

PROPRIETARY, "BLACK BOX" CODING EDITS

ACP–ASIM opposes the use of proprietary Commercial Off-the-Shelf Software (COTS), known as "black box" coding edit systems. Congress should instruct HCFA to refrain from entering into contracts with entities that maintain proprietary editing systems. Also, Congress should instruct HCFA to disclose all existing proprietary coding edits. We believe that such a closed edit system is inappropriate. The Medicare Correct Coding Initiative (CCI) demonstrates the need for a coding edit system that is open to peer review. ACP–ASIM and other medical organizations often identify numerous inappropriate coding edits in each proposed version of the CCI when HCFA distributes it for public review. Ideally, inappropriate edits are deleted or altered before they are implemented. The end result is that the claims payment system is more accurate because it had been appropriately peer reviewed. Many inappropriate edits would remain if the CCI was a closed system, which would deny payment for appropriately provided services.

While we understand that proprietary, black box coding edit systems are used to save money, we point out that the appropriateness of these edits cannot be judged solely on their ability to generate savings by denying payments to providers. The OIG report, "Using Software to Detect Upcoding of Hospital Bills," released August 12, 1998, questions the ability of commercial software to accurately detect inappropriate over-billing. The report, which analyzed two off the shelf software products currently on the market to identify hospital upcoding, found that only about 20 percent of the Medicare billing cases that commercially available software identified as being upcoded were in fact upcoded.

MedPAC takes a similar position. In its 2000 report, MedPAC recommends that "HCFA should disclose coding edits to physicians and should seek review of the appropriateness of those edits by the medical community."

There are numerous other issues that impose a regulatory burden on physicians. Examples include: random prepayment review of E/M claims; prescribing durable medical equipment and supplies, including completing certificates of medical necessity forms; and the Medicare provider enrollment process. The Task Force can contact our Washington, DC office for specifics.

Thank you for holding this hearing and for the opportunity to submit a statement for the record. We look forward to working with the Health Task Force and the entire Committee on Budget to reduce the Medicare regulatory burden imposed upon physicians.

Prepared Statement of the American Medical Association

On behalf of our 300,000 physician and medical student members, the American Medical Association (AMA) would like to thank the Budget Committee for holding this hearing to discuss the proliferation of Medicare regulations and their impact on health care providers. The government cannot continue to subject physicians to new Medicare regulatory requirements and burdens without commensurate reductions in existing Medicare rules and regulations.

Background

Physicians today are spending far too much time trying to comprehend and comply with the Health Care Financing Administration (HCFA) policies and paperwork requirements rather than focusing on patient care. For the sake of patients, physicians, and the Medicare program, Congress and the Administration must take immediate action to simplify Medicare and reduce the excessive regulatory burdens that currently exist for physicians providing care to seniors.

Numerous examples of these unnecessary regulatory requirements exist. The following instances are illustrative of existing regulatory roadblocks for physicians:

- A physician was trying to secure a wheelchair for a quadriplegic patient. The carrier required the physician to supply a great deal of additional information, beyond the certificate of medical necessity and the appropriate diagnosis code, to verify that the chair was medically necessary. The fact that the diagnosis was for a quadriplegic patient should have sufficed.
- Under the Emergency Medical Treatment and Labor Act (EMTALA), when a patient presents at the emergency room, the physician must treat the patient without asking about his or her ability to pay. However, under Medicare if a physician ends up providing services that are not covered by Medicare, Medicare requires that prior to providing the service the physician must inform the patient that the service may not be covered. The physician must ask the patient to sign the Advance Beneficiary Notice, which says that the patient understands that he or she may be liable for the cost of the service. Under EMTALA, however, a physician cannot discuss payment with a patient.
- Physicians report that Medicare documentation requirements impose the greatest burden on their practices and do little to improve the quality of care. Physicians are forced to spend more time documenting their medical records and less time on patient care.

Regulatory Overload

In recent years, HCFA has imposed requirement after requirement on physicians. This is due in large part to the extensive focus that Congress and the Administration have placed on addressing alleged "waste, fraud and abuse" in the Medicare program. Since the early 1980's, Congress has enacted the following fraud and abuse statutes:

- "Ticket to Work and Work Incentives Improvement Act of 1999;"
- "Balanced Budget Act of 1997;"

- "Omnibus Consolidated Appropriation Act of 1997;"
- "Health Insurance Portability and Accountability Act of 1996;"
- "Medicare and Medicaid Patient and Program Protection Act of 1987;"
- "Health Care Quality Improvement Act of 1986;"
- "False Claims Amendments Act of 1986;"
- "Medicare and Medicaid Budget Reconciliation Amendments of 1985;"
- "Medicare and Medicaid Budget Reconciliation Amendments of 1984;"
- "Medicare and Medicaid Amendments of 1981;" and
- "Medicare and Medicaid Amendments of 1980."

Legislation enacted over the last several years has dramatically escalated the billing and documentation requirements and their attendant penalties. Consequently, HCFA has been under intense pressure from Congress, the White House, the Department of Justice (DOJ) and the Office of the Inspector General (OIG) to promulgate regulations and policies to address perceived waste, fraud, and abuse problems.

The aforementioned legislation and regulations have had substantial negative effects on physicians, providers, and patients in the Medicare program. The cumulative impact of these laws and ensuing regulations has amounted to an insurmountable morass of bureaucracy, burden, and hassle for physicians. Physicians are confronted by an extremely complicated system of regulations with which it is virtually impossible to comply. In the current environment, it is difficult to know where billing errors end and fraud begins. Much of what carriers are pursuing is inadvertent billings errors. Frequently, these involve situations about which honest people can disagree.

There are more than 100,000 pages of Medicare rules and guidances with which a physician must comply. Physicians and their office staffs are absolutely overwhelmed by the current paperwork requirements generated by often poorly thought out regulations. In fact, physicians and their staffs have no single guidebook which they can consult for billing and coding questions. Rather, physicians' offices regularly receive reams of notices, guidances, and issuances from their carriers describing ever-changing policies and regulations. Vital information for the physician is often buried in these carrier communications, which can contain dozens of pages of new information each month. Not knowing of the information's existence could result in violations of new carrier or HCFA regulations or issuances.

In addition to being extremely voluminous, many Medicare policies frequently are unclear. Medicare billing is subjective in nature and involves understandable differences in opinion over clinical judgments or the level of service provided. Physicians have been forced to hire attorneys, consultants, and compliance experts to attempt to comply with these complex and continuously-changing regulations. A 1995 OIG report demonstrated the difficulty of complying with coding requirements. The report found that carrier personnel even had difficulty in selecting correct billing codes. Due to the confusion, physicians and their office staffs spend countless hours attempting to deal with the denial and resubmission of claims.

To further complicate matters, there is great variation nationwide in how carriers implement policies and procedures. Medicare coverage policies are also frequently inconsistent in different regions. Furthermore, physicians frequently have difficulty securing direct and consistent answers from carriers. Several years ago, just as the requirements on physicians dramatically increased, HCFA eliminated its carrier toll-free line service which had answered physicians' billing and coding questions. Ever since, the AMA has been urging HCFA to restore the lines. Although HCFA recently committed to reopening the toll-free lines, these lines have yet to be restored. Congress should require HCFA to reestablish these toll-free lines.

Even Federal legislation impacting physicians can be contradictory and confusing. For instance, the Medicare anti-kickback statute, the self-referral laws, and the False Claims Act cover the same types of behavior with different intent standards and different penalty structures. In addition, the Federal self-referral laws actually conflict with many state self-referral statutes, making physicians uncertain as to which standards they should follow.

In response to physician concerns with over-regulation, HCFA assigned a part-time physician employee to head an internal working group 2 years ago, known as the Physician Regulatory Initiative Team (PRIT). PRIT has had one public meeting seeking input but has failed to reduce the number of rules and regulations that physicians must comply with when treating Medicare patients or to produce a report that suggests a meaningful reduction in paperwork will be forthcoming. Instead, local carriers and HCFA's Central Office continue to promulgate new initiatives, place new administrative burdens on physicians, propose new forms for physicians to complete, and increasingly threaten physicians with audits of their medical practice if information is not submitted in a satisfactory manner to the Medicare program.

The AMA has several recommendations that would begin to ameliorate the regulatory overload most physicians are experiencing:

• Congress should take immediate steps to instruct HCFA to work with physician organizations to streamline and clarify existing regulations and policies.

• The AMA has endorsed H.R. 2651, the " Physician Self-Referral Amendments of 1999," introduced by Chairman William Thomas (R–CA), which would reform existing self-referral laws to ensure that commonplace business practices and group practice arrangements do not run afoul of the ban on self-referrals.

• The AMA has endorsed H.R. 3300, introduced by Representative Shelley Berkeley (D–NV), which would require HCFA and the Medicare carriers to educate physicians as to billing and coding changes. It would also prevent carriers from violating physicians' due process rights during audits by forcing physicians to settle in order to avoid expensive and time-consuming audits.

• The AMA requests that Congress call on the HCFA Administrator to report each year first, which regulations that have been eliminated or reduced, and second, which initiatives will relieve the administrative burden on the physician community.

Inadequate Physician Education Efforts

With respect to waste, fraud, and abuse, Washington policymakers continue to focus on enforcement initiatives rather than education. HCFA's current education efforts are woefully inadequate. The agency's education initiatives present overly general directions that fail to aid individual physicians with specific Medicare coding and billing issues. There is virtually no individual outreach to a physician when he or she is identified by the carrier as making billing mistakes. In addition, physicians frequently cannot obtain written opinions from their carriers regarding their billing and coding questions. They are forced to rely on carrier personnel's oral advice which will not suffice if a problem later arises.

Surprisingly, HCFA does not have a program in place to address systematic billing errors in a region or within a medical specialty. Rather than education, HCFA's response is to conduct prepayment audits when an entire group of physicians does not understand the Medicare billing procedures and are billing incorrectly. In essence, HCFA has failed to create navigable pathways for physicians who attempt to understand the most current and appropriate way to bill and document their Medicare claims. The AMA strongly believes that in this "zero tolerance for errors" environment, the Federal Government has an obligation to emphasize prevention and education for physicians. The AMA strongly urges Congress to require HCFA and its carriers to conduct innovative and extensive education initiatives for individual physicians and to work with specialty and local medical societies in education efforts that would address the most widespread billing errors..

We would also like to note that the Administration has proposed in its Fiscal Year 2001 budget to allocate $15.8 million in funding for Provider Education and Training out of a total Medicare contractor budget of $1.3 billion. The funding level for provider education and training in Fiscal Year 2000 was also $15.8 million. This funding level, which represents approximately 1 percent of the carriers' budget would not ensure that physicians and health care providers learn about new changes to Medicare laws and billing and coding requirements. It is particularly striking that HCFA has proposed such a miniscule level of funding for this activity at the same time that it has implemented new payment systems for hospitals, nursing homes and home health agencies. The AMA urges Congress to significantly increase funding for physician/provider education so that fewer billing errors occur and that the relationship between HCFA and physicians becomes less adversarial.

Enforcement Activity

The AMA believes that HCFA's actions and those of its contractors have created a strong fear among honest physicians that they will be targeted by their carriers with overly aggressive audits. The agency has transformed itself into the Internal Revenue Service (IRS) that existed before Congress heeded the demands of taxpayers and forced the IRS to restructure its policies. Just as the IRS is struggling to reinvent itself as a "taxpayer friendly" agency, HCFA must reassess its role and relationships with medical professionals who care for Medicare patients.

As a result of pressure from HCFA, the carriers are now carrying out a multitude of audits of physicians for alleged billing errors, with the result being that the Medicare claims submission process has become legally treacherous for physicians. The carriers and HCFA have readily acknowledged that these audits almost always involve billing errors due to the physicians' confusion regarding Medicare regulations. They do not constitute fraudulent billing. In fact, insurance policies are now being offered to cover physicians against future government audits where "Medicare can

conduct an audit and make an affirmative statement that the physician owes an extreme amount of money for very little justification at all." (Miami Herald, 2/7/00)

The AMA cannot underscore enough the devastating impact these overzealous actions are having on physicians, patients and the Medicare program. For example, in Denver, Colorado, many physicians have left the Medicare program. According to Jack Berry, MD, President of the Colorado Medical Society, they have done so because of "the fear of being targeted by the government's increasingly aggressive anti-fraud and abuse program." Dr. Berry stated further, "To some doctors, the final straw came last year when the government and the American Association of Retired Persons started recruiting seniors to inform on medical providers they suspected of fraud." (Denver Post, 2/13/00) Physicians across the country routinely have expressed these sentiments.

The Carriers Manual provisions relating to post-payment audits serve as an excellent example of rules that have gone awry and have resulted in the government's heavy-handedness and the deprivation of physicians' due process rights.[1] Once a carrier conducts a post-payment audit on a small number of a physician's claims, the carrier determines the amount owed to HCFA through extrapolation. As such, the overpayment calculation can rapidly rise to hundreds of thousands of dollars. Once the carrier arrives at this overpayment amount, the carrier gives physicians three options:

1. Repay the extrapolated amount and waive their appeal rights;
2. Repay the extrapolated amount and submit additional information while waiving their appeal rights; or
3. Open up their practice to a statistically valid random sampling (SVRS) of claims during the same time period. Thus, to preserve their appeal rights, physicians would have to agree to shut down their offices to allow the carrier to conduct the SVRS by auditing hundreds of charts. It is important to note that most physicians undergo these pre and post payment audits without the benefit of serious education efforts.

The AMA believes that HCFA must create an option that first, allows a physician to submit additional documentation on the cases previously audited while retaining his or her right to appeal without admitting liability, and second, does not require that the physician agree to a SVRS in order to appeal a finding and not admit liability. The AMA has been working for nearly 2 years to advance this change through discussions with HCFA. At this date, HCFA has still not agreed to change the post-payment audit options.

CONCLUSION

In closing, the AMA implores Congress to carefully scrutinize both the abundance of regulations impacting physicians and HCFA's and the carriers' inappropriate targeting of honest physicians. The AMA strongly believes that HCFA's paradigm for addressing physician billing errors should shift from its current punitive approach to one that stresses education. Complex Medicare rules should be simplified, physician education should be strengthened, and HCFA's oversight of carriers should substantially improve. The AMA urges Congress to take prompt action.

Thank you once again for holding this hearing and for the opportunity to submit testimony for the record. Please feel free to contact the AMA's Washington DC office with any questions you may have related to government activity in this area, and we look forward to working with you and your staff.

PREPARED STATEMENT OF THE NATIONAL ASSOCIATION FOR HOME CARE

Thank you for the opportunity to submit written testimony for the record on the Medicare program's regulatory burden on home health care providers. The National Association for Home Care (NAHC) is the largest national home health trade association representing nearly 6000 organizations. Among our members are Medicare-participating home health providers, including non-profit providers like the visiting nursing associations, for-profit home health chains, hospital-based providers and freestanding providers. We also represent home care aide and hospice organizations.

NAHC is deeply appreciative of the interest the Chairman and Members of the Committee and its Health Care Task Force have shown in recognizing the importance of preserving home health services for seniors and disabled citizens. Your leadership in establishing and voting out of Committee, during budget deliberations, a Sense of the Congress on Access to Home Health Care, specifying the need to

[1] The Carriers Manual is a multi-volume, extraordinarily voluminous text that generally is not subject to the notice and comment process set forth in the Administrative Procedures Act.

avoid the implementation of the 15 percent reduction scheduled to take effect October 1, 2001, was strategic and prudent.

Since the enactment of the Balanced Budget Act of 1997 (BBA97) and imposition of the interim payment system (IPS), the Medicare home health benefit has been seriously eroded. As documented by several studies, access to care has become a major problem, particularly for patients with care-intensive needs. A prospective payment system (PPS) for home care is scheduled for implementation on October 1, 2000. The new system has the potential to better provide needed services to Medicare beneficiaries. However, the PPS will fall short of this goal if not properly developed and implemented, and adequately funded.

The Congressional Budget Office currently projects that home health outlays for fiscal years 1998–2002 will be reduced by $69 billion, more than four times the amount anticipated in 1997 ($16.1 billion). Home health spending was cut by 45 percent in the last 2 years. As a result, over 500,000 fewer beneficiaries received home care in 1998 than were served in calendar year 1997. Estimates for 1999 indicate a continuation of that downward trend.

Home health agencies, already under severe financial strain due to the IPS reductions, must also conform to a myriad of burdensome and costly regulations. Virtually all agencies are being reimbursed less than the actual costs they incur in providing care to Medicare beneficiaries. More and more new and costly demands associated with Medicare regulations are increasing agencies' financial and operational burdens and are straining agencies' ability to deliver quality care to their patients. While our testimony and the primary focus of this hearing is on Medicare regulations that affect and burden health care providers, it is important to note that the Medicare Conditions of Participation for home health require agencies to comply with all applicable federal, state and local laws and regulations. These other laws and regulations include Federal and state Occupational Safety and Health Administration requirements, such as standards for prevention of bloodborne pathogens or preventing transmission of tuberculosis, as well as reporting and recording work-related injuries and illnesses; medical device reporting under the Food and Drug Administration requirements, and state Medicaid statutes, among others. The cumulative effect of these regulatory initiatives has been devastating to providers and has siphoned scarce resources away from patient care.

Each year, NAHC identifies important regulatory issues for home care, hospice and medical equipment providers. NAHC's 2000 Regulatory Blueprint for Action provides a summary of each issue, recommendations, and a rationale for the recommendations. Our blueprint may be accessed at *http://www.nahc.org/NAHC/LegReg/blueprints.html.* The Committee and Task Force Members of the Committee are encouraged to view this Web site for a full and complete analysis of regulatory issues confronting the home health provider. For the purposes of this written testimony, NAHC will highlight several of the Medicare regulations that adversely impact the home health provider. These include requirements associated with implementation of OASIS, 15-minute visit increment reporting, increased claims reviews, expanded compliance surveys, surety bonds, sampling procedures for post-payment and audit reviews, sequential billing, and branch office restrictions. Many of these changes have been developed without adherence to regulatory procedural requirements.

REGULATORY BURDENS

In addition to the administrative and regulatory burdens listed below, home health agencies currently are undergoing significant changes, at great cost, to transition to a prospective payment system (PPS) and revised Medicare conditions of participation (CoPs) by October 1, 2000. The PPS requires providers to expand, modify and replace computer hardware, software and other technology to achieve compliance and retool operations to address new billing, accounting, claims management, and financial oversight needs. The CoPs are expected to significantly modify operations by requiring new quality assurance systems for home health agencies. The cost of transitioning to PPS and the new CoPs are not reflected in current payment limits or within the proposed payment rates under PPS. The changes required by PPS and the CoPs are unprecedented for home health agencies.

1. 15-MINUTE VISIT INCREMENT REPORTING

BBA97 required that claims for home health services contain a code that identifies the length of time for each service visit, measured in 15-minute increments. The Health Care Financing Administration (HCFA) issued instructions to the home health fiscal intermediaries (FI) on February 18, 1999, directing them to initiate necessary steps to implement this new billing requirement for all home health agen-

cies (HHA) participating in the Medicare program by July 1 of last year (Transmittal No. A-99).

This new administrative burden imposes a complex time-keeping requirement for agencies to stop the in-home clock when an interruption in active treatment occurs. The HCFA transmittal defines the "time of service visit" to begin at the beneficiary's place of residence, when delivery of services has actively begun.

Since the time counted must be actual treatment time, providers are expected to discount time spent on non-treatment related interruptions during the in-home visit. For example, if a beneficiary interrupts a treatment to talk on the telephone for other than a minimal amount of time then the time the beneficiary spends on the telephone and not engaged in therapy does not count in the amount of service time.

In-home time represents only a portion of the total time invested by an agency in caring for a patient. Numerous activities required by the Medicare Conditions of Participation and needed to ensure effective patient care are often performed outside the home, including communication with physicians and family members, coordination of services with other home health personnel and community agencies, care planning, and clinical documentation. In order for home care treatment time to be meaningfully quantified, visit time must be better defined and recognized as only part of the resource cost involved in providing home care services.

Neither Congress nor HCFA has indicated how this information will be used. Its value is questionable in light of the ongoing move from a cost-based reimbursement system to a prospectively set per-episode payment that is not tied to number of visits or visit length. In light of the substantial financial and administrative strains already being experienced by agencies, we urge you to revisit this requirement.

2. THE OUTCOME AND ASSESSMENT INFORMATION SET (OASIS) REQUIREMENTS

NAHC has long supported the use of a uniform data set for collecting data and measuring, and ultimately improving, patient outcomes in home care. Over 10 years ago, HCFA proposed the development of the Outcome and Assessment Information Set (OASIS), a data set aimed at accomplishing these goals. NAHC has demonstrated its support of OASIS development and use for outcomes measurement and quality improvement in its educational programming and publications.

More recently, HCFA determined that OASIS data would be useful in development of a case-mix adjuster for a home health prospective payment system (PPS).

While NAHC acknowledges the many benefits that may accrue from OASIS, we continue to believe that several actions must be taken before home care providers can adequately undertake OASIS data collection and reporting requirements.

HCFA has seriously underestimated the costs of OASIS-related requirements with respect to:

1. Initial start-up (hardware, software, clinical and administrative staff training);
2. Data collection (additional time required for patient assessment and reassessment, printing and supply costs);
3. Transmission of OASIS data; and 4) the willingness of third party payers to share in the burden of OASIS start-up costs.

Home care providers have reported that it costs them from one to three dollars per visit to comply with the requirement, whereas HCFA has allowed only three cents per visit by way of reimbursement. Further, reimbursement is tied to per-visit cost limits. Only agencies that have not already reached the per beneficiary limits will benefit from the per-visit adjustment; HCFA estimates that about 70 percent of agencies will not receive an adjustment for OASIS costs. There has been no adjustment in the per beneficiary limits to address the increased costs of OASIS. Agencies are unable to absorb the costs of OASIS, given that over 90 percent of agencies are being reimbursed less by Medicare than their actual costs of providing care and, on average, home health agencies are receiving 30 percent less in reimbursement than they were prior to implementation of the interim payment system in October 1997. In addition, third party payers are unaware of the value of OASIS and are unwilling to compensate agencies the additional cost of OASIS implementation, data collection and reporting.

Under legislation passed in 1999, Congress acknowledged that agencies incur significant new administrative costs due to OASIS requirements and mandated a one-time $10 per patient payment in 2000. While this additional payment provides some assistance and is greatly appreciated, the major portion of OASIS costs remains unreimbursed.

By way of comparison, in 1987, HCFA increased the home health cost limits when changes were made to the forms for home health agency (HHA) billing and verification. This series of forms is known as the 485 series as it encompasses today's plan of treatment, the medical information form and the medical information request

form (485, 486,487, and 488). In establishing reimbursement rates, HCFA was required to take into account the cost of this new series of forms by increasing the base limit values for per-visit reimbursement to the HHAs beginning July 1, 1986, by $.37, and by $.39 in 1987 (52 Federal Register 25562, July 7, 1987). The average cost of all Medicare home health visits in 1987 was $48. The OASIS paperwork burden is greater than that imposed by the 485 series of forms. But even performing a simple projection of the 485 series add-on for 1987 to OASIS in 1997, the increase to HHA reimbursement by HCFA would be, at a minimum, $.61/visit.

NAHC believes that agencies should be reimbursed the full costs associated with meeting OASIS requirements. HCFA should conduct further study regarding costs of OASIS and adapt its reimbursement structure to reflect the real costs agencies are incurring. If HCFA lacks the authority to adjust the per-beneficiary limits, Congressional action should be taken to empower HCFA to make the necessary adjustments. HCFA and the Congress should also ensure that rates of payment under the forthcoming home health PPS reflect the costs of OASIS. HCFA should allow agencies adequate time to ensure payment from third party payers that will cover the cost of meeting OASIS requirements for non-Medicare, non-Medicaid patients.

HCFA has determined that OASIS data must be collected and transmitted for all patients receiving skilled and/or personal care services, regardless of payer or patient health status. This determination has added substantially to the regulatory burdens under which home health agencies are currently operating.

NAHC believes that OASIS data collection requirements should be limited to Medicare and Medicaid patients who are receiving intermittent skilled services.

Patient privacy rights remain a serious concern throughout the country. OASIS represents a vast collection of patient information that, if used inappropriately, could cause great harm to patients. Additionally, patients may be at risk of not receiving needed care if they refuse to supply specific information or provide approval for the release of this information.

NAHC believes that HCFA should develop privacy protections such that patients are assured that confidential medical information will remain confidential. These protections should include the development of encryption software by HCFA before transmission is required for non-Medicare, non-Medicaid patient OASIS data. There should be no transmission of patient-identifiable information by a home health agency without the written consent of the patient. No patient should be refused services on the basis of an unwillingness to consent to the transmission of confidential information.

3. MEDICAL CLAIMS REVIEW/SEQUENTIAL BILLING

Home health providers are experiencing increasing difficulties in processing claims through the fiscal intermediaries (FI) for services provided to Medicare beneficiaries. Problems cited by agencies include increased inappropriate and excessive random and focused medical reviews, medical review inconsistencies, technical denials, and sequential billing.

A wide variety of inconsistencies exist in payment decisions by the FIs reviewing medical claims. Differences in interpretation of homebound, technical requirements, and medical necessity requirements have resulted in confusion among many home care providers. In addition, local medical review policies are often more restrictive than the coverage policy dictates, complicating coverage decisions further.

In response to a growing Medicare home health program, HCFA earmarked increased funding for medical review activities which have increased random and focused medical reviews, targeted audits, and fraud and abuse initiatives, such as Operation Restore Trust (ORT) and Wedge audits. Providers thought they would receive relief from medical review levels ranging from 25 percent to 100 percent when they received a HCFA letter stating that no more than 10 percent of a provider's claims would be subject to random review edits. At HCFA's urging, however, FIs have instituted other types of medical review edits. As a result, agencies are being subjected to multiple edits at one time, slowing payments significantly and exacerbating financial difficulties for providers. In addition, many of the denials issued as a result of medical review are for technical reasons which have no bearing on patient's eligibility or delivery of medically necessary services.

HCFA instituted the sequential billing policy to ensure proper allocation of home health expenditures to Medicare A and B. This has meant that home care agencies have not been reimbursed for services recently given to a Medicare patient if there are any outstanding claims, or if a dispute exists over previous services offered to the same patient. NAHC and others have worked since early 1998 to convince HCFA to suspend its sequential billing and payment policies on the grounds that they were unnecessary and caused harmful cash flow problems for financially

strapped home health agencies. Although HCFA ordered a halt to sequential billing in July 1999, the repercussions of this ill-advised policy have continued for some time. Agencies have missed payroll and further damaged their fragile credit ratings.

Given the current financial uncertainties related to intensified audits and disallowances and inconsistent medical reviews, thousands of Medicare claims are currently in dispute or on appeal. This has created severe cash flow problems for many providers. Agencies are under severe financial hardships when payments are delayed weeks or months while under review and appeal.

4. SURETY BONDS

BBA97 mandated that all home health agencies participating in Medicare and/or Medicaid secure a minimum surety bond of $50,000 in order to protect the programs from fraud. HCFA published implementing regulations that went far beyond the intent of Congress. In the wake of overwhelming Congressional objection HCFA withdrew its regulations and agreed to develop new regulations.

The House Government Reform and Oversight Subcommittee on Human Resources released a report highly critical of the HCFA and its handling of the BBA97 surety bond requirement for home health agencies. The report describes HCFA's surety bond rulemaking process as "inadequate" and "technically flawed;" HCFA, for the most part, did not take into account recommendations or technical expertise offered by the home health and surety bond industries. Similarly, the Small Business Administration (SBA) filed a petition to HCFA that was extremely critical of the agency's process in developing the surety bond regulations. In part, the SBA stated that the agency "changed the rule into a vehicle for punishing legitimate HHAs and for securing overpayments to Medicare rather than a vehicle to discourage bad actors from entering the Medicare program."

It appears that throughout the regulatory process there has been a significant lack of understanding of surety companies' practices, the principles behind surety bonds, and their uses. HCFA should establish surety bond regulations in accord with the intent of Congress—as a vehicle to keep "fly-by-night" operators from participating in the Medicare program. Last year Congress acted to bring more reason to the surety bond requirement for home health agencies by limiting the requirement to the lesser of $50,000 or 10 percent of Medicare/Medicaid revenues, to a single bond for Medicare and Medicaid participation, and to 4 years duration. Additional changes that would make the requirements more reasonable follow:

1. The bond should not be used as a vehicle to recoup overpayment, but rather as a means to ensure that an agency does not pose an unreasonable risk to the program.

2. As the bond requirement is a condition of Medicare participation, it should be reimbursable.

3. Agencies that have proven track records in the Medicare program should not be required to purchase bonds on a continuing basis.

4. Statistical sampling methodology for post-payment review

In March 1999, HCFA published an FI manual update outlining new procedures for comprehensive medical review using statistical sampling (Transmittal Number 1770). The updated instructions provide details for conducting comprehensive medical reviews, medical review audits, and for statistical sampling and overpayment projections.

The use of sampling procedures involves the FI identifying a specific portion of claims from among an agency's claims submitted during a specified period of time. The proportion of denied claims in the sample would be extrapolated to all claims for the period, resulting in denial of claims that were never reviewed individually.

Sampling imposes significant risks to agencies and eliminates some provider's appeal rights. Under HCFA's sampling policy, the overpayments projected through the claims reviews are recouped by Medicare prior to any rights of appeals. Since the projection can involve millions of dollars, home health agencies are unlikely to survive long enough to access the appeals process. Appeals are important because reversals of claims have routinely exceeded 80 percent over the years.

The HCFA Region V Associate Regional Administrator registered a protest alleging that the statistical methodology used is invalid and irresponsible. This claim is supported by the Region V statistician and the statistical consultant to the Department of Justice in Chicago. Documents have been submitted to this committee regarding this allegation. With an improper sampling methodology the risk of erroneous overpayment projection is dramatically heightened.

HCFA has rejected the majority of recommendations made by home care providers to stop sampling and overpayment projections. In addition to opposing the use of statistical sampling, NAHC objects to the manner in which HCFA implemented this

policy. At a minimum, policy changes of this nature should be subject to public review and comment as required under the Administrative Procedures Act, before it is finalized. NAHC recommends that HCFA suspend its instructions to the FIs on statistical sampling of home health claims until appropriate modifications are made in policy.

5. BRANCH OFFICES

HCFA has established new criteria for branch offices that emphasize the distance of the branch location from the parent without reasonable consideration of the parent entity's actual supervisory capabilities. The policy does not recognize the use of modern methods of communication such as faxes, telephones, pagers and telecommunications that are used by every other business in the country as acceptable methods of communication and supervision. HCFA's branch office policies are contrary to regulatory reform initiatives and the proposed conditions of participation which espouse the need to change from structure-based requirements to a focus on outcomes and quality of care. In many cases agencies have closed branch offices because of the added costs of complying with the conflicting and unnecessarily restrictive branch office policies, producing access problems for beneficiaries. NAHC drafted a petition for rulemaking on behalf of Medicare certified home health agencies, requesting HCFA to institute a new rulemaking procedure and establish a single set of national criteria for defining "branch office" of a home health agency under the Medicare program. After over 2 years, HCFA has failed to respond to this rulemaking petition.

6. PHYSICIAN REFERRALS

The "Health Insurance Portability and Accountability Act of 1996" (Public Law 104–191) included a provision that imposes severe civil monetary penalties on any physician who certifies a patient as eligible for the Medicare home health benefit who does not meet the eligibility requirements. This has produced a chilling effect on physician referrals. Although the statute limits liability only to those cases where the physician "knowingly" certifies an ineligible patient, HCFA has created such an environment of fear with its overzealous anti-fraud campaign that doctors are afraid to refer patients for home health services. NAHC has received numerous reports that for many patients this is limiting access to home health services for which they are, in fact, eligible.

HCFA has not adequately informed physicians of their role, coverage criteria, and clear definitions of the terms "homebound," "medically necessary," and "skilled care." In order for physicians to take an active and responsible role in ordering and gatekeeping home health services, they must be fully informed of the breadth of the benefit and eligibility requirements.

7. ITEMIZED BILL ON DEMAND

The BBA97 required that home health agencies provide patients with an itemized bill on demand. The staff time and computer programming required for this is an additional cost not accounted for in setting both the per visit cost limits and the per beneficiary limits.

As mentioned previously, Medicare will move to a prospective payment system for home health in October. We in the home health community have great fears that the payments made under the new system may be inadequate to care for some patients, particularly those patients that are in need of high cost care. The budget for spending under the new PPS is limited to what would have been spent if the current IPS system remained in place. Further, individual payments under the new PPS are based on data from 1997 that fails to take into account a number of costly regulatory requirements that have been imposed since that time. Following is an analysis developed earlier this year by NAHC outlining some of these regulatory requirements and their impact on home health agencies. We urge that Congress give serious consideration to increasing the allowable budget for the first year of home health PPS to help account for some of these increased costs that have not been included in the PPS base rates.

1997: ELECTRONIC COST REPORTING

HCFA initiated a requirement for electronic cost reporting for home health agencies. Prior to that point, home health agencies submitted cost reports either on paper or electronically.

IMPACT

Home health agencies were required to purchase necessary hardware and software to prepare and transmit electronic cost reports. Where agencies were unable to internally develop the capabilities for electronic cost reporting, outsourced services had to be acquired.

SITE OF SERVICE BILLING

Under the Balanced Budget Act, home health agencies were required to modify billing practices to submit bills based upon the site of the patient as compared to the previous long-standing practice based on the site of the health care provider.

IMPACT

Home health agencies had to significantly revise billing practices and supportive software to accommodate service provisions outside of a single wage index area. In particular, home health agencies with branch offices in MSAs or geographic areas distinct from the parent location had to adjust billing practices.

1998: IMPLEMENTATION OF INTERIM PAYMENT SYSTEM

BBA 1997 dramatically changed the reimbursement system for Medicare home health services, establishing a new annual, per beneficiary payment limit. Previously, home health agencies were subject only to a per visit cost limit.

IMPACT

Management and operations systems had to be significantly modified to accommodate the monitoring of per patient costs, patient census calculation, and financial forecasting for annual patient care within the per beneficiary payment limit. Financial, clinical and operations staff required intensive education to understand the new interim payment system. Computer hardware and software adjustments were required to secure, maintain, and manage the data for program administration.

IMPLEMENTATION OF SURETY BOND MANDATE

In accordance with BBA 97, HCFA issued regulations on January 5, 1998 requiring all home health agencies to secure a surety bond for Medicare and Medicaid purposes. While the surety bond requirement was ultimately suspended pending Congressional review, home health agencies were required to undertake the effort to secure the surety bond until the ultimate postponement.

IMPACT

Compliance with the surety bond requirement necessitated efforts by home health agencies to gain an understanding of the surety bond marketplace, evaluating potential supply sources, and undertaking the application process. The application for a surety bond requires a home health agency to develop and present detailed financial information regarding the status of the agency, background information regarding principals associated with the home health agency, securing an independent financial audit, and the bond cost itself.

MULTIPLE CHANGES IN BILLING REQUIREMENTS

1. SEQUENTIAL BILLING

In the early stages of 1998, HCFA concluded that it needed to modify the time frame for billing of home health claims in order to accommodate the switch of a portion of the Medicare Part A home health benefit to Medicare Part B. HCFA required that home health agencies bill claims in sequence which meant that a home health agency had to hold a claim for a month of services if the previous month's claim on behalf of the same patient had not been fully processed. The sequential billing requirement was not withdrawn until 1999.

IMPACT

Home health agencies were required to completely alter billing systems to accommodate the sequential billing requirement. Systems had been designed to bill on a periodic basis provided that all of the technical elements for completing the claim were met. With the sequential billing requirement, screening and monitoring systems had to be implemented that would hold a sequential claim for an undefined

period of time during the pendency of a proceeding claim. In some circumstances, the processing of the proceeding claim could be delayed for months as it was subject to full medical review. In addition, the sequential billing requirement slowed cash flow necessitating home health agencies to secure financing simply to meet payroll. The system changes and financing responsibilities for cash flow led to high cost for most home health agencies.

2. Line Item Billing

Effective with services provided on or after April 1, 1998, HCFA required providers to line item date all home health services furnished during a visit. The service date had to be present or the claim would be rejected. In addition, the line item dating limited the claim to 55 items, thereby forcing home health agencies to file additional claims where more than 55 services were provided during that period of time subject to the claim. The line item dating requirement was intended to provide further information to support HCFA's management of the Part A to Part B shift of the home health benefit.

IMPACT

Billing software and operation systems had to be modified to gather the necessary date related information, transmitted to billing operations, and properly record these services dates on the billing forms. The transition to this process forced home health agencies to incur significant costs to acquire revised software, educate staff on the new requirement, and monitor compliance.

Institution of Home Health Agency Parent, Branch and Subunit Criteria

In August 1998, HCFA issued a Program Memorandum that consolidated and clarified guidelines for distinguishing between branch offices and subunits of parent agencies. While HCFA may have considered its Program Memorandum to be merely a clarification, it entirely changed the standards that had been previously applied. With the "policy clarification" HCFA turned its primary focus to the distance that a home health agency branch was located from its parent in terms of time and/or miles. In many of the HCFA regions, a home health agency was precluded from maintaining a branch if the site was located more that 1-hour or more than 60 miles from the parent location. As a result, several thousand home health agencies were forced to either close branch office sites, relocate the sites closer to the parent, or transition the site to the subunit status. A subunit home health agency must demonstrate that it independently meets the criteria for participation in the home health agency without services from the parent. A branch does not have to independently meet the Medicare conditions of participation.

IMPACT

The cost of transitioning to subunit status, closing a branch, or relocating a branch can be measured in several ways. A subunit must have its own administrator, governing board, professional advisory committee, system of personnel and patient records, billing system, and cost reporting. Relocation costs of a branch to more proximate site to the parent, could involve higher space costs, moving expenses, increased costs for staff travel to patients, and potential penalties for early termination of a property lease. The closure of a branch generally would lead to a reduced volume of patient visits, thereby increasing the unit cost of service as fixed operations costs were allocated to a smaller universe of visits.

Institution of a Corporate Compliance Plan

While institution of a corporate compliance plan conforming to guidelines issued by the Office of Inspector General is voluntary, the OIG and others have strongly encouraged home health agencies to implement a detailed compliance monitoring system.

IMPACT

A comprehensive corporate compliance plan involves intensive administrative and management responsibilities. Internally, cost reporting and claims auditing system must be created, implemented, and managed. Staff education and direct leadership involvement are crucial to a compliance plan. The value of a corporate compliance effort is significant and direct to the Medicare program as claims error rates under the home health benefit have dropped dramatically.

1999: OASIS Implementation

Effective in June 1999, all Medicare and Medicaid home health agencies were required to conduct an OASIS assessment on all skilled care patients and electronically transmit the assessment to a centralized database within each state. The assessment was required for all patients; reporting is currently required for only Medicare and Medicaid patients. It is expected that HCFA will release patient identity encryption standards that will lead to the expansion of the reporting requirement to all skilled care patients regardless of payer source.

IMPACT

Home health agencies were required to engage in an intensive alteration of their patient assessment operation. The changes required included staff training, installation of performance monitoring systems, acquisition of software, creation of electronic transfer capabilities, and increase of data input resources. Many of these changes require expenditures both initially to establish the OASIS system internal to a home health agency and on an ongoing basis to maintain compliance. In addition, home health agencies are responsible for allocating significant additional nursing and therapy time to complete the OASIS assessment thereby increasing the average cost of a visit.

15-Minute Interval Billing

As part of the BBA 1997, home health agencies are required to submit home health service bills with the reference to the number of 15-minute intervals of face-to-face care time in each of the billed visits. The 15-minute billing requirement was instituted by HCFA effective for all bills after October 1, 1999.

IMPACT

Home health agencies were required to modify all billing processes to accommodate the 15-minute billing standard. Staff was required to record, in an auditable fashion, the actual face-to-face time in service to patients. This recording had to be translated to the number of 15-minute units. Billing formats and data inputs to support the formats required adjustments to meet the standard. As a result, increased service staff time, administrative staff time, and supportive software was required for compliance.

Medicare Claims Review

During 1999, HCFA increased its efforts in review of home health claims. These reviews took a variety of forms including prepayment claim review subject to the intermediary edits-focused medical review targeting certain providers or types of claims, comprehensive medical review of claims on a post-payment basis, and the use of statistical sampling for overpayment estimation.

IMPACT

While HCFA has full authority to engage in claims review, the increased volume of claims reviews combined with the variety in methods of claims review have significantly altered administrative responsibilities within a home health agency. Medical review requires home health agencies to allocate management, field, and support staff resources to responding to a claim review. These responsibilities range from processing the claim review request, securing and copying the requested patient records, forwarding the records to the intermediary, and monitoring the claim review results from a financial perspective. In addition, field staff resources are required for internal analysis of the claim compliance along with management staff resources to coordinate all activities related to claims review within the home health agency. Claims review also impacted on cash flow and necessitated borrowing to meet ongoing financial obligations such as payroll.

Beneficiary Notices

In 1999, HCFA issued instructions regarding the notices that home health agencies must provide the home health beneficiaries in advance to furnishing what home health agencies believe to be non-covered care, reducing, or terminating ongoing care. In addition, the instructions set out the process required for submitting bills to Medicare when the patient demands that a provider of services submit a claim for care which the home health agency believes to be non-covered.

IMPACT

Home health agencies had been using a HCFA model beneficiary notice that had been issued by HCFA in the early 1980's. The new HCFA instructions recommend using a series of three model notices to replace the single notice previously in use. In addition, the one page model notice was revised into a complicated four-page notice. It is also necessary for home health agencies to secure a written acknowledgement of receipt of a notice from the beneficiaries.

Home health agencies are required to replace existing notices with the recommended new model notices. This effort required a combination of efforts to compose the new notice to properly identify the particular home health agency along with obtaining printed notices for use with patients. Home health agencies had to engage in staff training efforts to familiarize them with the new requirements related to the notices and the demand billing process. Quality assurance monitoring systems had to be established to ensure compliance. Finally, increased staff time was required to respond to the numerous inquiries that came from beneficiaries who uniformly expressed an inability to understand the new model HCFA notice.

Y2K COMPLIANCE

As with other businesses, private individuals, and the government, home health agencies were required to undertake efforts to ensure that their computer systems were Y2K compliant prior to the close of 1999. Home health agencies are significantly reliant upon computerization for clinical record keeping, billing, and virtually all other aspects of their operation.

IMPACT

For some home health agencies, Y2K compliance meant a purchase of new hardware or software. At a minimum, home health agencies had to undertake a full assessment of their information technology capabilities and Y2K compliance.

Thank you, Mr. Chairman, and Members of the Task Force, for the opportunity to present our views on Medicare's regulatory impact on patients and home health providers. Your efforts to recognize the costs of new administrative requirements upon home care providers and your actions to ease the regulatory burdens can go far to stem the crisis in home health. Your actions can help ensure that the PPS is established on firm financial footing and provides access to countless eligible beneficiaries that might otherwise lose access to needed home care services.

Chairman CHAMBLISS. Let me just start off by asking Dr. Robinson, we have been involved in Medicare now for 35 years. Obviously, I think when you started practicing, Medicare was on the books and being implemented. But if you will take a minute to tell us what differences you have seen in the complexity of dealing with Medicare, particularly from a regulation causation standpoint over the last 20 years in your medical practice.

Dr. ROBINSON. Well, I think there has been a cultural shift, if I could say that, in the practice of medicine. When I commenced my medical practice, it was—I think the idea that a physician would know the patient's insurance status and would know anything about the compensation or billing issues that would be involved in a particular kind of patient, that was an anathema. It was a very unseemly thing to do. And there was—I think that served the patient's interest to have it that way.

And what has happened since that time is that this morass of regulations and coding issues and potential prosecutions has totally transformed the circumstances of health care delivery, and it is a very unwelcome intrusion and I think it has had a negative impact on patient welfare.

Chairman CHAMBLISS. Let me ask the same question to Ms. Murray and Mr. Vaughan, if you have any comments that you can make on that same issue.

Ms. MURRAY. I would agree absolutely with Dr. Robinson's comments. I was sitting here thinking about examples in hospitals. For

example, when Medicare started to reimburse for observation care, we needed patients to stay in the hospital for maybe a day after a certain procedure or certain surgical procedure. Medicare said, here are the rules regarding observation care, here are the rules regarding inpatient care. And we started classifying patients rather than thinking about how long do they actually need to be in the hospital. We were thinking about what is the right reimbursement format and how do we code these patients, et cetera.

Right now there is a conflict between the PRO and HCFA on observation care. HCFA rules—or our intermediary for HCFA rules has stopped paying patient for observation care and told us to classify these patients as inpatients. The PRO, however, denies these patients as inpatients because they don't meet the inpatient criteria established by PRO. Again, our choices are don't take care of the patient, which of course we couldn't do, or take care of the patient without reimbursement which is exactly what we have been doing for some time now on observation cases.

The other major concern obviously is the tremendous additional administrative burden in the over 100,000 pages of Medicare rules and regulations. We try to shield our staff taking care of patients from this problem, which isn't so easy in a physician's office. And it isn't always easy on the day-to-day basis if you don't have sufficient administrative staff to do all these things, as in the case of Mr. Vaughan. But in our case, all we do is add costs and that has been a major problem for us over time.

Chairman CHAMBLISS. Mr. Vaughan.

Mr. VAUGHAN. Yes, sir. Again, I would agree in full. The changes I have seen that are the most burdensome, again, are the paperwork requirements, much more advanced coding. It is very difficult, very nebulous; also, to a large degree, really interferes with your ability to treat a patient. As an example, the laboratory having to have the exact codes for the diagnosis prior to the diagnosis essentially being made for the patient. A lot of that is exploratory and a person is coming in with lab work, say, for an outpatient testing procedure, it ties up the process of us being able to get that patient in quickly, possibly for surgery. A lot of things today involve a much more complex system of reimbursement than it was years ago when I first started out. And the talk many years ago, again, was simplifying the system, but I have not—I can't think of any simplification that I have seen in what we do. The complexity level now is at a point that regardless of size of a hospital or a physician's office or any other providers, it is nearly impossible to comply.

I think you will find that the industry, while there are problems—and I know a large part of this hearing today involves compliance and actual regulatory measures there, are very important. Most of the providers in this country want to be complaint with the law, make every extra effort possible. Again, you are dealing with small offices and small hospitals, and, again, even large hospitals have the same difficulties when you make the regulations very difficult to interpret. Again, it is that Catch-22, as was mentioned, it is a formula for disaster. I think that the true—essentially people that are breaking the law need to be identified. They are the ones that need to really be burdened by these things.

On the other side of the coin, the efficient providers of care are the ones that should be rewarded, those that seek the highest quality and do it most efficiently. The system doesn't do that now. There is no reward for a hospital that runs better than the next, particularly with the evolving legislation that is out there.

Hospitals—again, just as an example, some of my doctors as recently as last week talked to me about the amount of time in their office spent on paperwork, which has gone up as high as 50 percent in some instances. I would estimate my nurses spend 25 percent of their time on paperwork and charting versus actually hands-on patient care. It is probably one of the largest complaints a hospital administrator hears today: That wasn't enough time, really, spent talking to my mother or my father. You provide good care but you don't have enough nursing staff. It is essentially a lot of things are taken away of why that patient is really there.

Again, our organization seeks to be the highest quality. We were recently surveyed by the Joint Commission and scored extremely high. We put the effort in, we achieve the things we want to achieve, not because we are required, but it is so much more difficult these days. And that is my overall feeling. I have been in hospital administration about 15 years and it is vastly different. At some point along the way I thought it would probably improve and things would level out to a degree, but at this point it has gotten almost to a destructive nature.

Just by chance I picked up the Savannah News. I have only been in Georgia one week—and this was two days ago, and on the front page here is a hospital in rural Georgia that is closing. In fact, it is already closed. So, again, it is just a good example. The smaller hospitals, less than 50 beds, are really up against the wall.

Chairman CHAMBLISS. Thank you. We have got one other change in schedule that has just come about. The folks that have the room at 12 o'clock are going to be through at 1 o'clock. We are going to break now and instead of coming back and rushing through a few questions, if you all could come back at 1 o'clock, we will start again. Before we break, Mr. McDermott has a comment.

Mr. MCDERMOTT. I have just one question or one request of you. You have 2 hours which we didn't know you were going to have. If you would sit among yourselves and write down the 10 things, if you had your wish list, that you would have done. We will give you 2 hours to think about that. This is a blue book challenge.

[Recess.]

Chairman CHAMBLISS. We appreciate very much your patience. And I am sorry instead of 1 it is 1:15, but hopefully we will be able to complete this hearing without any more interruptions. I am not sure how many of our folks will be able to come back. I have talked to a couple of them, who said they were not going to make it back, that asked me to raise a couple of questions and ideas which we have previously talked about. I will let Mr. McDermott get to his David Letterman Top 10 List when he gets back.

You know, in dealing with some other Federal agencies, particularly those that have service within their name, we find that those organizations who are supposed to be service organizations from the Federal Government standpoint are really not service organizations. They are more organizations that tend to try to wield a

heavy hammer rather than trying to help people out, even though they are intended to be a true service agency. And I am wondering if we have that in Medicare.

For example, if you have a situation in your office that you are unsure about, whether it is legal, ethical, or whatever within the rules of Medicare, is there anybody you can pick up the phone at Medicare and call and say hey, this is a situation that we are facing; we need some guidance and we need some help in establishing a program or making sure we are doing the right thing. What has been your experience that that respect?

Ms. MURRAY. If I can start, you know we work through Medicare intermediaries who are the organizations that we work with to clarify Medicare policies and to make our payments, et cetera.

Medicare intermediaries can change. And for us, for example, our Medicare intermediary changed recently and we now have 30 new policies that came out from our intermediary to guide their requirements for our payment. They happen to be different from the physician intermediary policies. So there is some conflict between the two sets of policies.

We are required to go to the intermediary for questions and it is often very difficult to get clarification from the intermediary. For example, there are hospitals who are occasionally overpaid by Medicare. And we know of instances where hospitals who have tried to repay the money through the intermediary and the intermediary will not take the payment. This reflects poorly on the original intermediary processes, et cetera, et cetera.

Hospitals then tend to put that money in an escrow account, hold it, and try to pay it back in some fashion. If, however, they are audited by the Federal Government, they can be accused of fraud for keeping an overpayment from the Federal Government.

These kinds of issues are very difficult to resolve through an intermediary, if not impossible. So it is just an example of some of the difficulties that we have. The intermediaries also interpret the regulations differently on the basis of the intermediary and sometimes on the basis of the individual that you talk to with the intermediary on any given day. And that also makes the situation even more complicated.

Chairman CHAMBLISS. Do you ever get to anybody at the grassroots level of Medicare who is making a decision up here at the top, or do you strictly have to deal through the intermediary?

Ms. MURRAY. We generally deal through the intermediary. I can't answer specifically if we have ever gotten through our finance office to somebody else, but generally we have to deal through the intermediary.

Chairman CHAMBLISS. Anybody else?

Mr. VAUGHAN. I would agree with Kathleen's statement. It is pretty much the same, but again it would be a possible solution to have the parties get together. The intermediary has always been the middle and it is not like you have a local representative that you can discuss any situation with really. But if that would be a possibility in the future, it would be something worth looking at if you have an issue or problem that can really be worked out on a more local level, but the system is not designed that way currently.

I don't think it is anybody's particular fault right now; it is the system design that we have.

Chairman CHAMBLISS. Apparently that kind of problem must not be an uncommon problem, because in some reading that I have done I have seen where folks have had some—for some reason, the figure 11.80 has appeared in three different examples, and I guess that is coded to something. And they wound up spending thousands and thousands of dollars in legal fees and accounts fees plus their time in trying to get it resolved. Maybe that is something that we can look at on our end to establish some sort of direct line of connection between you all and HCFA.

Dr. McDermott is back with us. I told them I was saving your Top 10 David Letterman issues until you got back here. So I know you have got to leave. I will give you the freedom to take care of whatever.

Mr. MCDERMOTT. First of all, I have a couple things to say. One is that you must not be doing too bad a job, since I understand Medicare pays 95 percent of the clean claims without any questions. So we are talking about 5 percent of the claims that they are questioning or at least that is the way it looks to me. And I wonder if I could ask a question of the two doctors. If you order a chest x-ray, shouldn't you be able to put down a diagnosis that might be related to that chest x-ray? Now when I was a medical student we used to have kind of standing orders; we just ordered a chest x-ray on anybody whether or not the issue was related to the chest. And I suspect there have been hundreds of thousands of chest x-rays done that were not useful in terms of diagnosis.

So what I am interested in is wondering if you—I mean, I picked this because it is the one specific you gave me. You said lab tests are being held up because there is no ICD9 code. If I am going to do a chest x-ray, I probably am looking for something in the chest. And if I put down carcinoma of the lung, because that is what I think it is, and it turns out to be bronchitis, that is not going to invalidate my claim, is it?

Mr. VAUGHAN. That is directed to me. First of all let me state I am not a doctor, but I will try to answer your question. My understanding from the physicians on our clinical staff, again, is—and your point is valid, I understand what you are saying, but the regs are nebulous as it stands. If, say, that diagnosis turns out to be a false negative, say, it doesn't exist, say, will that claim be paid or not and does the patient indeed have the responsibility? So again, it is—these are new regs and they are very difficult to interpret.

In the past, you know, it wasn't the type of system we had. Again, it is—I think people agree with the intent and, again, waste in the system and so on. But it is a little bit more front line right during the time that you are practicing medicine as a physician and the hospital is trying to respond by offering you the test that you need. And it is kind of in the way right now—the way people are interpreting the regulations.

Again, my statement would be that they need to be looked at, they are coming on real fast, and very few people are having a chance to understand the regulations and really operationally put them in place, because you are talking about many, many thousands of contacts just in a small hospital with the lab and x-ray

and ultrasound and other things. Laboratories are particularly complex due to the multitude of tests and the diagnosis lining up with the test. But, again, I am speaking not as a physician but as an administrator.

Mr. MCDERMOTT. Your response, Ms. Murray.

Ms. MURRAY. I would agree with what Mr. Vaughan has said. I think the fear that Dr. Robinson mentioned of potential fraud accusations contributes to this problem, too. So if you are a physician and the hospital says you know you've got to put in ICD9 codes, which by the way is an inpatient diagnostic code, in there before you order these three lab tests, they are going to say, well, I don't know what the diagnosis is. And if I put something down that is wrong, I might be accused of fraud in the future.

So the physician is in a position of having to supply information that he doesn't necessarily have, even if he might have a rule-out diagnosis, which is not acceptable anymore. Then he has got to put some diagnosis down, might be wrong, fears fraud, doesn't want to do it, comes to the hospital without the diagnosis; hospital fears fraud, doesn't want to do the test. And, as I say, we are doing the test, sometimes we are going back retrospectively trying to get an ICD9 code once the patient has the diagnosis information they need. But that is not what the law requires, the regulation requires the code in advance.

Mr. MCDERMOTT. When was the rule-out diagnosis made invalid?

Ms. MURRAY. I can't answer that question. But I am told that the old, more general, ICD9 codes are no longer acceptable. It was recent but I am not sure when.

Mr. MCDERMOTT. The issue, I guess, you can see it from our side, that if somebody has a lab in their office and they want to run everybody through, no matter whether or not and charge $15 a crack, they can have a good time making a lot of money but not doing anything for the patients. Obviously no one wants to deny the test for the patient who needs it, but the question is how do you determine where some people do a urinalysis on 100 percent of the people who come through their office and some do it on 20 percent, the question at least could legitimately be raised, couldn't it?

Ms. MURRAY. I absolutely agree that there is an issue there. I would go at it more from a variance reduction in quality standpoint and perhaps look at self-referral—there is a strong look being taken at those kind of things. But I think what we have done instead of going after, say, the 80/20 rule in the areas where there is self-referral or where there is a variance from standard, is we have just taken a broad brush and penalized everybody and caused a problem in actually giving care.

Mr. MCDERMOTT. Dr. Robinson, you raised the issue of fear. I don't know how you write rules and regulations without putting the fear of God in people, do you?

Dr. ROBINSON. Yes.

Mr. MCDERMOTT. OK, tell me how.

Dr. ROBINSON. Well, I think the first thing is to, I think, consider exactly what kind of conduct you are attempting to moderate. And so if the conduct that you are attempting to moderate is merely a misunderstanding of the billing codes—and that is not an appropriate area in which an American citizen should fear his govern-

ment—some dispute over the nuance of a billing code when there is a motivated practitioner attempting to do something. So there should not be any criminal penalties, there should be no sanctions attached to that type of dispute. There shouldn't be any sanctions attached to it.

Those behaviors that I think every ethical physician recognizes is egregious and wrong and bad, I think would be important to identify that particular cohort of people that behave that way and I then I think try and particularize the demographics of where these abusive procedures have occurred, and then that is the place to place sanctions. And also I think it would be important to try and cooperate with physicians to accomplish that.

I think it would be an important step forward in this whole debate to accept the idea that physicians are on the same side as the objectives of the government in many ways. They want cost reduction, they want quality of care. The problem is if the government or HCFA treats them as presumed to be guilty of some kind of fraudulent behavior, it minimizes their contribution to this process. So that would be one suggestion I would have.

Mr. MCDERMOTT. So you think that if the doctors felt they were part of the process, they don't—your medical association doesn't make input into the rules and regulations, they don't make comments during the rule period?

Dr. ROBINSON. Well, you know I am speaking from the point of view of a person at ground zero. There is a whole apparatus that exists in Washington. And when I leave here I am going to go back to my vineyard and do my best for my patients, and I will leave the apparatus here. But as far as I can tell, the perception of physicians out in the provinces, if I can say that, is that they have very little ability to influence HCFA policies. HCFA policies seem to just be propagated by some distant czar and they are coming down upon us, raining down upon us, and there is not the perception that we have any influence on what is occurring. And many times we see things that seem to us to be quite outrageous, and there is not any easy mechanism that the ground zero physician has to do anything about it.

Mr. MCDERMOTT. Interesting fact about what has happened recently. In the last 4 years you have added 40,000 pages to that pile you described of 130 pages. Thirty of those have come in the last 4 years. So it is increasing. That is a 25 percent increase in a very short period of time. And I suspect that as we have pressed for more and more looking at fraud and abuse, that the result is that you get more rules and regulations. And I am not sure, I would like to hear what you agreed upon as 10 things to get rid of.

Dr. ROBINSON. Maybe I will just start out by saying it is interesting that we had sort of a quick little lunch here. In the course of our quick little lunch—we got a nice Thai cuisine—we came up with 26 different ways to straighten the process out.

Mr. MCDERMOTT. I hope they are written in legible handwriting, by somebody other than you as a physician.

Dr. ROBINSON. We have a very, what can I say, a very nice scribe here who has actually just written them down, and maybe she could start by going over hers.

Ms. MURRAY. Actually he accuses me of being a physician because of my handwriting. So we cannot answer in the affirmative to that question. We tried to come up first with some short-term practical suggestions. And then we have got some medium-term suggestions and then we have a few comments on long term. But let's start for me with the short term first.

We think that if we could have our wish list, which is how we viewed your request, the first thing would be to eliminate the requirement for physicians to submit inpatient diagnosis codes before diagnostic tests are done. Just the subject that you have raised here.

The second would be to eliminate the requirement for patients to fill out the Medicare secondary payer questionnaire at every single time of service. This is really a patient care issue for our patients as well.

Mr. MCDERMOTT. I don't understand why that isn't simply done administratively. What do you think they are trying to get at? If someone is coming up for their next radiation treatment, why do you have to go through that? I would think they would just say to the patient that came into the hospital, would you—are you—has anything changed since we saw you last? No. And that would be the end, and you reprint it.

Ms. MURRAY. That is not my understanding of the interpretation of the rule. I understand what they are trying to get at. Maybe you have acquired secondary payer coverage since you were last seen. And I don't think it was intended to affect patients who are seen two or three times a week, but that is really the outcome of it. Whether we can print off the same form—it has to be signed every time. And if we can print off the same form every time, then we can take it, but some more reasonableness about that rule would be helpful.

In addition, it is now a requirement that the physicians collect the Medicare secondary payment questionnaire for outpatient work that they refer to the hospital. This requires that the physicians do the hospital's billing work. And this is something that just doesn't work. And so this is something else we would love to see addressed.

Fourth, the intermediaries, as I mentioned, sometimes are part of our difficulties. The intermediaries all have something called—they are electronic checks on the claims system. And this is a check that they use to make sure that our bills meet the requirements. We would like them to give us that software so that we can do our checks before we submit the bills so we can submit a clean bill. Now, we have ways ultimately of manually finding out what those electronic claims checks are and then we try to get them into our system, but it would be much easier if we could simply have access to that and we could submit a clean bill that meets the requirement that is what they are looking for.

Mr. MCDERMOTT. What percentage of your billings do you have to resubmit?

Ms. MURRAY. That is a very good question and I am sorry I don't have the answer to it. But I will find out.

If you go to a little bit more medium term, we think that it would be nice to, as the vital statistics organizations have suggested, have one billing system rather than two.

Mr. McDERMOTT. One billing system meaning A and B?

Ms. MURRAY. Inpatient, outpatient.

We believe that you have some tools at your disposal, including the compliance with—including the Paperwork Reduction Act which also allows for regulatory flexibility for smaller hospitals. And we think that ensuring that HCFA follows the suggestions in the Paperwork Reduction Act would also be a helpful set of activities; and if necessary, use the Congressional Review Act to review regulations that may be beyond the intent of the law. And finally, we just have kind of a general simplicity in the consolidation subject which may get into a long-term approach.

That is my set of lists and then we each have a few others.

Dr. ROBINSON. I hope I can read this, Kathleen. I will do my best. But number 7 was to put in place an outcome analysis apparatus to evaluate the impact of HCFA regulations on health care quality. And I think that is a big deal. Quality. We need to have that in place in HCFA regulations.

Number 8 is a total cost analysis of HCFA regulatory decisions, the total economic impact on individuals, on the community, on enforcement and compliance costs. It shouldn't merely be that the government saves $2 if it costs society $10.

Number 9, there should be hearings with doctors at hospitals.

Mr. McDERMOTT. Let me ask one thing about that because that is something from your testimony. If they deny a $2 event, and the patient has to pay $10 out of their pocket, is that what you are talking about? Or are you talking about someplace down the road, the cost of not having dealt with it earlier is more expensive because it was not early diagnosis or whatever?

Dr. ROBINSON. I would say the latter. Often HCFA is exercising a tremendous role in our society. They are making decisions on a bureaucratic basis that have extraordinary economic impact. For instance, if someone is—maybe the regulations don't allow them to get a particular kind of treatment. The treatment is deferred, the patient gets sick, is not able to work, not able to—has to go into a nursing home. That has a very large economic consequence that is past the micromanagement of HCFA regulations. Or a patient is discharged to a nursing home a great distance from the family, and that family has to take—all the family has to get off from work, they have to drive 200 miles. That is an expensive economic event that has transpired against the Nation's interest, all referable to HCFA regulations. So I think that is an approach that needs to be adhered to by HCFA.

Well, number 9 is hold hearings with doctors in hospitals who have been audited to hear firsthand their stories. There are a lot of stories out there that are circulating about very inflammatory events that have occurred. And I think those stories need to be aired, and if there is some violation of good sense that has transpired, the exact causal factors that allowed that to happen should be dealt with. I think that would be a useful hearing to have.

Number 10 is a comment about fraud, and I think it is important to remember. Every ethical physician is against fraud. They think it is reprehensible, it is bad, it is wrong when it happens. And I think an effective way for HCFA to proceed against these cases of fraud would be to isolate those cases that are egregious, they are

obvious, there is just no doubt there is criminal intent involved, and then see in what circumstances those criminals actions occur. What were the demographics of it? Where did this take place? And then concentrate resources on that particular situation.

And there is some kind of 80/20 rule out there, is there not? So if you focus your resources on 80 percent of the problem, you will have a maximum amount of efficiency. So I think that might be a good suggestion.

Number 11 would be to decriminalize billing errors. So there ought to be some sense that—and I think this is an important thing I'd like to stress—is that doctors by their nature, by their training, by their predispositions, are ethical people. They try and do their best in often difficult circumstances. They are not bad people. The regulations are complicated, and it is an appropriate gesture to recognize that and not hold them liable for some coding error.

Number 12——

Mr. MCDERMOTT. Do you have some kind of threshold about that? I mean, I understand what you are saying. And having been a physician and having filled out lots of billings, I understand one can make mistakes. One mistake is certainly not a hanging offense; 2, 10, 500, 1,000, always the same, they have always jacked it up one level. Instead of being a brief visit it becomes an extended visit. If you hadn't had an extended visit, you would have to have seen 20 patients in an hour.

What I am trying to get at is how do you—where do you put the screen for that issue?

Dr. ROBINSON. Well, you know, I would let common sense be my guide. What a reasonable, rational person would say, just looking at the situation, is that these regulations are unbelievably complicated and they are changing all the time. And if there is some kind of just obvious situation where the physician said, look, these new regulations came in, I am supposed to do this, I am supposed to do that, I put a 2 down, I put a 3 down, this is what happens, there should be some way to balance possibly on the other side under coding that occurs.

So one thing that often happens, you have said, we have got this type of conduct where things are being overcoded, probably the more common things are things to be undercoded, because a physician generally in doubt over any of these issues tends to, in my opinion, overcode. That has been my experience. The compensation is not extraordinary. It is a relatively small difference. And most physicians go out of their way to avoid any entanglement with the Federal Government. So I just think common sense would be a guide.

Ms. MURRAY. If I could just add one thing, I don't think it is the number of times it occurred, 50 times 1,000 times, I think it really does come down to intent. For example, there is a hospital recently who had a billing clerk who was consistently checking the wrong box. It was an error. It was a clerk, there was a box, and she checked the wrong box. That hospital, I think, needs to pay back the government whatever they owe them but not pay tens of millions of dollars in fines and penalties because there is an assumption that all of this was done on purpose.

If you have institutionalized upcoding, you have built it into your computer systems, you have built it into your physician capability, they can only check the higher level, that I think is very different and does provide an opportunity for penalties, et cetera. But it isn't a matter of how many times did it occur; it is a matter of how did it occur.

Dr. ROBINSON. If I might just speak—a lot of times what is going on here is the documentation issue. I mean, it is very complicated to know if you are having some kind of coding going on for a service that has been rendered. The evidence of the service being rendered is the documentation of a particular service, if I could say it that way. And the skill and effort that goes into documenting, that is often a major variable in how things work out. But it is not necessarily in the patient's interest that the physician spends his time on trying to placate HCFA.

In other words, if you are sick in the hospital, a physician is putting notes on your chart, those notes should be directed toward your welfare and not these arcane coding regulations or identification about what service has been rendered. I think that is often a confusing issue and it is not—when these coding disputes occur, it is often related to documentation, documentation dispute, which is I think the wrong thing to criminalize.

Well, OK. Number—if I may continue. Number 12 is we suggest that there be an ethical oversight committee to assess HCFA's micropolicies and to make sure those micropolicies are not having a negative ethical influence on patient care. I think we are concerned that there is too much focus by accountants on micromanaging numbers, and that in the culture that is present at HCFA, that we are concerned that the patients may be penalized. There may be ethical lapses that are occurring.

For instance, if a patient is—the numbers shake out a certain way in the coding and the patient is denied appropriate care—there needs to be some kind of overview attached to that; or if these micropolicies are sabotaging physician independence or causing an erosion of the quality of people that go into medicine, if that is what is happening, there need needs to be a mechanism in place for HCFA to take a look at that. So we think that might be a good idea.

Mr. MCDERMOTT. Sort of a patient's bill of rights.

Dr. ROBINSON. I certainly think that is not a bad idea.

Mr. MCDERMOTT. Or a doctor's bill of rights.

Dr. ROBINSON. The two are the same. I would like to think they are the same. It is not that physicians—they are the agents of the patients. Their attention is focused on the patients. I think the two are the same.

Let's see. I have now—we put this one in, our 13th one is there are a lot of individual parts of medicine that are having a negative—being negatively impacted by HCFA. And we considered mentioning neurosurgery but we elected to mention psychiatry, just to throw a pitch at you. But one of the things that goes on is that frequently it is necessary to send in confidential records to HCFA in order to receive payment.

We think this is an egregious situation and you should have—your psychiatric records should be confidential and no government

clerk should have access to them. We hope we will get some action on that.

Mr. MCDERMOTT. That is why I voted against the amendments actually, because I recognized what was in them, read them, and said this isn't going to work in the long run, or it shouldn't work this way in the long run.

Mr. Chairman, unfortunately I have something I must go to. You have been very generous in letting me ask a long series of questions. I would hope that you would note those questions and that, Mr. Chairman, we could submit them to HCFA when they come before us and let them respond to them as a way of seeing if we can't actually do something positive about this rather than just sort of moan about it.

I would like to actually get some action, and maybe if we present it to them in advance, they could look at them and respond for our committee, if that is a reasonable suggestion.

I am very sorry I have to go. I appreciate what you did at lunch in putting your list together. And if you would submit it to the committee for our consideration and let us try and pass it on, I would certainly be willing to work with the Chairman to try and get some answers on the specifics, because that is really what we hope will come out of this.

Chairman CHAMBLISS. Well, thank you for that suggestion. That is exactly what we had talked about earlier today of doing. Once we complete this—and one reason for getting written responses to questions is that we want to be able to compile a list to send to them to be prepared to respond to this set of circumstances or facts when they come before us. Thank you.

Ms. MURRAY. We actually hadn't completed our list.

Chairman CHAMBLISS. Why don't you go ahead and complete your list and we will get it all in the record. Let's go ahead with it.

Mr. VAUGHAN. Yes, sir. Mine are fairly brief and not numerous, to finish the list:

Expedite the processing of provider numbers when the number exists or the ownership of a hospital or organization changes and therefore that number needs to change, or if an existing physician provider moves to another location or works for a different organization, as many physicians now are employed. And that causes a great deal of problem. It used to transpire within a few days; now it is very lengthy. I am not real sure why the change took place, but a lot of organizations now are changing ownership so it has even more profound affect.

Prompt payment from government and private payers. It is a real key issue with any provider, particularly rural hospitals.

Simplify cost reports. Cost reports reimbursement now has not really driven up costs. Again we still submit a quite lengthy and involved cost report which involves quite a bit of work, a lot of interaction with the government getting it finished up.

Secure the Medicaid DSH program for States. That has been an issue that is subject to I am sure a lot of discussion. But in the rural areas, the disproportionate share is very important. My hospital alone—again, we are a 116-bed hospital, but we provide over $1 million of indigent charity care each month. So, again, that DSH

payments from the State of South Carolina in combination with Federal funds assist us in some level to help offset that, but it is at risk of disappearing. South Carolina lost over $50 million in the program this year.

Rationalize the geographic system of payment to hospitals. I don't know, again, when the lines were drawn and the system worked out. I think today, though, it needs to be reevaluated. For instance, my new hospital in Georgia is right on the boundary of the wage market for Savannah. So you know we have a high-wage bracket, but we are in a rural area and are paid as such. I am sure that situation exists throughout the country.

I think the advance beneficiary notification needs some clarification. It is very complex. And it goes back to the statement I made about the lab and whether the hospital would be paid or the patient has to pay it. Again it is an extremely difficult piece of legislation for us to deal with. It is pretty much an unknown right now for us to be able to handle it operationally.

Again I'd have to mirror target true fraud and abuse and come down hard. I think everybody agrees on that. It is a blight on our system. Again I don't have the suggestion, how do you pick out that true fraud? But again I think some different ways of enforcing that need to be looked at. I think where there is intent it is pretty obvious, and when it is found out—I think I speak for most of the hospitals I am familiar with—it needs to be dealt with severely. Reward efficient hospitals and organizations and physicians but, again, reward the ones that show a high degree of quality in outcomes.

There are many outcomes measurements out there now with the Joint Commission and also other organizations, and I think efficiency is important, but outcomes and quality of care are the key issue here. Today I can't say that someone that offers high-quality services is rewarded any differently, other than their own self-satisfaction in what they do, than, say, an organization that doesn't. That might ought to be an objective for the long term. That would complete my statements.

Chairman CHAMBLISS. Did we get them all?

Ms. MURRAY. We did. Thank you.

Chairman CHAMBLISS. All right. Dr. Fletcher.

Mr. FLETCHER. I appreciate your testimonies and your list also. And having just come recently from practicing medicine, I know exactly what you are talking about in working with hospitals.

Chairman CHAMBLISS. Before you get started let me—they have just called me to the floor. I have got to go over and participate in a debate that we have got on our defense authorization bill. I hate to run and leave you, but I will leave you in good hands with the vice chairman of the Task Force, Dr. Fletcher.

I want to tell you how much we appreciate your being here. We thank you for your patience. We want to continue the dialogue with you on this issue which I think is extremely important to your profession, but most importantly I think you would agree it is extremely important to patients out there that you care for and we try to look after in this level up here. So thank you all again very much.

Mr. FLETCHER [presiding]. As I was saying, I understand clearly the concerns you have, and I guess I differ with my other colleague that mentioned how do you write regulations without instilling fear. I think that is a very wrong approach. I think, clearly, those folks that are intending to defraud HCFA and the American taxpayer do need to fear that there will be punishment and criminal penalties for that. But the physician that is out there practicing, the nurse that is in the hospital, and the hospital administrators need to be focusing on patient care and quality, not on fear of their payer. And I think that is what is happening.

Whether some of it is warranted or not may be questioned, but I think there is that feeling out there and I think we have done a disservice, because I don't think even, though, when we all have a great deal of complaints about private insurance and we need patient protection—and there is no question about that—but I don't think there is the same fear of other folks that are paying the bills that there is against HCFA.

Let me just say also in light of that, I think regulations can be promulgated to have HCFA and the administrators help assist us to make sure that we are doing the kind of jobs we need. I know they have been helpful in some cases.

I am very concerned that in my own experience—and I would like for you all to comment on this—two things. One, much of the time that we spend now and I spent with my office staff was on just trying to comply with regulations. That took away our attention and our time toward making sure we kept up on the latest in what is available to care for our patients, making sure that we were overseeing the care of our patients; hours in the evening, making sure that we document everything clearly, dot every I and cross every T. So there was a lot of continuing medical education that is focused toward just CPT coding, et cetera, compliance. We set up a compliance board and structure just so, if they did come in, they would be assured or at least more assured that it was our intent to comply. And the very purpose of that was just to make sure that our intent was understood.

How much time do you all spend, would you say, in making sure that you are educated or your staff is educated just to comply with HCFA regulations?

Ms. MURRAY. I will lead off. I know we all have answers to that. At the hospital, we say—I couldn't agree with your comments more. Let me start there. At the hospital, we say that every person should serve the patient or serve someone who serves the patient. And right now——

Mr. FLETCHER. Let me interrupt you right now. Could you tell me how many folks you have in administration versus people that work for you that touch patients?

Ms. MURRAY. It is another very good question, but I don't know that I can add up all the FTEs right now. But I will be happy to answer that question. But I can give you some examples.

Mr. FLETCHER. That would be fine. If you could look back at your numbers and forward that to the committee for entry into the record it would be great.

[The information referred to follows:]

MS. MURRAY'S RESPONSE TO QUESTIONS FROM MR. FLETCHER

I thank you and the Health Task Force for the opportunity May 18, 2000 to provide testimony on behalf of the American Hospital Association and Northwestern Memorial Hospital (NMH) about the burden of Medicare regulations on providers. Your subsequent request of the Office of Management and Budget to review the Medicare Secondary Payment Questionnaire as a possible violation of the Paperwork Reduction Act is much appreciated. This arduous process requires providers to ask beneficiaries up to 25 questions each time they present for a different type of service. A copy of each questionnaire must then be kept (either electronically or on paper) for 10 years.

Below are responses to questions posed during the hearing for which I did not have an immediate answer. I have also included suggestions for change and examples of problems experienced by providers that I hope will be useful to the Committee in future meetings with the Health Care Financing Administration on this issue.

Congressman Fletcher inquired as to the number of NMH employees assigned to patient care activities as opposed to those whose work entails non-patient care activities. Currently at NMH, 3,084 employees provide patient services (e.g. nurses, physicians) while 1,563 employees have non-patient care roles (e.g. housekeeping, food service, billing and accounting, administration, attorneys, facilities management, etc.) for a total of 4,647 employees.

The Congressman also asked about the necessary staff time and expense of complying with Medicare regulations. Six departments handle the bulk of the Medicare compliance and billing: Patient Accounting, Admissions and Registration, Case Management, Medical Records, Information Systems and Corporate Compliance. We estimate these departments (25 FTEs) spend 46,352 hours annually on Medicare compliance. The estimated annual cost of this, including salaries, benefits, equipment, materials and vendor fees, is $1,590,747. However, this is not a complete estimate of the true annual cost of compliance with existing Medicare regulations. It does not include the work of our legal team, senior management, and the physician relations department, nor does it include the cost of conducting a necessary internal audit to ensure compliance. We are in the process of developing a system to better track the time and money spent in this regard.

My testimony also included an explanation of the difficulties surrounding the requirement that claims for certain lab tests include an ICD9 code diagnosis (inpatient) prior to testing or the claim will be rejected. The catch 22 here is that the diagnosis cannot be made without the test results. Congressman McDermott asked when this requirement became effective. This policy went into effect on January 1, 2000. As I said in my testimony, because of this policy, hospitals are forced to choose between providing the care or delaying the test until the proper diagnostic code is received. NMH chooses to provide the tests and risks not receiving reimbursement. In May I reported to you that NMH was holding $3 million in Medicare laboratory billing for this reason. This figure has grown to $4.6 million in just over a month.

In addition to addressing the above issue, other suggestions for change include:

I. Medical necessity standard.

The problem is not with Medicare's expectation that physicians and hospitals provide only medically necessary services to Medicare beneficiaries, it is with the implementation of the standard. HCFA has delegated the responsibility of determining medical necessity to the local fiscal intermediaries. The vehicle for this determination is a publication called the local medical review policy (LMRP). Medical necessity standards or LMRPs should not be "local", they should be implemented nationally and for both Part A and Part B for the reasons listed below:

1. Patients who access services in multiple fiscal intermediary areas find inconsistencies in the benefits covered.
2. Areas serviced by multiple fiscal intermediaries are subject to differing policies.
   (a) Hospitals (Part A) and Physician Offices (Part B) offering similar services are not subject to the same requirements.
   (b) Areas where hospitals in close proximity are covered by two different FIs are not subject to the same requirements.
3. Fiscal Intermediaries are not communicating policies (which determine whether benefits are paid) to patients, physicians, or hospitals on a consistent basis.
   (a) Part A FI does not distribute draft policies to providers or physicians for review and comment; they are distributed to professional organizations, who then distribute them to local providers (not physicians).
   (b) Part B FI does not distribute new Part A policies to physicians who refer their patients to Part A providers.

(c) Part A FI does not communicate benefit changes (by service area) to beneficiaries.

EXAMPLE

Consider three physicians and their patients, noted as physician A, B, or C. All three physicians' offices are in the same building (different offices) and each orders a chest x-ray for their patient, with the exact same reason for the test.

Physician A orders and performs the chest x-ray in his office.

- No Part B LMRP exists for chest x-ray.
- Physician bills Medicare; claim is paid.

Physician B orders chest x-ray and refers patient to Hospital 1 for test.

- No Part A LMRP exists for chest x-ray
- Hospital bills Medicare; claim is paid.

Physician C orders chest x-ray and refers patient to Hospital 2 for test

- Part A LMRP exists for chest x-ray
- Diagnosis provided does not meet LMRP requirements
- Service considered "non-covered" by Medicare

As a result, Hospital 2 is faced with the following possible scenarios:

1. Prior to rendering care, the hospital explains to the beneficiary the services are not covered by Medicare and the patient either:

- Agrees to sign the Advanced Beneficiary Notification (ABN), which makes the patient responsible for the charges.
- Insists the provider bill Medicare. This requires manual intervention on the part of the hospital to ensure the proper coding is on the claim to indicate the patient's demand for billing, so as not to be included as an example of a "false claim".

2. Hospital 2 is unable to make the determination prior to the provision of care, and therefore is

- Not reimbursed for the service by Medicare and is prohibited from seeking reimbursement from the patient because it did not notify the patient in advance, or
- Able to follow-up with the ordering physician to determine if has "another" reason for ordering the test, but is prohibited from providing information regarding the "acceptable" reasons for ordering the test.

A number of problems exist because of this inconsistency in LMRPs:

BENEFICIARY PERSPECTIVE

1. Covered Medicare benefits are not consistent from provider to provider. A beneficiary could interpret this an unequal access to services among Medicare providers.
2. Medicare patients may interpret these requirements as the hospital trying to limit access to services, thereby preventing him from receiving medically necessary treatment.
3. The beneficiary is not aware prior to the point of service that this very routine test ordered for what appears to be medically necessary reasons (based on his/her discussion with the physician), will not be paid for by Medicare. The patient is placed in the upsetting situation of deciding whether he can or cannot afford to have the test.

PROVIDER PERSPECTIVE

1. This situation impacts the facility's ability to meet community health care needs and impacts the facility's financial viability.
2. Medicare does not save money in this fashion; Medicare pays the same amount from one provider or another.
3. This situation is not ensuring Medicare beneficiaries receive medically necessary services, but rather redirects business from one healthcare facility to another.
4. Providers assume all responsibility for communicating the coverage limitations under the pertinent LMRP to both physicians and patients as nedither HCFA nor the fiscal intermediaries do so.
5. Neither the patient nor the physician cares where the patient has the test done; both are approved/certified/licensed facilities. Both the physician and the patient want the test so treatment for the patient's condition can be defined and begun.
6. This situation negatively effects providers' ability to satisfy their patients' healthcare needs.

PHYSICIAN PERSPECTIVE

Though the physician is required to provide coding for services ordered, but performed outside of his practice,

1. The physician has not been notified by Medicare of the requirements
2. The physician has not been provided with the applicable policies associated with the outside referral points
3. The physician's administrative costs are now increased to provide the necessary coded information for each and every test ordered (beyond the single reason for visit to his office).

II. HCFA should work in tandem with major patient accounting systems vendors and hospitals, physicians, independents (e.g., labs, clinics, etc.) to develop a strategic information technology (IT) plan that provides for successful implementation of proposed changes.

Essentially, the problem is that HCFA implements process changes the same way it did 10 years ago despite the automation of today's information technology. A decade ago, HCFA announced changes that were then manually managed by providers from paper documentation. Today the complexity and inter-relatedness of the electronic file layout are substantial and require numerous verifications to assure accuracy. The precise manner in which the electronic file layout has changed is extremely important due to the ramifications to other data.

For instance, when a new code is introduced, it must be determined whether the code is alpha or numeric, where the characters fall in a data line, whether it is a new character set or whether characters are to be reused. Small changes in coding effect numerous "jobs" and reports, all of which must be tested to ensure accuracy and system balancing. However, implementation is invariably rushed because of the schedule set by HCFA, and yet hospitals and other providers are subject to prosecution for fraud and abuse for any errors which occur as a result.

Thus, a comprehensive, strategic IT plan would include:

1. Full disclosure of complete and accurate code/program changes, edits, etc.
2. Defined testing periods that include fiscal intermediary software development and validation testing, provider development and validation testing, joint validation testing, full production level/parallel testing between the the provider and the FI.

This would, at its most basic level, require defined periods for each phase of testing that do not exist today. Providers have found that FI's are still in the development stages right up to the point of implementation. Providers are then forced to implement systems that are neither tested, nor functioning properly and thereby require manual change resulting in payment delays at the provider level.

Additionally, because these local medical review policies are implemented in select areas and inconsistently within areas, none of the major systems vendors see this as a federally mandated change. Thus,

1. Vendors are unable to plan, develop, test and implement system solutions to support compliance.
2. Hospitals are unable to implement changes in a timely or efficient manner to support compliance, thereby resulting in high risk for reimbursement losses.

HCFA's response has been that hospitals are reimbursed via the cost report mechanism. However, at its best, the cost report mechanism only realizes 25-30 percent of actual costs (outpatient) and this practice is scheduled for elimination within the next 2 to 3 years.

As a result, hospitals bear the public relations, educational, and financial costs of communicating, educating, implementing, and enforcing these significant changes for beneficiaries and physicians, while the Medicare program itself has assumed little responsibility.

III. The Outpatient PPS implementation should be delayed further due to the fiscal intermediaries inability to test these systems and reimbursement changes with providers or major hospital system vendors.

1. As of today, our fiscal intermediary has not provided test capabilities to any of the hospitals it services in the Chicago area, nor has it tested PPS with any of the major patient accounting software vendors. Thus we anticipate an increase in the number of claims denied, payment delays and other problems. Though we are pleased at the Office of the Inspector General's announcement that OIG will not pursue providers for fraud and abuse during the outpatient PPS implementation, a further delay in the implementation would allow for a smoother, less problematic transition.
2. Medicare has not required Medicare Replacement (e.g. HMOs) or Supplemental carriers to implement these changes. As a result, neither group will be ready to accept the expanded line item billing, nor calculate fees based on the PPS. In addition, Medicare has not been able to define how beneficiaries will manage multiple Expla-

nation of Benefits forms that might be received for rejected line items that are subsequently submitted and processed. Supplemental carriers have informed Medicare of their inability to process these claims.

IV. HCFA should decriminalize billing errors and release information that will enable providers to bill for care more accurately and more efficiently. HCFA should take steps to communicate directly with all providers (e.g., hospitals, physicians, clinics, etc.) of impending changes, with plain English definitions of how these changes will impact their practices in advance of their implementation.

As any billing error in Medicare can be interpreted as a false claim and thus is subject to criminal penalties, hospitals cannot submit many claims for legitimately provided care as they are unable to code and process these claims without risking prosecution for fraud and abuse.

Ms. MURRAY. Let me tell you that the fastest growing segment of our costs is administrative. Despite the fact that we are maintaining our nurse/patient ratios at their historical levels, we are having serious difficulty controlling the growth of our administrative costs, particularly in legal, audit, and outside consultation, utilization management, corporate compliance staff, et cetera.

We have whole new staffs now in place to comply with the new corporate compliance constant issues of fraud and abuse corporate compliance, Federal audits, et cetera. We too have a whole corporate compliance program, committee, et cetera, as I mentioned earlier. Our people who want to either serve a patient or serve someone who serves a patient are now telling me, "But I only get to serve paper, I don't get to serve someone who serves a patient. I have to serve the paper." and that is extremely demoralizing for people who really want to take care of patients.

So my committee, my staff, has just incredibly high hopes that something could be done about this by the testimony at this hearing. I think it is probably not as easy as that. But if there were some way that we could get our focus back on patient care and quality, we should do that.

Mr. FLETCHER. Dr. Robinson.

Dr. ROBINSON. In our situation—well, I will just speak as the country doctor, if I can say that. Actually I try and avoid as much entanglement as possible with these regulations. I try and focus as much as I can on patient care. And so I am a reluctant, I guess I would say, acolyte to the HCFA's regulations, in general, and general paperwork. But in our office we have three employees that are pretty much full-time people devoted to trying to keep the paperwork straight with the——

Mr. FLETCHER. How many physicians do you have?

Dr. ROBINSON. We have five. So three of them are essentially devoted to keeping the HCFA paperwork straight. There are numerous conferences people go to, there are numerous bits of information that have to be looked into. The paperwork that comes my way, there is a big effort on the part of my office to minimize it, but I still have to spend some—I can't tell you the exact time, I will say if I work—maybe a workweek for me might be 60 or 70 hours a week, and maybe 5 to 7 percent of that would be enmeshed in some kind of bureaucratic paperwork, some number like that. So, a significant amount of time and a significant amount of energy trying to keep things straight.

Mr. FLETCHER. Mr. Vaughan.

Mr. VAUGHAN. I would say in the South Carolina hospital that I just served, we have 360 FTE and about 200 or so were nurses

and 100 or so were ancillary involved in the lab or what have you, another 50 that were involved in business functions, and very few in administration per se but involved in the business office and accounting and data processing. And then I would say, of those, the best estimate of those is probably about 15 people are involved in regulatory. That is FTEs. It is spread amongst various people, but that would be full-time equivalents, 40-hour weeks, particularly in a year where you know you have—you are dealing with the Joint Commission survey, as we have just had, and getting totally up with the standards and doing a lot of work and checking yourself.

At any given time, I'd say it is more like 10 FTEs, which may not sound like a significant percentage, it is like 3.6 percent, but for a smaller hospital when there is really not a lot of support staff, as I mentioned earlier, it falls on the shoulders of clinical people.

For instance my lab director with a new lab regulation as I just mentioned, I recall how hard it was for her to put the software into the system and deal with the coding, you know, which is almost a completely different type of thing to use. And then I have got the physicians, on the other hand, talking to me about how they comply and remain compliant when they don't know what the patient has, that is why they are ordering the lab tests. You can see the frustration on everybody's part.

At least speaking for small hospitals, we don't have as many staff so the biggest problem is it falls on clinical people's time and again takes away from things you would rather have them doing; checking the laboratory as that director, as she should, you know, for the clinical functions and staffing. And all my directors are working directors. I don't have a single director in any hospital that doesn't staff and take a position on the floor or at a piece of equipment. They back off and take care of administrative duties as well.

But again, it is not so much that, and I don't feel that, again, the things that everyone is trying to achieve are not important, they all are; it is just the method. And maybe more so the understanding of the day-to-day functions of a doctor's office, a large hospital—or even a small hospital or nursing home, it appears to me, and it has over the years—I am not trying to be critical, but it doesn't seem, the regulations don't come down with a great deal of knowledge of what the work flow is really like. In other words, they are not practical. I think everybody agrees on the intent.

Hospitals I can speak for go to great lengths to comply and really, as I say, look down on anyone that is not. If you look out there, I think the bad reputation is again on a few. But everyone now is burdened significantly by the few that really have gotten us into this framework within the regulations. But there is probably more tension on a small hospital.

Mr. FLETCHER. Well, thank you all for your testimonies. I think you know, I clearly know, we all share the concern that we don't want dollars wasted and especially wasted on individuals or entities that clearly have the intent to defraud HCFA and the taxpayers. And so I think we all want very good efforts to make sure that the bad players are identified, that they are stopped and they are penalized, so that there is certainly a deterrent for that kind of action. So I think, you know, among the colleagues I have

worked with, most of the providers, an overwhelming proportion of the providers want to do a good job, are not out there to increase their billings unlawfully, but it becomes very difficult.

And let me ask Dr. Robinson one more question, then we are going to close out the hearing, and that is the problem that I found to be frequent was the fact that there are so many requirements on the specifics of documentation for a particular code that sometimes you tend even not to code things. You downcode, actually, is what we found when we reviewed many of our charts, because of the fear of overcoding and because of documentation. Just share with me a little bit of your concern on that personally, if you could.

Dr. ROBINSON. Well I will throw out maybe one or two examples. Some years ago, when the initial coding regulations were promulgated by HCFA in regards to office visits, as to how you would code those, it would be a complicated visit or not a complicated visit we, were totally befuddled about the correct thing to do, so we just basically elected to make everything the same. So we downcoded everything, and in fact then we were told this would be a terrible mistake, we would be audited, and we were forced to upcode. But we are still very nervous about it.

So the tendency is always to downcode. I mean, the thrust of every doctor I know of is to just avoid any kind of conflict with HCFA and to never do anything that is inflammatory. And if there is any dispute we would downcode.

One story involves a neurology group in my town who are very reputable, diligent, splendid physicians who do a good job. And they had a series of patients that they all undercoded upon. And there is a reason for it. They just felt that was the right thing to do. These patients were essentially extended care patients in a nursing home environment. But in any event, they put—all their codes were put in as the lowest possible code.

Then what happened was—they fell out of—the HCFA computer picked them up as undercoders. So out of the blue, the black helicopters arrived and they swooped in and they went through a pretty extraordinary ordeal. The reviewers came in and took random charts and they found documentation—there were documentation disputes about this. And these neurologists are very reputable, very compulsive, very uptight people. This was very upsetting experience for them. They retained an attorney, they got an accountant in there. They had numerous meetings, lost sleep, and this process went on for months. And they counteracted the accusations that the documentation wasn't correct, and there was back and forth.

The process went along for about 10 months. They then had a quick visit, they gave their—they gave their report, and they are still in limbo. So it hasn't been as if this process has been easily terminated. They said the difficulty that happened was that we made the mistake of undercoding. And if we had only charged the government more money, we would have been spared this ordeal.

And so that is—those are just some vignettes about that.

Mr. FLETCHER. Thank you all. I think it is time that we probably adjourn the hearing. Your testimony I think has been very informative. We are going to continue these hearings and hopefully hear from HCFA. I do think, whether it is the folks that work for HCFA as well as providers, I think everyone has the same intent, and

that is to make sure we get good patient care, good quality. But obviously from what we have learned today, I think in the implementation of that there is a lot of room for improvement.

So we look forward to holding these hearings and continue to hold the hearings and be able to provide a lot of information. Your testimony has been very beneficial. And we thank you for coming today. And this meeting is adjourned. Thank you.

[Whereupon, at 2:12 p.m., the Task Force was adjourned.]

Medicare's Regulatory Burden on Providers (Part 2)

WEDNESDAY, JUNE 14, 2000

HOUSE OF REPRESENTATIVES,
COMMITTEE ON THE BUDGET,
TASK FORCE ON HEALTH,
Washington, DC.

The Task Force met, pursuant to call, at 10:15 a.m. in room 210, Cannon House Office Building, Hon. Saxby Chambliss (chairman of the Task Force) presiding.

Chairman CHAMBLISS. All right, we will go ahead and get started this morning. Let me welcome all of our guests here, and I particularly want to say thank you to Dr. Berenson and Mr. Charrow for being here to make a presentation this morning. We are looking forward to hearing from you and looking forward to dialoguing on what are very critical health care issues facing this country.

As I said at the previous hearing that we had, these hearings are not intended to be a witch hunt of any sort. We are trying to get to the bottom of some issues that we are hearing about from our constituents, that at the same time we are hearing about from the other side, and I think Dr. Berenson is going to point out some things not just that he thinks are accomplishments of this administration with respect to Medicare, but hopefully some ongoing problems that HCFA is working on that still need to be addressed and still need to be worked on.

I am concerned because at the first hearing, my colleague and friend Mr. McDermott asked these folks to create a top 10 list of their regulatory burden concerns about Medicare. It turned out to be 23, but they were boiled down to 13 by staff.

Dr. Berenson, that information was given to your staff several weeks ago, on the 26th of May, and we asked that those issues be addressed. I read your written testimony a couple of times last night, and, frankly, they were not addressed. I am not presuming that you are not going to address those 13 points, but I want to make sure that you understood that those were presented in the spirit of bipartisanship, and that they need to be addressed. We want to either resolve them one way or other by correcting the law or the regulations.

It is important to us that these issues be addressed. I know that you are going to do so one way or the other in your testimony today or shortly thereafter.

I have a written statement that I will submit for the record, and I want to move on because we have a number of Members who have indicated that they are going to be here, and we want to give

everybody an opportunity to ask questions. I am advised that we are not going to have another vote for another hour and a half, possibly 2 hours, so we may be able to go through this whole hearing before there are any other interruptions from the floor.

One other bit of housekeeping, and that is I ask unanimous consent that all Members be given 5 days to submit written statements for the record after today's hearing, and hearing no objection, so be it.

[The prepared statement of Saxby Chambliss follows:]

PREPARED STATEMENT OF HON. SAXBY CHAMBLISS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF GEORGIA

Today, the Health Task Force continues its efforts in investigating the waste of resources associated with the burdens that Medicare's complex regulatory system imposes on the health care community and the patients they serve. Today's hearing will provide an opportunity for those responsible in administering significant portions of the Federal Medicare program to answer a number of comments and concerns raised at this panel's initial hearing on this timely subject.

As described during the initial May 18 hearing on this matter, these hearings are designed to provide a forum for Members of the Task Force and the Budget Committee to become familiar with the difficulties the health care community faces and to ensure that Federal programs like Medicare do not penalize honest providers struggling to comply with and meet the frustrating bureaucratic maze of Federal health care regulations.

The two hearing structure was designed to first solicit provider comments, which would then be summarized and presented to HCFA for response at a second hearing. On May 18, the panel heard oral testimony from individuals at "ground zero" in health care delivery. First, we heard from Dr. Joe Sam Robinson who provided a practicing physician's perspective on the burden of Medicare regulations in the daily practice of medicine. Second, Kathleen Murray, the Chief Operating Officer at a hospital in Chicago, told the panel of the high compliance costs hospitals face and that her employees were buried under bureaucratic paperwork. Ms. Murray also provided the panel with valuable information on the impact of broad Federal regulations on hospitals, which must comply with regulations promulgated from nearly 30 different Federal agencies. Finally, Page Vaughn, a hospital administrator, told the Task Force that regulations seem to come out of Washington without serious concern for hospitals' ability to implement those regulations.

During the May 18 hearing, at the excellent suggestion of Mr. McDermott, the witnesses were asked to create a "Top Ten" list of suggestions for lessening the regulatory burden placed upon Medicare providers. The witnesses took Mr. McDermott's request sincerely and compiled a list of suggestions to the panel well in excess of ten items. Before the conclusion of the initial hearing, the panel members were in agreement that the list of provider suggestions should be submitted to HCFA so its representatives could adequately respond to the concerns at today's follow-up hearing.

In an effort to ensure HCFA had ample opportunity to respond to provider concerns raised in the May 18 hearing, committee staff pared the provider suggestions to those which were directed at HCFA and germane to the issue of regulatory burden. This created a list of 14 manageable suggestions that were personally forwarded to HCFA following the May 18 hearing.

It was my hope that providing HCFA with a small and manageable list of provider suggestions in a timely fashion would provide them ample opportunity to respond to the provider's concerns in detail at today's hearing. I have had the opportunity to briefly read Dr. Berenson's prepared testimony before the panel today, and I must say that I am rather disappointed that his prepared remarks do not adequately address the limited number of provider concerns forwarded to HCFA following the May 18 hearing.

While Dr. Berenson's testimony regarding current initiatives at HCFA to lessen the burden on the health care community is valuable information to this panel, it is clear that a major disconnect still exists between a provider community that feels an increasing burden and the agency's initiatives that purport to be lessening such a burden. Given the intensity with which the providers concerns were registered with this panel last month, it was my hope that HCFA could use the opportunity of this hearing to respond in like detail to the concerns raised by the provider community. I hope Dr. Berenson's oral testimony will shed greater light on HCFA's re-

sponse to the provider concerns personally forwarded to the agency by this panel's staff last month.

With that, I look forward to Dr. Berenson's testimony before the Health Task Force today, as well as the testimony from Mr. Robert Charrow, who served as Principal Deputy General Counsel at the Department of Health and Human Services under President Reagan.

Enclosed is a copy of the list of provider suggestions forwarded to HCFA following the Health Task Force's May 18 hearing.

PROVIDER LIST OF SUGGESTIONS TO HCFA FOR LESSENING REGULATORY BURDENS

1. Eliminate the requirement to submit an inpatient diagnosis before diagnostic tests are done.
2. Eliminate the requirement that hospitals get patients to sign at every single visit a statement that they don't have secondary insurance coverage.
3. Eliminate the requirement that physicians provide secondary payer information when they refer a patient to a hospital outpatient department.
4. Give providers the software that has the program integrity edits so they can determine in advance how to prevent claims from being filed inappropriately.
5. Combine the Part A & B billing systems.
6. Want us to evaluate the impact of all regulations on: quality of care; and on a total cost analysis for the impact on individuals, communities, and compliance costs.
7. Target fraud, waste, and abuse instead of honest errors.
8. Decriminalize billing errors.
9. Establish an ethical oversight committee to assess HCFA micro-policies and make sure they don't have any negative impact on patient care and physician independents.
10. Expedite the process for changing provider numbers when a business is sold or moves.
11. Pay promptly.
12. Simplify the cost report.
13. Review and rationalize the advance beneficiary notice policy.

Chairman CHAMBLISS. Mr. McDermott.

Mr. MCDERMOTT. Thank you, Chairman Chambliss. I am glad that we are having this second opportunity to have some dialogue about these issues. I think they are very important ones. And I, too, would like you to be as specific as you can about the kinds of things that we actually heard here as problems, and maybe you will add to your testimony in some way.

But I think given the enormous size of HCFA, to have slashed the error rate from 14 to 8 percent I think is admirable. I am not taking the position that HCFA has not done a good job, and to quote, Nancy-Ann DeParle said that HCFA contracts with 55 private health care insurers to process nearly 1 billion Medicare fee-for-service claims per year with 346 private plans which provide managed care. For Medicare alone the Agency pays more than $210 billion to some 700,000 physicians, 6,000 hospitals and all of the other providers in the health care system. It really—HCFA is the largest insurer in the country, providing coverage for 74 million people when you add together Medicare and Medicaid and the children's insurance plan. So the job is a daunting one, and the fact that 92 percent of the claims that are filed are filed correctly is really a pretty good statement.

However, I think that in something as large as this, 1 percent is a lot of money. So we are looking for 2 percent or 3 percent, anything to drive that rate down. We are interested in cutting out the waste and the fraud.

No one, I think, would sit on this dais and say that they are in favor of continuing a system where it was possible to get by with fraudulent claims or do other things. However, it is the question

of how you orchestrate or how you put together the examination of that, of the claims, to get at the best system, because you obviously have to be systematic. You can't do it one claim at a time. With that many claims, it would be an impossible job. So it has to be a screening system, and I think that is what we are interested in hearing is how the system works, given the feedback from the people that we had before us last time, taking at least at face value that these are the prominent issues that affect providers.

So with that, I think we welcome your testimony, and I would ask unanimous consent to put my whole statement in the record.

Chairman CHAMBLISS. Without objection, so ordered.

[The prepared statement of Jim McDermott follows:]

PREPARED STATEMENT OF HON. JIM MCDERMOTT, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF WASHINGTON

Thank you Chairman Chambliss for this hearing, and the opportunity to hear more about how we can improve the Medicare system. I would also like to thank Dr. Berenson and Mr. Charrow for agreeing to share their thoughts on these issues.

When I asked the witnesses at our May 18 hearing to list their concerns with Medicare's regulations, I am grateful that they took that opportunity to compose the thoughtful list that they did. Using this list as a starting point, we can take a real look at how the Health Care Financing Administration (HCFA) can reduce the complexities and errors that exist in the current system. This hearing gives HCFA a chance to tell us what they are doing and to receive feedback from providers.

Given the enormous size of the job that HCFA is tasked with, the fact that they have slashed the payment error rate from 14 percent to below 8 percent is admirable. At the last hearing, I quoted HCFA's administrator, Nancy-Ann DeParle and I would like to quote her again by saying HCFA, "contracts with 55 private health insurers to process nearly 1 billion Medicare fee-for-service claims each year, and with 346 private health plans that provide managed care. For Medicare alone, the agency pays more than $210 billion in claims to some 700,000 physicians, 6,000 hospitals, and thousands of other providers and suppliers each year. HCFA is the largest health insurer in the nation, providing coverage for some 74 million Americans through Medicare, Medicaid, and the State Children's Health Insurance Program, and paying about $368 billion for health care services this year." The size of Medicare is daunting, and the fact that 92 percent of claims that are filed are filed correctly with an error rate of below 8 percent is great.

However, we still need to see improvement. I hope that today's witnesses will be able to provide us with logical and concise answers to this list. Using these answers, we can craft real fixes to Medicare that will, along with HCFA's efforts, reduce the burdens placed on providers and get the error rates to an acceptable level: zero.

I am greatly looking forward to this hearing Mr. Chairman, and I thank you for the time.

Chairman CHAMBLISS. Mr. Lucas, do you have any comments?

Mr. LUCAS. No, Mr. Chairman.

Chairman CHAMBLISS. Mr. Gutknecht, do you have any comments?

Mr. GUTKNECHT. Mr. Chairman, I would like to comment briefly. I am delighted that you are having this hearing, and I think this is an issue that deserves an enormous amount of congressional oversight. When we meet with our nursing homes, hospitals, providers of many kinds, this is an issue that gets them excited.

I apologize, we also have an agriculture hearing, so I am going to be in and out. I do appreciate the witnesses and the fact that we are having this hearing. I hope that this will not be the last.

Chairman CHAMBLISS. At this time, Dr. Berenson, we will turn it over to you.

STATEMENT OF ROBERT BERENSON, M.D., DIRECTOR, CENTER FOR HEALTH PLANS AND PROVIDERS

Dr. BERENSON. Thank you, Mr. Chairman. Let me say at the beginning that maybe there was some confusion about the 13 leading concerns. My staff did provide me a number of those questions. I read the testimony of everybody who participated, but I did not understand that we were to provide specific responses to each one of them. I can address many of them and can provide you written responses subsequently, but there was a misunderstanding about that specificity. And again, I will be able to address a number of those issues that I have read and been briefed about coming into today.

I have a firsthand experience with Medicare because I was, in fact, a practicing physician for more than 20 years and also served as medical director of a local Preferred Provider Organization and in that capacity reviewed many claims and dealt with concerns that physicians expressed about payment and related issues.

We all share the goals of minimizing Medicare regulations and maintaining and strengthening the program's efficiency and integrity. I think we also appreciate the challenges these sometimes conflicting goals can present. Such concerns have been heightened by the BBA's substantial impact on providers and our success in fighting fraud, waste and abuse.

We are taking a number of steps to review our policies for ways that they might be streamlined or simplified. We are also working to more sharply target our program integrity efforts. We want to make sure that honest practitioners and other providers have the information that they need to do the right thing. Helping us in these efforts is our new Physicians Regulatory Issues Team. Its job is to review, clarify, and simplify rules and ensure that clinician concerns are heard and addressed. This team is developing an impact analysis initiative to ensure that we explicitly address how policies that otherwise make sense affect practicing physicians to identify operational burdens which might not have been considered.

We are also establishing a sentinel practices system to query and monitor a selection of physician offices across the country and receive ongoing feedback on the real-world day-to-day impact of Medicare rules. We have launched wide-ranging education initiatives to help providers understand Medicare policies and bill correctly and prepare them for new payment systems mandated by the law.

We are establishing payment error rates for all contractors so we can focus education and error prevention efforts much more sharply.

We are requiring all claims processing contractors to establish toll-free lines for providers to call with billing questions.

We are testing new evaluation and management guidelines, which I am going to be talking about in a little more detail. When our Administrator Nancy-Ann DeParle arrived at the Agency, and when I joined her a number of months later, one of the immediate issues that we faced was physician dissatisfaction with these guidelines or evaluation management services relating to how to bill for office and hospital visits.

The administrator basically told us to start over. Our goal has been to develop simpler guidelines that are clear and streamline the documentation required. We will, in fact, next week be holding a town hall meeting where we will be announcing a new version of these guidelines and have committed to pilot-testing them in a number of physician practices before we would actually implement them. We are also revamping the advance beneficiary notice that providers give to beneficiaries when providing a service or item that Medicare may not cover. We want a plain-language, user-friendly document explaining that a given service or item may not be covered and that the beneficiary may be responsible for payment so that the beneficiary can make an informed consumer decision.

We have several other initiatives under way that are addressed in my written testimony. Several of these are designed to more sharply focus our program integrity efforts. We realize that our efforts to reduce fraud, waste and abuse have generated concerns among some clinicians and providers. We know the majority of providers are honest and conscientious, and we have no intention of punishing anyone for honest mistakes or for misunderstanding what are, in fact, complex rules and guidelines in many cases. If providers do make billing errors, we want to find those errors before we make payment, but there is a world of difference between honest errors and the outright fraud we have been working to reduce. We do not refer providers to law enforcement for minor or occasional errors. Only the most serious matters are referred to law enforcement.

I have spoken with hundreds of physicians about their concerns and repeatedly have asked them to tell us if they know of instances of improper pursuit of physicians for inadvertent errors, and so far have not heard of that. Indeed, while there are some 660,000 physicians receiving Medicare payments each year, we review about 1 percent of physician claims, and in the past 2 years physicians accounted for only 52 of some 500 criminal health care convictions at a time when the Justice Department has received an 85 percent conviction rate on cases it takes to court.

So our efforts really are not to criminalize what are otherwise honest errors, and we are working hard to clarify the rules and guidelines so that providers are not placed in ambiguous situations.

I noted in the hearing press kit for the May 19th hearing that you held you quoted Uwe Reinhardt, the economist from Princeton in which he said that the statutes and rules governing Medicare now run the risk of becoming themselves a form of waste, fraud and abuse, and that clearly is a concern to us. But he said also said in that Wall Street Journal article that those complaining about our regulations, if they were to be brutally honest, they would have to admit that the complexity of statutes and regulations has been hatched over the years by lawmakers and lobbyists. In the end, he said, a compromise must be struck between rules so crude as to tolerate widespread abuse and rules so finely honed as to become impenetrable. We want to work with Congress and the health care community to strike the balance.

The past few years have been particularly difficult for providers due to the many BBA changes in our active program integrity efforts, but we are turning a corner. We are moving beyond BBA im-

plementation. We are expanding efforts to help honest practitioners and providers, and we are more sharply targeting the kinds of fraud and abuse that we have had so much success in fighting.

I thank you for holding this hearing and giving us another opportunity to address these issues, and I would be happy to respond to specific concerns that you may have.

Chairman CHAMBLISS. Thank you very much, Dr. Berenson, and we will note that you have a written statement for the record.

[The prepared statement of Robert Berenson follows:]

PREPARED STATEMENT OF ROBERT BERENSON, M.D., DIRECTOR, CENTER FOR HEALTH PLANS & PROVIDERS, HEALTH CARE FINANCING ADMINISTRATION

Chairman Chambliss, Congressman McDermott, distinguished Task Force members, thank you for inviting us to discuss our progress in streamlining Medicare policies and helping providers participate in the Medicare program.

As a practicing physician for more than 20 years, and having managed a Preferred Provider Organization, I have a firsthand understanding of the types of concerns expressed by physicians and other health care providers who participate in Medicare. The laws governing Medicare are complex and extensive, and its administration is complicated—in large part because medicine and our ever-evolving health care delivery system are complex. And Medicare, according to the General Accounting Office, is intrinsically at high risk of fraud, waste, and abuse because of its size and scope.

We all share the goals of minimizing Medicare regulations and maintaining and strengthening the program's efficiency and integrity. I think we also all appreciate the challenges these sometimes conflicting goals can present. Such concerns have been heightened by the Balanced Budget Act's (BBA) substantial impact on providers, and by our unprecedented success in fighting fraud, waste, and abuse, which has cut the Medicare payment error rate nearly in half. We greatly appreciate the opportunity this hearing provides to explore additional actions we might take to help providers participating in the program.

We are already taking a number of steps to review our policies and procedures for potential areas in which they might be streamlined or simplified. Last year, for example, we worked with Congress to develop the Balanced Budget Refinement Act (BBRA). We also took a number of administrative steps to help providers adjust to changes mandated in the BBA. And we are open to considering other adjustments that might be appropriate.

We have several other initiatives underway to help providers and better target our program integrity efforts.

- We have launched a wide-ranging education initiative to help providers understand Medicare policies and how to bill correctly, and to prepare them for the new payment systems mandated by the law.
- We have formed a Physicians Regulatory Issues Team to review, clarify, and simplify rules, and ensure that clinician concerns are heard as we develop policies and guidance.
- We have worked with the HHS Inspector General to develop compliance guidance for providers, including those issued just this month for physicians, and inviting public comments on this guidance.
- We are studying payment error rates at the contractor level so we can focus education and error prevention efforts more sharply.
- We are requiring all claims processing contractors to establish toll-free lines for providers to call with billing questions.
- We will be testing simplified evaluation and management guidelines designed to reduce the documentation required for physicians to justify their claims.
- This month we sent a letter to more than 800,000 providers on how to address the most common documentation problems.
- And we are conducting an increasing number of town meetings and other endeavors to communicate directly with providers about their concerns.

BACKGROUND

The Health Care Financing Administration (HCFA) is the largest health insurer in the nation, covering some 74 million Americans through Medicare, Medicaid, and the State Children's Health Insurance Program. It will pay about $368 billion for health care services this year. For Medicare alone, we pay out more than $210 bil-

lion each year for nearly one billion claims by some 700,000 physicians, 6,000 hospitals, and thousands of other providers and suppliers. The people who work at HCFA care deeply about serving the 39 million senior citizens and people with disabilities who rely on Medicare, and I am proud of our record of accomplishments.

The innovations we have developed in quality improvement and prospective payment systems that promote efficiency have been widely adopted by other public and private sector insurers. We also have important statutory responsibilities to ensure that quality and safety standards are met, support medical education, and subsidize care for those who are unable to pay.

The volume of Medicare laws and regulations covering all these responsibilities, while often greatly exaggerated, is substantial. The Social Security Act includes 900 pages of legislative language related to HCFA programs and, for all these programs including Medicare, we have issued 1,700 pages of regulations to implement this legislation. Even with the manuals we provide for our contractors, the total number of pages is no where near the figures alleged by some.

Congress is frequently very prescriptive in telling us how to implement the legislative changes it makes to our programs. This was particularly true with many of the 335 BBA provisions related to our programs, including new prospective payment systems that require substantial change for skilled nursing facilities, home health agencies, and hospital outpatient departments.

The BBA represented the agreement of Congress and the Administration to slow the growth in Medicare spending. Reducing spending by such an unprecedented amount in a relatively short time was an unequaled challenge. Virtually every hospital, physician, home health agency, skilled nursing facility, durable medical equipment supplier, and other health care provider in the country has been affected, and almost all have seen an impact on their revenues.

Such significant change with such an ambitious implementation schedule has created pressures and dissatisfaction. HCFA, of course, was the face of the BBA for providers. While the past 2 years have not been easy, I do believe we have done a good job, albeit not a perfect job, in implementing the law and remaining true to the law's intent, given the time frames, the competing interests of program stakeholders, and the complexity of the changes.

The BBA and the Health Insurance Portability and Accountability Act of 1996 both also included important new tools to help us prevent improper payments. The vast majority of providers are honest and we have no intention of punishing them for honest errors. However, we have an indisputable obligation to try to pay fairly, prevent and identify errors, recoup improper payments, and root out the small number of providers who are not honest. This is a leading concern among beneficiaries, who tell us that they feel that fraud, waste, and abuse are rampant in the system. Still, moving in just a few short years from relatively lax program integrity efforts to a zero tolerance policy has been challenging for both us and providers.

But while difficult, the BBA and our successes in protecting program integrity have both been essential for preserving and strengthening the Medicare program. The Part A Hospital Insurance Trust Fund, which was projected to become insolvent in 1999 when President Clinton took office, is instead now projected to remain solvent until 2025.

IMPROVING GUIDANCE AND EDUCATION

The need to continue with payment reforms, spending growth controls, and program integrity initiatives underscores the importance of our increased provider education efforts. We are therefore redoubling our efforts to reach out to all providers to ensure that our guidance on Medicare policies is clear, understandable, and consistent among the private insurance companies that, by law, we must contract with to process claims.

We have initiated a wide range of provider educational activities. For example, we are:

- Airing satellite broadcasts to hundreds of sites across the country on topics of interest to providers such as Medicare coverage and payment requirements; new Medicare benefits, women's health and adult immunization initiatives, and more;
- Surveying health care providers nationwide and analyzing data collected to develop new education strategies for reaching out to Medicare providers;
- Developing computer-based training modules for providers on topics such as proper claims submission, Medicare Secondary Payer rules, and Medicare fraud and abuse efforts;
- Writing articles on timely topics for fiscal intermediary bulletins and other publications targeted toward physicians and other providers;

• Maintaining the *www.hcfa.gov/medlearn* web site to provide up-to-date, easily accessible material on a wide variety of issues, including interactive courses on the proper filing and documentation of claims;

• Communicating on a regular basis through conference calls with national and state provider associations and issuing nationwide mailings on issues of interest;

• Sharing feedback with providers, both on an individual and community level, about how to correct and prevent the types of errors identified in medical review of claims so we can reduce the number of improper claims among the vast majority of providers who make only honest errors; and

• Working to ensure that contractor toll-free service lines are responsive to provider questions.

Among the most important of these efforts is development and testing of simplified evaluation and management guidelines that are designed to reduce the documentation required for physicians to justify their claims. When our Administrator, Nancy-Ann DeParle, arrived at the agency and learned of physician dissatisfaction with a new revision of the guidelines, she ordered that physicians be allowed to use either the new or old version, and instructed me to review the situation. As a result, I and other HCFA physicians started over with three goals in mind:

• Simplify the guidelines;

• Reduce the burden; and

• Foster consistent and fair medical review.

We have developed simpler versions of the guidelines that we believe provide clear, unambiguous guidance and streamline the documentation required for clinically appropriate record keeping and verification that services were medically necessary and rendered as billed. We are going to rigorously test these new versions in the real world of clinical practice. We will also test training mechanisms to determine the best way to help physicians learn how to use the new guidelines.

Throughout the process we will seek physician input on whether the new version revisions being tested are, in fact, better for them in the real world of day-to-day clinical practice. To begin the feedback process, we are holding a public meeting next week in Baltimore to lay out our proposed guidelines and discuss our testing plans with leaders of physician organizations.

Another good example of our increased education efforts is our current undertaking in preparation for implementation of the hospital outpatient prospective payment system, which was mandated by the BBA. This initiative, involving hospitals across the country, is unprecedented in its scope and second in size only to our Year 2000 provider outreach efforts. As part of this effort, we are:

• Holding nationwide train-the-trainer sessions for claims processing contractors who, in turn, are providing training for local hospitals and billing vendors in their areas;

• Conducting additional training sessions for representatives from national and state hospital associations, as well as software vendors, in the coming months;

• Posting training materials for providers on our *www.hcfa.gov* website;

• Sponsoring a national satellite conference specifically on the hospital outpatient PPS on June 15;

• Instructing all contractors to take immediate steps to disseminate final program information as soon as we release it, and to post these instructions on their web sites; and

• Encouraging contractors to publish articles in their provider bulletins and conduct outreach to get detailed information to providers.

RESPONDING TO PROVIDER CONCERNS

Parallel to our educational initiatives, we are working to improve the service we provide to physicians and ensure that our regulations help, rather than hinder, provision of high quality patient care. To do so, we have doubled the number of physicians at HCFA and put them in key positions. We have rejuvenated and sharpened the focus of our Practicing Physicians Advisory Committee to ask their advice on how our policies affect real-life clinical practice.

We also have established a new, internal, physician-led Physicians Regulatory Issues Team. This team is developing new systems to create rules and regulations that are simplified, clarified, and refined specifically to reduce administrative workloads on providers and better meet beneficiary needs. To do this, the Physicians Regulatory Issues Team is:

• Developing an "impact analysis" initiative to ensure that we explicitly address the impact on practicing physicians before and after issuing new policies or interpretations of existing policies, and have already begun piloting these ideas with some current regulations;

• Developing a "sentinel practices" system to query and monitor a selection of diverse types of physician offices across the country in order to receive ongoing feedback on the real-world, day-to-day impact of Medicare rules;

• Developing a "physician service workgroup" in which staff involved in physician-related efforts—from developing regulations to outreach and education—will work together to ensure clear, concise, and consistent communication;

• Enhancing our communication with physicians at the State and County level by having each of our 10 regional offices develop an action plan that reflects the needs and character of local physician communities;

• Developing a set of "frequently asked questions" for physicians, as well as a "rules of the road" brochure on the basics of Medicare participation for physicians;

• Hosting monthly conference calls with physician organizations across the country to address real-time and emerging issues, such as hospital coding, Peer Review Organization efforts, Medicare payment error estimate, and new preventive health benefits; and

• Upgrading our website to provide clearer, more user-friendly information for physicians.

OTHER ADMINISTRATIVE ACTION

We also are taken a number of additional administrative actions to moderate the impact of the Balanced Budget Act, reduce administrative workloads, and assist providers in meeting the needs of the patients they serve. These steps complement the legislative changes included in the BBRA that was enacted into law last fall. For example:

• We are revamping the advanced beneficiary notices that providers give to beneficiaries when providing a service or item that may not be covered by Medicare. The goal is to provide a plain-language, user-friendly document explaining that a given service or item may not be covered by Medicare and that the beneficiary may be responsible for payment, so the beneficiary can make an informed consumer decision. A new draft notice for physician and other Part B services is now being reviewed by our Practicing Physicians Advisory Committee, and will soon go into the Paperwork Reduction Act clearance process, which includes opportunities for public comments. A new draft advanced beneficiary notice for home health services is already in the Paperwork Reduction Act clearance process.

• We are delaying implementation of the hospital outpatient prospective payment system until August 1. We are distressed about having to postpone the benefits of this new system for beneficiaries, but the 1 month delay will give both us and hospitals needed time to be fully prepared for this substantial change. We also are asking hospitals to not collect deductibles or coinsurance from Medicare beneficiaries beginning August 1 until we notify them of the correct amount. And we will provide all hospitals with a "plain language" flyer to help explain the change to beneficiaries.

• We are postponing expansion of the BBA's "transfer policy" for all hospitals for a period of 2 years, through 2002. As a result, the transfer payment limits will apply only to the current 10 Diagnosis Related Group (DRG) categories, as prescribed by the BBA. We are carefully considering whether further postponement of this policy is warranted.

• We are implementing new policies to make it easier for rural hospitals, whose payments are now based on lower, rural area average wages, to be reclassified and receive payments based on higher average wages in nearby urban areas. As a consequence of these policy changes, rural hospitals will receive higher reimbursement. Similarly, we are helping rural hospitals adjust to the new outpatient prospective payment system by using the same wage index for determining a facility's outpatient payments rates that is used to calculate inpatient rates.

• We are helping home health agencies by extending the time frame for repaying interim payment system overpayments from 1 year to three, with the first year interest-free. We are postponing the requirement for home health agencies to obtain surety bonds. And we have eliminated the sequential billing requirement.

• We are helping skilled nursing facilities by refining the payment classification system in a budget neutral way to increase pay for medically complex patients.

ENSURING PROGRAM INTEGRITY

Although we recognize the need to reduce the administrative workload on providers and simplify documentation requirements where we are able, we also have a responsibility to be prudent stewards of the trust funds and maintain the financial integrity of our programs. We recognize this is a delicate, but critical, balance.

Today, our efforts to identify fraud, waste, and abuse in all of our programs are more effective than ever before. From April through September, 1998, we stopped about $5.3 billion from being paid to providers for inappropriate claims. Our anti-fraud efforts returned nearly $500 million to the Federal Government, a 65 percent increase over the previous year. And we have reduced the Medicare error rate by almost half since 1996, and maintained that progress in 1999. And total Medicare integrity program savings in fiscal year 1999 totaled $9.9 billion. Yet Medicare pays 95 percent of "clean" claims submitted by physicians without asking for any medical record to confirm the accuracy of the code, the adequacy of the documentation, or the appropriateness of the service.

We realize that our efforts to reduce fraud, waste, and abuse have generated concern among some providers. We know the majority of providers are honest and conscientious, and we have no intention of punishing anyone for honest mistakes. If providers do make billing errors, we want to find those errors, preferably before we make payment. But there is a world of difference between honest errors and the kind of outright fraud we have been so successful in fighting.

While some physicians have said they are afraid of being jailed for minor errors, we do not refer providers to law enforcement for minor or occasional errors. Only the most serious matters are referred for prosecution. I have spoken with hundreds of physicians about these concerns, and repeatedly asked them to tell us if they know of any instances of improper pursuit of physicians for honest, inadvertent errors.

In fact, while some 660,000 physicians receive Medicare payments each year, we only review 1 percent of physician claims. And, in the past 2 years, physicians accounted for only 52 of some 500 criminal health care convictions, at a time when the Department of Justice has achieved an 85 percent conviction rate on cases it takes to court.

CONCLUSION

We are committed to helping providers participate in Medicare and to minimizing the amount of regulation, paperwork, and oversight as much as our obligation to taxpayers and beneficiaries will allow. We are taking many steps to be more responsive to provider concerns, and are open to considering others that may be appropriate. The past few years have been particularly difficult for providers due to the many BBA changes and our robust program integrity efforts. But now, I believe, we are turning a corner. We are moving beyond BBA implementation. We are strengthening and expanding efforts to help honest providers. And we are more sharply targeting the kinds of fraud, waste, and abuse that we have had so much success in fighting. I thank you again for holding this hearing and giving us yet another opportunity to address these issues. And I am happy to answer your questions.

Chairman CHAMBLISS. First of all, let me say that one thing that came out of our previous hearing, and one thing that I have heard continually from physicians around the country, is that there is a fact of intimidation that comes out of HCFA toward the physician community as well as the medical supplier community. I don't think that it is intentional on your part to do that or your agency's part to do that, but you do need to know it is there.

I think there ought to be some direction from the top to folks working in your agency that you really ought to be a service agency. You outlined a number of things that you are doing to make the program more positive. I appreciate that. I think they are things that needed to be done, and along with that we ought to make sure that anybody who feels like they have a concern about what they are doing, or how they are doing it, or why they are getting varying determinations by HCFA that their claims are not proper, can feel comfortable in picking up the phone and calling HCFA to sit down and walk them through the process.

The other thing that you mentioned, and we want to share the blame if that is where the blame ought to be put, Medicare is a very complicated program. Just the sheer amount of dollars, as Mr. McDermott said, dictates that it is a broad-ranging, tough animal

to get your arms around. And part of that may be Congress's fault, and if we have issued too many laws that require you to issue thereby too many regulations as a result of that, then we need to step back and take a look at that. That is part of why we are going through this process.

I note in your written testimony a couple of things. First of all, you refer to the fact that there is a certain volume of Medicare laws and regulations that is substantial, but you mention this often is greatly exaggerated, and you refer to some specific numbers in there. But, you know, we heard from the physicians and hospitals that testified earlier about the sheer volume of regulations that come out from HCFA every year. In fact, Dr. Robinson mentioned that he had his staff weigh the amount of regulations that he got last year, and it was 35 pounds of documents that came to his office alone from HCFA.

Now, under the Paperwork Reduction Act, if 35 pounds is going to every Medicare supplier in the system, then we are obviously spending an awful lot of money just on paper, not just on the regulations that are issued.

Secondly, the Mayo Foundation, of course, has indicated that there is 132,000 pages of Medicare regulations and laws regarding those regulations. If that is the fault of Congress, we want to address that, but at the same time we fully expect your agency to address that because that doesn't need to be the case. The more regulations we have out there, obviously the more difficult it is to comply with them, and the more cumbersome and expensive on both ends, not just on the physician's end.

You referred also in your written statement to the fact that you have rejuvenated the Practicing Physicians Advisory Committee and are seeking their advice on how your policies affect real-life clinical practice, and I can't help but note while again I think that commission was well-intended, I think it was put together for the right reasons, and it is composed of right types of people and hopefully the right personalities, but your immediate past president of that group, that committee, Dr. Marie Kuffner from the University of California at Los Angeles wrote a very stinging letter to Secretary Shalala on March 23, 2000, in which she really called the administration to task on the policies that it was applying with respect to the use of that committee and virtually saying that that committee is just called on to rubber-stamp and be involved in decisions to a very minimal extent.

Again, I would hope what you are saying in your written statement may have resulted from that very stinging criticism, which I don't know whether it went answered or not. I am assuming that it didn't, and that being the case, I would hope that some of the things that you are doing with respect to this advisory committee is as a result of the criticisms that you have received. While they were pretty strong, I hope that you take them in the right way.

The one thing that again we have heard, or at least I have heard, over and over as I go out into the field and talk to my—particularly hospitals about the problems they incur with Medicare, and one thing that we heard continually during the hearing here with our two hospitals and Dr. Robinson, was the fact that we have a paperwork nightmare with Medicare. Or they have a paperwork night-

mare with Medicare, not just on the fact that on routine visits there are complicated follow-up procedures that they have to do before they get paid, but simple things such as folks coming into the hospital to get recurring treatment for the same illness are required to fill out this questionnaire every time they come into the hospital.

Now, in looking at your numbers, I believe you said you all had a 1 billion claims that you responded to over—on an annual basis, and you have some 6,000 hospitals that are participants as Medicare suppliers, and I don't know what the number of questionnaires that would generate or what it would translate into, but certainly it is a huge volume of questionnaires alone just as one individual document. If we are hearing those complaints from our folks on a regular and recurring basis, I know that you have got to be hearing those same complaints.

What I want to do is take just a minute to go through this particular issue, and I want to make a suggestion, and hopefully my colleagues will follow along with it because I think it is one thing that we can do that will get some attention and start the ball rolling to give Medicare providers some relief. Our folks recommended that we encourage you do a better job of meeting your public comment requirements, independent OMB review and display of a control number on information requests. And I emphasize display of control number. Failure to display a control number triggers the public protection section of the act, which proclaims that illegal bootleg requests are unenforceable.

Now we asked the hospital industry to give us a copy of what it tells them they have to comply with under penalty of law with respect to the Medicare Secondary Payment Questionnaire. They gave us, as I understand it, part 300 to 303.4 of the HCFA hospital manual regarding admission procedures. These parts contain not only the questionnaire, but the following instructions and admonitions as well, and I quote, "You are required to determine whether Medicare is a primary or secondary payer for each inpatient admission of a Medicare beneficiary and outpatient encounter with a Medicare beneficiary. You must accomplish this by asking the beneficiary about other insurance coverage. Section 301.2 lists the types of questions that you must ask of Medicare beneficiaries for every admission, outpatient encounter or start of care." .

The instructions establish as well a 10-year retention requirement for hard copy and data related to all such questionnaires. In large bold print you also have stated in there, and again I quote, failure to obtain the information listed in these sections is a violation of your provider agreement with Medicare. Failure to file a proper claim can result in the unnecessary denial or development of claims.

Now, frankly, I think this is pretty cumbersome and pretty excessive and duplicative, even though some parts of that questionnaire I know you have to ask, but there has got to be a better way to do it from a recordkeeping standpoint than to have all 6,000 of these hospitals keeping a questionnaire on every hospital visit for every Medicare beneficiary for 10 years. I don't know of any agency, including the IRS, that requires keeping records for 10 years like this. I am not sure what the purpose of it could possibly be.

I know you have a copy of it. If you need a copy, we will give you a copy of what the hospital folks have given us, and we would certainly like your comment on that.

What I am going to propose to my colleagues here is that the Paperwork Reduction Act has a whistleblower provision which enables anybody to write the Director of OMB, who has overall responsibility for the operation of the Paperwork Reduction Act, and we are going to ask the Director of OMB for a written determination whether federally sponsored information requests are or are not bootlegs and do or do not comport with the law. He is required to consult with agency heads, so I know he will be talking with you, and respond within 60 days. Under the law, the Director has authority to take remedial action if necessary.

I hope all of my colleagues on this task force will join me in sending that letter to the Director of OMB. As a taxpayer, an individual, we are going to see if we can get something done on that particular issue which we keep hearing complaints about.

The last thing I want to comment on is I appreciate, as, again, Mr. McDermott said, the work that you all have done in what you contend to be decreasing waste, fraud and abuse by 50 percent, or I think it is waste and fraud you referred to by 50 percent. But, you know, that is a little bit misleading, too, because I think what you have done, and you have done a good job of this, and that is that you have educated our providers all around the country all up and down the line about doing a better job of completing the forms when they send them in to you, and that is critical, and that is important, and that has saved a lot of money, and it has made a lot of money for the taxpayers, and it has made money, I am sure, for our providers.

But the problem is when you look at those numbers, they are misleading in respect to those are clean claims that are filed for the most part. You have educated those folks to file those clean claims, but you are not really reaching out to the fraudulent claims that you need to. That particular procedure that you have used to educate folks does not reach out to those claims where you have got just a fake claim submitted by a post office box or somebody who simply has a post office box and fills out a form and sends it in, and we send them a check.

We have to do a better job on issues like that, and there are any number of other examples that we can give you. Those are the types of things that are really wasteful and are fraudulently taking money away from the American taxpayer and from a darn good system that we have in Medicare.

We appreciate the work that you have done there, but I don't want to walk away from here with everybody thinking that we have solved the problem by the fact that you have—you have done a good job in educating and saved money, but at the same time there is still an awful lot of fraudulent situations out there that have not been addressed.

Now, that is a lot that I have said, and you can address what you feel you need to address from my comments.

Dr. BERENSON. I have identified five topics. On the issue of 35 pounds of regs and 135,000 pages, I spent the last few days with my staff sort of trying to figure out where 35 pounds of regs could

be coming from. I was the practicing manager of a physician practice for many years and received nothing like that. We have—I will call Dr. Robinson now and try to understand. We don't know really what that could be comprised of, but I want to find out, and I will talk to him.

Specifically, the Mayo numbers, I think, need to be analyzed a little more critically. Thirty-four thousand pages were associated with Federal Register notices from 1982 to 1998. Federal Register notices contain some regulations. The large amount of the information contained in them are preamble language where we respond to questions and concerns from the public, and we give the rationale for our policies. The regulations themselves that are published in the Federal Register ultimately are codified in our formal Medicare regulations. Those pages in the Mayo analysis is 3,500. So I think largely the 34,000 is not anything that a hospital has to actively know, have at their fingertips, something they have to know.

The 24,000 pages associated with Provider Reimbursement Review Board decisions probably may have relevance to a hospital, but clearly does not have relevance to physician practices, even though the AMA uses the same number. Yet, even for hospitals, they are not precedential. They review in individual cases payment decisions, and again—and this information gets summarized in newsletters and advisories.

So I think there is a problem. There are a lot of rules, and it can be confusing. However, I do think that we have to get beyond just quoting the numbers of pages because I think there is something misleading in just identifying different page counts.

Some of the bulletins and newsletters are just that, educational materials that go out.

With regard to the Practicing Physicians Advisory Committee, our modification in its functioning is partly in response to the concerns that Dr. Kuffner and others had raised in the last year, and what we realized and what is in her letter to the Secretary are that in a number of areas HCFA rejected policy recommendations. What was happening was that that committee was engaging more in broad-based policy discussion, on which we also get comments from the American Medical Association; all of the medical specialty groups in some cases agreed and in some cases disagreed. What we wanted to do was direct PPAC much more into the area of operational implementation of the program: How does a regulation actually affect your practice of medicine, not PPAC's opinion about whether we should or shouldn't be deferring to nurse anesthetists to be able to practice independently. That is a policy call. We are interested in hearing PPAC's opinion, but we have many places to get that kind of input. What we want PPAC to do, and I think it is responsive to Dr. Kuffner's remarks, is work with us on understanding how our particular policies and requirements affect practicing physicians, and that is what we were referring to.

Chairman CHAMBLISS. Dr. Berenson, I think what she said was a darn good point. They were making policy recommendations to you on this and basically saying you have to comply with State law, and that was being disregarded, and Medicare was issuing rules and regulations saying you were basically not going to pay any at-

tention to State law, and you were going to provide payments to these folks irrespective of that, and I think that is a critical point.

Dr. BERENSON. Our position was to defer to State law on the issue of nurse anesthetists. Basically it was that we had had a requirement that nurse anesthetists had to be supervised by a physician in our conditions of participation, and there are varying State laws about independent practice for nurse anesthetists. What we basically were saying was that we do not need to overrule State law and hospitals' own guidelines in these areas. So our position, in fact, was to defer to State law, and Dr. Kuffner's advice was that we should ignore State law and have a Federal requirement regardless. It is a controversial and difficult issue.

My point here is the members of PPAC are selected because they have understanding of how to practice medicine and what it means to run an office and to be on the front lines with patients. When we have a controversial issue about the quality of care provided by anesthesiologists or nurse anesthetists, there are many other sources of information that present themselves to us, and PPAC is not particularly the expert panel. It happens that Dr. Kuffner was an anesthesiologist, and so she had a particular point of view on that issue and presented it very forcefully.

We now have had two meetings subsequent to Dr. Kuffner's chairmanship, and I think they have been very productive meetings where we are working through operational issues in a much more intensive way with that practicing advisory committee so we get their input before decisions are made, not after the fact. So that part of her criticism was justified, and we accepted that, and I really do think that we have made some important shifts in that committee.

On the issue of paperwork, I certainly share with physicians the concern about having to comply with HCFA requirements rather than taking care of patients and that sometimes the requirements become a distraction. In fact, when I was first announced for this job, many of my physician colleagues immediately called me up and said, you have got to do something about those evaluation and management guidelines which HCFA, with the American Medical Association, had jointly issued. The guidelines require physicians to document in the medical record certain items to be able to justify levels of payment.

There is a need for guidelines because the definitions themselves that physicians and HCFA follow, the definitions in the AMA's CPT code book, permit some ambiguity. For doing an identical service, one physician may bill what is called a level 2 service, and another physician might bill a level 4 service. None of them are defrauding the government. There is enough ambiguity, such that conscientios physicians might differ.

We think that there is a need for guidance in this area so we pay people appropriately. The difference between coding a level 2 and level 4 is 100 percent different payment. However, the guidelines that were developed, the joint guidelines, were much too intrusive and burdensome. In some ways, they actually interfered with good medical care.

I was especially impressed by a good friend of mine who is a trauma surgeon, who reported that when called to the emergency

room, she often couldn't find the information she needed to take care of a patient who was in a car accident because there was all of this documentation stuff in there, not the basic information she was accustomed to finding. So we have gone back to the drawing board and are very seriously doing that.

We think that there need to be guidelines, but what we are going to be announcing next week, I am quite confident, are dramatically simpler—basic guidelines that will be more easily understandable and should not lead to complying with somebody else's notion of what the medical record should have. We don't really want to interfere with a good medical record.

So I think that criticism was legitimate, and at the same time I do think that there is a need—this is one of the pressing issues right now that practicing physicians talk about a lot. I think we understand the concerns about paperwork and are working hard to respond.

On the Medicare secondary payer questionnaire, I don't know all of the detail that you have asked, but let me just say a couple of things. One is that OMB has reviewed the questionnaire, and, in fact, we do have an OMB approval number. There had been some confusion about whether we had actually received OMB clearance for that document. The more basic point, however, is that the MTAG, which is a committee of hospital representatives and HCFA representatives, the Medicare Technical Advisory Group, has been working now for many months to simplify the requirements. We think they are right, that the requirements go overboard, and we are about to have a set of recommendations presented to me for simplifying those requirements.

I think some of what you pointed out is absolutely right, and we can do a better job. My point is that we have been working with the industry in a forum that has been in existence for many years for the purpose of talking about operational issues, and we are close, I think, to having some options that should make the situation easier, at the same time making sure that Medicare is not paying inappropriately where there is a primary payer so that Medicare is not supposed to pay. So that is, again, trying to find the balance, but I am sure that we can improve on the current requirements.

I guess the final point is about fraud and abuse and whether we are targeting enough. I think in many ways we have, in fact, directed the program and the program integrity efforts to real criminal behavior and to eliminate gross abuse or overt fraud, and we are not doing a half-baked job across the board.

I would simply point to the Congressional Budget Office estimates or assessments as to why we are spending so much less on Medicare than we had projected going into the Balanced Budget Act or immediately after the Balanced Budget Act. Some of the savings the CBO and the GAO ascribe to the decreased spending in the BBA itself, but they also emphasize that HCFA and the other Federal agencies' successful efforts in fraud and abuse have been a major contributor to, the decrease in spending and the extension of the trust fund solvency estimate, the Part A trust fund, to 2025.

We actually do target. We do a small amount of random claim review. The CFO audit, the chief financial officer audit, is to determine an error rate, but in the field what the contractors do is identify aberrant patterns to do either prepayment review for a targeted group of providers, or postpayment review, and then seek overpayments if they can determine that there was, in fact, a pattern of improper billing.

So I think both activities are going on. I think we have been reasonably successful. I think we need to keep working on it and continue to do a good job in that area.

Chairman CHAMBLISS. You didn't address the 10-year record requirement. Why do we have that?

Dr. BERENSON. That will be coming into the recommendations to simplify the questionnaire. I don't have the specific answer on that. Off the top I think it sounds like it is excessive.

Chairman CHAMBLISS. Let me just say as you go through this, and you are obviously addressing some of the concerns that folks have, and I understand that you can't do it overnight, not even in the 8 years that this administration has been there, you can't address them all. We are going to have GAO here, and we are, frankly, going to ask them some questions about how you can do it better to get another opinion. But at the same time we need to ask GAO is there anything Congress can do to make this system work better. Are we imposing too much on you?

I will just ask you this without fear of intimidation that maybe our docs feel—Mr. McDermott and I will give you clearance and hold you harmless—but if there is any criticism of Congress that you think is justified, anything that we can do from our end to sort of not just reduce paperwork, but just make the system work better, we would certainly be willing to look at it and address that.

Mr. McDermott.

Mr. MCDERMOTT. Thank you.

Let me follow up on what the Chairman has suggested. I think I was the one that provoked the creation of this list. I did it because having practiced, and I have listened to my colleagues in various places, I figured that it would be an opportunity for us to talk about the sort of day-to-day kinds of things that people deal with. And I think that we in Congress sometimes talk in bumper strips that turn into 500 pages of rules and regulations, and I think that sometimes we don't see the connection. And I appreciate the Chairman's willingness, and I think all of us are willing, if some of these things can be changed by us, if it is things that we have done, we need to know about that.

The first thing that struck me about your testimony was that—the fact that you started this wide-ranging educational initiative. Is it new, or has it been going on?

Dr. BERENSON. It is relatively new. The regulatory impact analysis on physicians is a new activity that began when Administrator DeParle came to HCFA, and it has only been in the very recent past that we have—now have a director of that activity. She is Dr. Barbara Paul, who has been a practicing internist from California, is now the full-time director of that activity. That is a relatively new one.

Another relatively new activity is the new emphasis we are giving in contracts with our contractors on customer service, not only the beneficiaries where there had been an emphasis, but provider customer service.

Mr. MCDERMOTT. That is the 800 number?

Dr. BERENSON. That includes the 800 number.

Mr. MCDERMOTT. Was that not going on before?

Dr. BERENSON. It was, and it was stopped, and now we are putting it back out again. I do think that—to take the invitation and just comment on Congress's role here is that the BBA had so many requirements, I think our count was about 350 different pieces of initiatives that we had to accomplish, that the basic running of the program such as education and communication to providers about what the rules are—really took a back seat during that period of time, and I think where we have now finished most of the BBA implementation, there have been a few new items in the BBRA.

And there is another point. Two days ago there was a Heritage Foundation public symposium about HCFA which had a number of speakers, and I just want to quote from Lynn Etheridge, who is a health economist, who made the following point. HCFA will spend over $360 billion in the year 2000, while most of the 12 domestic Cabinet agencies have budgets less than $50 billion, and yet in terms of employment, SSA has 60,000 employees, Agriculture has 98,000 employees, Interior has 68,000 employees, and HCFA has 4,400 employees. So we have a little over 4,000 employees to monitor $360 billion of spending.

We can't do everything at once with that kind of a work force, and I think—I saw in the previous testimony there was a concern about correction errors, that we issue something and make a mistake and have to go back and issue it again. In some of our areas we are one or two people deep, thus affecting our ability to avoid errors. I think that kind of allocation of resources deserves attention. I think we could be doing a lot more in the area of education and guidance to practitioners and providers if we were better staffed.

Mr. MCDERMOTT. Is that 4,000 a fair statement if you consider all of the employees of the contractors that are processing your claims? You are obviously not counting them in that figure.

Dr. BERENSON. They are not, but most of those people are processing claims. That would raise the number, but nowhere near the kinds of numbers that we have seen elsewhere for the kinds of workload and expectation.

But I think the more specific point is that the BBA implementation is going well. The outpatient department prospective payment system will happen soon; the home health perspective payment on October 1; and I think we are increasingly talking about doing a better job of educating and communicating what we are doing.

Mr. MCDERMOTT. Can I ask a couple of specific questions and hear your response to them? That physicians have to submit an inpatient diagnosis for every diagnostic test that is done, and the query was if the diagnosis is null and the test is not needed, is this an unnecessary requirement?

Dr. BERENSON. I can give a response to that.

We have a requirement that with every claim for services, there should be an ICD-9 code submitted.

Mr. MCDERMOTT. Explain that.

Dr. BERENSON. It is the categorization of diagnoses. It is actually a classification system under the direction of the World Health Organization, which basically has a compilation of diagnoses, but it has a large section for signs and symptoms. So if I am seeing a patient for whom I don't know the diagnosis, for example fatigue and shortness of breath, and I order a blood test, I can put fatigue and shortness of breath, there are categories for that. That justifies the blood count—CBC—or whatever I need, and I don't have to have the diagnosis.

What we have said, and where I think there is some confusion, some physicians in their medical notes use the term, "rule out"—rule out heart attack, rule out myocardial infarction. We are asking them to list "chest pain." That is the technical difference between what we are requiring and what the doctor was complaining about. We permit blood tests or any number of other tests. All we require is a reason for the test, and it doesn't have to be a firm diagnosis if there is no diagnosis known. What we want is the most certainty that the physician has at that moment and there is a code for that level of certainty.

Mr. MCDERMOTT. Why do patients have to sign a statement at every single hospital visit that they don't have secondary coverage? People coming in for chemotherapy come in three times a week. Why do you have to do that every time?

Dr. BERENSON. That is exactly where we are looking to see if we can change that.

Mr. MCDERMOTT. What would be the process of looking at that change so we can anticipate where the answer will come from?

Dr. BERENSON. People's insurance status can change. A retiree can have employer group coverage 1 week and not have it the next week. Or there can be an accident in which the liability insurer is primary and not Medicare.

What I described a little earlier was that we have had an ongoing subcommittee of the MTAG, hospital representatives and HCFA, and we now have a series of options about to be presented at HCFA where we can simplify these requirements. That is the goal, to simplify those requirements, perhaps—I don't know, I can't prejudge what we are going to be saying, but you're right, three times a week to have to go through the questionnaire makes no sense, and we are looking for an alternative to that.

Mr. MCDERMOTT. I think the rules in the State of Washington were that you had to keep your records for 7 years. I find it difficult to justify keeping hard copy for 10 years in the day of commuters when you can put 150,000 pounds of data on a disk the size of a 4-inch floppy. It is hard for me to understand why there is still the requirement for hard copy. It sounds like a throwback to maybe——

Dr. BERENSON. Not everybody has their records on disk, but I got the point from you and the Chairman. The 10 years, I don't understand why it is there, and I will personally look into it and try to get that resolved.

Mr. MCDERMOTT. One of the suggestions made was that HCFA give providers the software that the program integrity edits so they can prevent claims from being filed inappropriately in advance. What is your response to that?

Dr. BERENSON. Most of the edits are publicly known, and there is, in fact, software available. There was one initiative that took place where we purchased proprietary software from a private firm which did not want us to release that information. It is interesting. That activity came out of a Commerce Committee oversight committee request that we, in fact, work with that software; because it was proprietary, we were not able to release it.

Our strong preference is to not have what are black box edits. We are not proceeding anymore with that contract.

Mr. MCDERMOTT. Is that contract over then, the one that was with the company?

Dr. BERENSON. It is in the process of ending, I believe. I don't know exactly, but I can clarify that for you.

[The information referred to follows:]

"BLACK BOX" EDITS

The license for these edits expires September 30, 2000, after which these edits will no longer be effective.

Mr. MCDERMOTT. It was a Commerce Committee?

Dr. BERENSON. Commerce Committee oversight. Their concern was that by providing the information, we would, in fact, be arming the people who were defrauding the program. I personally was trying to argue that this was not much about fraud, it mostly was to do with the complexity of the payment system, and we should be providing the edits because we are trying to educate physicians. For many years, we have had the correct coding initiative [CCI], where we have had a contract with AdminaStar, one of our contractors, to develop edits that are publicly known. We send them to a committee at the AMA. They review it and give us advice, and we accept their advice in most cases. When I was in practice every year, we got the new edits. It is an ongoing process, and we have no real desire to have this closed. We learn more and the physicians learn more by having the process open.

There are some edits that, arguably, an unscrupulous provider would take advantage of, but our basic decision has been that those edits should be public where we can.

Mr. MCDERMOTT. How do you make that decision? It seems to me that you have the difficulty of being an administrative agency and a police agency at the same time so that you have to, while you are administering all of these claims, also be in the position of hunting for people who are taking advantage of the system. How do you make the decision about what ways you are screening to look for people who are filling their pockets illegally? What is the process of the Agency?

Dr. BERENSON. Well, it is interesting. We have a component program integrity group, which is directly concerned about program integrity and works with our contractors around those issues.

Mr. MCDERMOTT. Does that go under the acronym PIG?

Dr. BERENSON. They have tried to call it PI and not PIG. That has been the subject of controversy internally, actually. I am the

head of the Center for Health Plans and Providers, which is involved with payment issues, and then there is Jeff Kang, who, I am sure you know, is the head of the coverage group, the Office of the Clinical Standards and Quality. On issues like this we will meet and try to reconcile the various interests to come up with a judgment. Ultimately where we don't work it out, it goes to the Administrator and the Deputy Administrator. It is a balance—as I quoted Reinhardt, it is a balance between having a system that is completely wide open to take advantage of and another that is so complex and impenetrable that it causes great problems. It is hard in a general way to say how we strike that balance, but on any given issue we work it through.

Mr. MCDERMOTT. Number 12 on the list is why does it take HCFA to pay so long? Are you the actual payer, or is it the contractors?

Dr. BERENSON. The contractors are the payers, and I am actually surprised by that question. Most physicians that I have talked to give HCFA great credit and criticize private insurers from whom they are not getting paid for 3 or 4 months. We have specific requirements about what our payment time period is. We are not supposed to pay within 14 days, but we pay interest if it is beyond 28 days, and we have virtually no complaints about missing those time frames.

Mr. MCDERMOTT. Does the interest come out of the hospital trust fund or whatever, or does it come out of the contractors' fees?

Dr. BERENSON. It does not come out of the contractors' fees, but meeting the payment timeframes is a major part of our oversight of the contractors.

Mr. MCDERMOTT. How do you make a judgment about when a contractor is doing a good job? I know in Washington State we have had several changes, and I suspect that may be true around the country.

Dr. BERENSON. On that one I am going to basically say I don't really directly have responsibility to work with the contractors and would probably not be the best one to address that issue, but I would be happy to provide a response for you.

[The information referred to follows:]

CONTRACTOR OVERSIGHT

In order to enhance our ongoing contractor oversight and provide consistency in our review processes, we implemented a new National Contractor Performance Evaluation Strategy in May 1999. This new effort is a nationwide, multi-tiered approach and focuses our review on key, high risk contractors and program benefits categories. Our evaluation strategy includes ten core evaluation areas such as accounts receivable, audit quality, standards for timely processing of claims and customer service, as well as follow-up on performance improvement plans that we require contractors to submit based on program deficiencies identified during previous reviews.

National teams comprised of HCFA regional and central office staff evaluate the fraud and abuse operations, as well as other functions of a number of fiscal intermediaries and carriers, including the five Regional Home Health Intermediaries and the four Durable Medical Equipment Regional Carriers. In conducting their reviews, the teams use a standardized fraud and abuse review protocol, and team members participate in reviews at multiple contractors, thus helping to ensure the consistency of our evaluations across different contractors.

We also have established specific, objective standards for contractor benefit integrity performance that have been incorporated into our Contractor Performance Evaluation review protocol. These standards focus on:

• Use of proactive and reactive techniques in detecting and developing fraud cases;
• Use of corrective actions, such as payment suspensions, Civil Monetary Penalties, overpayment assessments, pre-payment or post-payment claims reviews, edits, and claims denials;
• Proper development of fraud cases before referral to law enforcement entities; and
• Effectiveness of working relationships with internal and external partners.

Mr. MCDERMOTT. In closing, I would like to echo what the Chairman has said. We created Medicare. We created Medicaid. We created CHIPs. We essentially created HCFA by doing that, and I think it certainly—at least from most Members of Congress I think there is a real desire to make it function more effectively. I think, as I asked the physicians and the other providers to submit a list, if there are things that you think that we can reasonably do while we are maintaining quality of care and also protecting the public purse, things that we can do to simplify the process, we are open to considering those. I think there is no one here who thinks that Medicare is going to go away. We have a program that deals with too many people for it to suddenly disappear. So the question is how to make it work most effectively and painlessly and still protect the public purse. We would look for suggestions from you. Thank you.

Chairman CHAMBLISS. Dr. Berenson, I did not remember exactly what Dr. Kuffner had said with respect to HCFA not adhering to State laws on that issue, and just for the record, I am going to stick her letter in the record to make sure, and everybody can read for themselves.

[The information referred to follows:]

UNIVERSITY OF CALIFORNIA, LOS ANGELES,
DEPARTMENT OF ANESTHESIOLOGY, SCHOOL OF MEDICINE,
Los Angeles, CA, March 23, 2000.

DONNA E. SHALALA, PH.D,
Secretary, Department of Health and Human Services, Washington, DC.

DEAR SECRETARY SHALALA: I'd like to thank you for the opportunity to serve for the last eight years as a member, and for the past year as chair, of your Practicing Physician Advisory Council (PPAC). As a practicing physician and a charter member of the Council, I have been driven to make PPAC as effective as possible. I have been guided by my love for medicine and my sincere desire to make the Medicare and Medicaid program more responsive to the concerns of the physician community. It has often not been an easy road. I am disheartened and frustrated that our collective efforts have not resulted in the substantive improvements that the program so desperately needs.

Madame Secretary, I would respectfully urge you to re-examine the commitment and direction your Administration can and should take to improve the relationships between the Medicare program and the practicing physician community. For provision of care to occur, physicians must have faith in the system. But they do not. Physicians are increasingly frustrated and upset with the direction that the Medicare program is heading. Evidence of that came from a PPAC meeting a year ago when the President of the America Academy of Family Physicians told the council that 30 percent of their membership has opted to refuse to treat new Medicare patients. The President of the Colorado Medical Society recently was quoted in the Denver Post as saying much the same thing, i.e. physicians are increasingly reluctant to take new Medicare patents. In late January, Professor Uwe E. Reinhardt wrote an article in the Wall Street Journal "Medicare Can Turn Anyone Into a Crook." My personal reaction to all of this is, why isn't anyone in the Administration or the Congress listing?

I'm personally disappointed that after eight years of trying my very best as a member of PPAC to raise the Department's consciousness of the physician's plight of dealing with Medicare. I am departing without any real sense of accomplishment. I think it's unfortunate that PPAC members still receive only cursory background

information a day or two before PPAC meetings when they are expected to make substantive decisions. There are two many instances when there has been a lack of adequate follow through on PPAC recommendations. I'm disappointed that PPAC on many occasions is assigned issues of only marginal importance to physicians with little opportunity to affect the agenda.

I'm disheartened that issues of importance to physicians are handled internally, that issues such as evaluation and management guidelines and making Medicare rules less complex and numerous are decided elsewhere without our involvement. I am saddened that fraud and abuse detection is given higher priority than teaching physicians how to improve their Medicare documentation. I'm very concerned that Medicare and Medicaid payments don't keep up with the increasing cost of medical practice, and yet physicians are expected to comply with more and more regulations.

Also disturbing are three particular issues PPAC addressed at length and provided unequivocal advice and direction on which the Department/HCFA has now apparently opted to ignore. The first of these was the very strong quality of care concern from PPAC that the Department refrain from issuing regulations that would eliminate the need for physician supervision of nurse anesthetists services. Even the Congress agreed that your Administration should not proceed with this proposed rule until further data was available. Soon to be released data clearly indicates that PPAC and congressional concerns are well founded and yet the Department is apparently prepared to allow nurse anesthetists to work unsupervised. Why is the Department ignoring our recommendations?

At our last two meetings PPAC voiced strong opposition to the Department's proposed approach that would allow HCFA to pay for service rendered by clinical nurse practitioners and advance practical nurses without assuring that state laws requiring collaborative agreements, as required by most medical practices acts, were in place. Now, despite our concerns that the policy was fiscally unsound and state laws were being ignored, final regulations have been published that dismiss PPAC's concerns. Why was our advice ignored? What is the purpose of having an advisory committee of practicing physicians if the Department does not use them appropriately and ignore their advice?

Lastly, I am appalled by what appears to be the Department's abdication of its responsibilities to physicians and their patients with respect to the issues of private health plans, when Medicare is the primary payer. Reimbursing physicians less than Congress deemed-an amount necessary and reflective of the resources and cost needed to furnish services to our seniors-seems blatantly unfair. It is well known that health plan contracting in California is coercive-physicians accept contracts on a take it or leave it basis and accept capitation and other reimbursement rates which are so low that they do not cover the cost of care. But they must accept these contracts to maintain contnuity of care with their patients. Physicians have urged the Department to enforce the congressionally mandated fee schedule which, at least theoretically, should be actuarially sound, yet the Department has claimed it can not remedy this situation insofar as its own beneficiaries are concerned since it has not "jurisdiction" over private health plans. I believe this is wrong. The Department must act whenever the health and safety of our seniors are at stakes.

During the last year there have been some improvements in the PPAC process following organized medicine's letter to you in 1999. For several meetings we had a representative of your office attend portions of the meeting. For some meetings, we had the Health Care Financing Administration management participate in the summary recommendation portions of our public meetings. I continue to be disappointed, however, that instead of actively soliciting our input on critical issues of the day, we are handed agendas that appear to be a worn shopping list of items of secondary importance to physicians. I am also concerned that the Department could not assure the Council at our last meeting that our advice and recommendations are factored into the regulation development and rulemaking process. Was not that the purpose of the Council?

At times we have addressed issues that had joint responsibility within the Department. We are told that HCFA staff only has limited responsibility for a particular portion of the regulation or ruling and that The Office of the Inspector General or some other HHS component has the rest. We have had to schedule multiple meetings to resolve a single issue, rather than looking for a workable solution and then employing the talents of the Administration to resolve the issue. At other times we are told that the problem with an issue is that it would require a legislative fix and them the effort is dropped rather than having the Administration pursue the needed legislative fix.

After eight years of serving on PPAC, I therefore have to question whether there is the commitment or interest on the part of the public sector to address those issues that Congress agreed with when it created PPAC. The council was formed

in large part to respond to the hassle factor in dealing with Medicare. Eighteen months ago the Administrator of HCFA formed an internal task force known as the Physicians Regulatory Initiative Taskforce (PRIT) headed by Steven Gleasom, DO, who reported to the Administrator. Part of that task force's responsibility was to examine the reportedly 100,000 pages of rules, regulations, instructions, program memorandums, etc, that physicians and other health care entities need to comply with in order to bill the Medicare program correctly. Regrettably, there has been no known progress in reducing the amount of regulation and oversight and, in fact, there has undoubtedly been an increase in such regulation. Had the Department used PPAC more effectively, such an internal task force would not have been necessary. Why was it necessary to form such a group when PPAC already existed? What was the conclusion of PRIT? Why haven't the results been made public? When might the physician community begin to recognize a reduction in the number of rules, regulations?

I appeal to you Madame Secretary, don't squander the willingness of physician leaders to give of their time and experiences to advise the Department and HCFA on the future direction of the Medicare and Medicaid program. Each PPAC member sincerely and earnestly wants to improve the relationship of the program with those who provide the care to the nation's seniors, poor and disabled. That is why they sought to be chosen by you and to advise the Department. Please don't let us down!

Respectfully,

MARIE G. KUFFNER, M.D.,
Chair, Practicing Physician Advisory Council 1999–2000.

Chairman CHAMBLISS. She said that at the last two meetings of PPAC, that they "voiced strong opposition to the Department's proposed approach to allow HCFA to pay for services rendered by clinical nurse practitioners and advance practical nurses without ensuring that State laws requiring collaborative agreements as required by most medical practice acts were in place. Now despite our concerns that the policy was fiscally unsound and State laws are being ignored, final regulations have been published that dismiss PPAC's concerns. Why was our advice ignored?" .

You have stated your position, but I want that for the record.

Mr. Herger.

Mr. HERGER. Thank you, Mr. Chairman.

Thank you, Dr. Berenson for appearing before us.

Certainly one of the challenges that we have with such a large system is that of waste, fraud and abuse; but I do have a question that goes to the implementation of that. Lately as I have been traveling around my northern California district, I have been hearing from hospital administrators who are concerned about what they perceived to be an overzealous effort on the part of the Health Care Financing Administration to prosecute fraud and abuse, and many of these health care providers tell me that they are worried that legitimate billing errors are often being prosecuted as fraudulent behavior.

Given this atmosphere of distrust and apprehension, I would like to inquire about your agency's plan to implement the new Outpatient Perspective Payment System, or PPS, and I know that you did refer to it to a degree in your testimony, but as you know, HCFA has had to delay the implementation of this system because of the complexity of the transition involved. Could you tell me, Doctor, what assurances you can give to health providers in northern California and across the Nation that they will not be prosecuted for honest billing errors that may result from this incredibly complex transition, and what steps you intend to take to ensure that the transition to a new payment system is as smooth as possible, particularly for small and rural hospitals?

Dr. BERENSON. As your constituents say, it is a very complex change. We are moving from a system of cost reimbursement to one based on categories of procedures. In many cases the hospitals will need to learn how to do new forms of coding that they haven't had to do before, at least for payment.

We had hoped to and planned to have the new system in place on July 1, but in recent days realized in ongoing discussions with hospital administrators and their trade associations that many hospitals were ready and, indeed, some of our systems were not ready. So the Administrator announced very recently that we will be moving to an August 1 effective date for outpatient PPS.

We regretted doing that because beneficiaries cost-sharing in an aggregate sense will be limited once we implement this system. Right now beneficiaries pay far more for outpatient services than they should. Their obligation is not just limited to 20 percent of approved payments.

In any case, as part of those discussions with the hospital industry, the issue of errors made implementing outpatient PPS has been raised. As you know, HCFA does not prosecute. We don't have that authority. The inspector general of DHHS and the Justice Department do that. We establish the rules, and we sometimes make referrals. Nevertheless, we are facilitating discussions with the Office of Inspector General, and they will be, I believe, issuing a public statement to hospitals, giving them some comfort about what their oversight will be during this time period when the program is being implemented. I can't speak on their behalf at this moment, but they understand the concerns that the hospitals do have about making errors during this transition, and, again, they are having conversations. They will issue a public statement which I think will go a long way to providing reassurance to the hospitals.

Mr. HERGER. I have a number of rural hospitals, I have a large rural northeastern California district, and I have heard from a number about the complexity, and, again, maybe you are not the one prosecuting, and I don't want to give the impression that I—I don't know of any of our colleagues who don't want you to be doing everything that you can to ensure that we don't have waste, fraud and abuse, but now I am referring to the innocent mistakes that are made.

As a matter of fact, I was talking with one physician who said that he had different boxes that he would check on what the procedure was. As you come up with newer procedures, the procedure that he was doing was not there. It was somewhere between this and that. Again, is he going to be prosecuted for that?

So it is a very complex issue. It is not a black-and-white, easy issue. My concern goes to those who are not misusing the system, who are attempting to go by the rules, but because of the complexity are at least perceived as not going by the rules. I am not sure if you have exactly addressed that, but this is a major concern that I have heard from a number of my different hospitals.

Dr. BERENSON. I think that is right. There have been a couple of well-publicized settlements that have been entered into between certain hospitals and enforcement agencies that I think have had somewhat of a chilling effect. There were Judiciary Committee hearings that I participated in 2 years ago, when I first joined

HCFA, in which the Justice Department was basically asked to be more reasonable in the way in which they inquired of hospitals about what they were doing. DOJ themselves understood the concerns and took corrective actions as to the manner in which they were interacting with hospitals.

I think we are finding the right balance. For example, in 2 years, only 52 criminal health care convictions of physicians have been made. In addition, most of the payment edits really are there for coding complexity reasons, and it has nothing to do with believing that somebody is defrauding the program.

We use a coding system called CPT—common procedural terminology—that the AMA works very hard to maintain. It has over 8,000 different codes, and we believe that is what physicians have grown up with, and that is what they have used, and we have made a decision not to introduce a new coding system at this time. Well, 8,000 different codes represents a very complex system, and physicians legitimately may not know exactly how to code.

So our goal is to have some edits in the system so we can seamlessly convert what the physician coded into a proper payment. I would also offer an opinion here that some of the concern that physicians raise about enforcement and criminal behavior is generated sometimes by consultants and others holding conferences and scaring physicians about what HCFA is going to do. When we have a random audit of a physician claim, the worst that happens if we find that there was a miscode for example, is that we don't pay $50, we pay $40. It doesn't generate a referral. It doesn't generate an in-depth audit. It is simply our system for ensuring that we are paying correctly.

We need to do a better job. There is no question about. With the BBA getting behind us, I think we will need to assure that physicians can hear directly from us and not through other third parties who I think have an interest in promoting some scare tactics about what we are doing.

The Administrator now writes an article every quarter in the Journal of the American Medical Association. We have now monthly phone calls that Dr. Paul participates on with medical associations and specialty societies. We are working very hard in this area.

Mr. HERGER. Thank you, Dr. Berenson.

Thank you, Mr. Chairman.

Chairman CHAMBLISS. Mr. Davis.

Mr. DAVIS. One of the things that everybody has said this morning, including you, is the need to try to strike that balance. My personal impression is that the system is increasingly suffering both in level and service and cost from the complexity, particularly given the cumulative nature.

A lot of what we have talked about here today boils down to management of information. I am pleased to hear you implying that HCFA is sort of coming up for air after having worked through at least some of the implementation of the BBA, and you clearly have emphasized a renewed priority on this physician consulting process that you have been describing in various ways.

My question to you is what perhaps you should be doing to put an equal amount of emphasis on using a lot of the developments

in IT technology that are having positive effects in the private sector in terms of level of service and cost, and shouldn't we really be putting some fundamental emphasis on how we can make that technology tackle a lot of these problems?

Dr. BERENSON. I think that is exactly right. We have done a few things in that area. Again, our initial focus in the last year and a half was being Y2K-compliant, and that went well.

We now have a number of Web sites that physicians and others can consult with a lot of detail around policies and guidelines. We are in the process of having all of the local medical review policies, which have been a problem for physicians and hospitals to track. We are putting that on a Web site so that is publicly available using the Internet.

In another way we are actively working to provide information to beneficiaries as well. Medicare Compare is what we call the activity to inform beneficiaries about their choices among Medicare Plus Choice plans and the traditional fee-for-service plan. We are now putting quality measures up on that site as well so that beneficiaries have that kind of information as well as patient satisfaction surveys of the various health plans. So we are looking at the potential of using the Internet and are starting in these ways, but you are absolutely right.

Mr. DAVIS. To what extent do you think the provider community that you have to work with is using these tools or is prepared to use these tools if you work with them?

Dr. BERENSON. Most institutional providers are fully ready. The most recent survey data that I have seen from physician offices suggest that not half of physicians actually are on-line in their offices.

I think we are in the process of a revolution for physicians to actually get real-time information to help them make clinical decisions.

Chairman CHAMBLISS. Dr. Berenson, did you say that half the physician suppliers are on-line?

Dr. BERENSON. The last survey I saw said that fewer than 50 percent were on-line in their offices, but that is increasing fairly quickly now. I don't have the exact numbers with me, but that was the number, I am pretty sure.

Mr. DAVIS. Are you willing to speculate as to how quickly we are going to get up to a very high percentage of those doctors being on-line?

Dr. BERENSON. There is certainly a general belief that they are going to be on-line. There are many new ventures that are there to serve many purposes—I am not going to name any particular ones because I will have shown some favoritism. Basically, a website is envisioned to be a place where physicians can get up-to-date clinical information, where they can have the roster of physicians that are in the health plan that they participate in, where they can see HCFA rules, amongst other things, sort of a one-stop shopping, and where they can actually submit their claims.

Right now the majority—virtually 100 percent of Part A claims that come from hospitals are electronic. It is not that high for Part B claims, but it is well more than half, and I anticipate that we

will be moving close to 100 percent of electronic submissions of all claims in the very near future.

Mr. DAVIS. It would seem that there would be a significant financial incentive to get on-line and result in more timely processing.

Dr. BERENSON. There is no question about that.

Mr. DAVIS. Let's suppose we are at that point where there is a significant percentage. To what extent does that present significant new opportunities to use the technology to better manage the information? Your review of claims, for example.

Dr. BERENSON. There is no question that electronic transmission helps dramatically. We can build in the edits electronically and still maintain the integrity of the trust fund and do it all electronically. We can potentially move the money much quicker that way. Again, I am not the expert in this area, but HCFA, I think, is the leading payer in terms of electronic submission and being able to put in program safeguards into an electronic format. There will still be the need for some claims to be kicked out for medical review. We cannot automatically pay all of the time. But increasingly we will have software capability, as the Chairman pointed out, of emphasizing the problem providers, and not the large majority of the good providers who should get paid promptly and efficiently.

Mr. DAVIS. I want to emphasize the potential of elevating this issue to a very high consideration, including what you can do to more effectively engage the provider community to move more quickly to reach a critical level of the information infrastructure. It just seems to me that we are going to have to find some fundamental way to——

Dr. BERENSON. One thing that will help a lot, and this is something that I saw in the testimony from the last hearing, the concern about HIPAA implementation, the Health Insurance Portability and Accountability Act. We are moving to standardize the electronic formats. There is a start-up cost associated with that, that is correct, but the long-term efficiency of having all payers having the same rules, the same standards, will in the long run lead to much more efficient processing of information. Right now a hospital is faced with 100 or more insurance companies, all with different rules and standards for electronic submission. HIPAA will standardize all of that, and I think the start-up costs are well worth it. It will lead to great savings. We have estimates of savings in the long run that far outrun the actual implementation costs, and I think that will be a major change for the better in moving toward electronic submission. And we obviously have to deal with privacy and those concerns, but I think it is a major advance.

Mr. DAVIS. I think perhaps the issue is just timing, and it seems to me that we ought to err on the side of moving this as quickly as possible. Next year we will have a hearty debate on medical privacy. We need to be concerned how that impedes the ability to move up to this type of system.

Briefly, Mr. Chairman, I would like to turn to a more limited subject. It is the surety bond issue with respect to home health, which is in the 1997 BBA, and I worked on that in a small way with others. In my home State that has worked well with respect to Medicaid. Living somewhere near Dade and Broward County, I am painfully aware of people gaming the system. As you know,

with relatively modest administrative costs, we in Florida have saved a lot of money in terms of ferreting out some bad actors in home health care.

I am frustrated how long it has taken HCFA to work through the implementation. I think there was a regulation pulled back, and then it was reissued. Can you tell me what is happening with that?

Dr. BERENSON. I know that was a view that the requirement was excessive, so we did pull it back. I can't tell you the status of it, but I can get back to you on that.

Mr. DAVIS. The intent was to do something relatively similar to Florida, which was a $50,000 surety bond, which I think was intended to have the effect of forcing some due diligence on the part of the surety company as far as the identity and track record of the provider. I think what HCFA did instead was to set the level of the bond at a percentage of the billings.

Dr. BERENSON. It was one or the other, so it became a much larger dollar commitment for those who had high volume. At the time when many of the home health agencies were dropping out of the system, I think about 2,500 altogether, there was a view to pulling the surety bond requirement. I honestly at this moment can't tell you what the current plans are, but we will get back to you on that.

Mr. DAVIS. Thank you.

Thank you, Mr. Chairman.

Chairman CHAMBLISS. Dr. Berenson, I am glad to hear you say that you are moving toward getting 100 percent of our claims filed on-line. I hope we learn something from our MTS experience. That concept was certainly a good concept, and I hope that we will incorporate those mistakes that we learned from that into our next venture here, and perhaps we can still combine Part A and Part B, which I think would be beneficial.

Dr. Fletcher.

Mr. FLETCHER. Thank you, Mr. Chairman.

Dr. Berenson, thank you for coming. I know the Chairman asked a question about some of the technology that you all use in identifying or ferreting out those folks—maybe the real abusers rather than focusing a broad spectrum on probably very honest providers out there. You mentioned there are only 52 criminal convictions, and that there is about an 85 percent rate of conviction on that. So there were probably a little more that were at least taken to court. How many civil fines, though? And you mention in here physicians and providers are very concerned, there is a grave concern, and you mentioned consultants may raise that concern more than necessary because of their own interests.

How many civil fines have you all placed upon physicians and providers? Do you have any idea? I hear a lot of concern about that much more than the criminal aspect.

Dr. BERENSON. I do not have a number for you. What I am hearing mostly from providers is the concern about the settlement process related to overpayments and whether that is a fair process, and we are working to make sure that that is the case. I am not aware of the number on civil fines, but we will see if we have that information and can get that to you.

Mr. FLETCHER. We would like to get that because there is a concern that we hear often about $10,000 a mistake. There may be a lot more fear out there than actuality, but it doesn't take very many to raise concerns, and I think it is important that we have the number of fines out there and the types of problems that cause those fines.

[The information referred to follows:]

CIVIL MONETARY PENALTIES

The HHS Inspector General imposes most civil monetary penalties but does not break down collections between these and other monetary impositions. Inspector General monetary impositions totaled $324.1 million in fiscal 1999 through 534 civil actions and 303 criminal convictions. We have asked them for a more precise breakdown and will forward it to you as soon as we receive it

We have authority to impose civil fines on physicians, but have not used this authority. We have imposed fines on nursing homes totaling $19.2 million for both Medicare and Medicaid in fiscal 1999 and $9.7 million so far in fiscal 2000. We also have imposed fines on clinical laboratories totaling $227,105 in fiscal 1999 and $128,645 so far in fiscal 2000.

Mr. FLETCHER. And let me ask you, when you compare the private market with what you are doing at HCFA, when you look at the technology of when claims come through, what kind of computer systems do you have that look and say something is odd going on with this provider that stands out among others that would allow you to target what providers you actually inspect and look at? What computer systems do you have to do that?

Dr. BERENSON. Again, I don't directly work with the contractors on that. I know there is an extensive profiling done, and I am more familiar in the physician area. What we do is randomly just review about 0.01 percent of claims, and that is a general surveillance of what is going on. But, in fact, it will be physicians who, for example, are only billing level 4s and level 5s for all of their visits which come out of a profile, which then will be subject to prepayment review or postpayment review, and they are targeted specifically based on that kind of profiling.

I know that there has been some kind of discussions from scientists from Los Alamos and others to try to detect aberrancies of claims, and I don't have that information, but we can provide that.

[The information referred to follows:]

COMPUTER PROFILING

We have a number of projects underway that harness technology both to pay claims correctly and to detect patterns of fraudulent or aberrant billing.

CORRECT CODING EDITS

Medicare uses computer claims edits we have developed to ensure the accuracy of claims payment. Claims are subject to a prepayment electronic screen to verify:

- beneficiary information, such as whether the patient is enrolled in Medicare and if all copayments and deductibles have been met;
- provider eligibility and standing with the Medicare program;
- utilization history (for example, we pay only one claim in a patient's lifetime for an appendectomy);
- whether a beneficiary has other insurance the should pay instead of Medicare.

Since 1994, we have had a contract with AdminaStar Federal to develop edits to detect claims with codes for services that cannot or should not be performed together or for services that should be grouped together and paid as one item at a lower rate than if billed separately. The system, known as the Correct Coding Initiative, was first implemented in 1996. It includes more than 90,000 edits and saved

$290 million in fiscal year (FY)1998, $285 million in FY 1999, and $144 million for the first half of FY 2000.

We also purchase edits used in other private sector claims processing systems. These edits are distributed to the contractors that process Medicare claims and also screen for procedures that should not be billed together.

STATISTICAL ANALYSIS CONTRACTOR

Using our contracting authority under the Medicare Integrity Program, we have awarded a contract to perform trend studies of Medicare claims. This statistical analysis contractor will review Medicare claims data in three states and perform an analysis of utilization and payment to determine areas where we should focus additional resources on detecting aberrant billing. If the contractor identifies an aberrant pattern representing significant risk to the Medicare Trust Fund, then we may allow the contractor to analyze data from additional states.

The contractor also will test different software products to measure their effectiveness and efficiency in detecting Medicare fraud, waste, and abuse. The contractor will apply a rigorous and complete testing protocol in order to verify the tool's alleged functionality and performance in detecting fraud, waste, and abuse. Results of the test will be reported to us for internal use only. Results will not be published in order to protect vendor trade secrets and our sensitive fraud detection methodologies.

MCNEIL STUDY

In January 1999, we received the final report from a project that had the dual objectives of cataloging the functionality of 10 widely used electronic fraud, waste, and abuse detection products, and which also gave us a clearer picture of what detection technologies our current Medicare contractors employ. We found that the 10 systems reviewed had considerable strengths, though their approaches to data analysis varied considerably. In many cases, contractors had weaved together multiple systems to take advantage of particular strengths in each to produce an effect we dubbed the "suite of systems approach." We also found that the effectiveness of these tools is dependent on the personnel implementing the tools. Regardless of the strengths of the electronic products, tools must be underpinned by solid personnel who understand how to weave together suites of systems, and who understand data analysis and how to let the data lead them to solutions.

MCNEIL II MARKET SURVEY

We have also contracted with an information technology firm to conduct a market survey to identify and catalog the functionality of commercially available detection products. Working closely with both Medicare and Medicaid Program Integrity staff, this contractor has developed a market survey instrument to evaluate these tools, review past performance, and customer satisfaction with these products.

TECHNOLOGY CONFERENCE ON COMBATING FRAUD AND ABUSE

This June, we cosponsored with the Department Justice a conference on using electronic tools to combat fraud and abuse. The conference brought together both law enforcement and federal and state health care officials to (a) identify new and emerging technologies that may be applied to detecting health care fraud, waste, or abuse; (b) discuss the benefits and drawbacks of technologies currently on the market, (c) provide a networking forum for the various consumers of fraud, waste and abuse technology. Nearly 300 persons attended the conference, including representatives from HCFA's central and regional offices, the HHS Inspector General, Medicaid State agencies, Medicaid fraud control units, U.S. Attorney's offices, the General Accounting Office, and the Senate Select Committee on Aging. Nearly 30 vendors displayed some of the latest fraud detection tools available in the marketplace. We plan to follow up on this conference by producing a report of proceedings with recommendations for future steps, including the possibility of regional or national technology user groups.

Mr. FLETCHER. It would be interesting to get that. I was talking with an individual that works—more of a vendor of those types of systems, and from his experience found HCFA a bit reluctant to invest in some of the latest software. That may have been his perspective, and we would like to get your perspective on that.

I read an article, and it has been a number of years ago, that the Department of Justice was getting about $6 return for every dollar that they invested in waste, fraud and abuse, and it made me wonder somewhat, and I think physicians, because it was in a physician piece of literature, that made physicians and myself wonder is this really—the way it is being implemented, does this allow HCFA to reduce their costs and recoup $9.9 billion, or is it going at getting the bad players? I think that is a concern that providers have. It is targeting providers, or is there some other things going on here in trying to reduce costs? And so I wonder if you can address that briefly.

Dr. BERENSON. I think you need to do both. Clearly bad providers should not be in the system, and we should not be spending public money for fraudulent behavior. At the same time, I think there is a need also to pay correctly.

I don't know if you were here when I was talking about our concerns about the documentation guidelines for evaluation management services. For physicians with the same clinical interaction with the patient, one physician may bill a level 2 and get $35 or thereabouts back, and another physician for the same activity may bill a level 4 and get more than twice as much. Neither of them are fraudulent. I am not worried about that as a fraud problem.

What I am worried about is if, in fact, some doctors are not getting paid appropriately and are getting paid too little, they believe that Medicare is a bad payer and doesn't pay enough. The way that the physician fee schedule works, if the total spending on physician payments goes up a certain amount and results in a reduced conversion factor the following year. The physician who is billing a level 2 is getting "under paid," the physician at level 4 is pretty happy, I think we have an obligation at least to clarify, without becoming as burdensome as we were with those initial documentation guidelines—clarify how they are supposed to bill. We spend nearly $20 billion on evaluation management services. So taking it out of the fraud context, I think it is appropriate for us in a fee-for-service national payment system to try to pay correctly so physicians are paid appropriately.

And what we need to do, and I have heard it many times today, is take it out of the fear of prosecution or the fear of enforcement, but provide some guidance so that conscientious, well-meaning physicians and their staffs know how they are supposed to code and take it out of this fear of retribution.

The discussion that we were having with Mr. McDermott earlier was that some people viewed maintaining secrecy of our software edits as a way of not arming those who were perpetrating fraud on the program. I was arguing the purpose of the edits is to deal with the complexity of this payment system and to take it out of the fraud context and into paying correctly.

The major point that I am trying to make here is that it is not enough in a program of this size where we pay over $200 billion to simply go after the small percent who are committing fraud. We need some understandable payment rules to pay correctly. So some of our activities are in that area, and we have to work hard that it not be misunderstood and that our requirements not become a problem in and of themselves.

Mr. FLETCHER. I agree with you from personal experience and from managing several practices. At one time we found that the burden of dealing with the complexity of HCFA was costly, and we also found that generally we were probably undercoding because of fear of retribution. I think a simplification of the payment system and coding and clarification is certainly warranted, and I appreciate that.

And I also—the communication you mentioned is very important, but I think overall let me state in closing, I think it is very important we would like to see what kind of technology you have that ferrets out the bad players; secondly, the number of civil penalties that have been levied on providers and kind of a categorization of what they were for and why and the amounts, and then certainly come back with what your plans are for the simplification. You mentioned 8,000 CPT codes, and we dealt with those. Much of the provider visits are fairly simple and fairly few that we deal with most of the time, except in the procedural area where it becomes quite complex. And I think there are some very easy simplification that could be done there and really clarify much of what goes on with providers, at least for physicians.

Thank you very much for your testimony.

Chairman CHAMBLISS. Dr. Berenson, just in closing, let me say that we, first of all, appreciate very much your being here and being forthright and straightforward with us and admitting that there are some deficiencies out there that you are working on. We have some witnesses that tell us what a great job that they are doing, and everything is perfect at their agency.

This is a situation where we helped create that monster. We as Members of Congress have helped create that—I won't refer to it as a "monster" because it is a very valuable and needed agency that obviously serves our taxpayers well, but we want to work with you to help resolve these problems that we have talked about and any that maybe we have not identified.

One thing you said strikes me or strikes at the heart of something that I have been talking about since I have been here, and I can't wait to go back in the next hearing where I have Mr. Glickman before the Agriculture Committee and talk about he has 90,000 employees and you have 4,000, and his budget is significantly less than yours. And I have told him all along that he has too darn many folks.

Dr. BERENSON. Don't tell him where you got the numbers.

Chairman CHAMBLISS. That is an excellent point. You don't need as many per capita since you have got the contractors out there doing a lot of leg work, as Mr. McDermott said, but your folks are obviously somewhat understaffed, at least if you compare it to other agencies with smaller budgets and more people.

Also, even though you have addressed some of these specific 13 concerns that have been identified, I wish you would take—we have got them listed in our book, and we will make sure again that you have got them. I wish you would address each one of those, even though it will be somewhat repetitive on some of the issues. We want the answers to those. Those are concerns that folks sat and talked to. We are going to talk to GAO and other witnesses. These are some of the basic concerns that I think everybody needs

to give their opinion on and everybody needs to give thought to as to how they should be addressed.

Dr. BERENSON. I apologize for that misunderstanding, and we will do that right away.

[The information referred to follows:]

RESPONSE FROM DR. BERENSON ADDRESSING 13 CONCERNS IDENTIFIED BY PROVIDERS

1. *Eliminate the requirement to submit an inpatient diagnosis before diagnostic tests are done.*

Physicians and other providers are not required to submit a diagnosis before tests are done. They should code what signs and symptoms of the patient they know at the time of ordering the test. When they are unsure what the diagnosis might be, they can code for signs or symptoms, exposure to communicable disease, or other such reasons.

2. *Eliminate the requirement that hospitals get beneficiaries to sign at every single visit a statement on secondary insurance coverage.*

The law makes providers responsible for acquiring information needed to bill any other insurer who may be responsible for a claim before billing Medicare. We are very aware of providers concerns about this issue, and are working with the American Hospital Association to develop options that we think will comply with the law, minimize the paperwork for hospitals and beneficiaries, and continue to help ensure that Medicare does not pay claims that are the responsibility of other insurers. We have had a number of conversations with a joint HCFA–American Hospital Association Medicare Secondary Payer workgroup.

3. *Eliminate the requirement that physicians provide secondary payer information when they refer a patient to a hospital outpatient department.*

As mentioned above, the law makes providers responsible for acquiring information needed to bill any other insurer who may be responsible for a claim before billing Medicare. We are very aware of providers concerns about this issue, and are working to develop options that we think will comply with the law, minimize the paperwork for hospitals and beneficiaries, and continue to help ensure that Medicare does not pay claims that are the responsibility of other insurers.

4. *Give providers the software for program integrity edits.*

The majority of program integrity edits, those that were developed by HCFA, are available to providers, and can be purchased from the National Technical Information Services at the Department of Commerce. This does not include edits associated with local medical review policies that are established by individual claims processing contractors. However, we recently established a website at: *www.lmrp.net* where a comprehensive list of all local medical review policies can be accessed online. We also use Commercial Off-the-Shelf edits that are not available to the public because they have been licensed from a private company and are proprietary. The license for these edits expires September 30, 2000, after which these edits will no longer be effective.

5. *Combine the Part A & B billing systems.*

Historically, the Social Security Act has always separated Medicare into Part A and Part B. The law provides for separate organizations to process claims for institutional (Part A) and noninstitutional (Part B) providers. Basically, fiscal intermediaries process claims for institutional providers (hospitals), and carriers process claims for noninstitutional providers (physicians, suppliers). These providers historically were paid on very different bases that necessitated the development of different payment processes and procedures, including different coding structures and claims forms. As some of the processes and procedures for payment have changed, we are beginning to reexamine systems to determine how best to respond. However, combining the Part A and Part B systems would require a change in law, as well as extensive changes in administrative structures.

6. *Evaluate the costs of regulations.*

We conduct extensive analyses of the costs and benefits of Medicare regulations as required by law and Executive Orders. We perform routine impact analyses for any regulation that is likely to result in:

- An annual effect on the economy of $100 million or more;
- A major increase in costs or prices for consumers, individual industries, Federal, State or local government agencies, or geographic regions; or
- Significant adverse effects on competition, employment, investment productivity, innovation, or on the ability of United States-based enterprises to compete with foreign-based enterprises in domestic and export markets.

We are required by Executive Order to assess all costs and benefits of available regulatory alternatives and, when regulation is necessary, to select regulatory approaches which maximize net benefits. This includes examining potential economic, environmental, public health and safety effects, distributive impacts, and equity. We also examine the effect our rules will have on States.

Should a rule result in expenditures in any 1 year by State, local, or tribal governments, in the aggregate, or by the private sector, of $100 million, the Unfunded Mandates Reform Act of 1995 requires us to prepare an assessment of anticipated costs and benefits.

The Regulatory Flexibility Act requires us to prepare a regulatory flexibility analysis unless we certify that a final rule will not have a significant economic impact on a substantial number of small entities, which we consider to include all hospitals.

The Social Security Act requires us to prepare a regulatory impact analysis for any final rule that may have a significant impact on the operations of a substantial number of small rural hospitals.

And, before issuing a rule that requires submission of information to us, the Paperwork Reduction Act requires us to provide 60-day notice in the Federal Register and solicit public comment on:

- The need for the information collection;
- The accuracy of our estimate of the information collection burden;
- The quality, utility, and clarity of the information to be collected; and,
- Recommendations to minimize the burden on the affected public.

We also have begun pilot testing a new "impact analysis" initiative designed to ensure that we explicitly address the impacts, including any impacts on costs, for practicing physicians before and after issuing new policies or interpretations of existing policies.

7. *Target fraud, waste, and abuse instead of honest errors.*

We are not looking to punish anyone for honest mistakes and we do not make referrals to law enforcement agencies for occasional errors. In fact, 95 percent of physician claims are paid without any medical review. However, we have an obligation to taxpayers, beneficiaries, and providers to pay correctly. In fact, under the physician fee schedule, those providers who code correctly can be penalized through smaller payment updates because of those who inappropriately bill for higher codes than they should. Our program integrity efforts therefore must focus both on targeting abusive and fraudulent billing practices, as well as on provider education to help prevent honest errors. Most of this education is through a variety of training mechanisms, such as interactive courses available on our website, coding guidelines, and targeted medical review. Our goal is to ensure that these efforts are not intrusive or burdensome. We do need to perform some random review of claims to establish the baseline of proper billing in the program and determine where education efforts on correct billing should be increased.

8. *Decriminalize billing errors.*

Honest errors have never been criminalized and we have no intention of punishing honest errors. There is a world of difference between honest mistakes and the kinds of fraud we have been so successful in stopping. We know that most providers are honest and conscientious. We do not view honest errors as evidence of criminal activity and we are not looking to put anyone in jail for honest mistakes or to make referrals to law enforcement agencies for occasional errors. We are redoubling our efforts to educate the provider community so they understand Medicare policies and bill correctly. In general, only after repeated attempts of educating the provider have failed and the analysis of billing and other data supports a suspicion of fraudulent or abusive billing is a referral to law enforcement initiated.

We understand and are concerned that there is confusion among providers regarding this process, and we are taking every opportunity to clarify our position. For example, the HCFA Administrator recently sent a letter to more than 800,000 providers on how to prevent the most common documentation errors. We collaborated with the HHS Inspector General on compliance guidance that focus on practical concerns of smaller physician practices. We are requiring all claims processing contractors to establish toll-free lines for providers to call with billing questions. And we have formed a Physicians Regulatory Issues Team to review, clarify, and simplify rules, and ensure that clinician concerns are heard as we develop policies and guidance.

9. *Establish a committee to assess impact of policies on patients and physicians.*

We have recently taken steps to increase our attention to these concerns. We have rejuvenated and sharpened the focus of our Practicing Physicians Advisory Committee to ask their advice on how our policies affect real-life clinical practice. We also have established a new, internal, physician-led Physicians Regulatory Issues Team. This team is developing new systems to create rules and regulations that are sim-

plified, clarified, and refined specifically to reduce the administrative workload on physicians and better meet beneficiary needs. This team is developing an "impact analysis" initiative to ensure that we explicitly address the impact on practicing physicians before and after issuing new policies or interpretations of existing policies, and have already begun testing these ideas with some current regulations. The team also is developing a "sentinel practices" system to query and monitor a selection of diverse types of physician offices across the country in order to receive ongoing feedback on the real-world, day-to-day impact of Medicare rules.

10. *Expedite the process for changing provider numbers.*

We currently are implementing new standards for assigning provider numbers. Under these revised procedures, we expect that most new applications will be processed within 60 days or less. In general, when a provider business is sold, and the new owner accepts assignment of the assets and liabilities of the previous owner, the new owner can continue to bill using the previous owner's provider number. If a provider moves within a State, and there are no other changes to the business, the provider number also remains the same. However, if a new owner does not want to accept the assets and liabilities of the previous owner, they are viewed as a new business and the new owner must complete a new enrollment application to receive a new number.

11. *Pay promptly.*

Medicare is the fastest payer in the industry, paying electronic claims on average in 16.5 days, which is much faster than private insurers. A recent study of private health insurance payers in Ohio found that 42 percent of undisputed claims missed the state's statutory deadline of 24 days. Other data shows that private payers typically reimburse paper claims only after 90 to 120 days. In fact, the law stipulates that, if our contractors do not pay claims within 30 days, we must pay interest on the claim. Therefore, we keep a close eye on ensuring that claims are paid in a timely manner.

Current law mandates that we wait a minimum of 14 days to pay claims that have been submitted electronically, and 26 days for claims submitted on paper. This requirement affords us time to conduct prepayment medical review, which is an essential part of our program integrity efforts. It is far more cost-effective than the alternative known as "pay and chase," in which we must attempt to recoup funds that have been improperly paid out.

12. *Simplify the cost report.*

We have convened an internal workgroup to review the current cost report. It is examining the data necessary to monitor payments to providers in a fully prospective environment, and any changes that may be warranted in the cost reporting process.

13. *Review and rationalize the advance beneficiary notice policy.*

We are revamping the advanced beneficiary notices that providers give to beneficiaries when providing a service or item that may not be covered by Medicare. The goal is to provide a plain-language, user-friendly document explaining that a given service or item may not be covered by Medicare and that the beneficiary may be responsible for payment, so the beneficiary can make an informed consumer decision. A new draft notice for physician and other Part B services is now being reviewed by our Practicing Physicians Advisory Committee, and will soon go into the Paperwork Reduction Act clearance process, which includes opportunities for public comments. A new draft advanced beneficiary notice for home health services is already in the Paperwork Reduction Act clearance process.

Chairman CHAMBLISS. I made an announcement earlier that all Members will be given 5 days to submit written statements. I want to make sure that all Members also understand that they have 5 days to submit additional written questions to both of our witnesses, and we will get those questions answered.

I was trying to stall around enough to see if Mr. Gutknecht was going to make it back.

Thank you, Dr. Berenson. Thank you for your testimony.

Mr. Charrow, thank you for patiently waiting. We look forward to your testimony. I can't have you here without commenting on the fact that I was particularly interested in the personal experience that you alluded to in your written statement. I have gone through a somewhat similar situation from a personal standpoint, and it has been frustrating, but I think we finally have gotten to

the end of the road with mine, and I was glad to see or glad to find somebody who is an expert in this area. I know who to call next time.

We thank you for being here, and we will turn it over to you.

STATEMENT OF ROBERT P. CHARROW, ESQ., CROWELL & MORING, WASHINGTON, DC

Mr. CHARROW. Mr. Chairman and Mr. Davis, I am honored to be appearing before this committee to share with you some of my experiences, perspectives and thoughts about the Medicare system and how HCFA operates and perhaps, how HCFA should operate in the future.

The interesting irony is or was that Dr. Berenson was a client of our law firm until he went into government, and he was an enjoyable client.

I would like to share with the committee information in a few specific areas by asking and answering three fundamental questions. First, has the Medicare system become too complex and mired in arcane rules that can only be understood by lawyers and accountants? Second, are the rules that govern the system actually cost-justified, and has anyone bothered to test them? Third, do the rules and red tape unnecessarily diminish the amounts of funds available for medical care?

With the permission of the Chair, I would like to relate a personal story that highlighted for me the complexity and opaqueness of Medicare to providers and beneficiaries alike. About a decade ago when my father was dying of prostate cancer, the family, including my father, had to make some tough decisions concerning what type of care he was to receive under Medicare. The choice was between home health and hospice care. My mother gathered the details from a home health agency and hospice in Los Angeles. When she told me the level of care and the various restrictions each claimed that Federal law required, I knew something was amiss. I am a health care lawyer, and for once I thought I would be able to benefit my family. This turned out to be only partially true. Even I needed help.

I quickly confirmed that what the providers had told my mother was wrong. The coverage that the home health agency offered to my father appeared to be inconsistent with existing law. A quick check of the Federal rules and other program documents confirmed my initial suspicion. Learning what my father would be entitled to receive if he opted for hospice care proved to be more challenging. The statutory law governing hospice care had been significantly changed, and the information given to my mother had been based on the old laws. This was not surprising since the regulations implementing those changes had never been issued by HCFA.

As a Washington health care lawyer, I was used to dealing with the people at HCFA. After making a few phone calls, I learned who at HCFA was setting policy for hospice care. I called him and came away with lots of information about how HCFA would be implementing the statutory changes. I called both the home health agency and the hospice in Los Angeles, told them who I was, and provided them with about 2 hours' worth of free legal advice.

My father ultimately opted for hospice care. Had I not suspected that what we had originally been told was wrong, had I not known how to use the Code of Federal Regulations and the various HCFA manuals, and had I not known whom to contact at HCFA, we would have made the wrong treatment decision, and my father would have been provided with fewer benefits than he was legally entitled to receive.

That was my first experience as a quasiconsumer of Federal health care services, and it was both sobering and frightening. It drove home as nothing else could the basic fact that our health care system is simply too complex and inelegant. If I as a health care lawyer could not easily find the law, how can we expect consumers or providers to understand the law?

We have heard this morning that Medicare is, in fact, a very complex system. There seems to be some quibbling whether we are talking about 80,000 pages of regulations or 100,000 pages or 130,000 pages; or whether we are talking about 35 pounds of documents in a physician's office, or whether we are talking about 15 pounds. But the fact remains that everyone agrees that Medicare is extremely complex.

I had need last month to print off the State operating manual. This is the manual that is used by surveyors (inspectors), when they go in to inspect a hospital. My secretary printed off the document, and she said, "What should I do with it?" And I said, "File it," and she said, "It is 4½ feet high."

Chairman CHAMBLISS. Did you weigh it?

Mr. CHARROW. I couldn't pick it up.

We have heard mention of statutes, and the actual organic legislation which is contained in Title 18 of the Social Security Act is about 400 pages long; the rules that govern Medicare only, these are the formally promulgated regulations that appear in the Code of Federal Regulations, 1,300 pages. On top of that you have Medicare issuances, program memoranda, manuals of various types, inspector general alerts, advisory opinions, local medical review policies, coverage decisions, departmental appeal board rulings, PPRB decisions, Administrator decisions and the like.

I think there can be little doubt that HCFA is too complex; there are too many rules and regulations, and too much red tape.

The second question that was more fundamental, is whether the current level of regulation is necessary? Astonishingly, we don't know. Before the government buys a $2 billion weapons system, it tests the system for years and requires the contractor to make necessary design and manufacturing changes. Before HCFA implements a regulatory initiative that could cost significantly more than a billion dollars and will affect hundreds of thousands of providers and millions of beneficiaries, does it do any testing? The answer is usually no. In short, we are making changes to a $2 billion system without first testing the impacts of those changes.

To illustrate this, and since there has been so much talk this morning about fraud, waste and abuse, I would like to turn my attention to the rules that govern fraud, waste and abuse. Everyone will agree, and I think everyone I heard this morning agreed, that fraud is evil. It is criminal and should be punished decisively, and

providers who engage in fraud should be unceremoniously removed from the system.

Fraud is relatively easy to define. We not only know it when we see it, but we can articulate why some conduct is fraudulent and other conduct is not. For example, the hospital chain that billed Medicare for treating patients that never existed was committing fraud. That is a no-brainer. The physician who bills Medicare for long office visits when, in fact, he saw the patient for less than 3 minutes is also committing fraud. There is no question about that.

The Federal laws governing fraud apply equally across the board. They apply to defense contractors, to universities, to hospitals, to physicians, to clinical laboratories and even beneficiaries. Interestingly enough, though, we have been led to believe that health care is rife with fraud. And, in fact, we do receive information that there are large settlements every year. The real question, though, in my mind is not how much fraud there is, because we honestly don't know, but rather—how do we differentiate between fraud on the one hand, and waste and abuse on the other, and how do we define what waste is and what abuse is? One person's waste is another person's medical necessity.

Those are complicated decisions. So when the inspector general comes before Congress and says, I have saved the system $20 billion by reducing fraud, waste and abuse, I would like to know how much of that is true fraud and how much of that is waste and abuse, and of the waste and abuse, how much of that really relates to medical decisionmaking which the inspector general may not be competent to decide.

I would like to turn my attention for a moment to kickbacks. Like fraud, kickbacks should be, and in fact are, outlawed. The physician who accepts a 20 percent kickback in exchange for ordering a specific battery of tests from a specific clinical laboratory should be treated no differently than the defense contractor that gets secret kickbacks from its subcontractors. Kickbacks in Medicare are bad. They promote overpayment, overutilization, and inappropriately interject financial considerations into medical decisionmaking.

The antikickback law that governs Federal health care programs is extremely different than the antikickback law that governs defense contractors and everyone else. It is far broader and procedurally distinct from those laws. In fact, it is so broad that it outlaws conduct that in every other setting would be perfectly legitimate. For example, under the antikickback law of 1997, a physician commits a felony when he or she sells his or her practice. A physician commits a felony when he or she accepts a warranty on a piece of equipment that he or she buys.

The law is extraordinarily broad. It was passed that way by Congress with a reason, because when they enacted an antikickback law in 1972—it didn't work. Congress broadened it in 1977 to not only cover kickbacks, but any form of remuneration that one may receive in exchange for a direct or indirect referral of a patient.

As I indicated, the law was so broad that it covered arguably legitimate conduct. In 1987, Congress addressed this issue. Unfortunately Congress did not reword the statute as I hoped it would. Instead Congress developed the concept of the safe harbor and in-

structed the Secretary to issue safe harbors. Now a safe harbor is a set of procedures which if you follow, your arrangement becomes nonprosecutable even though it is arguably illegal. In 1991, the Secretary issued the first 10 safe harbors, and today there are 15 safe harbors, the last having been issued in November 1999.

The safe harbor system works this way. I am a physician, and I want to rent office space from another physician. This raises concern, and it can give rise to serious antikickback concerns. To qualify for the safe harbor, I would have to have a written contract. The written contract would have to be for longer than a year and at fair market value. The rental safe harbor is a fairly simple one to meet. The investment safe harbor is a fairly complex one to meet, and they vary in between. The point about all of them is that they are extremely rigid. They actually set out the contours in great detail of the types of conduct you must put in your contract in order to qualify for safe harbor protection.

And as Congress realized in the 1990's, the inspector general was issuing safe harbors at a very, very slow rate, and that those safe harbors that did exist were extremely rigid. Congress, as part of the Health Insurance Portability and Accountability Act of 1996, instructed the inspector general to issue advisory opinions, which would act like a mini safe harbor directed to a specific person with respect to a specific transaction, sort of a one-shot safe harbor. The problem with that is that it is giving the inspector general extraordinary power in determining what sorts of arrangements ought to be permitted and what sorts of arrangements ought not. And I question the wisdom of a public policy which transfers significant congressional responsibility and the responsibility of political appointees in the executive branch, to career attorneys to make decisions about what is good medicine and bad medicine, and what makes economic sense, and what does not make economic sense when the attorneys have little training in economics and no training in medicine.

These are some of the things that drive up the cost of the regulation under which HCFA operates, because physicians and everyone else are extraordinarily afraid to act without seeking an advisory opinion. And who do you go to to get an advisory opinion? Your friendly Washington lawyer, me. I put the advisory opinion requests together. I will submit them to HCFA for you. It is a marvelous business for Washington lawyers, but the money has to come from somewhere, and it comes out of money that ordinarily would be used to treat patients.

In short, there are lots of hidden costs underlying Medicare. There are very high transaction costs, yet we do not know the magnitude of those costs. And remember, regulation is not free. Complexity is not free. It all costs, and the question is—has HCFA under this administration, or indeed under the administration when I was present, done an adequate job of quantifying the regulatory burden, and I submit it has not. It has not done a good job of this with respect to its formal regulations, which are relatively few, or its informal regulations, in the form of guidelines and issuances, for which it doesn't make any attempt to do a regulatory impact analysis.

Given the time, I am going to truncate my formal statement. In my printed statement there is a typographical error. the "1995" after "HIPAA" should be "1996." Aside from that, I would like to respond to questions from the members of the committee.

Chairman CHAMBLISS. Thank you for that. You certainly raised a number of good questions.

[The prepared statement of Robert P. Charrow follows:]

PREPARED STATEMENT OF ROBERT P. CHARROW, ESQ., CROWELL & MORING

Mr. Chairman and members of the Task Force, I am deeply honored at being asked to share some of my experiences, perspectives, and thoughts with the Committee. Health care—the way it is provided, the way it is regulated, and the way it is funded—is of critical importance to most Americans. As our population ages, concerns about the quality, availability, and affordability of health care will only grow. These concerns with attendant political and societal pressures will focus primarily on Medicare—a system designed in 1965 and largely modeled after the way medicine was practiced in that era.[1] The practice of medicine, though, has changed dramatically—both organizationally and scientifically—and is remarkably different now than it was then. Medicare, though, has remained fundamentally unaltered. The dissonance between the way medicine is practiced and the way Medicare operates has given rise to regulatory burdens and inefficiencies that frustrate all—hospital administrators, family physicians, and Medicare beneficiaries alike.

I would like to share with the Committee my concerns in a few specific areas by asking and answering three basic questions. First, has the Medicare system simply become too complex and too mired in arcane rules that can only be understood by lawyers and accountants? Second, are the rules that govern the system truly cost justified and has anyone bothered to test them? Third, do the rules and red tape unnecessarily diminish the amount of funds available for medical care?

1. IS THE MEDICARE PROGRAM MIRED IN TOO MUCH REGULATION?

With the permission of the Chair, I would like to relate a personal story that highlighted for me the complexity and opaqueness of Medicare to providers and beneficiaries alike.

About a decade ago, when my father was dying of prostate cancer, the family, including my father, had to make some tough decisions concerning what type of care he was to receive under Medicare. The choice was between home health and hospice care. My mother gathered the details from a home health agency and a hospice in Los Angeles, where my parents lived. When she told me the level of care and the various restrictions each claimed that Federal law required, I knew that something was amiss. I am a health care lawyer and for once, I thought I would be able use my esoteric specialty to benefit my family. This turned out to be only partially true. I needed help.

I quickly confirmed that what the providers had told my mother was wrong. The coverage that the home health agency offered to my father appeared to be inconsistent with existing law. A quick check of the Federal rules and other program documents confirmed my initial suspicion. Learning what my father would be entitled to receive if he opted for hospice care proved to be more challenging. The statutory law governing hospice care had been significantly changed and the information given to my mother had been based on the old laws. This was not surprising, since the regulations implementing those changes had never been issued by the Health Care Financing Administration.

As a Washington health care lawyer, I was used to dealing with the people at HCFA. After making a few phone calls, I learned who at HCFA was setting policy for hospice care. I called him, spent about 45 minutes on the phone with him, and came away with lots of information about how HCFA would be implementing the statutory changes. I called both the home health agency and the hospice in Los Angeles, told them who I was, and provided them with about 2 hours worth of free legal advice. My father ultimately opted for hospice care. Had I not suspected that what we had originally been told was wrong, had I not known how to use the Code of Federal Regulations and various HCFA manuals, and had I not known whom to contact at HCFA, we would have made the wrong treatment decision and my father

[1] The Medicare and Medicaid programs were enacted in 1965 as Titles XVIII and XIX of the Social Security Act, respectively, and began operation on July 1, 1966. See Title I, Social Security Act Amendments of 1965, Pub. L. No. 89–97, 79 Stat. 286.

would have been provided with fewer benefits than he was legally entitled to receive.

That was my first experience as a quasi-consumer of Federal health care services, and it was both sobering and frightening. It drove home, as nothing else could, the basic fact that our health care system is simply too complex and inelegant. If I, as a health care lawyer, could not easily find the law, how can we expect consumers or even providers to understand the law?

The Medicare statute is more than 400 pages long and is not a model of clarity. In theory, HCFA is supposed to issue regulations to give life to the statute. The regulatory process, though, takes years, and usually what you end up with is a rule that is comprehensible and accessible only to lawyers. Medicare's regulations take up about 1,300 pages in the Code of Federal Regulations. But that's only the beginning. On top of the statute and regulations—all of which are accessible to the public, but essentially unreadable—are Medicare issuances, publications, program memoranda, manuals, Inspector General Alerts, advisory opinions, local medical review policies, coverage decisions, Departmental Appeals Board rulings, and so on. All told, the 400-page statute has given birth to more than 100,000 pages of secondary Medicare laws, guidelines, issuances, and the like. All of these affect the level of services and how they are delivered. Yet, little of this information is readily available or easily understandable. The Medicare system is simply collapsing under its own regulatory weight.

2. Is the Current Level of Medicare Regulation Cost Justified?

There can be little doubt that Medicare is mired in regulation and that the regulation impedes both providers and beneficiaries. The second question, though, is more fundamental—is the current level of regulation necessary? Astonishingly, we do not know. Before the government buys a new $2 billion weapons system, it tests the system for years and requires the contractor to make necessary design and manufacturing changes. Before HCFA implements a regulatory initiative that could cost significantly more than $1 billion and will affect hundreds of thousands of providers and millions of beneficiaries, does it do any "testing?" The answer is usually "no." In short, we are making changes to a $200 billion system without first testing the impact of those changes.

To illustrate this, let's look at the rules that govern fraud, waste, and abuse. Everyone would agree that fraud is evil, is criminal, and should be punished decisively. Moreover, fraud is relatively easy to define. We not only know it when we see it, but we can articulate why some conduct is fraudulent and other conduct is not. For example, the hospital chain that billed Medicare for treating patients that were never hospitalized was committing fraud. Or the physician who bills Medicare for a long office visit, when in fact he saw the patient for less than 3 minutes is also committing fraud. The Federal laws governing fraud apply equally across the board from defense contractors to universities to hospitals, physicians, clinical laboratories and even beneficiaries. Interestingly enough, although we have been led to believe that healthcare is rife with fraud, in fact the numbers indicate to the contrary. The Inspector General, for instance, reports having recovered less than $500 million on account of all types of improper conduct; when compared to the about $400 billion spent on Medicare and Medicaid, the actual percentage of measurable fraud is relatively small—medicine is about 99 and 44 one hundredths percent pure; so far, so good.

Like fraud, most of us consider that kickbacks should also be outlawed. The physician who accepts a 20 percent kickback in exchange for ordering a specific battery of tests from a specific clinical lab should be treated no differently than the defense contractor that gets secret kickbacks from its subcontractors. Kickbacks in Medicare are bad—they promote overpayment and over-utilization and inappropriately interject financial considerations into medical decisionmaking. The antikickback law that governs Federal healthcare programs, though, is far broader and procedurally distinct from the one that applies to the other sectors of the government. In fact, these laws are so expansive that they prohibit conduct that is perfectly legitimate in other settings.

Under the antikickback statute as written, for example, it is illegal for a physician to sell his practice if the sale includes "goodwill." No arrangement—whether it is a complex merger, acquisition, joint venture, or a simple purchase of hospital or medical office equipment—can be seriously considered without evaluating its antikickback implications. Moreover, the healthcare antikickback laws vest extraordinary discretion in the Office of Inspector General to modify, to interpret and to apply these already broad laws. The law effectively has transferred significant healthcare policy decisionmaking from the Congress and the political appointees to

career OIG attorneys with no formal training in medicine and little in developing or testing cogent policy.

How did all of this happen? Congress first enacted an antikickback law for Medicare in 1972;[2] that law, however, was somewhat ambiguous. To eliminate that ambiguity, Congress in 1977 amended the law and broadened its coverage.[3]

The new law went beyond prohibiting kickbacks and other forms of fraud, and sought to use the threat of prosecution as way of regulating "abuse" and "waste," terms that have no real legal meaning. Not unexpectedly, the new law proved to be too broad, effectively outlawing all sorts of legitimate business arrangements: a physician could not sell his practice, a physician couldn't sublease space in his office to another physician if that sublessee referred patients to the owner and so on. To cure this problem, Congress in 1987, enacted legislation that authorized the Secretary of Health and Human Services with the approval of the Attorney General to develop so-called safe harbors.[4] The theory was that if a person who conformed his or her arrangement to the conditions of the safe harbor, then that person would not be prosecuted even though the arrangement technically violated the antikickback law. In 1991, the Secretary issued the first ten safe harbors. Today there are fifteen safe harbors, the last two having been issued in November 1999.[5] There are safe harbors for renting office space, for receiving a discount on the purchase of equipment, for obtaining a warranty and for a variety of other normally straightforward business arrangements.

The safe harbor system though had its problems. The Inspector General was reluctant to issue safe harbors and when she did they tended to be extraordinary rigid. Moreover, it took years to issue a new safe harbor. Thus, as part of the Health Insurance Portability and Accountability Act of 1996, Congress required the IG to issue advisory opinions—these advisory opinions are essentially single transaction, one time safe harbors. In deciding whether to approve a proposed transaction, the OIG must consider, among other things, whether the proposed arrangement will cause overutilization or adversely affect patient care. Should these types of policy decisions, requiring expertise in medical economics and medicine itself be made by lawyers in the Inspector General's Office? I think not. Those whose training is law enforcement tend to see "waste" and "abuse" everywhere. Indeed, the IG has expressly noted that the advisory opinion process "permits this Office to protect specific arrangements that 'contain limitations, requirements, or controls that give adequate assurance that Federal health care programs cannot be abused.'" Advisory Opinion 98–14 (quoting from 62 Fed. Reg. 7350, 7351 (Feb. 19,1997).

Moreover, is it wise to effectively require people to seek governmental approval before entering into a normal business arrangement? The perils associated with violating the antikickback law are so great that even those who are providing free goods or services to health charities have sought advisory opinions first. Clearly, this is good for lawyers, since we draft the advisory opinion requests. But is it good for medicine and health care and does it make sense?

The most interesting aspect of the antikickback saga is that a broad antikickback law may not make any sense today. Medicare payment has changed since 1977 so that overutilization is far less of a problem than it was then. For example, in 1977, hospitals were reimbursed for their costs—the more they spent, the greater their reimbursement. If they paid kickbacks to suppliers, those kickbacks were passed through to the government. In such a setting a broad antikickback law made commercial sense. In 1983, however, Congress changed the way in which hospitals were paid so that they were no longer reimbursed for their expenses, but instead were paid a fixed fee for treating a given illness. If they paid kickbacks, the hospital, not the government, would eat the cost. Correspondingly, the introduction and quick spread of fee schedules and capitated payment arrangements in the late 1980's and early 1990's also shifted the cost of kickback from the government to private party. In short, there is now a serious question as to whether this complex antikickback

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[2] See section 242(b), Social Security Amendments of 1972, Pub. L. 92–602, 86 Stat. 1419–1420

[3] See Medicare-Medicaid Antifraud and Abuse Amendments of 1977, Pub. L. No. 95–142, § 4(a), 91 Stat. 1175, 1179–1181 (1977). In lieu of the phrase "kickback or bribe," as used in the 1972 law, the amended version banned "any remuneration (including any kickback, bribe or rebate) directly or indirectly, overtly or covertly, in cash or in kind" to induce a referral. 42 U.S.C. § 1396h(b)(1)(1977). The antikickback law has been recodified as section 1128B(b), Social Security Act, 42 U.S.C. § 1320a-7b(b).

[4] See section 14, Medicare and Medicaid Patient and Program Protection Act of 1987, Pub. L. 100–93.

[5] See 42 CFR § 1001.952; see 56 Fed. Reg. 35,799 (July 29, 1991); 57 Fed. Reg. 52,723 (Nov. 5, 1992); 59 Fed. Reg. 37,202 (July 21, 1994); 61 Fed. Reg. 2,122, 2,125 (Jan. 25, 1996); 63 Fed. Reg. 46,676 (Sept. 2, 1998); 64 Fed. Reg. 63,503 (Nov. 19, 1999); and 64 Fed. Reg. 63,517 (Nov. 19, 1999).

mechanism is even cost justified. Surprisingly, though, no one at HHS has indicated any interest in studying the problem or attempting to resolve it. The antikickback laws provide the government with a way to micromanage medical care and there does not seem to be any desire to give up that authority.

3. Can Over Regulation Affect the Quality of Care?

The antikickback law is symptomatic of a system that is overly complex and overly regulated. Neither complexity nor regulation is free—the more regulation, the less that can be spent on health care. The real question is how much regulation is optimum, and for that we must be willing to conduct experiments or develop models to see how best to curtail regulation. There is certainly evidence, albeit anecdotal, to suggest that over-regulation adversely affects the quality of care by shifting resources from the medical treatment to paper pushing and compliance activities.

You might ask, how can this be? After all, HCFA constantly reminds us that Medicare's transaction costs are 80 percent less than those of private insurers. HCFA has achieved low government transaction costs by shifting those costs from the government to the private sector. For example, private insurers take on the responsibility for conducting compliance programs and auditing functions. Not so with Medicare; HHS expects providers to undertake those functions.

Many now believe that when you add in all the compliance activities and added administrative burdens associated with Medicare, its overall transaction costs far exceed those of the private insurers.

Given that providers—whether hospitals or physicians—are paid fixed fees, those extra transaction costs must come from somewhere and, in many cases, they are coming out of the treatment side of the office, rather than the administrative side. Given a choice, do we want our hospitals to hire more coding clerks and compliance officers, or more nurses and physicians?

Conclusion

I am not advocating that we abandon regulation nor am I suggesting that regulation is unnecessary. Rather, I am advocating for the notion that regulation is not free. We should at least determine empirically which regulations make sense, and should be retained and which are counterproductive and ought to be abandoned.

Chairman CHAMBLISS. Now I am going to ask you for the solutions. Starting with your last point there, I think we all agree that the volume of rules and regulations out there are just too burdensome and overbearing.

Number one, is HCFA just issuing rules and regulations to cover their backsides, or is Congress passing laws or issuing mandates over to HCFA that are causing this flood of rules and regulations to come out, and what do we do about it? What is Congress's role in this? Should we look at maybe repealing some laws or passing some laws that will reduce those rules and regulations, or should we stay on HCFA's case just to make sure that they review and eliminate a number of rules and regulations that are obsolete or just impractical?

Mr. CHARROW. That is a good question. I think it is a little of each. Congress issues as part of its statutory changes directions to HCFA to issue rules, and HCFA goes out and issues those rules.

I also think, on the other hand, that HCFA sometimes goes overboard. Remember, the guidelines, the informal rules, those which comprise the vast bulk of the paperwork, those are not mandated by Congress. None of that is required by Congress. The only thing that Congress requires is the formal notice and comment rulemaking, and that takes up a relatively small volume. But even there HCFA has on occasion gone overboard.

For example, HCFA recently issued a regulation revising its conditions of participation. These are the conditions that hospitals and providers must meet in order to participate in the program and re-

ceive funding. It was a thick rule. One of the provisions in the rule that caught the attention of the medical community, hospitals and doctors alike, was what was called "the 1-hour rule" which came out of nowhere. It was not required by Congress or suggested by Congress. It wasn't even in the proposed rule. It only appeared in the final rule, and none of the commenters even suggested that rule.

The 1-hour rule applies, for example, when a patient is in the psychiatric ward of a general hospital and somebody has to put their arms around the patient to restrain him. The 1-hour rule requires that that patient must be examined by a physician within 1 hour. Take a rural psychiatric hospital, it doesn't have physicians living in the hospital 24 hours a day. The closest staff physician lives 45 minutes to 1 hour away, not uncommon. That physician cannot get to the hospital in 1 hour. The physician has to live on the premises. That drives up costs, not required by Congress. That is sort of the genre of regulation that I have been seeing in the past few years, and it has caused me concern.

Chairman CHAMBLISS. Your comments on waste and abuse, waste and abuse first is fraud, and we talked with Dr. Berenson about that. I am sure that you are familiar with the numbers where we got the fee-for-service payment—improper fee-for-service payments have been decreased from 23.2 billion in 1996 to 13.5 billion in 1999. I think Dr. Berenson understood my point there that what we are talking about is an education of physicians. We are not talking about fraud. How do we reach out or how do we tell HCFA to reach out to more fraud cases? What, in your opinion, is the answer to that?

Mr. CHARROW. The one thing that we have to do if we want to look at true fraud, is to have Congress differentiate clearly between what is real fraud and what is waste and abuse.

We have really three levels of—three schemes in place to deal with fraud, waste and abuse. Dr. Berenson addressed one of those, the criminal prosecution. Dr. Fletcher mentioned the civil penalties as what causes the physicians to be concerned, and it is the civil penalties that drive the fear of God into hospitals and into physicians because the civil penalties are extraordinarily onerous.

There was a case when I was at HHS, a doctor in Nevada was charged by the inspector general with having billed Medicaid for I think it was—Medicaid for 800 urinalyses that had never been performed, at about $3 a urinalysis, about $2,400 worth of tests over a multiyear period. The inspector general then applied the civil monetary penalty law as it existed at the time, which was $2,000 for each false claim, so that is $2,000 times 800 which is about $1.6 million. So they went after this physician for $1.6 million. After a trial, the Department concluded that the submission of the claims were not false claims, but rather were billing errors on the part of his billing clerk, but he had to fight this battle with us for, I think, 5 years.

When you talk about $2,400 worth of submissions versus a $1.6 million potential penalty, that does strike the fear of God into most businessmen. It certainly would strike the fear of God into me. That is the concern, not the 52 criminal prosecutions.

Chairman CHAMBLISS. You talked about kickbacks, and you talked about the fact that in 1977 we broadened the scope of that particular provision. Do you think that we ought to go back and relook at that now, and let's bring it back in, particularly in light of what has happened and our experience over the last 23 years?

Mr. CHARROW. First of all, if you have a different antikickback law for health care providers than you do for defense contractors, you have to ask yourself why. Perhaps in 1977 it was justified. Remember, in 1977 the way Medicare paid hospitals and physicians was very different than the way that they are paid today. In 1977, hospitals were paid on a reimbursement system, which means every dollar that they incurred in costs was passed on to Medicare. So if they paid a kickback, who paid for it ultimately? The trust fund.

Hospitals aren't paid that way anymore. They are paid on the DRG prospective payment system, a flat fee for treating a specific illness. If they pay a kickback, it is the hospital that pays it, not the trust fund. So you have a lot of private folks who have a real economic interest in not paying kickbacks, which wasn't the case in 1977.

Chairman CHAMBLISS. As you know, in 1999 we created the MedPAC, Medicare Payment Advisory Commission, to conduct a study and look at our rules and regulation process and come back with some recommendations. Are we headed down the right road there? From what you've seen thus far, are we doing the right things with respect to that advisory commission?

Mr. CHARROW. I think you are, and I also think that the Congress and the administration have to work together to figure out how to really bring Medicare into the 21st century. This paper tiger is sort of hobbling across the millennium line, and it is weighted down with 135,000 pages of regulation, and it is going to have to service many more people as our population grows older.

Medicare requires far more in the way of paperwork than private insurers. Why is that? Private insurers are spending their own money. They have stockholders. So you have to wonder why does Medicare require so much more than the private insurer. Some of it is Congress, and some of it is just the momentum of a bureaucracy.

Chairman CHAMBLISS. Mr. Davis.

Mr. DAVIS. To follow up on your last comment, which I think is an interesting one, is there currently institutionalized any effective process, in your judgment, to engage in this balance with respect to the cost of compliance versus the projected benefits of regulation?

Mr. CHARROW. Yes and no. There are, of course, two schemes for doing the cost-benefit analysis that you refer to. One is the Regulatory Flexibility Act, which was amended by this Congress to make it, I think, a far more potent weapon in 1995. That piece of legislation requires that before an agency issues what is called a major rule—which is usually a rule with an impact of 100 million or more dollars on the economy—that it engage in a fairly detailed cost-benefit analysis. And if the agency doesn't believe that it is going to have a major impact on the economy or on small businesses, the Secretary of the department that issues the rule is re-

quired to do a certification. Sometimes it works. Sometimes you get very good cost-benefit analyses done, and sometimes you get none and no certification. But it only applies to major rules.

OMB in theory is supposed to review on its own initiative all rules and do a cost-benefit analysis for all rules, but that is an internal proceeding, and the public never sees what goes on. In some administrations that is taken more seriously than other administrations. So it is mixed results.

Mr. DAVIS. So no process specific to HCFA?

Mr. CHARROW. No.

Mr. DAVIS. Do you think there should be?

Mr. CHARROW. Yes.

Mr. DAVIS. Can you detail that a little bit?

Mr. CHARROW. I would love to see cost-benefit analysis done with respect to the types of forms that providers are burdened with. I think Dr. Berenson was extremely candid when he said, yes, 10 years is too long. And, yes, maybe we should revisit having physicians or hospitals fill out these forms every visit. That may not make sense. But the real question is how did that come into being; why is it there, and why didn't somebody catch it?

Mr. DAVIS. You think if we had such a process at HCFA, we would be able to make some projections about the cost of compliance and engaging in this balance?

Mr. CHARROW. Yes. And there is nothing that prevents HCFA from going out and doing that with respect to some of its regulatory initiatives that are up and running.

Chairman CHAMBLISS. With respect to the incredible proliferation of software and other technology in the IT industry that is being used in health care, does that dramatically alter this debate, in your judgment, in terms of the extent of the problem or the availability of solutions?

Mr. CHARROW. It certainly should help reduce what we call the real transaction costs, and I think HCFA is moving in the right direction. They still have significant problems with their computer systems. I think you are all aware of that. Hospitals, for example, have to query the HCFA computer systems to find out whether a patient has used up their eligibility, and frequently that computer system is down, and because they have no way of getting the information, they have to admit the patient, and only later do they find out that the patient has used up his eligibility.

Mr. DAVIS. Do you have an opinion as to the extent to which the provider community is seeing the advantages of being on-line and what we can do to entice that?

Mr. CHARROW. I would like to see more providers on-line. I think the hospitals are on-line. They tend to interact electronically with their intermediaries, the contractors, quite efficiently, and I think the PPS system has really reduced transaction costs. I know Mr. McDermott was a key player in the recent piece of legislation that extended that to psychiatric hospital, which reduced their costs dramatically.

I think we have to bring the docs into the game, and I think a lot of what is happening with respect to the private companies, MEDM which is run by the AMA and a group of specialty societies, and Koop, M.D., are going to have that effect.

Mr. DAVIS. My final question is do you have any recommendations for us in Congress as to what we can do to assist or influence HCFA putting more emphasis on this kind of promise? And I am not referring to bringing more providers on-line, just the whole notion that technology can dramatically improve our ability to tackle this problem?

Mr. CHARROW. I think HCFA realizes that. Having been in the bureaucracy for 4 years, it is like golf. It looks real simple until you try to do it. As a law prof, I thought it would be easy to go into an agency and snap my finger and have things done. I snapped my finger, and nothing got done. I had to learn how the system operated. It is a big bureaucracy. It is 4,000 people plus 50,000 contractors, and it is the entire Department. So it is tough. And in Congress, of course, it is tough to figure out ultimately what impact your legislation is going to have. Legislating is a tough job.

Mr. DAVIS. Well, it just seems to me what is unique about this situation is the technology is improving the level of service and reducing costs in the private sector in ways that seemed unfathomable a few years ago. How do we get involved sooner rather than later?

Mr. CHARROW. As someone who comes from a law firm that has difficulty keeping their computers up and running—we have two summer associates here who suffered through a day of down computers yesterday—I am not sure.

Mr. DAVIS. Thank you.

Mr. CHARROW. Thank you.

Chairman CHAMBLISS. Mr. McDermott. The gentleman has yielded to Dr. Fletcher.

Mr. FLETCHER. Well, thank you for the testimony. I read through it and heard part of your questioning. I have some concerns. I said if I went back to practice, I probably would consider eliminating much of the insurance and the other things and lower the costs on patients and reducing the administrative staff, because the complexity of billing, of dealing with insurance companies, and HCFA particularly, has gotten so burdensome that I believe—and I don't know if we have numbers—that a substantial cost of the system—when I look at the number of administrative people involved in hospitals versus the number that actually touch the patient, I wonder how much regulations costs versus how much it saves.

United Health Care looked at—they were spending a great deal of money on reviewing procedures to see if they were medically necessary and found that they spent three or four times as much doing that as the procedures would cost. I would welcome any reduction in bureaucracy, red tape, a simplification.

I agree that it does look like golf, it looks simpler than it really is. I think sometimes it certainly—and I would like to hear—and I am not sure that the answer is getting every physician computerized and on-line. If we don't change the billings, it is just going to require more advanced technology. I remember when we practiced, I went a number of years without computerization because it was much more efficient, but we eventually went there.

If you could help me with maybe some of what you see in the regulation and the implementing, and I asked the last gentleman for the number of civil penalties that are levied and how they re-

flect the complexity of the regulations, and I wonder if you can address that a bit.

Mr. CHARROW. As I alluded but actually did not state expressly a few moments ago, the civil money penalty law operates at two levels. It operates under the aegis of the Department of Justice where they can go into court and under the False Claims Act sue a doctor or other provider for treble damages plus $10,000 per false claim. To be guilty under the Civil False Claims Act, you do not have to have committed fraud. If you made a bad mistake, you could be civilly prosecuted. That is one option the Department of Justice has.

The other option, available also on the civil side, is what is called the civil money penalty law. It is done entirely administratively at the Department of Health and Human Services. Prosecution is by the Inspector General'S Office. Trial is before an administrator law judge. Same penalties. It is easier for the Department to do it that way, and it is that civil money penalty law that creates the fear of God in most providers.

Mr. FLETCHER. I appreciate that because in the last testimony it was more a fear of criminal penalties, and we hear that, criminal penalties, but from my experience it has been more the civil penalties because folks have a greater fear because there is no necessity for them to show a particular intent.

Do you have any idea how often that is used against providers when it may have been due to the complexity of the regulation?

Mr. CHARROW. My guess is that like any agency, the agency does in its own head a cost-benefit analysis before it seeks to go after somebody. One of the factors that always factors into the equation is how much can we recover. The greater the potential recovery, the more likely you are to see an action independent of the level of intent. Now, as the amount of the potential recovery decreases, the level of intent the prosecutor is going to require before they go after that person increases. There is a lot of money at stake, and it is going to be done administratively civilly. Invariably they are going to settle. You are not going to take it to trial. So they will settle for 25 cents on the dollar, but it is 25 cents not on the Medicare dollar, it is on the treble dollar plus the $10,000 per false claim.

Mr. FLETCHER. Do you have any idea the degree—because I think we are getting down to where the fear—the source of fear is.

Mr. CHARROW. I don't have the most recent numbers. The Office of the Inspector General would have that. They would be able to tell you the number of cases that they referred to the Department of Justice for the False Claims Act. They would be able to tell you the number of civil money penalty cases that they have initiated against providers and doctors.

There is a list on the Web of practitioners and other providers who have been excluded from the program, usually through some form of CMP process, and the list goes on and on and on.

Mr. FLETCHER. That is the reason when they talked about 50 some having been convicted criminally, I think that is really a very small part of what is going on in waste, fraud and abuse that concerns providers. I want to make sure that we do stop the waste, fraud and abuse and that we eliminate the bad players out there.

And you brought up in your testimony that it is very important to make a system that is simple, easy, understandable, very clear, and that it is not just the monetary return that the administration may get out of a particular case, but rather it has to involve the intent. And that I think there is a much greater use that is needed of the carrot rather than the stick approach when we come to honest providers. I fear we are losing many of them, and there is a lot of talk out there of not participating with Medicare in the future, and that is going to have a tremendous impact on the health care of our seniors in this country.

So I would hope as we work on this committee and other committees to do oversight hearing that we can work with HCFA and yourself and folks to see if we can't get regulations that are more simple; that we are not operating under a system of fear, but rather cooperation and collaboration.

Mr. CHARROW. I think the most interesting statistic that I can relate to you is that the most common type of request I had after HIPAA was enacted in 1996 was requests by physicians for opt-out forms. This would be the form they would submit to the secretary to opt out of Medicare.

Chairman CHAMBLISS. Dr. McDermott.

Mr. MCDERMOTT. I appreciate your coming today, and I particularly appreciate the story you tell in your testimony. Yesterday standing on the steps of the Capitol, as we left last night a Member told me almost an identical story of dealing with her own mother's problems that day and what it took for a Member of Congress to find out from a home health agency what, in fact, her mother was actually entitled to, and I think the system undeniably is complicated.

What is interesting to me is that sometimes we think that this is a political problem of one party or another, but I think your coming and testifying really is saying no matter what your intention is, no matter how you want to change it, it is difficult to do it without an enormous period of figuring out what Murphy's law is really going to produce, because we pass these laws thinking X is going to happen, and Y happens. How did that happen? Well, it is the bureaucrats.

Well, it is not quite as simple as that, and I think what you have contributed, and I hope that you will feel, as we said to the last witness, that anything you think that you can suggest to us in terms of things that we really could do, having had your experience, that those are things that we can make changes to lift the burden off the bureaucrats, because the bureaucrats are always caught in the position of covering themselves. The Congress directed us to do this, and therefore we have to do all this to make sure that we do what they ask us to do. I was thinking as I——

Mr. CHARROW. I do have one suggestion. It probably doesn't affect this committee, but the thing I noticed the most when I was at HHS was that 2 a.m. to 3 a.m. to 4 a.m., I would get calls from the Ways and Means Committee when they were marking up major pieces of Medicare legislation—one of us would always be present—the legislation was being written in the middle of the night by, as someone who is a bit older can say, kids, who were exhausted, and I always scratched my head and thought, oh, my

God, I wonder what it is going to look like when it is signed by the President.

Mr. MCDERMOTT. My wife does complex environmental litigation, and she asks me how did this get in the Superfund law.

I only close by telling a short story about Elliott Richardson. They asked him what thing had he not been able to accomplish, and he said, well, if I had my way, I would call all of the members of HHS to the D.C. stadium, and I would go out on the floor of the stadium with a bullhorn and say, my name is Elliott Richardson, I am your boss, you work for me. And, of course, the problem when you come into it trying to change stuff is it has gotten—it has evolved in ways that anybody coming in from the outside, it looks very easy.

I think your golf analogy is quite correct. I don't know how we will change Ways and Means writing bills in the middle of the night. It doesn't make any difference whether it is Democrats or Republicans in charge of the committee, they are both doing the same thing. We will work at it.

Thank you very much.

Mr. CHARROW. Thank you for having me.

Chairman CHAMBLISS. I agree, that seems to be the nature of the beast around here.

Mr. Charrow, your personal example, do you think that your hospice folks and your skilled care facility, whatever the other one was there, didn't know the answer to your question, didn't know what benefits your father was entitled to because they were not aware of all of the rules and regulations, because they were too burdensome? What was the problem?

Mr. CHARROW. They were surprised. They had been operating off the old play book when there was a new play book. I felt sorry for them in a way. They were good people trying to do a good job in a very complex environment. These people are not lawyers. They don't have in-house counsel. They are small businesses by and large, nonprofits.

Mr. MCDERMOTT. Do you mean they were not sent a copy of the new rules and regs?

Mr. CHARROW. They didn't exist. They were in development in the hospice situation. The home health was a bit more complex. I never figured out what they had received and had not received, but what they cobbled together from what they had received was not correct.

Chairman CHAMBLISS. That is interesting, and that ought to be something that we can address and we can fix, and I agree with your comment. I was willing to spot Dr. Berenson about 60,000 pages, but that still left us 70,000 pages. Undoubtedly from that answer there are a lot of pages that are obsolete rules and regulations, and we need to throw them away. How we are going to do that, I don't know. Our MedPAC has their work cut out for them.

Mr. CHARROW. Give them a page limit. Courts do it all of the time.

Chairman CHAMBLISS. There you go.

Mr. Charrow, thank you for being here and for your very thoughtful insights. We thank you for coming, and if there are any

additional written questions, we will sure get them to you right away.

This hearing is adjourned.

[Whereupon, at 12:42 p.m., the Task Force was adjourned.]

Blowing Smoke on the Invisible Man: Measuring Fraud, Payment Errors in Medicare and Medicaid

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WEDNESDAY, JULY 12, 2000

HOUSE OF REPRESENTATIVES,
COMMITTEE ON THE BUDGET,
TASK FORCE ON HEALTH,
Washington, DC.

The Task Force met, pursuant to call, at 10 a.m. in room 210, Cannon House Office Building, Hon. Saxby Chambliss (chairman of the Task Force) presiding.

Chairman CHAMBLISS. We will call the hearing to order. And, Ms. Jarmon, Mr. Hamel, we will let you all take seats as we begin to make a few opening comments here.

This is another of our hearings in our process of reviewing waste, fraud and abuse in Medicare/Medicaid programs, and we are excited today to look at another aspect. We have talked about Medicare exclusively just about in each of the hearings that we have had thus far. We are going to continue to talk about Medicare to a certain extent today, but also look at Medicaid and what the Federal responsibility with respect to waste, fraud and abuse in Medicaid is and just as importantly what it should be.

So we have folks from the GAO as well as folks from HCFA back with us today, and also a gentleman who has had more practical experience at the State level to bring us some information about what is going on out there.

And he had—we have a chart over here that Dr. Sparrow, who was hired by HCFA to do some work—and I think Ms. Thompson referred to the work that he did with respect to coordinating some of the ideas at the State level and bringing all that together. And we have adopted one of the quotes from Dr. Sparrow here as somewhat of an underlying theme. And we have had a blowup of that quote made available here this morning.

It is—when we talk about waste, fraud and abuse with respect to Medicare and Medicaid, it is kind of like looking at the invisible man. I like his quote: "It is like in the Hollywood movies, trying to blow smoke on the invisible man. For a moment you see what is there, but only for a moment." that literally is true because it is so hard to get your arms around the sheer volume of this program, and trying to pick out the real instances of waste, fraud and abuse is extremely difficult. You think you got it at one moment, then you turn around and it is gone.

Let's put those other two charts up, too.

I just want to emphasize the real significance of what we are dealing with here. We have got an appropriation bill that is going to be coming to the floor here sometime, I guess, this week or next week, the foreign operations bill. In that bill we spend somewhere around $15 billion a year. If you look at the Medicare outlays, and we don't know what the waste, fraud and abuse number is, if it is 1 percent, it is 2.1 billion, but it goes all the way up to, if it is 15 percent, 32.55 billion. We could pass two foreign ops bills if it were 15 percent, and we could bring it within some sort of reasonable control. So that is the significance of Medicare waste, fraud and abuse.

Medicaid is not too far from that. We have total outlays last year of Medicaid of $203 billion. And again, if 1 percent of the Medicaid allocation is where the waste, fraud and abuse lies, then we are looking at 2.03 billion all the way to 30.45 if it turns out to be 15 percent of the program. So we are talking about real dollars, we are talking about significant money, and we are talking about dollars that ought to be used for the beneficiaries of those two programs and obviously not going out the back door.

I want to thank our witnesses in advance for being here. As I have said in each one of these hearings, we are not here to point fingers. It is not a partisan issue that we are dealing with. I think every administration has had the same problems with respect to trying to put their finger on waste, fraud and abuse. We just think we can do a better job with it. And we want to make sure that we understand from our end where the problems are, and if we need to participate from a legislative perspective and in helping solve that problem, we need to know that, and we need to get on board with you to try to help get to the bottom of this issue that we know is out there.

By the same token we want to make sure that our Federal agencies are doing everything they ought to be doing and in the most efficient manner possible to try to get to the bottom of the issue of waste, fraud and abuse.

So, again, we thank you for being here. We look forward to your testimony.

[The prepared statement of Saxby Chambliss follows:]

PREPARED STATEMENT OF HON. SAXBY CHAMBLISS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF GEORGIA

Today, the Health Task Force continues to focus on waste, fraud, abuse and mismanagement in the Federal health care system by investigating fraud measurement techniques in the Medicare and Medicaid programs.

As the title of the hearing—"Blowing Smoke on the Invisible Man"—implies, the key to determining the level of fraud and abuse in America's two largest public health care delivery programs is identifying criminals and fraudulent techniques designed to elude detection.

Or as health care fraud expert Malcolm Sparrow said: "There's a trap of circularity—you look for what you've seen before. Meanwhile other kinds of fraud are developing within the system that remain invisible because you're not familiar with them and you have no detection apparatus for that. * * * It's like in Hollywood movies, trying to blow smoke on the invisible man. For a moment you see what's there—but only for a moment."

To most properly allocate valuable resources to combat improper payments under Medicare and Medicaid, we need the best information available on areas of waste, fraud and abuse—identifying the invisible man in effect. The purpose of today's hearing, relative to Medicare, is to find out whether the current methodologies used by the Department of Health and Human Services to measure improper payments

provide the most accurate reflection of actual improper payments made under Medicare.

For example, the Department of Health and Human Services' Inspector General has estimated for Fiscal Year 1999 that "improper" Medicare fee-for-service payments totaled $13.5 billion, which is a dramatic decrease from the $23.2 billion in improper payments estimated in Fiscal Year 1996.

While the Department and the Clinton administration have publicly attributed the sharp decrease in improper payments to their efforts to combat waste, fraud and abuse, there is increasing dispute over the nature of such a claim as we learn that true Medicare fraud often goes unmeasured.

Even though the General Accounting Office has kept Medicare on its "high risk" list, meaning the program is exceptionally vulnerable to fraud and abuse, questions persist whether the Department has measurement techniques in place to accurately gauge the level of fraud and abuse within the program.

To help ascertain the extent of the government's Medicare fraud measurement techniques, the House Budget Committee called upon the GAO because numerous academics, government watchdog organizations, and concerned citizens have noted that audits, such as the type used by the HHS to arrive at the $13.5 billion figure in FY1999, do not detect fraud because they are not designed to. Instead of concentrating on fraud, the Task Force has heard from previous witnesses that the measurements are aimed at billing correctness, utilization review and policy coverage. Additionally, many of the so-called errors identified as "improper" may not result from abuse but from honest differences of opinion regarding how medicine ought to be practiced, what is "medically necessary."

More troubling is that recent accounts show that Medicare has attracted its own class of organized criminals, persons who specialize in defrauding health care and health insurance systems. I believe one of our witnesses, a special investigative agent with GAO, will be able to provide first-hand testimony regarding the sham medical entities, fictitious physician groups, and "post office box" clinics that organized criminals have created to defraud Medicare. Everyone would certainly agree that such fraudulent activities need to be included in a calculation of improper Medicare payments.

I anticipate the GAO witnesses will discuss the results of its study into fraud measurement techniques and will discuss how the existing methodology employed by HHS was not intended to detect fraudulent schemes such as kickbacks, services not actually provided, and those developed by organized criminals.

With that, I look forward to hearing GAO's critique of the current improper payment measurement methodology, and to learning GAO's recommendations on how government can best adopt a comprehensive methodology to measure fraudulent activities and allow for the best allocation of resources to combat waste, fraud and abuse.

Finally, the second panel will testify on payment error measurement rates relative to Medicaid. Currently there is no comprehensive Federal system in place to measure Medicaid improper payments. The witnesses on the second panel are here today to discuss both the pros and the cons of whether such a system would be feasible or effective in measuring Medicaid waste, fraud and abuse.

Chairman CHAMBLISS. And at this time, I would recognize the gentleman from Washington, the ranking member of the Task Force, Dr. McDermott. Jim.

Mr. MCDERMOTT. Thank you, Mr. Chairman. I think the figures and the quote that the Chairman has put up on the board are sort of interesting. The man who wrote that quote also wrote a book called License to Steal. He works at the Kennedy School of Government. He is a very respected gentleman.

I think the issue here and I think the conundrum—and for those of you who aren't from the Northwest, that means puzzle—that we face here is that HCFA hires contractors to administer the program, and they pay the bills sent in by the providers. And the dilemma that faces this committee and faces all of us in the government, in the Congress, is the question of on whom do we put the responsibility for finding fraud, waste and abuse?

Now, I assume that North Dakota Blue Cross/Blue Shield, which administers the program in the State of Washington, when they

are dealing with their own claims are very vigorous in preventing fraud, waste and abuse. I wouldn't think that as a for-profit company they would be lax, otherwise their stockholders would eat their lunch, and their president would be gone. So, when they are doing that for themselves, the question then is are they doing the same for the government under the contracts that the HCFA writes with them?

Now I know we have had more than one contract in the State of Washington. We have had about three of them that I can remember in the last 10 years. And the question then, is the best place to go after fraud, waste and abuse by saying to HCFA, go and redo all the claims that North Dakota Blue Cross/Blue Shield did; or go out to all the hospitals in the State of Washington and all over the Northwest?

Actually North Dakota has three or four States for whom they examine claims or for whom they process claims, and the question is, should they go out there, should HCFA go out and examine all those claims? Well, we already had a hearing where we heard from providers who said there is too much of that coming out there looking at our records. So we are caught in a real conundrum, and that is if you are going to look for fraud, waste and abuse, how much pressure can you put on the providers, and who should do it, and where is the law of diminishing return? I mean, if HCFA wants to hire 100,000 people to go out and examine every hospital and every doctor's office, that is going to cost something. And if you are going to do that, on top of what is already being done apparently or presumably by the contractors who are hired, isn't that a duplication of effort?

It is those kinds of issues that I think this committee is struggling with. No one thinks that any human system is perfect. Especially in the United States where we have the free enterprise system and we value entrepreneurship, we are going to have some entrepreneurs who are going to skate too close to the line in trying to maximize their profits. No question. It happens everywhere. Whether you are talking about the defense industry or the health industry it doesn't really make any difference. Wherever there is money involved, some people are going to try to push the rules as far as they can.

As we had in the Defense Department recently, we had a wire manufacturer who was making the controls for airplanes who is saying that the wire is of a certain strength, and it turns out it is not of a certain strength, and you have every military aircraft had to be examined for whether or not they had that kind of steel in their controls. Now, that kind of thing goes on in the military industry. It certainly goes on in health care. But the question we have is who should we put the responsibility on to press, and how hard should they press?

So I am eager, Mr. Chairman, to hear what the GAO has to say on this whole issue. Thank you.

Chairman CHAMBLISS. Thank you.

Mr. Lucas, you care to make any statement?

Mr. LUCAS. Mr. Chairman, this last 4th of July district work period I had three health care roundtables in three different hospitals in my district. The one common thread through all these meetings

were the comments from the hospital administrators—two of them I have known personally for a long time and I think they are people of integrity. They complained that when honest mistakes were made in filing Medicare claims, the ultimatums that were issued were either fines or "we are going to sue you." I heard this clear across my district. So I am wondering if we aren't being overzealous in the pursuit of people who are making honest mistakes.

Chairman CHAMBLISS. There is no question but that is a real problem, and some of that will be addressed today I know.

Before we begin, let me just ask unanimous consent that all Members be given 5 days to submit written statements for the record.

Our first panel this morning comes from the General Accounting Office, Gloria L. Jarmon and William D. Hamel. Ms. Jarmon, Mr. Hamel, welcome to this Task Force hearing. We appreciate you being here today. We look forward to your testimony.

Ms. Jarmon.

STATEMENT OF GLORIA JARMON, DIRECTOR, HEALTH, EDUCATION, AND HUMAN SERVICES ACCOUNTING AND FINANCIAL MANAGEMENT ISSUES, ACCOUNTING AND INFORMATION MANAGEMENT DIVISION, U.S. GENERAL ACCOUNTING OFFICE; ACCOMPANIED BY WILLIAM D. HAMEL, SPECIAL AGENT, OFFICE OF SPECIAL INVESTIGATIONS, GENERAL ACCOUNTING OFFICE

Ms. JARMON. Thank you.

Mr. Chairman and members of the Task Force, we are pleased to be here today to discuss our review of HCFA's efforts to improve the measurement of improper payments in the Medicare program. With me today is Bill Hamel from our Office of Special Investigations.

You asked us to provide suggested improvements to assist HCFA in its efforts to further estimate Medicare improper payments, including potential fraud and abuse. I will summarize our statement and ask that the full statement be made part of the record.

While we believe HCFA's efforts to measure Medicare fee-for-service improper payments can be further enhanced with the use of additional fraud detection techniques, we support the efforts they have taken thus far. Considering the challenges associated with identifying and measuring improper payments, the projects discussed in our statement represent important steps toward advancing the usefulness of HCFA's improper payment measurement efforts.

I will first briefly discuss the current methodology used by HCFA to estimate Medicare fee-for-service improper payments. Next I will mention HCFA's three planned projects to further measure improper payments. Then I will summarize our results.

The current methodology, which estimated fiscal year 1999 Medicare fee-for-service improper payments at $13.5 billion, was a significant step toward quantifying such payments. It was not designed to identify or measure the full extent of levels of fraud and abuse in the Medicare program. The methodology generally assumes that medical records received for review represent actual services provided. While this estimate has been useful for financial

statement information and as a performance measure for the program, given the size and complexity of the Medicare program, its usefulness as a tool for targeting specific corrective actions is limited.

To enhance its understanding of improper payments and help it develop targeted corrective actions, HCFA has recently begun three projects. These projects are shown in my statement in the charts on pages 16 and 20. I will briefly summarize the projects. The first one is the Comprehensive Error Rate Testing project, referred to as the CERT, C–E–R–T, project. It is similar to the current methodology; however, it is designed to produce a paid claims error rate at each contractor by provider type and service category levels. It is undergoing a phased implementation with a scheduled completion date of October 2001.

The second project on the charts is called the Payment Error Prevention Program, or the PEPP, P–E–P–P, project. This is also similar to the CERT project and the current methodology, but it is designed to develop payment error rates for each State and for each peer review organization area of responsibility. HCFA officials stated that this project is the furthest along in implementation, with the first quarterly reports expected in September of 2000.

The third project is the Model Fraud Rate project, or MFRP, and this is an effort to develop a potential fraud rate for a specific locality and specific benefit type. It has been tried in southern California. However, HCFA officials told us that they intend to eventually expand the scope of this project to provide a national potential fraud rate. However, the Medicare contractor assisting HCFA in developing this project is dropping out of the Medicare program in September of 2000 and has ceased work on the project.

Given the billions of dollars that are at risk, it is imperative that HCFA continue its efforts to develop timely and comprehensive payment error rate estimates that can be used to develop effective program integrity strategies for reducing errors and combating fraud and abuse. HCFA's projects could collectively address some of the limitations of the current methodology if properly executed. For example, expanding the scope of the Model Fraud Rate project to include studying provider visits and a more extensive assessment of the cause of improper payments and other techniques could help HCFA pinpoint additional high-risk areas and develop more effective corrective actions.

The chart to my right, which is also on page 7 of my statement, shows the six most common types of potential fraud and abuse cases from HCFA's fraud investigation database. It shows the relative frequency of these cases based on information gathered by HCFA from 1993 to April 2000. You can see that, based on information in their database, 37 percent of the errors relate to services not rendered, going down to, according to their database, about 7 percent relating to kickbacks and accepting/soliciting bribes. HCFA officials told us that while more complex types of fraud or abuse, such as fraudulent cost reporting and kickback arrangements, which on this chart show 7 percent each, may be less frequent than other types, such cases often involve significantly greater losses, especially fraudulent cost reporting.

The next chart that we have to my right, is a version of the chart on page 9 of our statement, which shows five of the most promising techniques identified by health care fraud experts and investigators. The chart we have here is a summary of some of the key questions that investigators try to answer by employing those techniques. Many of these techniques are currently performed by Medicare contractor fraud units to detect potential fraud and abuse. I will talk briefly about each of them.

First, the medical record review. It primarily tells you whether there is reasonable documentation for the services that were provided.

Secondly, data analysis. This often highlights unusual relationships between the data.

Third, beneficiary contact. This addresses whether services were actually received by the beneficiary.

Provider contact is important because it is done to ensure that the provider actually exists and has documentation on site that supports the billed amount.

And the fifth technique on that chart and on page 9 is third-party contact, which addresses whether entities, such as state licensing boards and a wide list of other third-party entities, can validate key information related to the claim, such as whether the doctor is licensed.

It is important to note, however, that no matter how sophisticated the techniques, not all fraud and abuse will be identified. Using a variety of techniques holds more promise for estimating the extent of potentially fraudulent and abusive activity and also provides a deterrent value to such illegal activity. The implementation of more extensive detection techniques is bound to be challenging and expensive. So using rigorous study methods and consulting with the people affected, such as beneficiary and provider advocacy groups, are essential steps to ensure success as well as considering the tangible and intangible benefits of using particular techniques.

Mr. Chairman, this concludes our statement. We would be happy to answer any questions that you or other members of the Task Force may have.

Chairman CHAMBLISS. Thank you very much, Ms. Jarmon.

[The prepared statement of Gloria Jarmon follows:]

PREPARED STATMENT OF GLORIA L. JARMON, DIRECTOR, HEALTH, EDUCATION, AND HUMAN SERVICES ACCOUNTING AND FINANCIAL MANAGEMENT ISSUES, ACCOUNTING AND INFORMATION MANAGEMENT DIVISION, U.S. GOVERNMENT ACCOUNTING OFFICE

Mr. Chairman and members of the Task Force, I am pleased to be here today to discuss our review of the Health Care Financing Administration's (HCFA) efforts to improve the measurement of improper payments in the Medicare fee-for-service program. Identifying the extent of improper payments and their causes, including those attributable to potential fraud and abuse, are the first steps toward implementing the most cost-effective ways to reduce losses. In my statement today, I would like to share with you the results of our review which is being conducted at the request of the Chairman of the House Committee on the Budget.

HCFA, an operating division within the Department of Health and Human Services (HHS), has designated ensuring the integrity of the Medicare program a top priority. It recognizes that inappropriate payments are a drain on the program's financial resources—resources intended to provide essential health care services to millions of elderly and disabled Americans. In conjunction with its audit of HCFA's annual financial statements since 1996, the HHS Office of the Inspector General (OIG) has conducted a nationwide study to estimate Medicare fee-for-service im-

proper payments.[1] The statistically projectable results cited in the OIG's study have provided valuable insights regarding the extent of Medicare vulnerabilities. Results from the most recent study indicate that, of the $164 billion in fiscal year 1999 Medicare fee-for-service claim payments, a projected $13.5 billion were paid improperly for various reasons ranging from inadvertent errors to outright fraud and abuse. The magnitude of these estimated losses has led to considerable concern regarding HCFA's efforts to protect Medicare dollars as well as the need to obtain a better understanding of the nature and extent of the problems.

The OIG's study was a major undertaking and, as we recently reported,[2] the development and implementation of the methodology (referred to as "current methodology ") it used as the basis for its estimates represents a significant step toward quantifying Medicare improper payments. It is important to note however, that this methodology was not intended to and would not detect all potentially fraudulent schemes perpetrated against the Medicare program. Rather, it was designed to provide users of HCFA's financial statements with an initial estimate of Medicare fee-for-service claims that may have been paid in error and has served as a performance measure for the program. However, given the size and complexity of the Medicare program, the usefulness of this estimate as a tool for targeting specific corrective actions is limited.

To demonstrate a commitment to improving payment safeguards, in January 2000, HCFA reaffirmed its goal of reducing the Medicare fee-for-service payment errors to 5 percent or less by the year 2002, about a 3 percent or $5 billion reduction from fiscal year 1999 levels. However, without additional information on the extent of improper payments[3] attributable to potential fraud and abuse, HCFA's ability to fully measure the success of its efforts remains limited. Accomplishing this goal will depend, in part, on HCFA's ability to further develop improper payment measures to enable it to more effectively target specific corrective actions. In response to this need, HCFA has begun three projects intended to enhance its understanding of improper payments and help it develop targeted corrective actions.

Given the importance of Medicare to millions of beneficiaries and concerns about the financial health of the program, you asked us to provide suggested improvements to assist HCFA in its efforts to further estimate Medicare improper payments, including potential fraud and abuse. In summary, we concluded that:

- Because it was not intended to include procedures designed specifically to identify all types of potential fraudulent and abusive activity, the current methodology does not provide an estimate of the full extent of improper Medicare fee-for-service payments;
- HCFA has initiated three projects designed to further its measurement efforts which offer some promise for determining the extent of improper payments attributable to potential fraud and abuse; and
- Based on careful evaluation of their effectiveness, performing additional potential fraud identification techniques as part of its efforts to measure improper payments could assist HCFA in arriving at a more comprehensive measurement and, ultimately, develop cost-effective internal controls to combat improper payments; however, no set of techniques, no matter how extensive, can be expected to measure all potential fraud and abuse.

We are making recommendations designed to assist HCFA in its efforts to further enhance its ability to measure the extent of losses emanating from Medicare fee-for-service payments. Although we believe HCFA's efforts to measure Medicare fee-for-service improper payments can be further enhanced with the use of additional fraud detection techniques, we support the efforts they have taken thus far. Considering the challenges associated with identifying and measuring improper payments,

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[1] The Chief Financial Officers Act of 1990, as expanded by the Government Management Reform Act of 1994 (GMRA), requires 24 major departments and agencies, including HHS, to prepare and have audited agencywide financial statements. Major "components" of these 24 agencies, such as HCFA, may also be required to have audited financial statements.

[2] Efforts to Measure Medicare Fraud (GAO/AIMD–00–69R, February 4, 2000).

[3] Improper payments are defined as payments made for unauthorized purposes or excessive amounts. Improper payments can be caused by fraud and abuse, which involve a deliberate disregard for the truth or falsity of information or an intentional deception or misrepresentation that an individual knows or should know to be false or does not believe to be true and makes, knowing the deception could result in some unauthorized benefit to himself or some other person. Using information, such as the factors contributing to improper payments, to address fraudulent or abusive payments only as such payments are specifically identified and adjudicated unnecessarily limits and delays developing effective corrective actions. Accordingly, we believe that using these data as soon as practical to analyze and develop appropriate initiatives, represents effective management efforts to increase accountability over Federal assets.

the projects discussed in our statement represent important steps toward advancing the usefulness of its improper payment measurement efforts.

To fulfill our objectives, we analyzed the current methodology and HCFA's three planned projects related to improper payment measurement; related documents discussing the methodologies, designs, planned steps, and time frames for implementation of these initiatives; and relevant HHS OIG and GAO reports. We also interviewed HCFA officials and recognized experts in health care and fraud detection in academia, Federal and state government, and the private sector on the various types of improper payments and the techniques used to identify and measure them. We performed our work from November 1999 through June 2000 in accordance with generally accepted government auditing standards. See appendix 1 for a more detailed discussion of our objectives, scope, and methodology.

In my statement today, I will summarize our conclusions and recommendations regarding:

- The three HCFA projects that have been designed or initiated to measure Medicare fee-for-service improper payments;
- How such projects will potentially enhance HCFA's ability to comprehensively measure improper payments, including those attributable to potentially fraudulent and abusive provider practices based on the extent to which effective techniques used to detect common types of potential fraud and abuse are included in their design; and
- Actions HCFA should take to further enhance its efforts to measure the extent of improper Medicare fee-for-service payments and help HCFA better develop targeted corrective actions.

But, first I would like to begin with some relevant background about HCFA, the Medicare program, and the vulnerabilities of the Medicare program to fraud and abuse.

MEDICARE IS VULNERABLE TO FRAUDULENT AND ABUSIVE ACTIVITY

In 1990, we designated Medicare as a high-risk program,[4] and it continues to be one today. Many of Medicare's vulnerabilities are inherent due to its size and administrative structure, which make the largest health care program in the nation a perpetually attractive target for exploitation. Wrongdoers continue to find ways to dodge program safeguards. The dynamic nature of fraud and abuse requires constant vigilance and the development of increasingly sophisticated measures to detect fraudulent schemes and protect the program.

With total benefit payments of $201 billion in fiscal year 1999, Medicare enrollment has doubled since 1967 to nearly 40 million beneficiaries today. Beneficiaries can elect to receive Medicare benefits through the program's fee-for-service or managed care options. With benefit payments of $164 billion in fiscal year 1999 and about 85 percent of participating beneficiaries, the fee-for-service option represents the most significant part of the program. The managed care option accounts for the remaining $37 billion and 15 percent of participating beneficiaries. The program is comprised of two components. Hospital Insurance or Medicare Part A covers hospital, skilled nursing facility, home health, and hospice care. Supplementary Medical Insurance, also known as Part B, covers physician, outpatient hospital, home health, laboratory tests, durable medical equipment (DME), designated therapy services, and some other services not covered by Part A.

HCFA's administration of the Medicare fee-for-service program is decentralized. Each year, about 1 million providers enrolled in the program submit about 900 million claims to about 56 Medicare contractors for payment. The bulk of the claims are submitted electronically and never touch human hands during the entire computer processing and payment cycle.

Ensuring the integrity of the Medicare fee-for-service program is a significant challenge for HCFA and its Medicare claims processing contractors and Peer Review Organizations (PROs). They are HCFA's front line defense against inappropriate payments including fraud and abuse and should ensure that the right amount is paid to a legitimate provider for covered and necessary services provided to eligible beneficiaries. Except for inpatient hospital claims, which are reviewed by the PROs, Medicare contractors perform both automated and manual prepayment and postpayment medical reviews of Medicare claims. Various types of pre- and postpayment reviews are available to contractors to assess whether claims are for covered services that are medically necessary and reasonable. These include automated reviews of submitted claims based on computerized edits within contractors' claims processing systems, routine manual reviews of claims submitted, and more

[4] High Risk Series: An Update (GAO/HR–99–1, January 1999).

complex manual reviews of submitted claims based on medical records obtained from providers.

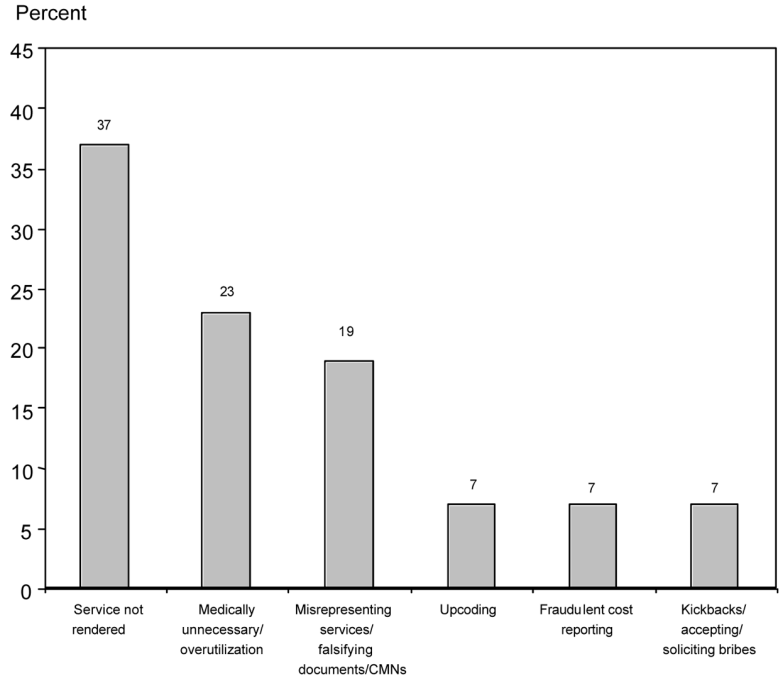
Reliance on postpayment utilization and medical record reviews to detect potential fraud and abuse has created opportunities for unscrupulous providers and suppliers to defraud the program with little fear of prompt detection. For example, a few providers—subjects of past health care fraud investigations in which they have pled guilty to or have been indicted for criminal charges—had set up storefront operations and fraudulently obtain millions of dollars from Medicare before their billing schemes were detected through postpayment reviews. HCFA is moving toward more extensive use of prepayment reviews, but contractors' efforts to prevent and detect improper payments are challenged due to the sheer volume of claims they are required to process and the need to pay providers timely. The program's vulnerabilities have been compounded by the emergence of some organized groups of criminals who specialize in defrauding and abusing Medicare, which has led to an array of fraudulent schemes that are diverse and vary in complexity. For example, based on our recent review of seven investigations of fraud or alleged fraud, we reported that the criminal groups involved had created as many as 160 sham medical entities—such as medical clinics, physician groups, diagnostic laboratories, and durable medical equipment companies—or used the names of legitimate providers to bill for services not provided.[5]

Medicare contractors and PROs are identifying thousands of improper payments each year due to mistakes, errors, and outright fraud and abuse. They refer the most flagrant cases of potential fraud and abuse to the OIG and Department of Justice (DOJ) so they can investigate further, and if appropriate, pursue criminal and civil sanctions. HCFA tracks the cases referred by Medicare contractors and PROs to the OIG and DOJ in its Fraud Investigation Database (FID).[6] Figure 1 shows the six most common types of potential fraud and abuse cases in the FID and the relative frequency of these cases. Definitions of these common types of fraud and abuse and examples are provided in appendix 2 to this testimony.

[5] Criminal Groups in Health Care Fraud (GAO/OSI–00–1R, October 5, 1999).

[6] The Fraud Investigation Database is a comprehensive nationwide system devoted to Medicare fraud and abuse data accumulation. The system was created in 1995, but contains data on potential fraud and abuse referrals going back to 1993.

Figure 1: Fraud Investigation Database Statistics for Cases Referred, 1993 to April 2000



Source: Prepared by GAO from data in HCFA's FID. We did not independently verify this information.

We were unable to assess the level of actual or potential program losses for the different types of potential fraud or abuse due to the limited financial data in the FID. However, HCFA officials told us that while more complex types of fraud or abuse, such as fraudulent cost reporting and kickback arrangements may be less frequent than other types, such cases often involve significantly greater losses.

Efforts to Measure Potential Fraud and Abuse Rely on Effective Use of Diverse Techniques

Given the broad nature of health care fraud and abuse, efforts to measure its potential extent should incorporate carefully selected detection techniques into the overall measurement methodology. With billions of dollars at stake, health care fraud and abuse detection has become an emerging field of study among academics, private insurers, and HCFA officials charged with managing health care programs. A variety of methods and techniques are being utilized or suggested to improve efforts to uncover suspected health care fraud and abuse. Such variety is needed because one technique alone may not uncover all types of improper payments.

Although the vast majority of health care providers and suppliers are honest, unscrupulous persons and companies can be found in every health care profession and industry. Further, fraudulent schemes targeting health care patients and providers have occurred in every part of the country and involve a wide variety of medical services and products. Individual physicians, laboratories, hospitals, nursing homes, home health care agencies, and medical equipment suppliers have been found to perpetrate fraud and abuse.

Fraud and abuse detection is not an exact science. No matter how sophisticated the techniques or the fraud and abuse audit protocols, not all fraud and abuse can be expected to be identified. However, using a variety of techniques holds more promise for estimating the extent of potentially fraudulent and abusive activity and also provides a deterrent to such illegal activity. Health care fraud experts and in-

vestigators have identified techniques that can be used to detect fraudulent and abusive activity. According to OIG officials, these techniques are performed by Medicare contractor fraud units[7] to detect potential fraud and abuse. Table 1 summarizes the most promising techniques they identified along with some of their limitations.

TABLE 1.—TECHNIQUES FOR DETECTING POTENTIAL FRAUD AND ABUSE

Medical record review: Doctors and nurses review medical records to assess whether the services billed were allowable, reasonable, medically necessary, adequately documented, and coded correctly in accordance with Medicare reimbursement rules and regulations.

Limitations: Medical reviews may not uncover services that have not been rendered or billing for more expensive procedures when the medical records have been falsified to support the claim.

Beneficiary contact: Verify that the services billed were actually received through contacting the beneficiary either in person or over the phone, or by mailing a questionnaire.

Limitations: Beneficiary may be difficult to locate and not be fully aware of, or understand the nature of, all services provided. Contact may not reveal collusion between the beneficiary and provider to fraudulently bill for unneeded services or services not received. In some instances, medical necessity and quality of care may be difficult to judge.

Provider contact: Visit provider to confirm that a business actually exists, that the activity observed supports the number of claims being submitted by the provider, and that medical records and other documentation support the services billed.

Limitations: Provider contact may not reveal collusion between the provider and beneficiary to fraudulently bill for unneeded services or services not rendered. In some instances, medical necessity and quality of care may be difficult to judge.

Data analysis: Examine provider and beneficiary billing histories to identify unusual or suspicious claims. Provider focused data analysis attempts to identify unusual billing, utilization, and referral patterns relative to a provider's peer group. Beneficiary focused data analysis looks for unusual treatment patterns such as visiting several different providers for the same ailment or claims for duplicate or similar services.

Limitations: Data analysis may only identify the most flagrant cases of potential fraud and abuse because it relies on detecting unusual patterns relative to the norm. Application of additional techniques may be necessary to assess the appropriateness of unusual patterns identified.

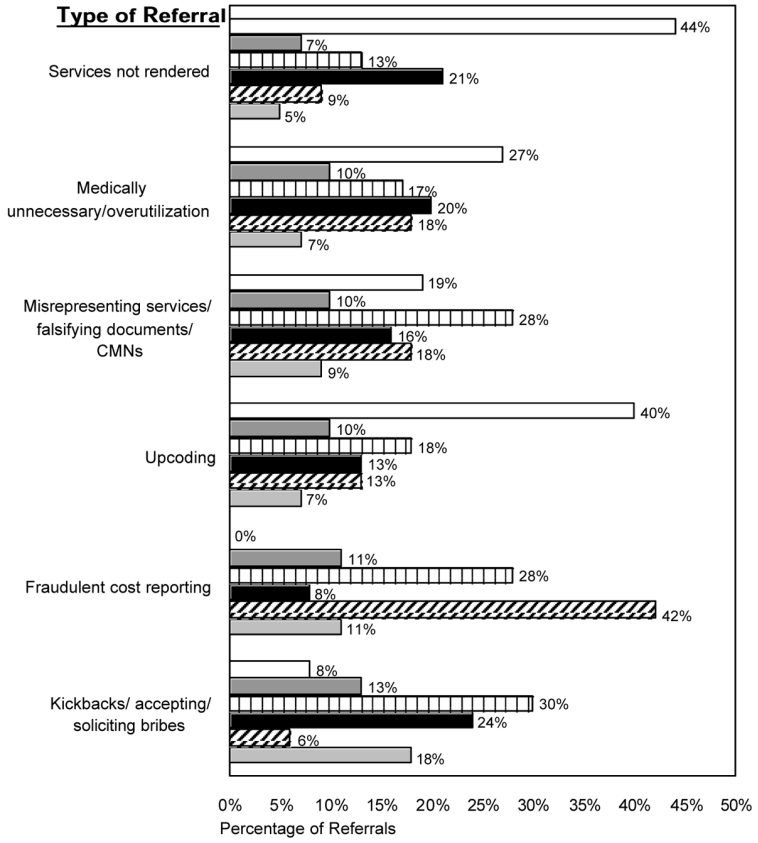
Third party contact/confirmation: Validate information relied on to pay claims with third parties to assist in identifying potential fraud and abuse. For example, verify that a provider is qualified to render medical services to Medicare beneficiaries through contacting state licensing boards or other professional organizations. Also, other entities, such as employers, private insurers, other governmental agencies (e.g., Internal Revenue Service, Social Security Administration, state Medicaid agencies) and law enforcement authorities represent valuable sources in determining the validity of claim payments when the reliability of data from primary sources (e.g., claims data, beneficiaries, and providers) is questionable.

Limitations: Does not address utilization patterns, whether services were rendered, the need for services, or quality of services.

Consequently, health care experts and investigators also told us that effective detection of potential fraud and abuse necessarily involves the application of several of these techniques and considerable analysis, especially for the more sophisticated types of billing schemes and kickback arrangements. In addition, data on fraud referrals contained in the FID indicate that information necessary for identifying potential Medicare fraud and abuse comes from a variety of sources, as shown in figure 2. In particular, these data and the fraud experts we spoke with suggest that Medicare beneficiaries represent a valuable source for detecting certain types of potential fraud and abuse, especially services not rendered. HCFA officials told us that beneficiary complaints stem largely from the beneficiaries' review of their explanation of Medicare benefit (EOMB) statements received after health services and supplies are provided. These findings suggest that potential fraud and abuse can only be comprehensively measured by effectively applying a variety of investigation techniques using a variety of sources.

[7] Medicare contractor fraud units are located at each HCFA contractor and are responsible for preventing, detecting, and deterring Medicare fraud and abuse.

Figure 2: Sources of Common Fraud and Abuse Referrals, 1993 to April 2000



Beneficiary: A person eligible to receive Medicare payment or services. This category includes beneficiary telephone, walk-in, and written complaints.

Referral: A formal submission of a case by various federal investigators (for example, Federal Bureau of Investigations, Office of Inspector General, and Health Care Financing Administration).

Provider: Persons or entities, including their employees and former employees, who provide health care services or supplies to Medicare beneficiaries.

Fraud Unit: Individuals responsible for preventing, detecting, and deterring Medicare fraud and abuse. Such a unit is located at each HCFA contractor.

Other contractor/PRO: In addition to fraud units, Medicare contractor medical review, claims processing, and audit units perform a broad range of activities in the identification of fraud, including reviews of submitted claims and medical records by medical professionals to assess whether services billed were allowed, medically necessary, adequately documented, and coded correctly in accordance with Medicare requirements. In addition, audits of provider cost reports are performed to determine the appropriateness of costs reimbursed in connection with the cost report settlement process.

Other: In addition to the sources listed above, referrals of fraud and abuse cases are sometimes generated based on leads obtained via calls made to the OIG Hotline, from media sources, or other anonymous sources. The OIG Hotline allows employees and the public to directly report allegations or provide information regarding problems of possible waste, mismanagement, and abuse in the Medicare program.

Source: Prepared by GAO from data in HCFA's FID and interviews with HCFA and contractor officials. We did not independently verify information contained in HCFA's FID.

PLANNED HCFA PROJECTS WILL PROVIDE SOME IMPROVEMENTS

The inherent vulnerabilities of the Medicare fee-for-service program have fueled debate over how extensively the measurement of potential fraud and abuse should be pursued to provide information that policymakers and HCFA managers need to effectively target program integrity efforts. Implementing the current methodology to estimate improper payments is a major undertaking and represents an attempt to give HCFA a national estimate of payment accuracy in the Medicare program. The current methodology focuses on estimating Medicare payments that do not comply with payment policies as spelled out in Medicare laws and regulations, but does not specifically attempt to identify potential fraud and abuse. In addition to the current methodology, HCFA has three projects in various stages of development that could somewhat enhance the capability to uncover potential fraud and abuse and help HCFA better target program safeguard efforts over the next few years.

CURRENT METHODOLOGY NOT DESIGNED TO MEASURE THE FULL EXTENT OF POTENTIAL FRAUD AND ABUSE

The primary purpose of the current methodology is to provide an estimate of improper payments that HCFA can use for financial statement reporting purposes, and it has served as a performance measure. The OIG is responsible for overseeing the annual audit of HCFA's financial statements, as required by the Chief Financial Officers Act of 1990 as expanded by the Government Management Reform Act of 1994. The current methodology has identified improper payments ranging from inadvertent mistakes to outright fraud and abuse. However, specifically identifying potentially fraudulent and abusive activity and quantifying the portion of the error rate attributable to such activity has been beyond the scope of the current methodology.

The focus of the current methodology is on procedures that verify that the claim payments made by Medicare contractors were in accordance with Medicare laws and regulations. The primary procedures used are medical record reviews and third party verifications. Medical professionals working for Medicare contractors and PROs review medical records submitted by providers and assess whether the medi-

cal services paid for were allowable, medically necessary, accurately coded, and sufficiently documented. OIG staff perform various procedures including third party verifications to ensure that health care providers are in "good standing" with state licensing and regulatory authorities and are properly enrolled in the Medicare program. They also verify with the Social Security Administration (SSA) that the beneficiaries receiving the services were eligible for them.

The OIG reported that the medical reviews conducted in the current methodology have been the most productive technique for identifying improper payments—detecting the overwhelming majority of the improper payments identified.[8] According to OIG officials, medical reviews have led to some major prosecutions. In addition, some of the health care fraud experts we talked with stated that such medical reviews are most effective in detecting unintentional errors. However, they also told us that medical reviews are less effective in identifying potentially fraudulent and abusive activity because clever providers can easily falsify supporting information in the medical records to avoid detection.

With respect to identifying potentially fraudulent or abusive activities, OIG officials indicated that medical reviews performed during the current methodology have resulted in referrals to its Investigations Office. However, they acknowledge that the current methodology generally assumes that all medical records received for review are valid and thus represent actual services provided. In addition, they agree that additional improper payments may have been detected had additional verification procedures been performed, such as first, confirming with the beneficiary whether the services or supplies billed were received and needed and second, confirming the nature of services or supplies provided through on-site visits and direct contact with current or former provider employees. Recognizing the potential for abuse based on past investigations—such as falsified certificates of medical necessity or where beneficiaries are not "homebound", a requirement for receiving home health benefits—the OIG has included face-to-face contact with beneficiaries and providers when reviewing sampled claims associated with home health agency services. Further, during the course of our review, OIG officials stated that they will conduct beneficiary interviews when reviewing DME claims selected in its fiscal year 2000 study. However, according to OIG officials, they have not extended this or certain other techniques to the other numerous types of claims included in its annual review because they consider them costly and time-consuming.

Accordingly, the OIG recognizes that the current methodology does not estimate the full extent of Medicare fee-for-service improper payments, especially those resulting from potentially fraudulent and abusive activity for which documentation, at least on the surface, appears to be valid and complete. In fact, the OIG testified[9] that its estimate of improper payments did not take into consideration numerous kinds of outright fraud such as phony records or kickback schemes. To identify potential fraud, the OIG also relies on tips received from informants and other investigative techniques.

A secondary benefit that has been derived from the current methodology is that it has prompted HCFA into developing additional strategies, as we discuss later, for reducing the types of improper payments identified. However, HCFA is limited in developing specific corrective actions to prevent such payments because the current methodology only produces an overall national estimate of improper payments. Having the ability to pinpoint problem areas by geographic areas below a national level (referred to as subnational), Medicare contractors, provider types, and services would make improper payment measures a more useful management tool.

HCFA PROJECTS ENHANCE ERROR RATE PRECISION AND SOME POTENTIAL FRAUD AND ABUSE DETECTION CAPABILITIES

HCFA has two projects that center on providing it with the capability of producing improper payment rates on a subnational and provider type basis—the Comprehensive Error Rate Testing (CERT) project and the surveillance portion of the Payment Error Prevention Program (PEPP). These projects are designed to improve the precision of future improper payment estimates and provide additional information to help develop corrective actions. However, since the methodologies associated with the CERT and PEPP projects incorporate techniques for identifying improper payments that are similar to those used in the current methodology, the extent to

[8] Improper Fiscal Year 1999 Medicare Fee-For-Service Payments, Department of Health and Human Services, Office of Inspector General, February 2000, A–17–99–01999.

[9] July 17, 1997, testimony of the HHS Inspector General in a hearing before the House Committee on Ways and Means, Subcommittee on Health, entitled Audit of HCFA Financial Statements.

which these two projects will enhance HCFA's potential fraud and abuse measurement efforts is limited.

HCFA has a third project in the concept phase that will test the viability of using a variety of investigative techniques to develop a potential fraud rate for a specific geographic area or for a specific benefit type. This project, called the Model Fraud Rate Project (MFRP), provides HCFA the opportunity to pilot test more extensive detection techniques that, if effective, could be incorporated into the other measurement methodologies to improve the measurement and, ultimately, prevention of potential fraudulent and abusive activity. Table 2 compares the scope and potential fraud and abuse detection capabilities of the current methodology to the HCFA projects.

Table 2: Comparison of HCFA Efforts to Measure Medicare Improper Payments

	Current methodology	Comprehensive Error Rate Testing (CERT)	Payment Error Prevention Program/Surveillance (PEPP)	Model Fraud Rate Project (MFRP)

Key design attributes	• First national statistically valid estimate for all types of fee-for-service claims, beneficiaries, and providers
	• Includes tests for:
	  • medical necessity and reasonableness
	  • proper documentation,
	  • proper coding,
	  • provider eligibility,
	  • determination of whether providers are subject to current sanctions or investigations,
	  • beneficiary eligibility,
	  • duplicate payments,
	  • medicare as secondary payer (MSP) compliance,
	  • compliance with pricing, deductible, and coinsurance rules, & other selected rules
		• Test procedures expected to be similar to current methodology
		• Independent medical review
		• Larger sample and on-going reporting improves analyses/utility
		  • Statistically valid national error rates by contractor, provider type, benefit category, and claims processing,
		  • Trend analysis to assist in targeting of integrity efforts,
		• Potential platform for testing claims software
			• Designed to estimate payment error rates for inpatient Prospective Payment System (PPS) claims by state
			• Larger sample and frequent reporting designed to improve analyses and targeting of integrity efforts
			• Tests focus on:
			  • medical necessity and reasonableness,
			  • unnecessary admissions,
			  • incorrect diagnostic coding,
			  • some quality of care measures
				• Pilot study to develop a model fraud rate
				• Scope focused on specific benefit or geographic area
				• Fraud investigative techniques will be used:
				  • Beneficiary contact,
				  • Medical records review,
				  • provider and beneficiary profiling,
				  • investigation of complaints
				• Results to be categorized under fraud types and causes

Limitations for detecting potential fraud and abuse	• Significant reliance on the integrity of medical records • Lacks provider-focused data analysis during testing • Limited provider or beneficiary validation • Not designed to identify certain types of fraud or abuse	• Similar to current methodology	• Similar to current methodology • Scope limited to inpatient PPS	• Plan for comprehensive nationwide study evolving • Limited provider or third party validation
Status	• Fourth annual review completed	• Contract awarded 5/00 • Phased implementation designed to be completed by 10/2001	• Contracts completed 3/00 • Baseline error rates and first quarterly report due by 9/00	• Concept currently under development • Pilot testing projects designed to be implemented by 10/2000
Costs	• 1999 review $4.7 million	Base year $2 million plus $4 million annually thereafter	$7.5 million annually	Not yet determined

Source: GAO testimony 7-12-2000.

The CERT project focuses on reviewing a random sample of all Part A and B claims processed by Medicare contractors each year except inpatient Prospective Payment System (PPS) hospital claims. It involves the review of a significantly larger random sample of claims and thus, according to HCFA officials, allowing HCFA to project subnational improper payment rates for each Medicare contractor and provider type. It is the largest of the projects and is undergoing a phased implementation with a scheduled completion date of October 2001. In addition to developing subnational error rates, HCFA officials stated that the CERT project will also be used to develop performance measures that will assist HCFA in monitoring contractor operations and provider compliance. For example, CERT is designed to produce a claim processing error rate for each contractor that will reflect the percentage of

claims paid incorrectly and denied incorrectly, and a provider compliance rate that indicates the percentage of claims submitted correctly.

The PEPP project is similar to the CERT project and is designed to develop payment error rates for the Part A inpatient PPS hospital claims not covered by CERT. PEPP is designed to produce subnational error rates for each state and for each PRO area of responsibility. Claim reviews under PEPP are designed to be continuous in nature with results reported quarterly. HCFA officials stated that the project is the furthest along in implementation, with the first quarterly reports expected in September 2000. The contractors and PROs implementing the project are expected to identify the nature and extent of payment errors for these inpatient claims and implement appropriate interventions aimed at reducing them.

After their full implementation, HCFA intends to develop a national improper payment rate by combining the results of the CERT and PEPP projects. This rate will be compared to the rate produced by the current methodology to identify, and research reasons for, any significant variances among results. While the national estimate will continue to provide valuable information concerning the extent of improper payments, HCFA officials state that the availability of reliable estimates at the subnational levels contemplated by these efforts will greatly enhance the usefulness of these estimates as management tools.

While enhancing the precision of improper payment estimates will offer a richer basis for analyzing causes and designing corrective actions, conceptually, the MFRP holds the most promise for improving the measurement of potential fraud and abuse. However, the Medicare contractor assisting HCFA in developing this project is dropping out of the Medicare program in September 2000 and has ceased work on the project. Efforts to date have focused on developing a potential fraud rate for a specific locality and specific benefit type; however, HCFA intends to eventually expand the scope of the project to provide a national potential fraud rate. As currently conceived, the project involves studying the pros and cons of using various investigative techniques, such as beneficiary contact, to estimate the occurrence of potential fraud. HCFA officials informed us that before the contractor ceased work on this project, it conducted a small pilot test using beneficiary contact as a potential fraud detection technique that identified some of the challenges HCFA will face in implementing this technique. The results of the test are discussed later.

HCFA is seeking another contractor to take over implementation of the project. The contractor eventually selected will be expected to produce a report that identifies the specific potential fraud and abuse identification techniques used, the effectiveness of the techniques in identifying potential fraud and abuse, and recommendations for implementing the techniques nationally. The contractor will also be expected to develop a "how to manual" that Medicare contractors and other HCFA program safeguard contractors (PSC) can use to implement promising techniques. HCFA officials stated that promising techniques identified through MFRP could also be exported to the CERT and PEPP projects and the current methodology to enhance national and subnational estimates of potential fraud and abuse over time.

EXPANDING THE SCOPE OF THE HCFA PROJECTS COULD ENHANCE MEASUREMENT OF POTENTIAL FRAUD AND ABUSE

Collectively, HCFA's projects do not comprehensively attempt to measure potential fraud and abuse or evaluate the specific vulnerabilities in the claims processing process that may be allowing fraud and abuse to be perpetrated. Table 3 shows the limited use of selected identification elements among the current methodology and the HCFA projects. The MFRP project's scope, for example, does not include studying the viability of making provider and supplier contact or using third party confirmations to detect potential fraud and abuse.

Contacting beneficiaries and checking providers are valuable investigative techniques used to develop potential fraud and abuse cases. For example, California officials recently visited all Medicaid[10] Durable Medical Equipment (DME) suppliers as part of a statewide Medicaid provider enrollment effort and found that 40 percent of the dollars paid to the suppliers was potentially fraudulent. The on-site visits not only helped to identify the fraudulent activity, but also to obtain sufficient evidence to support criminal prosecutions for fraud.

[10] The Medicaid program represents the primary source of health care for medically vulnerable Americans, including poor families, the disabled, and persons with developmental disabilities requiring long-term care. Medicaid is administered in partnership with the states pursuant to Title XIX of the Social Security Act with combined state and Federal medical assistance outlays in fiscal year 1999 totaling $180.8 billion.

Table 3: Methodologies for Estimating Medicare Improper Payments

	Key characteristics	Current methodology	CERT	PEPP	MFRP
Measurement elements	**Scope -**				
	• Geographical	Nationwide	Nationwide [a]	Nationwide [a]	Evolving [b]
	• Claim type	All	All but Inpatient	Inpatient only	
	Measurement-				
	• Technique used	Sampling	Sampling	Sampling	Sampling
	• Annual claims sample size	5,000 – 8,000	100,000+	55,000+	Not yet determined
	Classification of errors [c]				
	• Cause	○	○	○	●
	• Type	●	●	●	●
Identification elements	**Claims Validation:**				
	• Medical record and claims processing review	●	●	●	●
	• Beneficiary contact	○[d]	○d	○	●
	• Provider/Supplier contact [e]	○[d]	○	○	○
	• Third party contact/confirm-ation [f]	●	○	○	○
	• Data analysis [g]				
	• Provider focused [h]	○	○	○	●
	• Beneficiary focused	●	○	○	●

Legend: ● Element included ○ Element not included

[a] The CERT and PEPP projects also provide for estimates of improper payments at the subnational and provider type levels.

[b] The scope of the MFRP is still conceptual. Efforts to date have focused on developing a potential fraud rate for specific benefit types and specific localities and to eventually expand efforts to provide a national rate.

[c] Errors can be classified in many ways; table 3 shows two types of categories. For example, cause classifications may include inadvertent billing errors or possible fraud and abuse errors. Type categories may include documentation errors or lack of medical necessity errors.

[d] Methodology includes face-to-face contact with beneficiaries and providers for home health agency claims only.

[e] Other than requests for medical records.

[f] Third part contact/confirmation, for example, may include contact with State licensing boards or other professional organizations to verify provider standing. This example represents only one of the numerous methods of utilizing third party confirmation to identify improper payments.

[g] See table 1 for a discussion of data analysis techniques for detecting potential fraud and abuse.

[h] OIG officials recently told us that each year at the end of their review, after all data has been entered in their national database, they profile each provider type in the claims sample.

Including an assessment of the likely causes of specific payment errors could help HCFA better develop effective strategies to mitigate them. The current methodology classifies errors by type, such as lack of documentation or medically unnecessary services, which is used to show the relative magnitude of the problems. Knowing the relative magnitude of a problem offers perspective on what issues need to be addressed. For example, based on its review of errors identified in the current methodology, HCFA recently issued a letter to physicians emphasizing the need to pay close attention when assigning Current Procedural Terminology (CPT) codes[11] and

[11] CPT consists of a list of 5-digit codes for most of the services performed by physicians as well as instructions for using them for billing purposes.

billing Medicare for two closely related, yet differing, types of evaluation and management services.

Further analysis of identified improper payments that provide additional insights into possible root causes for their occurrence is essential for developing effective corrective actions. For example, if errors are resulting from intentionally abusive activity, specific circumstances or reasons that permit the abuse to be perpetrated can be analyzed to develop and implement additional prepayment edits to detect and prevent their occurrence. In this regard, GAO has long advocated enhancing automated claims auditing systems to more effectively detect inappropriate payments due to inadvertent mistakes or deliberate abuse of Medicare billing systems.[12] Also, developing or strengthening specific enforcement sanctions offer an additional tool to deter providers or suppliers from submitting inappropriate claims.

Likewise, numerous individuals and entities are involved throughout the entire Medicare claims payment process, including providers, suppliers, employees (caregivers, clerical, and management), Medicare claims processing contractors, HCFA, beneficiaries (and their relatives), and others. Interestingly, in its review of Illinois Medicaid payments,[13] the Illinois Department of Public Aid (IDPA) determined that over 45 percent of the errors it identified were inadvertent or caused by the IDPA itself during the process of approving services or adjudicating claims, and that 55 percent appeared to be caused by questionable billing practices. IDPA officials told us that having a clear understanding of the root causes for these errors has been instrumental in developing effective corrective actions. Similarly, attributing the causes of Medicare fee-for-service improper payments to those responsible for them could provide HCFA with useful information for developing specific corrective actions.

Certain third party validation techniques are included and have been successfully implemented in the current methodology. For example, OIG staff confirm a provider's eligibility to bill the Medicare program by contacting state licensing boards to ensure that the doctors billing Medicare have active licenses. They also verify that beneficiaries are eligible to receive medical services under the Medicare program with the SSA. However, as currently conceived, none of the HCFA projects include third party contact as a potential fraud detection technique.

IMPLEMENTING MORE AGGRESSIVE FRAUD DETECTION TECHNIQUES WILL REQUIRE CAREFUL STUDY AND ADDITIONAL RESOURCES

The experiences of recent efforts to apply more aggressive fraud detection techniques coupled with our discussions with patient and provider advocacy groups indicate that finding successful protocols for implementing some detection techniques may require careful study. Our review of three studies that have attempted to use beneficiary contact as a measurement device—the MFRP and two Medicaid studies in Texas and Illinois—indicate that, while useful, it is a challenging technique to implement.

• The initial contractor for the MFRP conducted a small pilot test using beneficiary contact to verify Medicare billed services and found that making contact was more difficult than anticipated. Telephone contact was the most cost-effective approach for contacting beneficiaries, but the contractor could only reach 46 percent of them due to difficulty in obtaining valid phone numbers and difficulty in actually talking to the beneficiary or his or her representative once a valid number was located. Using more costly and time-consuming approaches, such as mailing written surveys and conducting face-to-face interviews only increased the success rate to 64 percent. To maximize the effectiveness of these alternative approaches, the contractor noted that it was important to obtain valid addresses and ensure that the written survey instrument was concise, easy to understand, and complete for beneficiaries to take the time to respond.

• The state of Texas experienced similar difficulties contacting Medicaid recipients in a recent statewide fraud study.[14] Telephone numbers for more than half of the 700 recipients that the state attempted to contact were not available or were incorrect. The state attempted to make face-to-face contact if telephone contact was not possible, and by the study's end, over 85 percent of the recipients were contacted. The state concluded that contacting a recipient by telephone is the only cost-

[12] Medicare Billing: Commercial System Could Save Hundreds of Millions Annually (GAO/AIMD–98–91, April 15, 1998) and Medicare Claims: Commercial Technology Could Save Billions Lost to Billing Abuse (GAO/AIMD–95–135, May 5, 1995).

[13] Payment Accuracy Review of the Illinois Medical Assistance Program, Illinois Department of Public Aid, August 1998.

[14] Final Staff Draft Report on Health Care Claims Study and Comments from Affected State Agencies, Texas Comptroller of Public Accounts, December 1998.

effective way to verify that services had been delivered. It also found that delays in making contact could impact the results since recipients' ability to accurately recall events appeared to diminish over time.

• For the Illinois Medicaid study, the IDPA found other problems in using beneficiary contact as a detection technique in the payment accuracy study of its program.[15] Department investigators met with almost 600 recipients or their representatives to verify that selected medical services had been received. The investigators found that while recipient interviews were an overall useful step in the study's methodology, they did not always produce the desired results. For example, investigators found cases where caretaker relatives could not verify the receipt of services. They also found other cases where recipients were unaware of the services received, such as lab tests, or could not reliably verify the receipt of services because they were mentally challenged.

Illinois officials involved with implementing the Medicaid study told us that direct provider contact is also challenging. For example, an important consideration is whether or not to make unannounced visits. According to the Illinois officials, unannounced visits can be disruptive to medical practices and inappropriately harm the reputations of honest providers by giving patients and staff the impression that suspicious activities are taking place. Announced visits, on the other hand, can give the provider time to falsify medical records, especially if they know which medical records are going to be reviewed. The Illinois officials resolved this dilemma by announcing visits 2 days in advance and requesting records for 50 recipients so it would be difficult for the provider to falsify all the records on such short notice.

Data on fraud referrals included in HCFA's FID indicates that health care providers and beneficiaries represent important sources for identifying improper payments, particularly for certain types of potential fraud and abuse. Moreover, the application of more extensive fraud detection techniques into efforts to measure improper payments will require their cooperation. Our discussions with patient and health care provider advocacy groups indicated they may oppose the application of more extensive detection techniques due to concerns with violating doctor-patient confidentiality, protecting the privacy of sensitive medical information, and added administrative burdens. For example, officials from the Administration on Aging, an HHS operating division, told us that they discourage elders from responding to telephone requests for medical and other sensitive information. Similarly, the American Medical Association and American Hospital Association emphasize the adverse impact that meeting what they consider to be complex regulations and responding to regulatory inquiries has on health care providers' ability to focus on meeting patient needs. They also voiced concerns with the added cost that would have to be absorbed by providers to comply with even more requests for medical information in an era of declining Medicare reimbursements. Further, some of the health care experts we talked with cautioned that there are practical limits to the amount of potentially fraudulent and abusive activity that can be measured. These experts emphasize that no set of techniques, no matter how extensive, can be expected to identify and measure all potential fraud and abuse.

In addition to beneficiary and provider contact, the health and fraud experts we spoke with told us that validating the information that Medicare contractors are relying on to pay claims, including provider and supplier assertions concerning the appropriateness of those claims, with third parties could also help to identify potential fraudulent or abusive activity. The current methodology incorporates such procedures to confirm providers' current standing with state licensing authorities and beneficiaries' eligibility status with SSA. Other sources—such as beneficiary employers, beneficiary relatives or personal caregivers, State Medicaid agencies, and employees of providers and suppliers—could also offer useful information for assessing the appropriateness of claims. However, determining the appropriate nature and extent of third party verification procedures to incorporate into efforts to measure improper payments should be considered carefully. Excluding third party verification efforts, and therefore placing greater reliance on the accuracy of data developed internally or provided independently, should be based on risks determined through analysis of reliable indicators.

The Comptroller General's *Standards for Internal Control in the Federal Government* stresses the importance of performing comprehensive risk assessments and implementing control activities, including efforts to monitor the effectiveness of corrective actions to help managers consistently achieve their goals. While the annual cost of the current methodology and the HCFA projects involve several million dollars, these efforts represent a needed investment toward avoiding significant future losses through better understanding the nature and extent of improper payments—

[15] See footnote 13.

including potential fraud and abuse. As shown in table 2, the current methodology costs $4.7 million, not counting the cost of medical review staff time at contractors. PEPP is estimated to cost $7.5 million annually, and CERT costs are expected to be over $4 million annually once fully implemented. While these may seem to be expensive efforts, when considered in relation to the size and vulnerability of the Medicare program and the known improper payments that are occurring, they represent prudent, needed outlays to help ensure program integrity.

In our recent report on improper payments across the Federal Government,[16] we discussed the importance of ascertaining the full extent of improper payments and understanding their causes to establish more effective preventive measures and to help curb improper use of Federal resources. However, as we recently testified,[17] HCFA's ability to protect against fraud and abuse depends on adequate administrative funding. Therefore, in developing effective strategies for measuring improper payments, consideration of the most effective techniques to apply in the most efficient manner is essential to maximize the value of administrative resources. While HCFA faces significant challenges for ensuring the integrity of the Medicare fee-for-service program, importantly, HCFA can use the results of these efforts to more effectively assess corrective actions, target high-risk areas, and better meet its role as steward of Medicare dollars.

MFRP HOLDS SOME PROMISE FOR ADVANCING POTENTIAL FRAUD AND ABUSE MANAGEMENT

HCFA plans to expand its efforts to measure Medicare improper payments by assessing the usefulness of performing additional fraud detection techniques with the MFRP. Meanwhile, since the current methodology and the CERT and PEPP projects do not incorporate the use of some techniques considered effective in identifying potential fraud and abuse, HCFA's ability to fully measure the success of its efforts to reduce fraud and abuse remains limited.

Health care fraud experts told us that the ability of these projects to measure potential fraud and abuse are somewhat dependent on the nature, extent, and level of fraud sophistication that may be involved. For example, the introduction of beneficiary contact, in conjunction with other techniques, should improve the ability to determine whether services were actually rendered. However, if the beneficiary is a willing participant in the potential fraud and abuse scheme, these additional techniques may not lead to an accurate determination.

CONCLUSIONS

The size and administrative complexity of the Medicare fee-for-service program make it vulnerable to inadvertent error and exploitation by unscrupulous providers and suppliers. Given the billions of dollars that are at risk, it is imperative that HCFA continue its efforts to develop timely and comprehensive payment error rate estimates that can be used to develop effective program integrity strategies for reducing errors and combating fraud and abuse. The current methodology represented a significant first step in obtaining such information, but the lack of key fraud and abuse detection techniques limit its effective use as a management tool to estimate potential fraud and abuse and ultimately achieve important program integrity goals. HCFA's projects could collectively address some of the limitations of the current methodology if properly executed, but do not appear to go far enough. Expanding the scope of the Model Fraud Rate Project to include studying provider visits and a more extensive assessment of the cause of improper payments and other promising techniques could help HCFA pinpoint additional high-risk areas and develop more effective corrective actions. The implementation of more extensive detection techniques is bound to be challenging and expensive, so using rigorous study methods and consulting with the people affected, such as beneficiary and provider advocacy groups, are essential steps to ensure success, as well as considering the tangible and intangible benefits of using particular techniques. Given the delays and potential challenges associated with implementing the Model Fraud Rate Project, substantial improvements in the measurement of improper payments, especially those stemming from potential fraudulent and abusive activity, will probably not be realized for a few years.

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[16] Financial Management: Increased Attention Needed to Prevent Billions in Improper Payments (GAO/AIMD–00–10, October 29, 1999).

[17] Medicare: HCFA Faces Challenges to Control Improper Payments (GAO/T–HEHS–00–74, March 9, 2000).

RECOMMENDATIONS

To improve the usefulness of measuring Medicare fee-for-service improper payments, including those attributable to potential fraud and abuse, we recommend that the HCFA Administrator take the following actions:

• Experiment with incorporating additional techniques for detecting potential fraud and abuse into methodologies used to identify and measure improper payments and then evaluate their effectiveness. In determining the nature and extent of additional specific procedures to perform, the overall measurement approach should first, recognize the types of fraud and abuse perpetrated against the Medicare program, second, consider the relative risks of potential fraud or abuse that stem from the various types of claims, third, identify the advantages and limitations of common fraud detection techniques and use an effective combination of these techniques to detect improper payments, and fourth, consider, in consultation with advocacy groups, concerns of those potentially affected by their use, including beneficiaries and health care providers.

• Include in the methodologies' design, sufficient scope and evaluation to more effectively identify underlying causes of improper payments, including potential fraud and abuse, to develop appropriate corrective actions.

Mr. Chairman this concludes my statement. I would be happy to answer any questions you or other Members of the Task Force may have.

APPENDIX I—OBJECTIVES, SCOPE, AND METHODOLOGY

Our objective was to identify additional improvements to the Medicare improper payments measurement projects that were recently designed by HCFA to further estimate improper payments including potential fraud and abuse.

Through interviews with HCFA Program Integrity Group officials and reviews of HCFA documentation including program integrity plans, project descriptions, statements of work, and requests for proposals, we identified HCFA projects that could improve the measurement of Medicare fee-for-service improper payments.

Through interviews with health care fraud and investigation experts, we gained an understanding of the vulnerabilities in the Medicare fee-for-service program that create opportunities for improper payments, especially those stemming from fraudulent and abusive activity, and the most promising detection techniques to identify these payments. Specifically, we talked with officials from the Department of Health and Human Service's Office of the Inspector General (OIG) and Office of Investigations (OI), Department of Justice (DOJ), Federal Bureau of Investigation (FBI), HCFA's program integrity group, HCFA's Atlanta Regional Office unit specializing in fraud detection efforts, a Medicare claims processing contractor, Association of Certified Fraud Examiners, three private health insurance organizations, National Health Care Anti-Fraud Association (NHCAA), Health Insurance Association of America (HIAA), three states in connection with their Medicaid program, and two academicians with notable fraud investigation experience. We also reviewed various documents including HCFA and OIG Fraud Alerts, prior GAO, OIG, and other studies on health care fraud and abuse, particularly those related to the Medicare fee-for-service program.

We analyzed HCFA's Fraud Investigation Database (FID) to identify the most common types of potential fraud referred to the OI and DOJ for further investigation and possible criminal and civil sanctions. We also analyzed the FID to determine the most frequent sources for identifying potential fraud. The FID was created in 1995, but has data on fraud referral going back to 1993. We did not attempt to validate the database.

To assess the potential effectiveness of the techniques planned for the HCFA projects for identifying improper payments attributable to potential fraud and abuse, we first performed a comparative analysis of common types and sources of referrals of fraud and abuse occurring in the Medicare program, the types of techniques identified by investigative experts as most effective for identifying them, and the extent to which identified techniques are incorporated in the respective methodologies and second, discussed the results of our analysis with officials in HCFA's Program Integrity Group and OIG.

To gain an understanding of how the implementation of additional procedures to identify and measure improper payments attributable to potential fraud and abuse could affect providers, suppliers, and recipients of health care services and supplies, we interviewed officials from patient and health care provider advocacy groups, including the American Medical Association, American Hospital Association, HHS Administration on Aging (AOA), American Association of Retired Persons (AARP), and the Health Care Compliance Association (HCCA).

We performed our work from November 1999 through June 2000 in accordance with generally accepted government auditing standards.

APPENDIX II—DEFINITIONS AND EXAMPLES OF COMMON TYPES OF POTENTIAL FRAUD AND ABUSE REFERRALS

SERVICES NOT RENDERED

As the category indicates, cases involving billing for services not rendered occur when health care providers bill Medicare for services they never provided. Potential fraud and abuse is usually detected by statements received from the provider's patients or their custodians and the lack of supporting documents in the medical records.

For example, a provider routinely submitted claims to Medicare and CHAMPUS[1] for cancer care operations for services not rendered or not ordered; upcoded procedures, as defined below, to gain improper high reimbursement; and double billed Medicare for certain procedures. As a result of the fraudulent submissions, the provider allegedly obtained millions of dollars to which they were not entitled.

MEDICALLY UNNECESSARY SERVICES AND SUPPLIES AND OVERUTILIZATION

Cases involving medically unnecessary services, supplies, or overutilization occur when providers or suppliers bill Medicare for items and services that are not reasonable and necessary for the diagnosis and treatment of illness or injury or to improve the functioning of a body part. They include incidents or practices of provider, physicians, or suppliers of services that are inconsistent with accepted sound medical practices, directly or indirectly resulting in unnecessary costs to Medicare, improper payments, or payments for services that fail to meet professionally recognized standards of care or are medically unnecessary.

For example, a provider ordered magnetic resonance imaging tests (MRIs) and neurological tests which investigators questioned whether the tests were medically necessary, and whether the neurological tests were actually performed. Most of the tests were performed on patients who responded to the provider's advertisements in the yellow pages. After a 5 to 10 minute consultation, the provider would diagnose almost every patient with the same disorder—radiculopathy, a disease involving compression of, or injury to the roots of spinal nerves.

MISREPRESENTATION OF SERVICES AND PRODUCTS/FALSIFYING CERTIFICATES OF MEDICAL NECESSITY (CMNS)/OTHER DOCUMENTS

Medicare publishes coverage rules on what goods and services the program will pay for and under what circumstances it will pay or not pay for certain goods and services. Providers sometimes bill Medicare, showing a billing code for a covered item or service when, in fact, a noncovered item or service was provided. Further, providers sometimes intentionally falsify statements or other required documentation when asked to support payments for claimed services or supplies. In particular, investigators have determined that falsification of CMNs—documents evidencing appropriately authorized health care professionals' assertions regarding the beneficiaries' needs for certain types of care or supplies, such as home health and hospice services or certain durable medical equipment—occur, providing unscrupulous providers and suppliers additional opportunities to abuse Medicare.

For example, a provider billed for an orthotic knee brace, when in fact the provider was providing Medicare beneficiaries with nonelastic compression garments and leggings. Although knee orthotics are reimbursed by Medicare and Medi-Cal[2] for a total of over $650 per brace, the nonelastic compression garment is not reimbursed by Medicare. The total billings totaled approximately $332,055.

UPCODING

One type of incorrect coding is called "upcoding." Upcoding cases result from health care providers changing codes on claim forms submitted to Medicare, causing reimbursements to be paid at higher rates than are warranted by the service actually provided. Upcoding can also result from providers billing for services actually provided by nonphysicians, which would be paid at a lower reimbursement rate.

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[1] CHAMPUS, or the Civilian Health and Medical Program of the Uniformed Services, is a fee-for-service health insurance program that pays for a substantial part of the health care that civilian hospitals, physicians, and others provide to nonactive duty Department of Defense beneficiaries.

[2] The Medicaid program for the State of California is known as the Medi-Cal program.

For example, a provider allegedly submitted false claims for services provided by physicians in training and inflated (upcoded) claims in connection with patient admissions services. The provider paid the U.S. Government $825,000 primarily to settle allegations resulting from an audit performed by the HHS OIG. The audit was triggered by a lawsuit filed by private citizens as authorized by the False Claims Act (31 U.S.C. sections 3729–3733).

FRAUDULENT COST REPORTING

Falsifying any portion of the annual report submitted by all institutional providers participating in the Medicare program. The report is submitted on prescribed forms, depending on the type of provider (e.g., hospital, skilled nursing facility, etc.). The cost information and statistical data reported must be current, accurate and in sufficient detail to support an accurate determination of payments made for the services rendered.

For example, a provider billed Medicare for hundreds of thousands of dollars for personal expenses disguised as legitimate healthcare expenses. The personal expenses billed included an addition to a private home, vacations, and beauty pageant gowns. The provider was fined over $500,000 for the fraudulent billings.

KICKBACKS AND ACCEPTING/SOLICITING BRIBES, GRATUITIES OR REBATES

Section 1128B of the Social Security Act, 42 U.S.C. § 1320a–7b(b), makes it a felony to solicit, receive, offer, or pay a kickback, bribe, or rebate in connection with the provision of goods, facilities, or services under a Federal health care program, including Medicare.

For example, a provider agreed to plead guilty to conspiracy, mail fraud, and violating the anti-kickback provision and to pay $10.8 million in criminal fines in connection with its scheme to defraud Medicare. The pleas relate to kickbacks and false Medicare billings made in connection with the provider's receipt of fees from another company for the provider's management of certain home health agencies.

Chairman CHAMBLISS. How much direct contact did your office have with providers out there? Did you all actually go out and visit with any of the providers with respect to the procedure that is now used to examine waste, fraud and abuse?

Ms. JARMON. We talked to some organizations that cover providers. I think we did talk to some providers.

Chairman CHAMBLISS. I am just curious what the reaction was to the—from the Medical Association of Illinois or Georgia or whoever you talked to. What reaction do you get from those folks with respect to your investigation into this?

Ms. JARMON. Their reaction was there is no way that you would ever get a handle on all the fraud because the schemes are continually changing, so that it would probably be impossible to ever come up with a fraud rate. They were concerned about more contact with the providers and how it would affect their operations.

They do understand that there is a fraud problem, and they were sympathetic to the fact that something needs to be done to address it, but they feel like most providers are honest, which is what we believe also, and that there needs to be targeted efforts to address where the problems are rather than make it an invasive procedure to all providers or many providers.

Chairman CHAMBLISS. Do you find within the Medicare review process is there any correlation between State licensing boards and the investigators from HCFA with respect to just determining the simple—something simple, like requiring notification from State licensing boards of all persons who are licensed in that State as well as all persons who are, for disciplinary reasons, becoming unlicensed, die or whatever; is there any correlation there, is that information being shared back and forth between State licensing boards and Medicare—I mean and HCFA, excuse me.

Ms. JARMON. The Medicare fraud units within the different contractors within HCFA, and I believe there are about 56 Medicare contractors throughout the country, do get information from the State licensing boards, but I am not sure of how and how often the information is shared. But they do receive information. They do perform third-party verification of information with the State licensing boards.

Chairman CHAMBLISS. Right. I think a little bit later on we are going to hear a statement with respect to the way in which most waste, fraud and abuse is uncovered is through review of medical records, which presents some problems in and of itself with respect to privacy issues. But would you agree with that, that based on y'all's research, that reviewing independent medical records of Medicare beneficiaries is, in fact, the best way to try to discover these problems?

Ms. JARMON. I will answer that briefly, then I will let Mr. Hamel answer it, because he has been more involved hands on in looking at some of this information. We found that all five of the techniques that we have here are important. Medical record review is one of the five techniques. Many of the experts we talked to who are fraud investigators have said it is important to combine the techniques. Any one technique in and of itself would not be effective. It is important if you are doing a medical record review to also do data analysis and combine some techniques if the emphasis is to try to determine potential fraud.

Mr. Hamel, anything you want to add?

Mr. HAMEL. No, I think that is a fair assessment.

Chairman CHAMBLISS. You didn't make reference either in your written statement or in your oral statement to where you think the scale of waste, fraud and abuse in Medicare is. Is there any way to get any kind of accurate number on pure waste, fraud and abuse; not errors, but waste, fraud and abuse?

Ms. JARMON. I don't think it is possible to know exactly how much waste, fraud and abuse is in the Medicare program. We do know, like I mentioned in the statement, that the estimate that the IG comes up with, doesn't include efforts to identify all the fraud and abuse. So we know that total improper payments, including the actual fraud and abuse is probably something more than the $13.5 billion that was estimated for fiscal year 1999. How much more we don't know.

Chairman CHAMBLISS. Well, and their numbers actually refer more to errors made by suppliers rather than by what we refer to as true waste, fraud and abuse though; isn't that correct?

Ms. JARMON. Right. They don't know how much of it is just errors or how much of it might be fraud. Right.

Chairman CHAMBLISS. As a layman, I have a little bit of a difficult time understanding the way some of these schemes evolve. For example, I keep reading and hearing about the fact that waste, fraud and abuse organizers, I guess, is a way I would categorize them, create false files, and they just have a mailbox out there, and they send claim forms in to HCFA, and they wind up getting paid. And I don't understand how that happens from a practical standpoint. Can you all talk a little bit about that and somewhat educate

me and maybe some other Members here that don't understand exactly how that can happen?

Ms. JARMON. I will let Bill talk about that. He has some hands-on experience with seeing some of it.

Mr. HAMEL. We also issued a report in October 1999 having to do with organized criminal groups that were engaging in health care fraud. What we found was that, generically speaking, individuals with criminal histories for non-health-care-related violations, such as securities fraud, weapons, drugs and narcotics, assembled themselves and organized themselves into groups for the specific purpose of defrauding the Medicare program and other health care insurers.

Some of the things that they would do would be to establish a drop box, for example. They would rent a mailbox and call it an office suite, and they would obtain Medicare beneficiary numbers, by either stealing them or paying people to steal them, or they would purchase them. They would rummage through garbage and use all kinds of various illicit means to get numbers without the consent of the beneficiary and then just submit claims for bogus services. The checks from Medicare would be sent to the mailbox, or in some cases electronically transmitted to a bank account, and after they had concluded enough billings, they would just close up shop and move elsewhere.

Chairman CHAMBLISS. So are they using falsified supplier numbers also? I am assuming that a physician, for example, has a number out there that Medicare has on file or HCFA has on file, and he has got to give that number when he submits his claim.

Mr. HAMEL. In the cases that we examined—actually some of them had legitimate numbers, and some of them had numbers that were no good.

Chairman CHAMBLISS. I guess that is what I can't understand. In this life of high tech that we now live in or this era of high tech, why we can't detect that as part of an electronic filing? If there is a false number there, why we can't correlate that to a claim that comes in? Is there any answer to that?

Mr. HAMEL. My understanding is that there are controls; as a result of some of these scams being identified, controls are being put in place to prevent bogus numbers or inactive numbers from becoming activated, and that HCFA has implemented controls to go by addresses and try and do physical verification to determine whether it is a legitimate organization or provider.

Chairman CHAMBLISS. Well, in y'all's examination, both from HCFA's perspective as well as the provider's perspective, do we have the appropriate software, hardware or whatever we need out there to try to develop this further, improve this further? Are we lacking in that respect? Or is it people not doing their job? Or what is causing the dropping through the cracks on that?

Mr. HAMEL. I would say that from my experience, there is always evolving computer software technology, but some of the data analysis that I worked with at Medicare contractors was sophisticated enough to be able to identify unusual utilization patterns, referral patterns, spike analysis. For example, if there was an uncommon ailment, and there was no known epidemic, and suddenly a pro-

vider was treating that particular condition, they had audits in place to be able to identify those.

Chairman CHAMBLISS. I guess what I can't understand is that if Dr. Joe Smith in Atlanta, Georgia, is supplier number Smith 2000, and he puts that on his requisition form, he gets a check to Dr. Joe Smith in Atlanta, Georgia. If somebody falsifies a name of Dr. James Smith with the number Smith 2001, why we can't pick that up as opposed to sending a check to him or depositing a check in his account? I have a very difficult time understanding that, and maybe some of our other witnesses who are dealing with it on the other side can help straighten that out a little later on.

Ms. JARMON. Some of those fraud schemes——

Chairman CHAMBLISS. Go ahead.

Ms. JARMON [continuing]. Are being picked up. The problem seems to be that the fraud is evolving. Sometimes, as HCFA builds in controls to address certain types of fraud, another type evolves. So it seems like it is a change in environment as fraud schemes change.

Chairman CHAMBLISS. So this is that moving target, that invisible man that Dr. Sparrow is talking about here.

Ms. JARMON. Yes.

Chairman CHAMBLISS. OK. Jim.

Mr. MCDERMOTT. Thank you, Mr. Chairman.

From your testimony and from reading it, it doesn't seem like you found any fault with what HCFA was doing, you just said they ought to do more. Is that a fair assessment?

Ms. JARMON. We said they need to continue experimenting with different techniques, and that they need to do more analysis to determine the causes of the improper payments. But we are encouraging them to continue what they are doing as far as experimenting with different techniques.

Mr. MCDERMOTT. So the $10 billion they saved and 42 percent reduction in payment errors is not—you are not saying that there is anything wrong with that, they just haven't done enough; they should do 100 percent, huh? Or close to it.

Ms. JARMON. We aren't saying they should do 100 percent. We are saying they should continue to evaluate the different approaches. We aren't saying anything about the 42 percent decrease.

Mr. MCDERMOTT. Besides doing more of what they are doing, does GAO have any other fraud detection models that they are saying they should be using?

Ms. JARMON. We don't have any fraud detection models we are saying they should be using.

Mr. HAMEL. I can say that the five techniques that are on the chart that Ms. Jarmon spoke to before are all useful tools and powerful tools in the detection of potential and actual fraud. What we are saying is that you can't use them in isolation of one another. That greatly diminishes their usefulness and their reliability from a measurement perspective, and that when you use them in combination of one another, and, having done health care fraud investigations, always using at least two or three of these techniques at one time, it greatly increases the reliability of identifying potential fraud.

Mr. MCDERMOTT. In looking at those, I know you don't want to take them individually, but I just want to take one of them, which is the one that says provider contact. My understanding is that the budget that was just put out by the House of Representatives cut that section of the budget by 6 percent. Now, if I understand what you are saying, you actually need to have more people going out, in part to answer Mr. Chambliss's question about does a place actually exist, is there actually a business at 411 Elm Street or not. And that is what I understand that whole question of provider contact to be about.

Is there something I am missing when we are cutting the budget to the section that, in fact, is the one that you say ought to be done here?

Ms. JARMON. We are saying that there needs to be some assessment of the risk. In areas where they determine there is a riskier population or there have been a lot of problems, they should evaluate the need to perform additional testing. For example, investigations in California have shown many problems in the area of durable medical equipment supplies. They did some work, and in 40 percent of the items, there were problems as far as, the providers weren't there, or there were significant errors. So utilizing this information, in determining improper payments on Medicare fee-for-service, the IG is planning to actually visit the DME suppliers and beneficiaries when they do the medical equipment part of their sample.

So we are saying that they need to determine where the risks are for a higher probability of errors. They need to do more contacting the beneficiaries and providers. We aren't saying it should be done overall, because we agree it would be costly if it was done on an overall basis.

Mr. MCDERMOTT. So you would be in agreement with the cut of the budget of that section of the appropriation?

Ms. JARMON. No, we aren't saying that.

Mr. MCDERMOTT. You don't think that they are doing too many, you are just saying they ought to emphasize more in certain areas.

Ms. JARMON. And determine where the risk is. Right.

Mr. MCDERMOTT. The other question I have that sort of puzzles me is this business about how you do it without casting a wider net, or do you believe that they ought to be doing unannounced audits?

Ms. JARMON. In some cases where there is a lot of risk, an unannounced audit may be necessary. Rather than casting a wider net, I know some of their approaches that they are looking at are larger samples. The IG's methodology that they were doing on behalf of HCFA, which is called the current methodology in our statement, that sample included reviewing 5,000 to 8,000 claims. Some of the approaches they are looking at are going to be much larger samplings. So I guess there is a broader net. But what we are suggesting is to go deeper into the areas where there is potential risks rather than having it broader.

Mr. MCDERMOTT. When I was in the State, in the State legislature, we had a program called WISPRO, an MRO organization that looked at claims. We always announced to a hospital, we are coming in on the 12th of August, and they had a month in advance to

get themselves—we didn't tell them what cases we were going do look at, but we told them a month in advance we were coming.

Now, it seems to me that one way that you get around that is to say we are not going to announce to anybody we are coming. We will just show up in the record room and start pulling charts that we think look bad. Is there—do you have any problem with that as an approach?

Ms. JARMON. I will talk briefly about this because I know some of this will be discussed further in the next panel. One of the studies we did look at was the Illinois study, and I know Mr. Miller is here, so you can talk further with him about that.

I know there were some problems with contacting providers such as, if you just show up unannounced. There would be concerns as far as whether the government is questioning a particular provider—who might be an honest provider. Then if you give a lot of notice, if it is not an honest provider, you give them time to falsify the documentation.

I think what Illinois eventually did was they gave the providers, the doctors, 2 days' notice. They would say, we are going to come in 2 days and look at 50 documents. In most cases 2 days may not be enough time for someone to falsify records if they aren't honest. I think that is what they decided to do instead of the unannounced visits. Like I said, he could talk further about that.

Did you want to add anything?

Mr. HAMEL. I was just going to say Ms. Jarmon said and in our statement we are suggesting to consider the risks to the program in using these techniques, and what is most appropriate when you consider what those risks are. If you are in a high-risk area where there has been a lot of fraud, perhaps durable medical equipment, then you would consider using an unannounced site visit to see if the business is really a viable entity. In other situations you would assess the risk and make a determination of what is appropriate.

Mr. MCDERMOTT. And HCFA is not now doing that?

Ms. JARMON. They may be doing some of it, and Ms. Thompson can talk further about that, we don't think they have done a broad enough risk analysis.

Mr. MCDERMOTT. I am sorry, I have to leave and go vote. We have got about 2 minutes. So thank you.

Chairman CHAMBLISS. I have asked Mr. Ryan to go vote and come back and resume the hearing. So we will try to keep going. As soon as he gets back, we will resume.

[Recess.]

Chairman CHAMBLISS. Mr. Ryan.

Mr. RYAN. Good morning. Thank you for coming. Appreciate all your work on this issue.

I just want to ask you a couple of quick questions. I think it was a little while ago when Secretary Shalala said that, quote, we have witnessed an enormous improvement with an estimated rate of improper payments in the Medicare fee-for-service drop from 14 percent in fiscal year 1996 to less than 8 percent in fiscal year 1999. Is it the case, Ms. Jarmon, that the largest portion of this decline has come from the area of documentation, and is it possible really to know whether the decline in this area reflects a real drop in improper payments or simply just better paperwork?

Ms. JARMON. Right. A large part of that error rate does relate to the lack of documentation. And since the model used to come up with that error rate doesn't identify or doesn't attempt to measure fraud, you really don't know whether there really has been a decrease or how much the decrease has been.

Mr. RYAN. So it is more kind of a clerical error measure rather than a real fraudulent measurement.

Ms. JARMON. It is not a fraud measurement, right.

Mr. RYAN. So without really knowing the true level of fraud and abuse in Medicare, it is tough to determine whether an enormous improvement has been made, isn't it?

Ms. JARMON. Yes, it is difficult to determine what the improvement has been when there hasn't been a fraud rate.

Mr. RYAN. I assume you have reviewed the three HCFA projects that are under way right now. Do you believe in your opinion and from your analysis whether any of the three HCFA projects currently under way employ all of the techniques that the GAO would recommend to get the best total measurement possible for improper payments in fee-for-service?

Ms. JARMON. Two of the projects that we talked about, CERT and PEPP, are very similar to the methodology that is used in the current methodology. And the one that comes closest to including all of the techniques that we think need to be looked into or included is the Model Fraud Rate project. But that one is also limited as far as provider contact and verification with third parties. So, right now, none of those three projects include all of the techniques that we talk about in our statement.

Mr. RYAN. So you think we could do a better job in actually getting at real fraud, and that these projects may be more going down the road toward kind of a clerical error instead of actual fraud.

Ms. JARMON. We think more can be done using the techniques. HCFA already uses some of them to identify fraud. More could be done to use the techniques to try to measure potential fraud.

Mr. RYAN. I come from Wisconsin, and in Wisconsin there is kind of an old saying when looking at the fraud and abuse in the United States that we are being penalized for being good. We are being penalized for being efficient; that in many ways in going after fraud, we kind of went after the whole country with the same approach, kind of with a meat axe rather than going after fraud with a scalpel or a laser focusing on where fraud actually occurs. Home health agencies is one of those examples that leaps to mind.

How dependent is a measurement of and how dependent is the enforcement of fraud reduction dependent on State insurance regulatory regimes? Louisiana clearly had a lot more real fraud in home health than did Wisconsin, but in Wisconsin home health agencies, which I think are pretty efficient, well-run, honest organizations, are clearly on the losing end of these efforts. And do you think that there is, A, a better way to go after this more, and in a way of not going after all of the actors in the system, but actually finding a way to go after the actual fraud that is occurring without unnecessarily and needlessly hurting the good actors in the system; and, B, how dependent is this on State insurance regimes and State enforcement?

Ms. JARMON. Yes. I think what we refer to as a risk-based approach would try to focus on the areas where there is more risk, including parts of the country where for some reason, there is more risk. We are suggesting that the HCFA look at a risk-based approach to determine where additional techniques should be used.

Like you mention with home health agencies and with durable medical equipment, in certain parts of the country it has been shown there is more risk in those areas. So we think there should be a use of all of the five techniques in those areas, but to do it globally throughout the country in all the States would be very costly. I don't think that is the best use of resources. But a risk-based approach and which involves determining high-risk areas and using possibly all the techniques is probably a good use of resources because we are talking about a very large program.

Mr. RYAN. That way we can leave the good actors in the system to go on with their business, and we can actually focus our effort where fraud actually does exist. Thank you.

Mr. MCDERMOTT. Would the gentleman yield for a question? Would you define, either one of you, who you mean by more risk? I mean, we want HCFA to focus on the areas of more risk. What criteria would you use for that investigation? What does "more risk" mean?

Ms. JARMON. I can use an example of a study in California where they really looked at all of the suppliers there of durable medical equipment, and based on their work, they concluded that there was about 40 percent errors in that population.

I think the Medicare contractors are doing some work and using all of these techniques to identify some cases of fraud. They aren't using them to measure fraud. I think some of the work that they are already doing are showing where there is a risk in the population. So, I think using some of the information that is available from some of the work that they have done in identifying fraud, can be used to determine where the risk is and where they found more errors, or where they found fraud.

Mr. MCDERMOTT. But they discovered that by looking at every durable medical equipment provider in California?

Ms. JARMON. In California, yes.

Mr. MCDERMOTT. How would you know if Wisconsin or Washington or Georgia—what ways to go about that? I mean, from learning whatever you learned from the California study, how would you know who to go for?

Ms. JARMON. The people who did the work in California talked to the fraud units in other States, and a best practices or lessons learned approach can be used. They can talk about what they did and what they found. They can use their prior experience regarding where there have been problems in the past. So communication among the different parties or the different entities that are involved in trying to manage this program can be effective.

Mr. RYAN. I yield.

Chairman CHAMBLISS. You talked about the methodology, current methodology, plus the new systems that HCFA is using now, the—I will refer to the acronyms as CERT and PEPP. The way I understand what you have said about those programs is that those programs are designed more to catch errors as opposed to being fo-

cused on true waste, fraud and abuse. Am I wrong in that perception, or is there some more direct focus in those methodologies on waste, fraud and abuse?

Ms. JARMON. You are right. The CERT and the PEPP are focused on payment claim errors rather than focusing on fraud.

Chairman CHAMBLISS. What bothers me about that is I am still not sure that I get any feeling that there is a real concentrated effort being made to strike at the heart of what we are talking about, and that being not penalizing honest suppliers who just simply make mistakes, but going after whatever that amount of waste, fraud and abuse is that exists out there. Am I wrong in that perception, or are we not really focusing in on that from a HCFA perspective?

Ms. JARMON. The third project that we mentioned that HCFA is looking into is the Model Fraud Rate project. It is a project where they are trying to focus on fraud. That project is very much in the infancy stage, but it is our understanding that it is their plan to try to focus on fraud through that project.

Chairman CHAMBLISS. OK. Mr. Hamel, you referred to that report in October of '99, which did point out several specific instances of schemes that were in place that were being carried out by certain organizations. Since that date, since that report of October of '99, have you come across any additional schemes that are being carried out today?

Mr. HAMEL. We are working on one investigation, but because it is under way, I am not comfortable discussing the details of it in an open forum.

Chairman CHAMBLISS. Sure. OK.

We have been talking primarily about Medicare, but let me ask a question about Medicaid. Does the GAO or the IG Office get involved in any audits of Medicaid?

Ms. JARMON. We can't speak for the IG. We have done limited work related to Medicaid.

Chairman CHAMBLISS. OK.

Ms. JARMON. We did visit Illinois and Texas and looked at what they were doing to try to estimate Medicaid error rate, but our work has been limited in that area.

Chairman CHAMBLISS. OK. Anything additional, Jim?

Mr. MCDERMOTT. I wanted—your statistical basis for your cases reviewed, if you could put that chart back up again, where you found them. I forget, you told us page 20, was that——

Ms. JARMON. The first chart is from page 7. That information came from HCFA's fraud investigation database, which is the database where they track the cases that have been referred.

Mr. MCDERMOTT. Now, when you look at that, what I ask myself is where would I put my resources, what areas do you think there are problems that are not being assessed because of lack of resources being put into them?

Mr. HAMEL. I would say that while that chart demonstrates the types of schemes for referrals, it doesn't address the volume of dollars for those schemes. For example, fraudulent cost reporting may only represent 7 percent of the referrals, but these cases represent a significantly disproportionately larger number of dollars. For example, it was in the newspaper that the Columbia HCA case in-

volved three-quarters of a billion dollars. So I think one has to consider how much the impact is on the program financially with respect to those schemes, not just what the schemes are.

Mr. MCDERMOTT. Explain to us, it would be interesting for the committee, I think, to understand how they caught HCA.

Mr. HAMEL. That was the result of a qui tam lawsuit, which is a lawsuit that is filed by a citizen under the False Claims Act. A whistleblower in which——

Mr. MCDERMOTT. Somebody working inside the organization blew the whistle?

Mr. HAMEL. Yes.

Mr. MCDERMOTT. So they were going to get some benefit from whatever the settlement was, they get some portion of that $750 million?

Mr. HAMEL. That is correct.

Mr. MCDERMOTT. How much did they get?

Mr. HAMEL. They only announced a partial settlement. It has not been completely settled, so I don't know what—they are called relators—what the relator's share will be. But generally, it is somewhere between 10 and 25 percent.

Mr. MCDERMOTT. It is not described in the law?

Mr. HAMEL. The percentage—I think this is a sliding scale and is described in the statute. I think the maximum, I believe, is 25 percent.

Mr. MCDERMOTT. So in that case, they shouldn't be given credit at all for finding that, should they?

Mr. HAMEL. We are not suggesting that HCFA is taking credit for that.

Mr. MCDERMOTT. So that is just where the reports are, but they don't get credit for it as a result of their fraud, waste and abuse issue, or their fraud, waste and abuse program.

Mr. HAMEL. The chart only demonstrates statistically where the sources or the types of fraud referrals come from.

Mr. MCDERMOTT. Did you analyze what they were doing inside in terms of what it had actually produced?

Mr. HAMEL. I am not sure I quite understand, "it" referring to the database?

Mr. MCDERMOTT. HCFA. Did you look at the database and decide what HCFA had found in there, or what was found from the kind of thing—I guess one of those 7 percent, or half of 1 percent or whatever was HCA, but it is up there as though they had discovered this.

Ms. JARMON. It is not clear as far as who identifies the information in their fraud database. It just shows that these are cases that are potential fraud, and in some cases, are being referred to the IG to further investigate. In some cases, they are referred to the Department of Justice. So the database just shows information that has come to their attention, through their own reviews, as being referred. I don't think it had detail as far as the ultimate resolution of those cases. This was just to give a picture as to where some of the potential fraud exists that they are aware of.

Mr. MCDERMOTT. Presumably, in all the big operations where there is fraud, I mean, we talk about these organizations, sort of anonymous or kind of unnamed organizations, it would seem there

would be somebody inside who would know what is going on. It would seem to be that protecting whistleblowers would be a really important thing to do to make qui tam suits more likely; would it?

Mr. HAMEL. They are not uncommon.

Mr. MCDERMOTT. You mean, that is a way to get the big ones, right?

Mr. HAMEL. Well, I am saying that qui tam lawsuits are not uncommon. There are many of them filed.

Mr. MCDERMOTT. Most of them are won by the person who brings the case?

Mr. HAMEL. The government intervenes on their behalf if they determine that there is a reason to intervene. And then when there is a resulting action, if the government recovers money, then they stand to receive a share of that. So there is an incentive in qui tams for someone to blow the whistle.

Mr. MCDERMOTT. Is there protection for people who bring these suits?

Mr. HAMEL. I can't answer to the specifics about that.

Mr. MCDERMOTT. Because one of the problems you have, it seems to me, in fraud, the people who perpetrate fraud generally are not stupid. They generally are pretty shrewd at having figured out the system and having figured out that there is a loophole here, and there is a hole I can drive a Mack truck through and fill it with money. Those organizations you are talking about are doing that because there is money there. And they back their truck up to it with fraud written on the side and drive away with it. And it strikes me that that is very hard to get on a systematic basis, that you could ever set up a unit that is going to find fraud itself. You might take these referrals from other people to get them. But just throwing a wide net over all the providers out in the United States is not going to get very much fraud.

Mr. HAMEL. Some of the criminal groups that we referred to, some of the ways that the conduct is identified is through, for example, data analysis where you know there is unusual utilization for certain kinds of billing procedure codes, where suddenly there is a dramatic increase. Those are the kinds of things that help identify red flags for problems for which other kinds of techniques can be used to determine whether or not it is just a billing error or where there is something more to it, such as fraud.

Mr. MCDERMOTT. Wouldn't those be in the screens that the intermediary has? If suddenly you get a big blip of, I don't know, whatever, whatever kind of—abdominal surgery, suddenly you have a 50 percent increase in a given area for abdominal surgery, shouldn't that show in the database or the records of the HCFA intermediary that is looking at those cases and paying those claims?

Mr. HAMEL. For the Medicare contractors I have worked with, it does. They have computer edits in place to identify some of those situations. But, I couldn't speak to how they design them.

Mr. MCDERMOTT. You didn't look at those, you didn't look at what was being done by the intermediaries; you only looked at what was being done by HCFA; is that correct?

Ms. JARMON. We looked at some intermediaries also. You are right. Some of that information is there that is being used by them

in their database to identify fraud. The techniques that we had on the other chart, include data analysis which you are talking about. The qui tam instances, would relate to the third party contacts. While they are being used to identify fraud, they aren't being used to try to measure it.

Mr. MCDERMOTT. When you looked at their records, are they using the same screens and the same techniques that they use on their private business?

Ms. JARMON. I am not sure about whether they are using the same screens, because I know the Medicare program is so different from the private health programs. I am not sure if they are.

Mr. MCDERMOTT. They are paying claims they have got—the insurance company, Blue Cross Blue Shield pays claim. They take in premiums and pay claims. On this one, they don't take in the premiums, they just pay claims. Why wouldn't they have the same mechanism in place to detect whether they were paying a fraudulent claim or not? Is it because their own money isn't involved? Is that what you are saying?

Ms. JARMON. I am not saying that. I am not sure why it is not the same mechanism, because they do use the same fraud techniques on the private side and on the public side. But why the results are different, I am not sure.

Mr. MCDERMOTT. OK. Maybe we will find out later.

Thank you, Mr. Chairman.

Chairman CHAMBLISS. I think you have seized on a good point there, that we keep looking to HCFA and seem to stop there. And obviously, I think we need to think in terms of maybe looking beyond HCFA. I want to make sure that I have fixed in my mind, before we let you go about this issue of when we hear that there has been an enormous improvement in the area of determining waste fraud and abuse in the Medicare program, that we really can't say that as a fact, because we don't know what the waste fraud and abuse number is. So whether we are improving it or whether it is getting worse, we really can't say; is that a fair statement?

Ms. JARMON. That is true.

Chairman CHAMBLISS. Yeah, the other thing I wanted to make sure, I had a clarification on, and we had in the record, we talked a little bit earlier about some privacy issues and whether we ought to have unannounced audits, announced audits or whatever. In your testimony, you talked about some advocacy groups that oppose more extensive measurement techniques on the ground of confidentiality, privacy problems, as well as administrative problems. Is there anything that HCFA or any other government organization can do a better job of to try to make sure that we can do a better job of doing our audits without allowing the supplier the opportunity to falsify records, but at the same time, satisfy these advocacy groups?

Ms. JARMON. I think it is going to be important that HCFA has the advocacy groups at the table with them and is consulting with them on ways to address the problem.

Chairman CHAMBLISS. And do you find that the case now? Is AMA or the Medical Association of Georgia or the Medical Association of Washington, are they involved in the process now?

Ms. JARMON. I think there has been much more communication between those groups and HCFA.

Chairman CHAMBLISS. OK. All right. Thank you all very much. We appreciate your testimony. We will ask our second panel of Penny Thompson, who is director of program integrity group of Office of Financial Management from HCFA and Mr. Robb Miller, inspector general, Department of Public Aid from the State of Illinois.

STATEMENTS OF PENNY THOMPSON, DIRECTOR, PROGRAM INTEGRITY GROUP OF OFFICE OF FINANCIAL MANAGEMENT, HEALTH CARE FINANCING ADMINISTRATION; AND ROBB MILLER, INSPECTOR GENERAL, DEPARTMENT OF PUBLIC AID, STATE OF ILLINOIS

Chairman CHAMBLISS. Again, we appreciate you two folks waiting patiently and being here, and we look forward to your testimony. And Ms. Thompson we will start with you.

STATEMENT OF PENNY THOMPSON

Ms. THOMPSON. Chairman Chambliss, Representative McDermott, Task Force members, thank you for the opportunity to discuss our efforts to promote and protect program integrity in Medicare and Medicaid. I would also like to thank our General Accounting Office and HHS/IG colleagues for their ongoing assistance in these efforts.

Since the Clinton administration took office, we have made paying right and fighting fraud waste and abuse one of our top priorities. We have implemented an agencywide comprehensive plan for program integrity, and we are committed to learning and refining our efforts to make further improvements. Some relate to some of the issues that you discussed with the first panel about the way that we enroll providers, about the way that we use technology, about how we contract and oversee intermediaries and carriers that work for Medicare, activities involving our enhanced and increased collaboration with law enforcement and with providers, physicians and suppliers.

Efforts to measure payment errors are an integral part of our overall efforts. While no measurement tool is perfect, findings from the national Medicare error rate estimate conducted each year since 1996 by the HHS inspector general have played an essential role in directing us to areas that most need attention and help guide our corrective actions. We are now increasing efforts to measure errors in both Medicare and Medicaid.

In Medicare, we are developing error rates for each of the contractors who process claims better to target and focus our corrective actions and our resources.

In Medicaid, we are working with States as they begin to conduct error rate measurement, and we are working to determine whether a common methodology that would allow for valid State-to-State comparisons and national estimate is feasible. We have several other efforts underway to assist States in promoting Medicaid program integrity. We hired a nationally recognized expert in health care fraud issues, Dr. Malcomb Sparrow of Harvard University's Kennedy School of Government, to conduct a series of seminars

across the country where State program integrity personnel came together to discuss their successes, their challenges, and their concerns.

And just last month, we held a special conference on how information technology can help fight fraud waste and abuse and prevent improper payments. Better data systems are key to improving efforts to fight Medicaid and Medicare fraud waste and abuse. But many States have inadequate technological infrastructures and a basic inability to interrogate their databases efficiently to ferret out improper claims.

In all these efforts, it is essential to stress that measurement of payment errors is a developing science, and we are learning as we proceed. Error rates are essential for accurately determining the extent of improper payments and assessing any improvement and preventing them. But it is important to understand and acknowledge as there has been discussion of this morning that acknowledged payment errors, most of which are honest mistakes, is not the same of measurement of fraud. That would be far more challenging, given the covert nature and legal definition of fraud. And States such as Illinois, that have about begun to measure payment errors, agree that measuring fraud is a much greater challenge.

There is also a critical need to overcome the common tendency to shoot the messenger, which can complicate and hinder efforts to measure and address payment errors. We are encouraged that a number of States have agreed to work with us on these issues and participated in discussions on this topic at our recent information technology conference. We look forward to continuing to work with our GAO and IG colleagues, other experts in Congress, to meet these detection measurement and administrative challenges. We welcome your assistance. Specific answers to the questions that you asked us to address at this hearing are attached to my written testimony. And I am happy to answer additional questions. Thank you.

Chairman CHAMBLISS. Thank you.

[The prepared statement of Penny Thompson follows:]

PREPARED STATEMENT OF PENNY THOMPSON, PROGRAM INTEGRITY DIRECTOR, HEALTH CARE FINANCING ADMINISTRATION

Chairman Chambliss, Representative McDermott, distinguished Task Force members, thank you for the opportunity to discuss our efforts to promote and protect program integrity in Medicare and Medicaid. I would also like to thank our General Accounting Office (GAO) and HHS Inspector General (IG) colleagues for their ongoing assistance in these efforts.

Since the Clinton Administration took office, we have made paying right and fighting fraud, waste, and abuse one of our top priorities. We began with the Operation Restore Trust initiative to coordinate efforts among Medicare, Medicaid, and law enforcement agencies on known problem areas. Lessons learned in that highly successful project are now standard operating procedure throughout our agency. The result is record success in assuring proper payments to honest providers and penalties for problem providers. To build on this success, we have implemented an agency-wide Comprehensive Plan for Program Integrity with clear objectives, such as increasing the effectiveness of medical review, targeting known problem areas, and increasing efforts to help providers comply with program rules.

Efforts to measure payment errors are an integral part of our program integrity agenda. While no measurement tool is perfect, findings from the national Medicare error rate estimate conducted each year since 1996 have played an essential role in directing us to areas that most need attention and guiding our corrective actions. We are now increasing efforts to measure errors in both Medicare and Medicaid. In

Medicare, we are developing error rates for each of the contractors who process claims.

In Medicaid, we are working with States as they begin to conduct error rate measurements, and to determine whether a common methodology that would allow for valid State-to-State comparisons and national estimates is feasible. We have several other efforts underway to assist States in promoting Medicaid program integrity. We have conducted seminars around the country to explore the challenges States face in these efforts. And just last month we held a special conference on how information technology can help fight fraud, waste, and abuse.

In all these efforts it is essential to stress that measurement of payment errors is a developing science, and we are learning as we proceed. It is also important to understand that measurement of payment errors, most of which are honest mistakes, is not measurement of fraud, which would be far more challenging given the covert nature and legal definition of fraud. There also is a critical need to overcome the common tendency to "shoot the messenger," which can complicate and hinder efforts to measure and address payment errors.

PROMOTING MEDICAID PROGRAM INTEGRITY

We fight fraud, waste, and abuse in Medicaid in partnership with States, beneficiaries, providers, contractors, and Federal agencies. We provide funding and technical assistance and oversee States in their efforts to ensure that taxpayer dollars are spent appropriately. Special Federal matching funds are available for State Medicaid fraud control units. These fraud control units are usually located in the State Attorney General's office and generally perform both investigatory and prosecutorial functions. Forty-seven States have established such units to investigate allegations. In States without fraud control units, the Medicaid agency is responsible for investigating allegations and referring cases to the appropriate authorities.

Some States are making good progress in making sure that their Medicaid programs protect taxpayer dollars. However, we all agree that more needs to be done, and we are committed to repeating and building upon this success across the country. To that end, we have established a Medicaid Fraud and Abuse Control Technical Advisory Group, in which State and Federal technical staff work together to advance program integrity issues.

To further these efforts, we hired a nationally recognized expert in health care fraud issues, Dr. Malcolm Sparrow of Harvard University's Kennedy School of Government, to conduct a series of seminars across the country where State program integrity personnel came together to discuss their successes, challenges, and concerns. High-level representatives from 49 States and numerous Federal agencies and Departments participated, and Dr. Sparrow produced a report on what we learned at the seminars. On May 2 of this year we held a Medicaid Fraud and Abuse Commitment Conference to focus on Dr. Sparrow's findings. Three essential themes emerged from the seminars:

- There are unique issues within managed care.
- There are substantial information technology issues.
- There is a need for building commitment at the State level.

MANAGED CARE

More than half of Medicaid beneficiaries across the country are now in some form of managed care, and managed care presents unique program integrity challenges. Many States are still learning how to address these challenges, and some are fighting the misconception that managed care somehow does away with program integrity issues. And there is a well-recognized need to improve the quality of managed care contracts to promote and protect program integrity.

To help States address these issues, we have sponsored a series of workshops, dating back to 1997, to bring State managed care staff together with utilization and review directors and fraud control unit directors. These workshops focused on how fraud manifests differently within the managed care setting and how programs to address it should be structured. They also featured "negotiating sessions" among State delegations and resulted in written agreements on how to work more cooperatively and effectively together.

We also have worked with State Medicaid agencies and fraud control units to develop Guidelines for Addressing Fraud and Abuse in Medicaid Managed Care. The guidelines focus on:

- Key components of an effective managed care fraud control program;
- Data needed to detect and prosecute managed care fraud;
- How to report managed care fraud;
- Suggested language for managed care contracts and waivers; and

• The roles of HCFA, State Medicaid agencies and fraud control units, managed care organizations, and the IG.

We hope to have these guidelines to the States later this year.

We also have developed a draft model Medicaid Managed Care Compliance Plan for States that is similar to our compliance plan for Medicare+Choice plans. Compliance programs help establish and promote awareness of applicable program regulations and to define a standard of organizational values regarding regulatory compliance. Effective compliance programs include:

Standards and Procedures: The organization must establish relevant compliance standards and procedures to be followed by its employees and other agents that are reasonably capable of reducing the prospect of criminal conduct.

High Level Oversight and Delegation of Authority: Specific high-level personnel must be assigned overall responsibility to oversee compliance with such standards and procedures.

Employee Training: The organization must communicate effectively its standards and procedures to all employees and agents, for example by requiring participation in training programs or by disseminating publications that explain what is required.

Monitoring and Auditing: The organization must take reasonable steps to achieve compliance with its standards, for example by utilizing monitoring and auditing systems and by having a system for reporting criminal conduct without fear of retribution.

Enforcement and Disciplinary Mechanisms: The standards must be consistently enforced through appropriate disciplinary mechanisms, including discipline for the failure to detect an offense.

Corrective Actions and Prevention: After an offense has been detected, the organization must take all reasonable steps to respond appropriately and prevent similar offenses.

We are considering whether to mandate, in final Medicaid managed care regulations, that plans participating in Medicaid have compliance programs in place.

INFORMATION TECHNOLOGY

Better data systems are key to improving efforts to fight Medicaid fraud, waste, and abuse. But many States have inadequate technological infrastructures and a basic inability to interrogate databases efficiently to ferret out improper claims. A number of States indicate that they need better, more targeted data, to pinpoint areas most likely to foster problems, as well as guidance and technical assistance on acquiring new data systems and other fraud and abuse detection tools.

To address this, we collaborated last month with the Department of Justice to conduct a conference on the role of information technology in promoting Medicaid program integrity. The conference had nearly 300 attendees from all across the country, and served as a highly interactive information exchange on electronic tools, techniques, and approaches for combating health care fraud and abuse. Robust discussions focused on the need for wider understanding of the technological tools available, funding to procure such tools, sources of data and how to access them, legal means for sharing data, and privacy issues. Nearly 30 vendors displayed some of the latest fraud detection tools available in the marketplace. We plan to follow up on this conference by producing a report of the proceedings with recommendations for future steps, including the possibility of forming regional or national technology user groups.

In addition, our Technical Advisory Group is addressing data issues. It is preparing an educational packet that identifies various reporting requirements and suggestions for how States can implement them. It also will disseminate information to all States on Medicare-Medicaid data sharing rules.

We also recently developed a national fraud and abuse electronic bulletin board, co-sponsored by the American Public Human Services Association, to allow States to exchange and share information on fraud and abuse related issues. And we are modifying our National Fraud Investigation Database to include Medicaid cases, which will further help in tracking down and stopping unscrupulous providers across the country.

COMMITMENT

States have primary responsibility for protecting Medicaid program integrity. While some States are having success, the seminars made clear that, in many States, the nature and magnitude of the Medicaid fraud problem is still not properly understood. In some States it may not even be treated as a serious or central issue in program administration.

We are taking several steps to help States meet this challenge and understand their obligation to ensure that taxpayer dollars are spent properly. For example, we have developed and posted on our *www.hcfa.gov* website a comprehensive listing of State statutes that target Medicaid fraud. This allows States to access and share innovative and effective program integrity legislation. The website also includes detailed contact information for State program integrity personnel and individual State legislation web sites.

We also have worked closely with the IG to clarify how States can ensure that payments are not made to providers who have been "excluded" from Medicare and Medicaid because of program integrity or other problems. Guidance for States now clearly addresses the specifics of what must be reported to whom, when, and where, as well as how to enforce exclusions, and the consequences for States that fail to comply. We are also working to help States enhance their processes for identifying excluded providers.

MEASURING PAYMENT ERRORS

Still, each State needs to be held accountable for protecting taxpayer dollars and meeting concrete goals and objectives for improvement in the fight against fraud, waste, and abuse. Error rates are essential for accurately determining the extent of improper payments and assessing any improvement in preventing them.

Four years ago, we worked with the IG to break new ground in developing a systematic, statistically valid estimate to assess the accuracy of payments. We did not want to merely examine whether claims processing systems were working correctly—avoiding duplicate payments, payments to ineligible providers or beneficiaries, or incorrectly calculated payment amounts. We wanted to examine in a statistically valid way whether payment was made for a service that met all requirements for documenting the service, coding it correctly, and representing medically necessary care. To do this, obtaining medical records is key. Other kinds of verification, such as contact with the Social Security Administration to verify beneficiary enrollment, and visits with beneficiaries designated as "homebound," also are important.

This systematic, statistically valid estimate was a great leap forward. Estimates of Medicare payment errors, done by the IG each year since 1996, have greatly aided us in improving our management of the program. They have provided us with a meaningful benchmark from which we have tracked our success—showing a decrease in improper payments of almost half since 1996. We also found interesting results that confirmed the validity of this approach. Indeed, the vast majority of errors we detect using this approach are found only through examination of medical records. Few errors are related to our claims processing systems, or detectable based on the data on the face of the claim. Few are related to third party verification or beneficiary contact.

In fact, medical records are by far the most important source of information on whether payment is made properly. While this methodology is not perfect or the only one we could have devised, it has been a valuable tool to evaluate and measure the effectiveness of our internal controls.

However, every methodology has its limitations. One limitation is that the national estimate is too broad to allow discrete judgments about where the largest problems reside, or what targeted interventions would have the most impact. As a result, after several years of experience with the national error rate program, we developed two new projects for Medicare—the Payment Error Prevention Program (PEPP) and the Comprehensive Error Rate Testing program (CERT). We designed PEPP and CERT to develop more targeted error rate estimates in States (for inpatient hospital discharges) and at claims processing contractors (for all other services). They are largely consistent with the way we calculate errors in the overall national error rate, but contain some important adjustments.

For example, rather than measuring only net errors (overpayments minus underpayments), we want to measure absolute errors (overpayments plus underpayments). In implementing CERT, we will use just one national contractor to review medical records, to ensure consistency and facilitate our oversight. These additional efforts will provide us additional useful information for making interventions to address payment problems, and represent step-by-step building on our collective efforts over time.

MEASURING FRAUD

It is essential to stress that these measurements are of payment errors, most of which are honest mistakes by well-intentioned providers. These are not measurements of fraud. Certain kinds of fraud—such as falsification of medical records—

probably would not be detected through current methodology. And other kinds of fraud—on cost reports, for example—are not detectable in a claims-based sampling environment.

Fraud measurement is, in fact, uncharted territory. Our progress in pioneering payment accuracy projects might not even be directly relevant to helping us navigate this new territory. Some experts suggest that a statistically valid estimate of fraud might not be possible at all, given the covert nature and level of evidence necessary to meet the legal definition of fraud. And methods to establish fraud might be considerably different than those used to detect other payment errors.

For example, given the importance of establishing patterns, it might be more reliable to sample providers rather than individual claims. And, to minimize the concern about manufactured records, it might be necessary to conduct unannounced visits to providers, or provide very little notice. More direct contact with beneficiaries to verify the provision of the services billed also may be warranted.

All of these approaches, while potentially useful, are themselves unproven as reliable, valid measures in establishing the probability of fraud. The State of Illinois did establish direct contact with beneficiaries to verify claims as part of its 1998 payment accuracy project. But in reporting on this effort, the investigators stressed that "this study was designed to measure payment accuracy. It was never intended to measure a fraud rate. Indeed, we are not sure that is even possible." They go on to say that establishing a fraud rate "would have required, at a minimum, conducting a criminal investigation on each service in the sample. Even then, we would not have been certain that every potentially fraudulent claim would be detected * * *"

We have found beneficiary contact in known Medicare problem areas, such as durable medical equipment or home health, to be quite useful. However, few investigations based on the hundreds of thousands of beneficiary calls we receive regarding suspected fraud result in any payment adjustments because discussion with the beneficiary and/or provider sufficiently explain the situation. Since these contacts with beneficiaries are initiated by them, we could expect "cold calls" outside of known problem areas to yield fewer instances of potential fraud.

Provider-based sampling has certain advantages methodologically, but creates great tension in the provider community, especially when combined with unannounced visits or interviews with employees. The benefits of such an approach, as weighed against the actual and unintended costs, have not yet been thoroughly researched, and care must be taken in assessing how such efforts would be viewed by providers. Already sensitive to random review of claims, in which we ask for additional documentation to support the claim, providers are very likely to object strenuously to greater invasions.

Also, since most providers are honest, the number of providers to be randomly sampled and the depth of investigation necessary to establish a statistically valid fraud rate would entail substantial costs. Profiling, i.e., the use of analytical tools to detect patterns which might be indicative of fraud, might provide an alternative to random sampling. And it is a valuable tool that we already use to detect fraud in both Medicare and Medicaid. However, it is not clear that it could provide a statistically valid measurement of fraud.

ERROR MEASUREMENT IN MEDICAID

All of this experience has provided a backdrop to informing our approach to dealing with States on Medicaid payment accuracy projects. We are very supportive of States' efforts in this arena, and believe that measurement programs are an essential part of proper fiscal management of Medicaid. Some States have already attempted such measurement. The Illinois Department of Public Aid, in 1998, conducted what it believes was the first comprehensive payment accuracy review of any State Medicaid program. The Kansas Medicaid agency conducted a similar review in 1999. And, pursuant to State law, the Texas Comptroller, in 1998, conducted the first of what will be biennial Medicaid payment accuracy reviews. In addition, Alabama, North Carolina, Missouri, and Ohio State audit agencies have performed limited reviews in one or several recent years to measure the accuracy of Medicaid payments.

To advance these efforts, we sent a national review team to conduct a targeted evaluation of anti-fraud efforts in eight States (Illinois, Wyoming, Oklahoma, Virginia, Vermont, Georgia, Nebraska and Nevada) selected to represent a cross-section of State Medicaid programs. These reviews were completed last month and will help provide an accurate assessment of where States are, what barriers may hinder their progress, and what most needs to be done to ensure substantial, measurable improvement.

However, it is clear from that start that the nature and structure of the Medicaid program presents different challenges and opportunities for both Federal and State partners in such measurements. Each State Medicaid program has unique eligibility and coverage rules, and other variables.

That makes development of a statistically valid, common methodology that could be used by all States particularly challenging. Such a common methodology would have substantial advantages in allowing State-to-State comparisons and a national payment accuracy rate to be constructed. Determining whether a common methodology is feasible is a high priority for us, and we have made it one of our Government Performance and Results Act goals.

To help us in this effort, we are requesting $3.5 million from the Health Care Fraud and Abuse Control Program for FY 2001 to:

- Provide incentive grants to several States to conduct payment accuracy studies and assess the feasibility of establishing a standard methodology;
- Contract with an outside audit/consulting firm to assess State and Medicare program payment accuracy study experience to date, work with the pilot States, and develop appropriate measurement methodologies; and
- Hire expert analysts to staff this initiative.

If development of a common methodology does not prove to be feasible, we want to help States develop measurement tools that they can tailor to their own programs to help reduce inaccurate payments, recover overpayments, and target reviews on the specific providers or services that are most problematic.

At the least, guiding principles, definitions, and reporting protocols should be developed so that stakeholders can easily understand, interpret, and draw proper conclusions about each State's approach. We expect that our Technical Advisory Group can help develop these important tools.

We also would like to see groups of States bind together to assess certain benefit areas. For example, it would be very useful for several States with differing payment rules, provider enrollment processes, and administrative review procedures to examine payment errors in a given benefit area, such as transportation or home health. The results would not only be useful for each individual State, but also to the system as a whole. Regression analysis and other techniques could be used to isolate variables that are most, or least, related to payment accuracy.

We also believe it is very important that States understand that they will be rewarded and respected for undertaking these long overdue efforts to measure and prevent payment errors. Unfortunately, as we have found in Medicare, such efforts are sometimes greeted with scorn and retribution despite the large amounts of taxpayer dollars in need of protection. We are encouraged that a number of States have agreed to work with us on these issues and participated in discussions on this topic at our recent information technology conference.

CONCLUSION

We have been working diligently to improve our payment error measurement systems and to help States fight Medicaid fraud, waste, and abuse. We are providing States with information, tools, and training to build effective program integrity infrastructures. And we are building a basis for holding States accountable for measurable improvement.

We look forward to continuing to work with our GAO and IG colleagues, other experts, and Congress to meet these detection, measurement, and administrative challenges. We welcome your assistance. Specific answers to the questions you asked us to address at this hearing are attached, and I am happy to answer any additional questions.

1. What is HCFA's role in guiding/developing error rate and/or fraud rate measurement methodologies? Is there a need for a common methodology for error rate measurement? Or do variations in the Medicaid programs across the States argue against a common approach?

We have a central role to play, particularly in determining whether a common methodology can be developed and used by all States. Such a common methodology would allow State-to-State comparisons to be made and a national payment accuracy rate to be constructed. We are now exploring whether and how such a common methodology might be developed. Our preliminary discussions with State officials experienced in this area suggest that developing a common methodology will be difficult because each Medicaid program is unique, in terms of eligibility, service coverage, reimbursement methodologies, managed care penetration, and other variables.

Determining whether a common methodology is feasible is a high priority for us, and we have made it one of our Government Performance and Results Act goals.

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- Provide incentive grants to several States to conduct payment accuracy studies and assess the feasibility of establishing a standard methodology;
- Contract with an outside audit/consulting firm to assess State and Medicare program payment accuracy study experience to date, work with the pilot States, and develop appropriate measurement methodologies; and
- Hire expert analysts to staff this initiative.

If development of a common methodology does not prove to be feasible, we will continue to have a key role in providing guidance and sharing best practices that States find to be successful in developing measurement tools that they can tailor to their own programs to help reduce inaccurate payments, recover overpayments, and target reviews on the specific providers or services that are most problematic.

2. Do States have statutory authority to use Medicaid funds to measure error rates?

Yes. The Social Security Act authorizes Federal matching of State expenditures the Secretary finds necessary for the proper and efficient administration of the State's Medicaid Plan. State costs incurred in performing Medicaid payment accuracy studies qualify for Federal matching.

3. Which States are measuring error rates?

The Illinois Department of Public Aid in 1998 conducted what it believes was the first comprehensive payment accuracy review of any State Medicaid program. The Kansas Medicaid agency conducted a similar review in 1999. And, pursuant to State law, the Texas Comptroller in 1998 conducted the first of what will be biennial Medicaid payment accuracy reviews. In addition, Alabama, North Carolina, Missouri and Ohio State audit agencies have performed limited reviews in one or several recent years to measure the accuracy of Medicaid payments.

4. What are the findings of recent error rate measurements in Texas, Illinois, Kansas, and other States?

The payment accuracy rates were:

- 95 percent in Illinois;
- 77 to 92 percent in Kansas (depending upon whether a claim for which the provider might have complete documentation but failed to mail it in was counted as an error);
- 89.5 percent in Texas; and
- 97 to 98 percent in North Carolina.

We do not have rates for Alabama, Missouri or Ohio. It is important to stress that the review methodologies differed from State to State. Illinois reviewed 599 individual medical services billed and approved for payment, while Texas examined all paid claims related to 1200 patient days. Some States visited provider offices to obtain documentation, while others merely asked the provider to mail in the requested documentation. Several States interviewed the sample beneficiaries, others did not.

5. What is the status of the HCFA working group which is reviewing the issue of Medicaid error rates? What are the goals and time frames of the working group?

We have established a Payment Accuracy Measurement Workgroup that includes HCFA Medicaid and Program Integrity Group staff, members of the Medicaid Fraud & Abuse Technical Advisory Group from Illinois, Alabama, Louisiana and North Carolina, and the American Public Human Services Association. We also expect to work closely with the HHS Office of Inspector General.

The working group's goal for FY 2001 and 2002 is to evaluate the payment accuracy methodologies used by States to date, provide incentive funding to several States for additional pilots, and assess the feasibility of developing a common measurement methodology suitable for use by all States. What we and our State partners learn over the next 2 years will suggest options for FY 2003 and beyond.

6. Do the States believe that error rate measurement is a good use of federal/state funds? Within a State, who should have the responsibility to conduct error rate measures?

Some States are interested in exploring error rate measurement and have already attempted to conduct measurement studies. Other States may see more value in focusing on suspect providers or services than on conducting comprehensive payment accuracy studies. Who within a State should have responsibility for conducting error rate measurement is a question we want to explore as we work to determine whether a common methodology is feasible for all States.

7. How expensive is it to conduct error rate measurement? If it is to be done, how frequently should it be done? What are the implementation difficulties?

The cost would vary dramatically depending upon the scale and depth of the review performed, for example, the size of the sample, whether the State visits providers to obtain claim documentation or simply ask providers to mail it in, whether

beneficiaries are interviewed face-to-face and, most significantly, whether full medical record reviews are conducted by medical professionals.

The optimal frequency for error rate measurement is a question we want to explore as we study this issue. For Medicare, measurement of the error rate on an annual basis has proven to be useful in assessing progress and the need for the further corrective actions. But there is, at this time, insufficient evidence to conclude that annual measurement would be optimal in Medicaid.

8. Is there a reliable estimate of the level of Medicaid fraud? If so, how much fraud is there in this program?

No. And it is important to stress the substantial difference between measurement of payment errors, which the HHS Inspector General and some States have been doing, and measurement of fraud, which is probably far more challenging given the nature and legal definition of fraud.

9. What is the Federal match rate for error rate measurement efforts in the states?

The Federal match rate for most State Medicaid administrative costs is 50 percent. For skilled professional medical personnel, such as those used to review medical records in error rate measurement efforts, 75 percent matching is available.

10. If a common methodology is justified, what can the Congress or this Task Force do to promote this effort? Has GAO or the IG issued any reports, letters, or testimony on error rate measurement? If so, what recommendations were made, if any?

If a common methodology proves to be a technically viable option, implementing it in every State will likely require a statutory mandate. We are not aware of any GAO or IG reports that evaluate or compare State Medicaid payment accuracy studies conducted to date, or that attempt to devise a Medicaid payment accuracy measurement methodology. However, the IG has for several years has recommended that we construct a national Medicaid payment accuracy rate.

Chairman CHAMBLISS. Mr. Miller.

STATEMENT OF ROBB MILLER

Mr. MILLER. Good morning, Mr. Chairman, and Representative McDermott and distinguished members of the Task Force. Thank you for the opportunity to be here today. As one of the messengers, I am always worried about being shot at, but I think I am fairly safe here this morning.

Chairman CHAMBLISS. We are bad shots up here anyway, Mr. Miller, don't worry about it.

Mr. MILLER. We were the first Medicaid program to buy Kevlar. I think it is important to get a little background on how we came to do payment accuracy measurement in Illinois, so that you can kind of understand the context in which we work. The State of Illinois Medicaid program has a long history, in my opinion, at least during the 9 years I have been there I know it does, of being a proactive, preventive organization, as well as being reactive to problems that occur. We have a long-standing commitment to empirical research. For example, for more than 5 years, we have had a full-time fraud research bureau in my office. We have published 21 reports on various aspects of program integrity since 1994. Many of these are on our Web site. I only share that with you so that you understand we are a State that is very interested in getting down to finding out what the real facts are, and not every State necessarily has that ability or has the resources to do that.

I think it is also important to understand that we have an excellent working relationship with our Medicaid policy and program staff, even though I am the inspector general, and that can be kind of an adversarial role. Often we work very well together—not often, but we always work very well together. I also think it is important to understand that I have benefited a lot, and the State of Illinois

has benefited a lot, from HCFA's leadership in fraud and abuse control; I have been a member of their technical advisory group. I am chairing that group's subgroup on measurement and have been working with HCFA closely on this.

I think that we are all making a lot of progress here. And I also think it would be appropriate to make sure we recognize, as you did, Dr. Sparrow's work. His work has been seminal in this area and it is a body of work that I have come to respect.

I'd like to briefly describe what I, at least, think are the goals of payment accuracy measurement. And first, you will notice I haven't used the word "error" yet. We measure payment accuracy in Illinois. I think that accentuating the positive is the first step toward getting other States and everyone involved in this toward acceptance. There will be plenty of people that will emphasize the errors and the negatives of this. We measured accuracy in Illinois. It established a baseline for us to know where we started. It will allow us to judge future program integrity initiatives and their success. In Illinois, our baseline is 95.28 percent accuracy in the payments we reviewed. It helps us identify specific problem areas. Even though we didn't stratify by provider type, it became quickly clear to us that nonemergency transportation in Illinois was a troubled area. 31 percent of the money we spent on nonemergency transportation was being misspent, and that has helped us then allocate resources. Payment accuracy measurement allows you to rationally allocate resources in an intelligent, thoughtful way.

For example, we are now ready to award a contract to a private firm that will more closely monitor nonemergency transportation, will handle the prior approvals for all these services, and also institute additional integrity checks, both pre- and post service. We went out and looked at the top 64 paid providers in Illinois. We did that in about 6 weeks. And six of them, or 10 percent, are now on their way out of the Medicaid program.

We have implemented a program where we are now monitoring newly enrolled providers more closely. We are getting out there within 60 days of their enrollment. We are trying to educate them, but we are also watching to make sure they are not on the wrong track. If they are, we'll be happy to explain the error of their ways. But there is a cost of payment accuracy measurement. To do it right, in my opinion, and my opinion only, it is very expensive. It is labor intensive. We spent 14,000 staff hours conducting the study that is on our Web site, payment accuracy review. And a large part of that came from client interviews, or what GAO refers to as bene, or beneficiary interviews. We went out and we found all but 14 of the recipients in our study, and we interviewed them personally. Those interviews were of great service to us as an old investigator, because I am an ex cop, I would not do a study like this without having a face-to-face contact with the person who supposedly received the service. We went out and physically collected the medical records. That was time-consuming, but it was also worthwhile. And you heard GAO describe a little bit about how we did it. And basically, and direct and indirect costs we think estimated costs to the State of Illinois and the Medicaid program about $1.7 million to conduct this study, but the benefits are going to be reaped many fold from that as we clean up various areas.

I wanted to take this opportunity to say from one State's perspective and one man's perspective what I think we need in terms of payment accuracy measurement. We need your encouragement. We need—not every State sees the value in measurement. Many of my counterparts around the country, and I have gotten to know a number of them, question expending the resources on measure payment accuracy and trying to establish a base line, and targeting problem areas when they are confident, and may be so, that they already know what those problems are, and they can expend their resources more directly. We need financial incentives. I am sure that is not shocking that somebody comes here and says we need more money. But most of our efforts are matched at just the base rate instead of a higher FFP matching rate. I think if Congress and if HCFA are serious about payment accuracy measurement, we need to be encouraged through a higher matching rate. And most importantly, we need flexibility. One size does not fit all. You have probably heard this before, but there are 56 Medicaid programs, you know, and there is an old saying if you have seen one Medicaid program you have seen one Medicaid program. There are no two that are exactly alike. Every one is different enough that to say one methodology will work will, I think, be a prescription for problems.

For example, earlier you mentioned providers that are more at risk. Some States might want to do targeted reviews, whether it is home health or transportation or some other problem area, and get at those providers that are more at risk of being fraudulent rather than measure their entire population, the vast majority of whom are honest providers.

I am also very leery, frankly, of the establishment of a national fraud rate. I don't know that it is possible. It would take, in my opinion, a criminal investigation of every service in the service sample that we studied in our project to determine intent. We determine accuracy, but we did not determine intent. I am not sure that that is possible. I am not sure that that does anything but titillate frankly, and sound like a good sound byte or a headline. Payment accuracy, determining what payment accuracy is, serves the goals that we are trying to get to, which are improving program integrity and improving payment accuracy. And I think, as Ms. Thompson alluded to, State-by-State comparisons create some fear and apprehension amongst us, frankly because somebody will be below average and those of us that are below average find probably that to be an unpleasant experience.

Finally, annual reviews. I don't think doing this every year is possible or practicable. We should, at the worst, so to speak, not do a payment accuracy measurement more than every 2 years. Because frankly, you need the timing between those periods to implement the changes that your study promulgated. It will be 2 years in August since we published this report, and we are still working on issues that were identified through that. I certainly hope that no one ever looks at quality control like goals and penalties where States are punished financially for not reaching their goals. Please don't mandate a common methodology. You know, encourage us to do it, but use incentives to do it. And I certainly appreciate the opportunity to having been here today. It has been an honor, Mr.

Chairman, Mr. McDermott, Mr. Lucas. If there are any questions I would be happy to answer them.

Chairman CHAMBLISS. Thank you, Mr. Miller.

[The prepared statement of Robb Miller follows:]

PREPARED STATEMENT OF ROBB MILLER, INSPECTOR GENERAL, ILLINOIS DEPARTMENT OF PUBLIC AID

Good morning. My name is Robb Miller and I am the inspector general for the Illinois Department of Public Aid. I have been responsible for Medicaid program integrity in Illinois since 1991. I am pleased to be able to testify today on the value of Medicaid payment accuracy measurement. In Illinois, we have seen the benefits of measurement and believe that those benefits outweigh the cost and effort it takes to conduct such a study. Nonetheless, I have misgivings over the potential that measurement might be mandated upon the states. I think it is critical that each state be allowed to find its own way through this new world of measurement.

I believe Illinois was the first state to independently measure the accuracy of its Medicaid program and publish the results. While our Payment Accuracy Review (PAR) was not a perfect effort, we conducted it in a professional manner and elicited the two primary outcomes we sought. Those were to establish a baseline against which we can measure the success of future program integrity initiatives and to identify specific problem areas upon which we would focus our attention.

Our interest in measurement is reflected in our long-standing commitment to empirical research. For more than 5 years, we had a full-time fraud research staff within the Office of Inspector General. Since 1994, we have published 21 reports on various aspects of program integrity. We combine preventive and reactive strategies in combating Medicaid fraud and abuse in Illinois. In the Office of Inspector General, we have more than 300 staff, the vast majority of whom are dedicated full-time to Medicaid program integrity.

We also had prior measurement experience. In 1994, we examined a statistically valid sample of hospital inpatient stays to identify the frequency of up coding. The results indicated that down coding occurred to almost the same extent as up coding and was statistically a near wash.

I would be remiss if I did not mention the valuable insights and guidance I have received through Illinois' participation in HCFA's Medicaid Fraud and Abuse Control Technical Advisory Group (TAG). Over the last 3 years, the TAG has brought together program integrity directors from around the country to identify common challenges and develop effective solutions. I am proud to be the chair of its National Measurement working group. We are working closely with HCFA to share the states' perspective on the value and challenges of payment accuracy measurement.

It is also important to note that our Payment Accuracy Review was the joint effort of the department's Medicaid staff and the Office of Inspector General. It simply would not have been possible to successfully complete if we were not already in a longstanding and effective partnership to combat fraud and abuse. We work closely together on a daily basis. We jointly created the Medicaid Fraud and Abuse Executive Workgroup which has met monthly for more than 3 years to identify and eliminate challenges to the integrity of the Medicaid program. Finally, any success PAR achieved is also directly attributable to the commitment demonstrated by the former agency and Medicaid directors. That commitment continues today through the current agency and Medicaid directors' support of program integrity efforts.

In brief, the Payment Accuracy Review studied 599 randomly selected paid services from January 1998. Our four part review consisted of a client interview, medical record examination, contextual review of all other services during the 7 days before and after the sample service and a multi-stage expert review. Payments in error were categorized as "agency," "inadvertent" and "questionable."

Questionable errors represented 54.7 percent of the overpayments followed by agency (23.4 percent) and inadvertent (21.9 percent). Up coding caused 45.6 percent of dollars overpaid. Nonexistent or incomplete documentation represented 33.2 percent of the overpayments.

The universe included fee for service and inpatient hospital and hospice stays. Planning for the study began in late 1997 and the report was published in August 1998. (The entire report can be obtained from our web site at *www.state.il.us/agency/oig.)* Illinois' payment accuracy rate was 95.28 percent and represented estimated annualized errors of $113 million on a base universe of approximately $2.4 billion.

Even though we did not stratify our sample by provider type, PAR readily confirmed our worst fears in one specific area. Nearly one-third of all payments to non-

emergency transportation providers were in error. As the result of PAR and other analysis efforts, the Illinois Department of Public Aid has been able to take a number of steps that will improve the overall integrity of this provider type.

For example, we are preparing to award a contract for nonemergency transportation prior approvals and integrity checks. Late last year, we conducted an examination of the top 64 providers which resulted in our seeking to terminate six of them. We are currently piloting a project to physically visit and inspect all transportation providers within 60 days of enrollment to more closely monitor them. We are also working on an RFP to obtain additional automated code review software and planning a random claims selection project.

The Payment Accuracy Review also validated our ongoing program integrity efforts. For example, 29 providers were identified through PAR as having submitted questionable claims for payment. Of those 29, 28 were already under some form of scrutiny by our department.

The insights we gained from PAR are also being incorporated into other initiatives that will continue to build on this knowledge base. We are now planning what we expect will be our ongoing payment accuracy measurement system for the future. Through the examination of approximately 1,800 randomly selected claims each year, we expect to continue to assess our payment accuracy, identify additional problem areas and make even better management decisions on the allocation of scarce program integrity resources.

I believe that most states could expect to achieve these same outcomes by conducting similar studies of their programs. Establishing a baseline is important. If you don't know where you started your journey, you won't know when you reach your destination. Developing empirical evidence about specific risks allows you to rationally allocate your resources. It also strengthens your resolve to address those risks head on.

SPECIFIC QUESTIONS

To offer more specific information to the members of the Committee, I have listed below ten questions posed to me and my responses to them. Please understand these represent my opinions only. I hope you find this information useful.

1. What is HCFA's role in guiding/developing error rate and/or fraud rate measurement methodologies? HCFA should have the lead role in educating states on the benefits of measurement and encouraging them, through incentives, to measure payment accuracy. I consider HCFA to be our partner in program integrity and improving payment accuracy. Partners should work together toward mutually agreed upon goals.

Is there a need for a common methodology for error rate measurement? Or do variations in the Medicaid programs across the states argue against a common approach? Not only is there not a need for a common methodology, my experience tells me that mandating one would be a terrible idea. As the question acknowledges, if you have seen one Medicaid program, you have seen just that—one Medicaid program. Each of the 56 states and territories have different payment rules, hearing procedures, enrollment practices, etc. Even within states, payment systems vary dramatically among fee for service, managed care and long term care.

Through my TAG participation, I know many of my Medicaid counterparts around the country. It is fair to say that a number of them have reservations about the value of measurement. Some of them would argue that they already have sufficient experience and knowledge to effectively allocate their resources without expending the time and money on measurement. They would posit that those resources are better expended attacking problems directly. I also do not think I would be overstating the case by adding that a common measurement methodology would be of great concern to all of us.

Each state needs to decide how to measure its payment accuracy. Every state should be free to determine for itself whether to study its entire Medicaid program or only components thereof. Some programs might want to zero in on specific programs within Medicaid, such as pharmacy, home health or durable medical goods. A uniform methodology would likely preclude targeted reviews.

Illinois' experience in measurement is just that—Illinois' experience. Each Medicaid program is unique. This was demonstrated in the different approaches that Kansas, Texas and Illinois employed to achieve the same goals.

A common methodology could even hinder states' efforts to address problems unique to each of their situations. For example, Illinois' payment accuracy review did not include any managed care payments. In the bigger fiscal picture, managed care does not represent a significant issue in the Illinois Medicaid program. But it

certainly does in Arizona and Tennessee. How could one methodology address all of our needs?

A common methodology might seem desirable on the Federal level. It would allow, on its face, for state by state comparisons and the establishment of a national Medicaid payment accuracy rate. But neither of those goals support the real value of payment accuracy measurement. Frankly, comparing the states to each other would likely lead to even greater apprehension about the value of measurement.

I question the value of establishing a national Medicaid payment accuracy rate. If one accepts the premise that there are no two identical Medicaid programs, then each needs to be able to establish its own baseline and identify the problems unique to each of them. A national rate would likely be used to pummel states that fall below that rate. This would be a further disincentive to most of us. While I support the need to measure payment accuracy, there are many different ways to skin this cat. The liabilities of a uniform methodology far outweigh any benefits.

2. Do states have the statutory authority to use Medicaid funds to measure error rates?

Yes.

3. Which States are measuring error rates? The only states that I am aware of which have conducted comprehensive measurements are Illinois, Texas and Kansas.

4. What are the findings of recent error rate measurements in Texas, Illinois, Kansas, and other States? Illinois' payment accuracy rate was 95.28 percent for the universe it examined (fee for service and inpatient hospital and hospice services).

5. What is the status of the HCFA working group which is reviewing the issue of Medicaid error rates? I cannot speak for HCFA on this but I can advise you that the TAG is working closely with HCFA on this issue. We have shared our concerns about mandatory measurement requirements.

What are the goals and time frames of the working group? Defer to HCFA.

6. Do the states believe that error rate measurement is a good use of federal/state funds? I can only speak for Illinois but it has been a very positive experience for us. Besides establishing a baseline measurement, PAR provided us with the evidence we needed to address serious problems in nonemergency transportation. Arguably, we could have taken some or all of these steps without the analysis of payment accuracy. PAR, however, eliminated nay sayers and strengthened our resolve to tackle this issue directly.

There is one potential area of measurement, though, that would definitely not be a good use of Federal and state funds. States should never be required to collect the overpayments discovered through payment accuracy measurement. In the vast majority of cases, the overpayment is insignificant. In addition, the due process required to adjudicate the collection in most states would so bog down the measurement process as to make it virtually unworkable.

Within a state, who should have the responsibility to conduct error rate measures? There is no question in my mind that the Medicaid agency should be responsible for this. Making measurement part of the Single Audit Act would serve as a disincentive to the states. The long term goal of measurement is program integrity and payment accuracy improvements. The best way to achieve that is for each Medicaid program to buy into the value of measurement. Reaching that consensus will not be likely if the Medicaid agency is not responsible for measuring itself. Mandating the state auditor to conduct these studies will inherently cause tension that can be avoided by encouraging states to explore the benefits of measurement. It would also be more difficult to accomplish because of the strict time frames under the Single Audit Act. Sufficient safeguards to prevent over-reporting payment accuracy rates can be designed into the measurement projects.

7. How expensive is it to conduct error rate measurement? Measuring payment accuracy is an expensive and laborious process. In Illinois, we devoted nearly 11,000 staff hours to conducting this study ($335,000 in salary and benefits). We estimated that we likely lost an additional $1,300,000 in collections from audits that were not conducted during that time period. Replicating our study alone would consume more than half of what I understand HCFA is seeking in next year's budget to encourage other states to conduct measurements.

The bulk of the staff hours resulted from conducting 585 client interviews and visits to almost every provider to personally collect the medical records. We spent $14,000 in travel costs alone on these tasks. This effort is necessary, though, for several reasons.

Client interviews are key, in my opinion, because they place a human face on what would otherwise be a document review. It would be presumptuous to declare a service was not delivered without asking the recipient if he or she did, in fact, receive the service. In future reviews, we will use client interviews more selectively but they will continue to be an important part of the process. For example, there

may be limited utility to interviewing a client for whom the service was a consult or arcane lab test. Nonetheless, a number of client interviews provided us with assurance that the payment was erroneous. They were also very helpful in making the final determination as to whether the error was "inadvertent" on the part of the provider or if it was "questionable."

The physical collection of medical records ensured that we did not have any payments declared in error because the provider simply neglected or refused to provide the documentation. We accomplished this by first asking the provider, on short notice, to have the records of 50 patients (we were only seeking the records of one patient) available to us within the next 72 hours. An auditor or nurse reviewed the record in question at the provider's site and copied the relevant documents. Our theory was that asking for one record would have led to falsification of the documentation. By asking for 50 records on short notice, we were pretty sure that the provider would have neither the time nor the energy to forge so many documents.

Our commitment of staff, time and other resources was significant. However, I do not regret making that commitment. It was necessary to carry out the project in the most professional manner we could.

If it is to be done, how frequently should it be done? I do not believe it needs to be conducted more often than every 2 years. If conducted thoroughly and on an annual basis, the current measurement project would barely be finished before the next one would have to start. When would you have time to analyze your results and plan your next program integrity initiatives to address the problems that measurement identified?

What are the implementation difficulties? Training and staff resources are always a challenge. Drawing a statistically valid sample soon after the period you are studying is closed can also be difficult. If you are committed to client interviews, the trick is to use a period of time for which you are fairly confident that all claims have been adjudicated. At the same time, that period has to be pretty recent so that client memories have not significantly faded.

8. Is there a reliable estimate of the level of Medicaid fraud? If so, how much fraud is there in this program? I am not aware of any reliable fraud estimates. Moreover, I am unconvinced of the value of trying to establish one even if you could. The reason is simple. To establish fraud, you have to establish intent. At a minimum, that would require interviewing every provider in the sample and probably many others. It would essentially call for a full criminal investigation of each service in the sample. The additional resources necessary to establish intent would be better directed toward other areas. To establish a fraud rate just to have one does not serve the interests of program integrity. Measuring payment accuracy, on the other hand, achieves the goals we are seeking without going to the extremes necessary to establish intent.

Finally, in Illinois, we measured payment accuracy, not payment errors. Accentuating the positive is a first step toward de-stigmatizing the entire process.

9. What is the Federal match rate for error rate measurement efforts in the states? I believe it is eligible for the standard match rate for each state. Specialized medical staff reviews are eligible for 75 percent match, however.

10. If a common methodology is justified, what can the Congress or this Task Force do to promote this effort? I want to reiterate that I believe a common methodology is the wrong approach to this challenge. Congress and this Task Force can and I hope will play a leading role in encouraging payment accuracy measurement. Measurement is a strange, new world to many of us. The appropriate way to encourage states to explore this world is through incentives, not penalties. Two approaches immediately come to mind. First, Congress should appropriate additional funds to HCFA for grants to states to begin their own pilot measurement projects. Second, measurement activities should be matched at an increased rate of at least 75 percent to encourage us to continue this commitment. Use the carrot, not the stick.

Has GAO or the IG issued any reports, letters, or testimony on error rate measurement? If so, what recommendations were made, if any? Defer to GAO or the IG.

Other Issues I also want to briefly touch on two final issues that merit consideration in measurement. Neither medical necessity nor client eligibility should be considered when making a determination on payment accuracy. Judging the medical necessity of a service calls for extensive medical consultant review and, in Illinois at least, extensive due process. This is an area better left for quality of care peer review processes. Secondly, the client eligibility determinations are often made by other state agencies. The measurement process would be better served if eligibility is not considered a factor in measurement.

CONCLUSION

Thank you for the opportunity to share my thoughts on this important topic. I look forward to our successful partnership to combat fraud and abuse in the Medicaid program.

Chairman CHAMBLISS. We do appreciate you both being here. Ms. Thompson made the statement that it has been a top priority of this administration to look after the taxpayer dollar and try to improve the situation regarding waste fraud and abuse. I hope you found that to be the case when this administration came in. And I don't say that in a political way, because obviously, that ought to be a top priority of every administration. And I am assuming that was probably the case. You also said in your written testimony that when it comes to looking at taxpayer dollars, that this is a top priority and that you had certain goals and objectives with respect to weight fraud and abuse. And I just like to know what those goals and objectives are, how you have been going about reaching those goals and objectives, and how far have you gotten?

Ms. THOMPSON. Well, we have a number of different and interlocking goals. We, of course, have goals under the Government and Performance Results Act, which we have published, about our desire to get our error rate down to 5 percent by the year 2002.

Chairman CHAMBLISS. Well, let me interrupt you just a minute. I appreciate what you are saying with respect to error rate. But we have talked both with Dr. Berenson when he was here a couple of weeks ago, we talked again today about error rate versus waste fraud and abuse. And I'd like for you to concentrate on true waste fraud and abuse.

Ms. THOMPSON. If I can speak to that too, because I was interested to hear that conversation earlier. I often talk to people about this and say, tell me what your definition is when you think of waste, fraud, and abuse. Is that all improper payments or is that improper payments classified by the source of the error? In other words, if we make an improper payment to someone for whatever reason, clearly that is wasteful. That is not a payment that we should have made, and it is not a payment that was intended to be made, and it was not a payment that supports the goals and objectives of the program.

It may also be abuse, depending, again, on what the rules are and what people intended to do. It may also be fraud. When we look at improper payments, we are looking at a cross section of fraud, waste, and abuse. What we haven't done, and it's a fair criticism, is that in looking at our assessment of improper payments, we have not attempted to classify them. We have not attempted to say, in this case, this improper payment occurred because someone was honest in trying to do the right thing and was simply confused. In this case, this improper payment occurred because someone was being an aggressive entrepreneur, was trying to push the envelope and they pushed it a little too hard. In this case, an improper payment occurred because someone knew they weren't entitled to a payment but submitted a claim. It was only as a result of asking for a medical record, going deeper beyond the claim, that we identified the improper payment itself.

Chairman CHAMBLISS. Well, unfortunately, it looks like we are going to cut short due to votes. I want to very quickly and give an

opportunity for Dr. McDermott and Dr. Fletcher to ask questions, because this may be it. But with respect to Medicaid, I have a little bit of a problem in the fact that we send this money out to the States without any oversight, and I think it is a good idea to block grant that money, let the States control it.

I agree with what Mr. Miller says, that you are not going to find a cookie-cutter approach to looking at waste fraud and abuse with 47 different programs out there. But I think there must be some commonality that can be achieved in all of those programs. And I think, also, that there has got to be some oversight on the part of GAO, IG, HCFA, whoever it needs to be, I mean, the States have got to report back to us on some kind of basis as to how they are spending this money. Now, I don't see that being done from anything that I have read, or anything we have talked about. And I will just make that in the form of a comment. And what I'd really like to do is to have both of you submit written comments back to the committee with respect to how you think we can improve the oversight in the Medicaid program. How we can have the States be more accountable to the taxpayer for the dollars that we are sending out. If I could just ask you to do that in writing rather than trying to do it today and taking this time. So with that, I will defer to Mr. McDermott.

Mr. MCDERMOTT. Thank you, Mr. Chairman. I also have a kind of a general question. Ms. Thompson, you were responsible for both Medicare and Medicaid?

Ms. THOMPSON. For coordinating program integrity activities in both those programs, right.

Mr. MCDERMOTT. In the Medicaid area, it sounds like you have given it to the States and said since you guys got half the money in the bag here, you look after it; is that correct?

Ms. THOMPSON. There is absolutely no doubt that the States are primarily accountable for the Medicaid program in a variety of different matters.

Mr. MCDERMOTT. I asked the question of the previous panel of whether or not the intermediates on the Medicare side had the same standards for their private businesses as they did for what they were doing in Medicare. Do you know the answer to that?

Ms. THOMPSON. It is a very interesting question and one that we have looked at in a variety of different settings. And it cuts both ways. We do have specific program requirements under Medicare that we want contractors to apply. But of course, one of the reasons that we contract with private insurers when the program was first started, 35 years ago—today is actually a celebration of the 35th anniversary of both Medicare and Medicaid—was the idea that private insurers knew how to do this. They already had the capacity, they already had the infrastructure, they already had the experience. Why did the Federal Government need to recreate a claims processing or health insurance capacity at the Federal level when there were private insurers more than capable of doing that? I think over time, what we have come to realize is that, we can't simply walk away from our responsibility and say it is theirs.

But we do need to hold them accountable for their decisions. We need to make sure that the resources we give them to do the job are adequate, which has been an issue that they have raised with

us. We need to make sure that our instructions to them are clear, which is another issue that they have raised to us, and that we make tools available to them. But clearly, it is not HCFA employees or Federal employees who are there actually touching those claims and processing them through. So without a good partnership with our contractors, and without a robust oversight on our part, we are not going to be successful.

Mr. MCDERMOTT. One of the things that has happened in the State of Washington, I know because I was in the State legislature for a long time, we have changed intermediaries several times. What is the process by which you come in and suddenly saying to these people, hey look, you folks aren't doing the job, you are out and these folks are in.

Ms. THOMPSON. As you can imagine that is a rarely invoked provision. It is very traumatic, actually, for providers and suppliers and physicians that are doing business with an insurer. Obviously, the stakes are very high for that insurer. And so the program has sought to try to work out problems, to try to develop corrective action plans for identified deficiencies.

For the most part, contractors that have left the program have done so voluntarily. And in many of those transitions that you are discussing, that is a result of the contractor deciding that the Medicare business was no longer worthwhile for them or was not a line of business they wished to pursue.

Mr. MCDERMOTT. So you put so much pressure on them to perform that they decide we would rather do something else.

Ms. THOMPSON. That sometimes has happened.

Mr. MCDERMOTT. Sometimes. Maybe just one other thing, and I guess maybe the two of you can do this in writing for the committee. And that is, I'd like to know what other experts besides Illinois are on the books and who is doing it, and who is doing it in a different way, because I concur with Mr. Miller's suggestion that one plan may not work everywhere, but if laboratories of democracy are State legislatures and they have half the money on the line, they have come up with different ways, in different places, some may be sharable. So if you have any ideas about that, I think it would be helpful to us in part, because maybe you know some right here off the top of your head that are also as good as Illinois. I don't know how Illinois got here. I think it is a good State, but having been born there——

Mr. MILLER. I like to think so.

Ms. THOMPSON. There have been a couple of other States—off the top of my head, Texas and Kansas—the methodologies have not been entirely similar. They have come up with some different results, and had some different kinds of experiences in terms of the reaction in their communities to those findings and so forth. Part of the group that we have established in HCFA is with the States, some of the States that have had those experiences in trying to develop some information about how people approach things differently. Talking to beneficiaries, was that useful? How was that done? Was it costly? Did that actually add information that was not readily apparent through other mechanisms such as getting information directly from the provider? Did you go and see the provider on site? Did you review medical records? Who was in the universe?

Were all claims possible to be selected from the universe or were there certain kinds of claims that were excluded specifically?

So some of those dimensions which I think are very useful to start with are, what are the differences in what people have done, and obviously also bringing in the experience that Medicare has had doing 4 years worth of this kind of measurement and what we consider to be the benefits and the disadvantages of the way that we have approached it. So we would be happy to provide further information on that. And certainly, as the group continues its deliberations and issues any products, we would be happy to share those with the committee also.

Mr. MILLER. One, I guess, demonstration of our commitment to research is in our report, we put exactly how we did this. So it could be replicatable, and also so we wouldn't forget the next time we would have it right there, documented. We even have the formulas.

Mr. MCDERMOTT. You don't think you'll be there forever?

Mr. MILLER. I am the messenger, remember. But I think it's important that we learn from each other and we share these results with each other. I think that's why it is important that Texas and Kansas reports are out there, HHS OIG's work is out there for us to all learn from.

Mr. MCDERMOTT. I think you will make that available to the committee. I have one question of you as a good cop. You go into some doctors office you ask for his sheet, his appointment sheet, and you look at that. How do you tell whether he saw 30 minutes with Mrs. Johnson or he only saw her for 5 and billed for 30?

Mr. MILLER. Well, that is very difficult, obviously. The more, the smarter the crook is, the better their documentation. Sometimes perfect documentation is your best clue that you should look at this more closely. But that is why a multi-part review was so important to us. We interviewed clients. We looked at the medical record. We did a contextual analysis. We looked at all of the services 7 days on either side of the claim. Then we brought in our own internal experts and had a multi-layer review; that is the chart the GAO had up here, we did almost all those things to every one of those claims, so that we could be confident that we were making the best decision possible. And also that, for example, the client interview was very helpful to us in categorizing whether this service or the error was inadvertent by an honest provider, or whether it was questionable. That was the term we used for——

Mr. MCDERMOTT. On the cost benefit analysis, you said you spent a million 4, what did you get back, or what do you estimate as having been saved as a result of this process?

Mr. MILLER. Actually, we spent out of pocket less than 400,000, but we lost about a million 3 in audit revenue that we would have collected from audits we didn't do during that period. I don't have a good number for you representative on what we expect to save. But we are working toward that because like I say, we have tightened transportation up dramatically already, and we think to bring a much tighter, and that alone, probably more than offset the cost of the study, plus everything else we have learned from it.

Mr. MCDERMOTT. Thank you, Mr. Chairman.

Chairman CHAMBLISS. Very quickly, Dr. Fletcher.

Mr. FLETCHER. Let me go quickly because we do have to run to vote. We have a chart up here that those $203 billion expenditure Medicaid in the range of fraud, 1 percent to 15 showing the amount that it cost; 2 billion to over $3 billion. Let me ask kind of a combined question. Are we putting enough resources waste and fraud abuse, first of all? And what additional incentives could the Federal Government provide to States to conduct a periodic rate study? Let me leave that, if you can answer that very quickly, we would appreciate it.

Ms. THOMPSON. The first question, again, enough resources. I am one of those people that tends to believe that you make resource choices depending on what you think is important. If you think something is important enough, you have the resources, and you will make the choices to implement those resources. For Medicaid programs, they have to come up with half the money basically to perform an error rate study. The Federal Government chips in the other half. And the kind, of course, that Mr. Miller is talking about are not, you know——

Mr. FLETCHER. Are we putting enough in, do you feel like or not?

Ms. THOMPSON. Throughout the States I don't think our investments are there in the way that they should be, no. In terms of incentives for States, I keep asking the question, and I asked the question of the States at a session a few weeks ago in which I said why isn't the incentive to save your own money enough incentive?

Mr. FLETCHER. I have one other question I would like to submit it. I will submit that to you.

Chairman CHAMBLISS. What I will conclude with is, and I have a number of questions also, and am sure other panel members do that we will submit to you in writing. I apologize for having to cut this short. Thank you all for being here. Your testimony has been very enlightening. And we will submit written questions to you that we would like to get answered as soon as possible. Thank you very much.

[The prepared statement of the Office of Inspector General, HHS, follows:]

PREPARED STATEMENT OF THE OFFICE OF INSPECTOR GENERAL, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Pursuant to our discussions with Budget Committee staff, the Office of Inspector General (OIG) of the Department of Health and Human Services offers the following thoughts on identifying improper payments and fraud in the Medicare program. This statement focuses on the development and purpose of the annual Medicare fee-for-service error rate and describes the numerous methods we use to detect fraud and some of the results we have achieved in our continuing fight against fraud, waste, and abuse.

First, we would like to express our belief that the vast majority of health care providers are honest in their dealings with Medicare. When we talk about fraud, we are not talking about providers who make innocent billing errors, but rather those who intentionally set out to defraud the Medicare program or abuse Medicare beneficiaries. The importance of our ongoing work is not only to protect the taxpayers and ensure quality healthcare for Medicare beneficiaries but also to make the Medicare environment one in which honest providers can operate on a level playing field and do not find themselves in unfair competition with criminals.

At the same time, we are concerned about all errors, even those that are totally innocent. The complexity of the Medicare program places an obligation on health care providers, beneficiaries, fiscal intermediaries, carriers, and the Health Care Financing Administration (HCFA) to take reasonable care to comply with its rules.

Thus, our audits and studies are also intended to identify vulnerabilities to administrative errors and to the related dollar losses, which can be quite significant.

BACKGROUND

The HCFA is the single largest purchaser of health care in the world. With expenditures of approximately $316 billion, assets of $212 billion, and liabilities of $39 billion, HCFA is also the largest component of the Department. In 1999, Medicare and Medicaid outlays represented 33.7 cents of every dollar of health care spent in the United States. In view of Medicare's 39.5 million beneficiaries, 870 million claims processed and paid annually, complex reimbursement rules, and decentralized operations, the program is inherently at high risk for payment errors and fraudulent schemes.

Like other insurers, Medicare makes payments based on a standard claim form. Providers typically bill Medicare using standard procedure codes without submitting detailed supporting medical records. However, regulations specifically require providers to retain supporting documentation and to make it available upon request.

The OIG is statutorily charged with protecting the integrity of our Department's programs, as well as promoting their economy, efficiency, and effectiveness. The OIG meets this mandate through a comprehensive program of audits, program evaluations, and investigations designed to improve the management of the Department; to detect and prevent waste, fraud, and abuse; and to ensure that beneficiaries receive high-quality, necessary services at appropriate payment levels. As part of this effort, we conduct annual audits of the Department's and HCFA's financial statements, as required by the Chief Financial Officers Act, as amended by the Government Management Reform Act of 1994.

ANNUAL ESTIMATE OF IMPROPER PAYMENTS

One objective of a financial statement audit is to determine whether there are material instances of noncompliance with laws and regulations. To that end, for the Fiscal Year (FY) 1996 financial statement audit period, we developed the first methodology to measure noncompliance in the Medicare fee-for-service program, which included reviewing supporting medical records. This work resulted in the first-ever, statistically valid, national rate of improper Medicare payments. At HCFA's request, we have continued these reviews because of the high risk of Medicare payment errors and the huge dollar impact on the financial statements.

This past year, we completed our fourth annual review, covering FY 1999, of the extent of fee-for-service payments that did not comply with laws and regulations. Our primary objective each year has been to determine whether Medicare benefit payments were made in accordance with Title XVIII of the Social Security Act (Medicare) and implementing regulations. Specifically, we examine whether services were (1) furnished by certified Medicare providers to eligible beneficiaries; (2) reimbursed by HCFA's Medicare contractors in accordance with Medicare laws and regulations; and (3) medically necessary, accurately coded, and sufficiently supported in the beneficiaries' medical records. Our objective is not to determine the extent of fraud in the Medicare program.

METHODOLOGY

To accomplish our objective, we begin with a statistically valid sample. For FY 1999, our multistage, stratified sample design resulted in a sample of 600 beneficiaries with 5,223 claims valued at $5.4 million. For each selected beneficiary, we review all claims processed for payment. We first contact each provider in our sample by letter requesting copies of all medical records supporting services billed. In the event that we do not receive a response, we make numerous follow-up contacts by letter, telephone calls, and/or onsite visits. Then medical review staff from the Medicare contractors (fiscal intermediaries and carriers) and peer review organizations assess the medical records to determine whether the services billed were reasonable, adequately supported, medically necessary, and coded in accordance with Medicare reimbursement rules and regulations.

Concurrent with the medical reviews, we make additional detailed claim reviews to determine whether (1) the contractor paid, recorded, and reported the claim correctly; (2) the beneficiary and the provider met all Medicare eligibility requirements; (3) the contractor did not make duplicate payments or payments for which another primary insurer should have been responsible under Medicare secondary payer requirements; and (4) all services were subjected to applicable deductible and co-insurance amounts and were priced in accordance with payment regulations.

RESULTS IN BRIEF

These audit procedures have enabled us to determine the extent of sampled claims that did not comply with Medicare laws and regulations. By projecting the sample results, we have estimated an annual national error rate. In FY 1999, for instance, net payment errors totaled an estimated $13.5 billion, or about 7.97 percent of total Medicare fee-for-service benefit payments. As in past years, the payment errors could range from inadvertent mistakes to abuse or outright fraud, such as phony records or kickbacks. We cannot quantify what portion of the error rate is attributable to fraud.

Our historical analysis of payment errors from FY 1996 through FY 1999 identified four major error categories: unsupported services, medically unnecessary services, incorrect coding, and noncovered services and miscellaneous errors. Where appropriate, we also identified specific trends by the types of health care providers whose claims were erroneous. For example, this past year's estimated $5.5 billion in unsupported services was largely attributable to home health agencies ($1.7 billion), durable medical equipment (DME) suppliers ($1.6 billion), and physicians ($1.1 billion).

When the sampled claims were submitted for payment to Medicare contractors, they contained no visible errors. It should be noted that the contractors' claim processing controls were generally adequate for (1) ensuring beneficiary and provider Medicare eligibility, (2) pricing claims based on information submitted, and (3) ensuring that the services as billed were allowable under Medicare rules and regulations. However, their controls were not effective in detecting the types of errors we found. Instead, reviews of patient records by medical professionals detected 92 percent of the improper payments.

Summing up, our error rate methodology enables us to quantify, with statistical certainty, the extent of improper payments and to clearly see the pervasiveness of these improper payments across the various types of Medicare services. The methodology also identifies the types of errors and the types of providers accountable for these errors. More importantly, it provides a performance measure for HCFA's use in reducing improper payments. We have seen significant progress in this area; the FY 1999 $13.5 billion estimate represents a 42 percent reduction since the FY 1996 estimate of $23.2 billion.

USING THE ERROR RATE PROCESS AS AN INTERNAL CONTROL

The HCFA subsequently incorporated the error rate process as part of its internal control structure. It intends to further expand the scope of this technique through two processes: Comprehensive Error Rate Testing (CERT) and the surveillance portion of the Payment Error Prevention Program (PEPP). The PEPP is designed to produce an error rate on inpatient hospital services, and CERT, while similar to the current methodology, provides more detail on error causes at specific Medicare contractors.

The current error rate process has been endorsed by the General Accounting Office (GAO) for several years and is consistent with its report, "Increased Attention Needed to Prevent Billions in Improper Payments" (GAO/AIMD–00–10), calling for agencies to establish processes to determine compliance with laws and regulations. The GAO states that "cost-effective internal controls should be designed to provide reasonable assurance regarding prevention of or prompt detection of unauthorized acquisition, use, or disposition of an agency's assets." We concur with GAO and believe that HCFA's current and proposed error rate processes will do exactly that.

EXPANDING THE ERROR RATE METHODOLOGY TO MEASURE FRAUD

With respect to incorporating into the error rate methodology the additional techniques being discussed at this hearing, we believe that beneficiary interviews and provider profiling are appropriate tools in certain circumstances. While medical reviews clearly were the primary identifier of improper payments in all 4 years' error rate samples, we also conducted beneficiary and/or caregiver interviews concerning services billed by high-risk providers. For example, we contacted beneficiaries who had received home health services to determine whether they were, in fact, homebound—a requirement for Medicare reimbursement of these services. In FY 1996, when problems in meeting this requirement were more prevalent, beneficiary and caregiver visits were quite valuable in establishing whether beneficiaries were homebound. However, when errors shifted in the following years to problems with beneficiaries' plans of care, these types of contacts had limited value in determining improper payments.

This observation is shared by Medicare contractor fraud control units, which find that beneficiary interviews generally are not a valuable resource for detecting fraud. According to fraud control officials, beneficiaries (like any other patients) do not always remember what services were rendered, do not understand the usual/customary charges associated with surgeries, or do not recognize the scope of certain therapy services. Recalling specific details of time spent or services performed by the physician during an office visit 6 or 8 months ago would be a major challenge for anybody, with often questionable results. We therefore believe that beneficiary contacts should be used on a case-by-case basis for selected high-risk Medicare services. For instance, because of the high risk of abusive billing practices by DME providers, we are expanding our ongoing FY 2000 error rate methodology to include contacts with beneficiaries who received DME services.

On the other hand, the fraud control units we contacted found provider profiling an excellent technique for identifying fraud. This technique highlights irregular billing patterns and other anomalies so that a provider's claims can be targeted for more detailed review of medical records. We, too, apply this technique, not as part of our error rate methodology but in in-depth reviews of individual providers. These reviews often follow our multi-State reviews used to develop a "national" error rate for specific provider types or services. Through individual provider audits, we can identify patterns of misconduct or multiple questionable actions that may be referred for investigation. It is interesting to note that a review at one provider often takes as many, if not more, resources than a multi-State error rate review.

We do not devote investigative resources to cases unless we have a proper predication, such as a particularly egregious situation or a strongly suspected pattern of abuse based on a sample. For example, in the current error rate process, if we find a claim for services that were not performed, we cannot conclude that there is a pattern of abuse or fraud. If we were to expand the audit scope as suggested by GAO, we would have to review a significant number of additional provider claims to establish such a pattern. In addition, substantial evidence must be developed before an investigation can be initiated. For instance, to obtain a search warrant, both the U.S. Attorney and the Federal magistrate must be convinced that there is probable cause, based on the evidence, that a crime has occurred. Thus, determining fraud is extremely time-consuming, often taking several years and thousands of staff-hours to prove intentional deception or misrepresentation on the part of just one provider. Additionally, expanding the current error rate methodology in an attempt to determine actual or potential fraud would go substantially beyond what is expected in a normal internal control process, and it is unclear whether cost-effective corrective actions could be developed to preclude the types of schemes discussed below.

FRAUD DETECTION

As we have stated, the error rate methodology does not detect fraud, such as kickbacks, deliberate forgery of bills or supporting documents, or violations of the Stark law regarding the financial relationship between an entity and a physician or an immediate family member. To fulfill this function of our legislative mandate, we look to sources and techniques outside the error rate process. And we know from our investigations and from complaints we receive that waste, fraud, and abuse are still pervasive in the health care sector. We are therefore continuing to watch all areas of Medicare through our audits, inspections, and investigations, as well as to encourage and receive support from industry and beneficiary groups in our efforts.

Before we describe these efforts, it may be useful to define what we mean by "fraud." The Government's primary enforcement tool, the civil False Claims Act, covers only offenses that are committed with actual knowledge of the falsity of the claim, reckless disregard of the truth or falsity of the claim, or deliberate ignorance of the truth or falsity of the claim. The other major civil remedy available to the Government, the Civil Monetary Penalties Law, has the same standard of proof. Neither statute covers mistakes, errors, misunderstanding of the rules, or negligence, and we are very mindful of the difference between innocent errors ("erroneous claims ") and reckless or intentional conduct ("fraudulent claims ").

To actually determine fraud, we typically obtain information through a combination of investigative techniques tailored to each case. These tools include subpoenas of medical and billing records, use of search warrants, investigative interviews of provider employees, surveillance, and undercover operations. For example, establishing that a claim is tainted by an illegal kickback often requires an analysis of contracts in the context of safe harbors as well as a review of the provider's Medicare and private billings over time. Once this information is gathered, it is presented to a U.S. Attorney whose office will evaluate the information and, with input

from the OIG, make a final decision on whether the conduct constitutes criminal or civil fraud. If the evidence demonstrates an intentional violation of the law, the U.S. Attorney may opt to present the case to a Federal grand jury for potential criminal action. If no criminal intent can be shown, but there is evidence of provider knowledge that false claims were submitted, a civil False Claims Act case may be authorized.

Now let us describe the sources and techniques that we use to detect and combat fraud, along with some related accomplishments.

ALLEGATIONS OF WRONGDOING

The OIG receives allegations of wrongdoing from a number of sources, including beneficiaries, ex-employees of providers, competitors, contractors, and Qui Tam complaints. Each of these allegations is taken seriously and is evaluated as quickly and thoroughly as possible. Because Qui Tams are based on insider information, they have proved most useful in terms of identifying large-dollar vulnerabilities. In fact, since Calendar Year 1996, we have received 1,074 Qui Tam allegations, of which over 300 are under active investigation.

For example, one case that began with a Qui Tam complaint centered on misconduct engaged in by National Medical Care, a nationwide dialysis company, and various of its subsidiaries before a 1996 merger with Fresenius Medical Care Holdings, Inc., the Nation's largest provider of kidney dialysis products and services. The Government recently reached a record-breaking Medicare fraud settlement with Fresenius. As a result of a joint investigation by OIG and multiple law enforcement agencies, the company agreed to a global resolution under which three subsidiaries pled guilty, and it agreed to pay $486 million to resolve the criminal and civil aspects of the case. As part of the civil settlement agreement on credit balances, the company paid directly to HCFA $11 million for overpayments that were previously reported to the fiscal intermediaries but never recouped. The alleged criminal misconduct involved illegal kickback activity, submission of false claims for dialysis-related nutrition therapy services, improper billing for laboratory services, and false reporting of credit balances. As part of the settlement, the company also entered into the most comprehensive corporate integrity agreement ever imposed by OIG.

MEDICARE CONTRACTOR FRAUD CONTROL UNITS

Medicare contractor fraud control units, which are a required part of the Medicare claim processing contractors' operations, are used in the effort to prevent, detect, and deter Medicare fraud and abuse. They employ a number of techniques, including sampling claims to determine propriety of payments, contacting beneficiaries to verify delivery of services, reviewing DME certificates of medical necessity, analyzing high-cost procedures and items, and analyzing local billing trends against national and regional trends for the top 30 national procedures. Unusual trends are targeted for focused medical review. Potential fraud is also identified by researching complaints and referrals received from beneficiaries, providers, and industry insiders and through various data analysis techniques. One proactive technique profiles providers using special software designed to highlight irregular billing patterns and other anomalies to target a provider's claims for more detailed review.

If fraud is indicated, the fraud control units refer cases to the OIG and other law enforcement authorities for consideration of civil or criminal prosecution and application of administrative sanctions. Over a third of the more than 1,600 referrals in FYs 1998 and 1999 were developed using proactive techniques.

AUDITS AND EVALUATIONS

Many of our leads on potential fraud are developed through audits and evaluations of various aspects of the Medicare program, most often on a provider-by-provider basis. Some significant examples are summarized below:

Home Health Care. Looking behind the explosive growth in Medicare expenditures for home health care since 1990, OIG, using claim data from 1995 through part of 1996, found that 40 percent of the payments were improper. We also determined that many home health agencies shared characteristics that could undermine the Department's ability to recover overpayments or levy sanctions. Our recommendations to strengthen the Medicare certification process and to otherwise protect the trust fund were adopted in the Balanced Budget Act of 1997. Conducted at the Department's request, our follow-up work, which examined 1998 claim data, noted that the payment error rate had fallen to 19 percent.

Additional reviews at individual home health agencies have led to 420 investigations of potential fraud since October 1997, and 130 of these investigations are ongo-

ing. A particularly egregious case of misappropriated Medicare funds and potential abuse of Medicare patients was noted at St. John's Home Health Agency, the highest paid home health agency in South Florida. We found that St. John's billed Medicare for nonrendered or upcoded home health services, that nurses and home health aides permitted subcontracting groups to use their names and/or create fraudulent documents to support nonrendered services, and that some nursing visits were provided by unlicensed persons. Further, subcontractors paid kickbacks to St. John's employees in order to do business with them. In December 1999, 26 people were indicted for racketeering, conspiring to racketeer, conspiring to launder money, and conspiring to submit false claims to the Medicare program. Subsequent to plea or trial, there were 24 guilty verdicts (1 individual became a fugitive and 1 was acquitted); all 24 of those found guilty are in the process of being excluded from Federal health care programs.

Durable Medical Equipment. After sampling 36 new durable medical equipment applicants in the Miami, Florida, area, HCFA reported in 1996 that 32 were not bona fide businesses. Among other problems, some bogus applicants did not have a physical address or an inventory of DME. According to HCFA, those companies should not have been issued a supplier number because they were not operational entities. To determine the prevalence of this problem, we sampled suppliers and applicants in 12 large metropolitan areas in New York, Florida, Texas, Illinois, and California at HCFA's request. Our inspection found that 1 of every 14 suppliers and 1 of every 9 new applicants did not have a required physical address. When we checked questionable addresses, we usually found that the business had closed or had a questionable presence at the address. Some addresses were merely mail drop locations or were nonexistent or could not be located. These types of problems with physical addresses often indicate potentially illegitimate business arrangements.

A classic example is a case we uncovered in New York. The OIG was drawn into investigating this scheme after numerous Medicare beneficiaries complained to their carriers that they had not received the services for which Medicare was billed. We interviewed the beneficiaries and verified that claims had been submitted for services that were not actually rendered. These companies billed Medicare for millions in fraudulent claims. In one instance, three of the companies billing for ear implants received checks from Medicare totaling approximately $1 million in less than a month. The bank where the money was being deposited became suspicious and called the carrier which, in turn, stopped payment on the checks. The carrier had placed a system alert on these companies if they submitted claims for MRI services, so the fictitious companies began submitting claims for ear implants and were paid.

Partial Hospitalization and Community Mental Health Centers. In collaboration with HCFA, we examined the growth of Medicare expenditures to community mental health centers for partial hospitalization services (highly intensive outpatient psychiatric services). We found that Medicare was paying for services to beneficiaries who had no history of mental illness and for therapy sessions that consisted of only recreational and diversionary activities, such as watching television, dancing, and playing games. Our review in five States, which accounted for 77 percent of partial hospitalization payments to mental health centers nationally during 1996, disclosed that over 90 percent of the services, or $229 million in Medicare payments, were unallowable or highly questionable. From that review, we were able to identify potentially abusive centers for in-depth audits and, based on our results, referred all of these centers for investigation of potential fraud. Currently, investigations are underway at 18 centers identified from this work and from other sources.

Hospital Outpatient Psychiatric Services. The OIG conducted a 10-State review of outpatient psychiatric services which accounted for 77 percent of the value of partial hospitalization and other outpatient psychiatric claims at acute care hospitals nationally. We estimated that almost 60 percent of the $382 million in 1997 outpatient psychiatric claims made by hospitals did not meet Medicare reimbursement requirements. These unallowable services were not reasonable and necessary for the patient's condition, not authorized and/or supervised by a physician, not adequately documented or not documented at all, or rendered by unlicensed personnel. Our reviews at individual hospitals found similar problems, as well as alteration of medical records after we selected the records for review. To determine whether fraud was a factor in these cases, additional work is being performed. Overall, we have 69 ongoing investigations.

UNDERCOVER OPERATIONS

We occasionally conduct undercover operations to identify potential fraud. Past undercover operations have targeted podiatrists, opthalmologists, chiropractors, medical doctors, DME companies, billing companies, and laboratories for various

Medicare billing fraud schemes, such as billing for medically unnecessary services, billing for services not provided, soliciting and receiving kickbacks, upcoding services, unbundling services, and misusing provider Medicare billing numbers. Many of these undercover operations are conducted jointly with other Federal agencies, including the Federal Bureau of Investigations (FBI), the Internal Revenue Service (IRS), and the Drug Enforcement Agency, since violations often fall within their jurisdictions as well.

For example, an ongoing multiagency undercover project targeted certain DME providers. The DME companies offered cash kickbacks to undercover operatives (Federal agents) in exchange for patient referrals. In addition, some companies billed Medicare and/or Medicaid for medically unnecessary services, services not provided, and/or upcoded services. The operation also identified physicians involved in the scheme. To date, this project has resulted in 20 convictions with nearly $1 million in restitutions, fines, and savings. Additional cases are currently being adjudicated, and more convictions are expected.

In conclusion, we would like to commend HCFA for incorporating an improper payment methodology into its internal control structure for Medicare, and we note that it was one of the first health care programs to develop such a technique. Modifications to the methodology being made by HCFA would further enhance its ability to identify areas in need of corrective action. With respect to other techniques being discussed today to expand the error rate process, we believe they are currently being used to the extent appropriate. For example, we have used beneficiary contacts in high-risk areas for the past 4 years. Such techniques as provider profiling have long been used as a means for targeting providers for fraud investigations and, as we have noted, have led to a significant number of investigative referrals. To incorporate additional fraud development techniques into the error rate methodology, in our opinion, would be cost prohibitive and extremely time-consuming and would divert substantial resources from the Department's highly successful fraud-fighting efforts. We believe that all the techniques discussed have their appropriate uses in a comprehensive, flexible anti-fraud system. We, HCFA, the Department of Justice, the FBI, and other enforcement entities will continue to apply these techniques in the most cost-effective manner that ensures the best outcomes for Medicare and other Federal health care programs.

[The responses to followup questions from Robb Miller follow:]

RESPONSES TO FOLLOWUP QUESTIONS SUBMITTED TO ROBB MILLER, INSPECTOR GENERAL, ILLINOIS DEPARTMENT OF PUBLIC AID

Question: What factors lead Illinois to conduct an error rate study?

The Illinois Department of Public Aid's Office of Inspector General has had a longstanding interest in empirical research to identify the causes of and solutions to Medicaid fraud and abuse. We had internal discussions years ago about the viability of measuring payment accuracy.

However, there were several events tied to our decision to conduct the Payment Accuracy Review (PAR). The first was becoming involved with HCFA's Medicaid Fraud and Abuse Technical Advisory Group (TAG). The TAG has provided a valuable forum of program integrity administrators from around the country who were grappling with the same issues.

The second was the challenge laid down in Sparrow's License to Steal. He clearly articulated the value and worth of establishing the payment accuracy baseline.

Finally, both the agency head and Medicaid director at that time believed it was also important to establish the baseline. Their support for the project and their willingness to deal with whatever the outcomes might have been were critical to embarking on this course.

We recognized that this study would be challenging. We were equally convinced that it would be invaluable for problem identification and the development of solutions. We felt that measurement was necessary to determine our effectiveness over time. As a consequence, we saw it as our responsibility to the taxpayers.

Question: What were the key implementation difficulties that Illinois experienced when measuring Medicaid error rates?

There are almost too many challenges to enumerate. Their volume and complexity serve to highlight why payment accuracy measurement has not been universally embraced. Effective payment accuracy is very difficult, time-consuming and expensive. Below please find a partial list of the challenges we encountered:

Six-month project period—once consensus was reached on conducting the project, we wanted to get it done in as timely a manner as possible.

Medicaid Management Information System (MMIS)—at that time, our data warehouse was not in existence. MMIS was not designed to support analytical needs as

much as operational ones, and it was not designed for rapid response projects like this.

Sampling methodologies—We held many hours of discussion before we settled on a service (as opposed to a claim or a patient day) as the unit of measurement and developed our particular stratified sample design.

Identifying which provider areas would be reviewed—while long term care and capitated payment services are also important, we focused on fee for service and inpatient payments.

Coordinating activities of multiple disciplines across organizational lines—no one entity within the department had all the expertise necessary.

Identification, extraction, and use of MMIS (internal) data—we had to rapidly develop, test and use a series of programs to select the stratified sample, develop field reports and develop the contextual data analysis reports, all in a legacy mainframe system. We also had to rapidly develope a complementary PC system that used these and other data to perform the statistical analysis and reporting.

Drawing the sample soon after service—this was done to ensure fresher client recollections during the interview but it also meant that there may have been services that had not been submitted for payment yet which might have affected the contextual analysis.

Data analysis—there were multiple levels of review; producing error rates required weighting because the sample was stratified and records in each strata had different probabilities of selection.

Medical record collection—on site visits were critical to preventing errors based simply on records not submitted.

Client interviews—they were particularly valuable in confirming that service was not provided but challenging to identify the vast majority clients.

Staff commitment—14,000 hours of staff time.

Lost audit revenue—because staff were redirected from other activities, including provider audits, we projected that the Department lost $1.3 million in audit revenues.

Question: You expressed concern about States being required by the Federal Government to use a common Medicaid error rate methodology. But, surely, there must be a common basic approach that could be modified to accommodate an individual State's needs. Don't you agree?

As you know, I am on the record as opposing a "one size fits all" approach to payment accuracy. There are major differences in:

A. The ways states determine client eligibility;

B. The types of providers allowed to be enrolled, and

C. The administration of the Medicaid program.

These differences would make a common methodology difficult if not impossible.

I would hope Congress and HCFA would focus on the outcome, not the process. If they are interested in payment accuracy and program integrity improvements, states need the flexibility to address the areas with which they are most concerned. A state's progress toward this goal should be measured only against itself, not some artificial national average.

Having said all that, my opinions are based only on my experiences and beliefs. I need to be just as willing to test them as we were to measure payment accuracy in the first place. I would suggest that more study and experimentation be conducted to determine whether a common methodology is feasible and if so, what that methodology is. HCFA and states could collaborate on efforts to deploy and evaluate different measurement approaches. A workgroup of state and Federal officials and members of the research community could then examine these experiences and advise HCFA and Congress on the question how best to proceed.

As part of these efforts, HCFA and states might first attempt to identify a universe of services and populations present in all Medicaid programs, and then determine the significance of that common universe to each state program. It would be unfortunate for states to feel compelled to focus their program integrity efforts on areas that constitute a minority of their expenditures or on areas where a minority of the problems are to be found. While allowing states the ability to initiate targeted measurement reviews would help, states would still have a strong incentive to focus their program integrity operations on only those services included within the common universe.

HCFA and states might also carefully examine the value of alternative strategies for conducting contextual record reviews, third-party verification, and client interviews. Such an examination might help identify best practices that could become part of a national methodology.

Question: In your testimony you urge the use of "the carrot, not the stick." Medicaid payments to those not eligible for Medicaid and failure of a State to collect from third party insurers would seem to (be) areas were both repayment and a penalty might be appropriate. Would you comment please?

Both of these are challenging areas for state Medicaid agency operations. However, I am not clear on their connection to the overall topic of payment accuracy measurement. Nonetheless, I agree that states need to be diligent in: a) preventing ineligible providers from enrolling or receiving payments, and b) collecting as much as possible from private insurers who provide additional coverage to Medicaid patients. At the same time, I am sure you also understand that every state has different laws that limit its abilities in both of these areas.

I believe that we are already required to return the FFP for payments to providers which should not have been made for whatever reason, including that they were excluded at the time of the service. I am not sure what value there would be to an additional sanction against the state.

Third party liability collections are more of an art than a science. The only way we should be required to return the FFP is if we know of the insurance in the first place. If we know that, we will have already made every reasonable effort to collect and, consequently, return the FFP. Again, I do not see any value in additional penalties for states.

[Whereupon, at 11:50 a.m., the Task Force was adjourned.]

HCFA and Health: The Impact of Medicare Regulation on Health Care Delivery

WEDNESDAY, AUGUST 9, 2000

HOUSE OF REPRESENTATIVES,
COMMITTEE ON THE BUDGET,
TASK FORCE ON HEALTH,
Washington, DC.

The Task Force met, pursuant to call, at 10 a.m. in the Blakely Auditorium, Keeneland Health Education Center, St. Joseph Hospital, Lexington, KY.

Members present: Representatives Chambliss and Fletcher.

Chairman CHAMBLISS. If we can have your attention, we will get started here this morning.

I first of all want to thank the folks here in Lexington and St. Joseph Hospital for hosting us this morning. This is our fourth hearing that the Waste, Fraud and Abuse Task Force has held. The other three have been in Washington, and this one is our first field hearing. We have another hearing scheduled in Macon, GA, on Monday of next week.

Our purpose in these hearings is not to throw darts or throw rocks at anybody, but simply to look at a system that is obviously a very needed system, and I have reference, of course, to the Medicare system in this country. We know it is a system that our senior citizens, in some instances, are totally dependent upon for their health care needs, which is why it is so valuable. But over the years, we also know and understand that the system has certain waste, fraud and abuse instances that have taken place, in part probably because of some things that Congress has done that we want to try to correct, but also in part because there are simply some things going on out there in the health care delivery system that ought not to be going on.

Also, there are any number of complex regulations that everybody in the health system that benefits from Medicare has to deal with that have caused this system to be expensive on the part of suppliers. And we are trying to seek to get to the bottom of some of these issues. We know we are not going to turn this program around and make it simpler and easier for our suppliers to deal with in the short term, but if we can start down that road of making some corrections in the system so that the end result is that the terrific quality health care that we provide in this country to our senior citizens is continued and the complexities are somewhat eliminated, then the patients are the ones that ultimately benefit, and at the same time, the taxpayer gets a better bang for the buck in health care delivery system.

We have held our other three hearings, as I say, in Washington, and I just cannot say enough about the good support and guidance and counsel that I have had as Chairman of this Task Force from my Vice Chairman, Congressman Ernie Fletcher from here in Lexington. Ernie and I have had any number of issues that we have worked on in his 2 years in Congress, dealing with issues from agriculture to health care. And he has been a good friend and certainly a good adviser to me, and a person who has a real concern about all issues that we deal with, but particularly with his background in health care, the issue of health care is certainly vitally important to him.

And Ernie, I am very pleased that we were able to come here this morning to Lexington, your home town, and to hear from witnesses that you have been gracious enough to have provided to us to talk about some of these issues. And thank you for being a host to us this morning. And I will recognize you for any comments you have.

Mr. FLETCHER. Well, thank you, Chairman Chambliss. And I would like to thank you.

Mr. Chambliss represents Georgia's 8th District and works on the Budget Committee there as Vice Chair there, on the full Committee. And we have established these task force, oversight task force, as he has mentioned, and our charge is to look at HCFA, the Health Care Finance Administration, which administers Medicare, and to look at the regulations they have promulgated, the way they administer the program, and how it affects health care delivery and the waste, fraud and abuse approach that they have taken toward providers.

And as I have traveled throughout this district, and we have had several hearings in Washington, and even from my own personal experience, I have found that Medicare, first off, is one of the most successful health care programs we have had. But in recent years, the administration, by HCFA, has caused a great deal of problems with reimbursal changes, with administrative changes, with growing red tape, with the complication of billing, with difficulties involved in making sure that reimbursement is there on time, with some of their waste, fraud and abuse, it does not seem to really promote, I believe, in the best way, the delivery of health care in the system that we have now.

So we are having these hearings, and I thank each of you for coming, and all of you that are willing to share your experiences with us this morning. This information will be very helpful to us as we go about to look at changes that are needed in the future. I think even the very fact that we are having hearings certainly brings information to HCFA itself, and the need for changes that they might see and do even before regulations or before new laws are passed.

So I see many of you out here I have worked with in the health care industry, and I want to thank St. Joe, their staff, for allowing us to use their facility in hosting this hearing this morning.

Mr. Chairman, I have some other comments, if I could ask unanimous consent to enter those into the record? And I will yield the rest of my time.

Chairman CHAMBLISS. Right. Well, I ask unanimous consent that all members and witnesses—and I say witnesses also—be given 5 days to submit written statements for the record. And without objection, that is so ordered.

[The prepared statement of Ernie Fletcher follows:]

PREPARED STATEMENT OF HON. ERNIE FLETCHER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF KENTUCKY

Thank you, Chairman Chambliss. I know I speak for everyone present when I say that we are all very happy and honored to have you visit us here in Kentucky's Sixth District.

I would like to thank as well the administration and staff of St. Joseph Hospital for opening their doors to the Budget Committee Task Force on Health for this hearing on the Health Care Financing Administration today. This is a special event for me personally, because I spent many years affiliated with St. Joseph as a physician here in Lexington—they are memories I carry with me to this day.

It has been an honor and a privilege to serve with you and the other Members of Congress who make up the Budget Committee. I believe that ensuring access to quality health care is one of the most vital issues facing the future of America, and the chance to have a hand in shaping the Federal budget to provide the funds necessary for this purpose is one that I appreciate and consider to be very important.

The Health Care Financing Administration, or HCFA, is at once one of the most critical Federal agencies—it administers many of the Federal programs that guarantee health care for millions of Americans-and one of the most tangled, convoluted, paper-choked, frustrating, and difficult to navigate Federal bureaucracies. It is precisely because HCFA's mission is so important that its glaring failures are so serious.

As a physician, I experienced firsthand some of the problems about which our witnesses today will testify. As a Congressman, I am contacted on a weekly basis by providers who are confounded by HCFA's rules, regulations, policies, and errors. These problems run the gamut from paperwork errors that need to be rectified to major policy decisions by HCFA that could have adverse impacts on the quality of care that patients will receive.

As you can see from these charts, there are more than 100,000 pages of laws, regulations, rules, interpretations, and court decisions governing the procedures necessary to process a claim presented to HCFA. Some of these laws and regulations are, in fact contradictory.

For example, the American Medical Association has reported to this Committee the experiences some of its members have had in treating patients covered by Medicare who arrive in the emergency room. EMTALA, the Emergency Medical Treatment and Labor Act, requires that physicians must treat patients received in the emergency room without inquiring about their ability to pay. But if that patient is covered by Medicare, and requires services that Medicare may not cover, HCFA requires that the physician inform the patient of this possibility, and ask the patient to sign an Advance Beneficiary Notice stating that the patient is aware that he or she may be liable for the cost of these services. Mr. Chairman, it is likely that this scenario is playing itself out right now just a short distance away in this hospital.

Due to the complexity and sheer volume of these kinds of rules, it has become increasingly difficult for providers to accurately bill for their services, exposing them to charges of fraud for honest errors. My staff and I have spent hours helping hospitals and other providers in my district who are on the verge of bankruptcy because of billing disputes with Medicare. Yet despite these kinds of common errors, several years ago HCFA eliminated its toll-free service lines that allowed providers to ask questions about billing and coding.

To address these concerns, I introduced with my colleague, Ms. Berkley of Nevada, H.R. 3300, the Doctors' Bill of Rights. This legislation would require HCFA to reinstate these hotlines; allow providers to request a telephone or in-person conversation with a carrier without being suspected of fraud; allow providers to repay inadvertent Medicare overpayments within 3 months without penalty, interest, or fear of audit; and require HCFA and its carriers to devote more resources to outreach and education initiatives designed to reduce billing error rates.

Our purpose here today is to let Congress hear first-hand from providers who are on the front-lines, delivering health care to our seniors. I can read statistics from studies, and tell you what I have heard from my medical colleagues, Mr. Chairman, but that is no substitute for the real world experience of these witnesses before us today.

I am proud and honored to have before us a panel of witnesses from across the provider spectrum, including physicians, those providing home health care, and hospital administrators. They can give us the perspective and information we need in Congress to correctly identify the problems with current system, and begin to solve them.

With that thought in mind, Mr. Chairman, I am looking forward to hearing from these witnesses who have graciously agreed to share some of their valuable time and experience with us, and I look forward to taking their lessons back with us to Capitol Hill when Congress reconvenes in September. I yield back the balance of my time.

Chairman CHAMBLISS. We do not have any particular order that we are going to ask witnesses to testify in this morning, but our procedure will be to hear from the witnesses, and then we will have questions from the panel, and then we will take questions from the audience when we conclude the testimony of the witnesses.

I understand Dr. Carloss has another engagement a little later on this morning and is going to have to leave us early, so we are going to ask if Dr. Carloss will start off. And we understand that, when you have to leave, that you will be excused, you are not mad at us and upset with us if you get up and walk out, but you have another meeting. So Dr. Carloss, we will start with you, and thank you for being here this morning.

STATEMENT OF HARRY W. CARLOSS, JR., M.D., FACP, PRESIDENT, KENTUCKY MEDICAL ASSOCIATION

Dr. CARLOSS. Thank you, Congressman Chambliss. Would you prefer me to testify from here or there?

Chairman CHAMBLISS. Let me ask the staff. What was our intention, guys?

Voice. I think from the table.

Chairman CHAMBLISS. From the table? Great, sure, we can see you.

Dr. CARLOSS. I thank you all for inviting me here today as President of the Kentucky Medical Association. I appreciate the opportunity to address this forum and to supply information about how regulations from HCFA are affecting the patients and the physicians of the Commonwealth of Kentucky.

I would like to say at the outset that Medicare is an essential program to our population, and determining regulations to cover a diverse population in a multiplicity of situations is a difficult task fraught with unforeseen consequences and difficulties. We as physicians recognize dealing with complex tasks, but we are used to dealing with them in a concise and efficient manner.

This is Harrison's Textbook of Internal Medicine. If your doctor knows everything in this textbook, he is an outstanding physician. Harrison's Textbook of Internal Medicine is 2088 pages. The Congressional Budget Office reports that Medicare regulations today number in excess in of 117,000 pages. When Congress thought that the IRS was burdensome and regulatory, and needed reform, its regulations had 17,000 pages.

A number of these regulations are subject to revision and interpretation by local carriers on a frequent basis. These carriers are allowed to put their own spin and their own interpretation on rules, thus it is possible for a Medicare patient from one area of

the United States to have an item covered, and move to another area of the United States and have an item not covered.

Treatment coverage and patient reimbursement should be uniform throughout the nation. Congress should establish a task force with representatives of all agencies with Medicare oversight and physician representation. They should be charged with compelling all medical directives to be listed in one source, establishing one single set of rules and guidelines for the entire program.

The government should further demonstrate its commitment to easing regulatory environment of micromanagement by assuring that these regulations are actually streamlined. Improving how the regulations and updates are communicated with physicians, improving education for physicians and their staff in regard to these regulations, and actually letting physicians take care of patients as they have been trained to do.

Too often in this country today, patients receive the care that their physician thinks Medicare wants them to have rather than what their physician thinks is the best care. This is the case because of fear of violating some obscure rule which could result in a compromise of the physician's ability to practice medicine or result in non-payment for the service. Recently in Kentucky, Administar, our Medicare carrier, has advised us that they will no longer print and distribute the monthly update bulletins, as a cost-saving measure. So now they are going to change the rules and their interpretations on a monthly basis, and they are going to hold us responsible for their contents, and they are not even going to tell us what their contents are.

We at the Kentucky Medical Association are all for removing all fraudulent medical practitioners. But with IRS or Gestapo-like authority, overzealous enforcement agencies throughout the nation are looking for rule violations when the rules are so complicated and so numerous that no one could possibly be responsible for their content. And now in Kentucky, they are not even going to tell us what the rules are.

If that is not bad enough, in Kentucky, if a case goes to review, it takes forever to get paid. On July 19th of this year, my office manager called Administar about some problem claims. She was informed by the Administar supervisor that they were opening mail from April 7th. July 19th, opening April 7th mail.

My accounts receivable over 90 days—and when I say my accounts receivable, I am referring to my medical practice; I am in a two-man oncology practice in western Kentucky—is $89,143.86. The bulk of this cost represents treatments for drugs for which I am forced to pay monthly. The Medicare bureaucracy has no complete list of covered and non-covered services. HCFA actually encourages its more than 60 carries to make their own coverage determinations on a case-by-case basis. This makes billing akin to Russian roulette, where you never know if you will be paid or if you will be subject to fraud and abuse investigation. This Medicare bureaucracy is forcing small group and independent practitioners to increase the time they spend on Medicare compliance, thus decreasing the time they spend on patient care.

I know you have had testimony in the hearings in Washington from other medical experts who are more familiar with these

things than I am. But I want to tell you how these bureaucratic hassles that we are subject to are affecting my practice and my patients, with some specific examples. This is resulting in substandard care for Medicare patients. In the early 1980's, I attended a conference at the Andy Anderson Tumor Hospital in Houston, Texas. A physician there presented his work on chronic myelogenous leukemia. He reported that a certain drug, Interferon, had reverted the chromosome abnormality, the Philadelphia chromosome, back to normal in patients treated with the drug, Interferon. This essentially meant that a population of these patients were cured with treatment with Interferon.

I went home from the meeting and started treating some of my patients with Interferon, as other physicians did throughout the country, and with great success in some patients. Last year, articles appeared in peer review journals, and the FDA recognized this as an indication for the drug. My patients and many other patients throughout the nation had already benefitted for years for treatment of this drug. The early 1980's to 1999. Currently, under the reimbursement rules in this State, these patients could not have been treated, not until they received FDA approval or until three peer review journals were published.

Oncology is a rapidly changing field. Innovations must be rapidly applied for maximum success against fighting this dread disease.

My second example involves another oncology drug, Neumega. This drug is given to prevent—prevent a specific complication of chemotherapy. In Kentucky, every billing day for Neumega must be accompanied by a copy of the patient's record. If you give it 4 days in a row, you send in four copies of the patient's record. This is a drug that prevents a complication. So I have to pay staff to copy records, send in claims, then because it is automatically going go into review because it has records with it, I have to wait 90 days for payment, 90 days to even be reviewed for review for payment. Please tell me how this micromanagement benefits anyone?

The government subsidizes the education of physicians, why not let them practice. Who is more qualified to determine who should get Neumega? Me? Other physicians? Or insurance clerks? Please tell me how can prevention be seen in the current medical record?

I do not use this drug on Medicare patients. It is an expensive drug. I cannot afford to. I have never received one penny of payment from Medicare for the drug Neumega. I stopped using it for that reason. So Medicare patients are subject to the complications that this drug prevents, whereas other patients are not. That is not right.

Further regarding oncology drugs, HCFA has said that, on October 1, we will be reimbursed at 17 percent less than the average wholesale price. Of that 83 percent, the patient is, of course, responsible for a 20 percent copayment. The first 6 months of this year in my office, we administered $1,902,716.54 of drugs. In 6 months. And during that time, we wrote off to bad debt $528,882.36. Many of our patients are poor. They cannot afford the 20 percent copayment. This 20 percent might amount to hundreds of dollars on a single treatment day.

Many uninsured patients cannot afford treatment for these drugs at all. You tell me. It does not take a lot to figure out. If I am reim-

bursed at 17 percent less than average wholesale price, pay a 6-percent Kentucky sales tax on these drugs, lose a 20 percent copayment for bad debt, lose the interest costs while I am waiting for Medicare review for 90 days, pay shipping, breakage, spillage and spoilage and provide care for the uninsured, how long can I stay in business?

On October 1, if this rule goes forth, Medicare patients may not be able to receive drugs in my office. It is just an economic decision. They will not be able to get this treatment, I cannot afford to give it to them. In a system where the government has paid $900 for a hammer, I do not understand why I am not allowed to make a profit on drugs so that I can distribute them among my indigent patients.

In closing, I would like you to consider how far HCFA has twisted the intent of Congress as stated in Section 1801 of the Act that created Medicare. This Act specifically forbids, and I quote, "any Federal officer or employee to exercise any supervision or control over the practice of medicine, or the manner in which medical services are provided, or over the selection, tenure or compensation of any officer of employee of any institution, agency or person providing health care services." We have certainly come a long way.

Thank you.

[The prepared statement of Harry W. Carloss follows:]

PREPARED STATEMENT OF HARRY W. CARLOSS, JR., M.D., FACP, PRESIDENT, KENTUCKY MEDICAL ASSOCIATION

Gentleman and ladies of Congress, as President of the Kentucky Medical Association, I appreciate the opportunity to address this forum and supply information about how relations with HCFA are affecting physicians and patient in the state of Kentucky.

I would like to say at the outset that Medicare is an essential program for our population. Determining regulations to cover a diverse population in a multiplicity of situations is a complex task fraught with unforeseen consequences and difficulties. We as physicians recognize the complexity of this task but we are used to dealing with complex medical problems in a concise efficient manner.

This is Harrison's textbook of Internal Medicine. It encompasses all of the organ systems of the human body. It is 2088 pages. Medicare regulations cover reimbursement for these diseases. Unfortunately, I could not bring a copy here today as it has been reported by the congressional budget office to be in excess of 100,000 pages. A number of these regulations, such as those issued by Medicare carriers, are updated frequently. When you thought IRS regulations needed reforming, they numbered approximately 17,000 pages.

To further confuse the issue, the country is divided into regions and finally carriers with each geographic region putting their own interpretation or spin on the rules. It is possible for a patient from one state to have an item covered only to have it rejected when they move to a different region. Treatment coverage and patient reimbursement should be uniform throughout the United States. Congress should establish a task force with representatives from all agencies with Medicare jurisdiction, as well as physician representation. They should charge it with compiling all Medicare directives into one source, thus establishing one simplified set of rules and guidelines for the entire program.

The government should further demonstrate its commitment to ease the regulatory environment of micro management by; 1) assuring that streamlining of Medicare regulations occurs, 2) improving how regulations and updates are communicated, 3) improving education for physicians and their staff, and 4) letting physicians take care of their patients as they have been trained to do.

Far too often patients receive the care a physician thinks Medicare wants them to have rather than what the physician thinks is best care. This is the case because of fear of violating some rule, which could result in a compromise of their ability to practice medicine.

Recently in Kentucky, Administar has advised us that they will no longer print and distribute the monthly bulletin as a cost saving measure. So now they change the rules and their interpretation and do not tell us. We at the KMA are all for removing fraudulent practitioners but with IRS or Gestapo-like authority, overzealous enforcement agencies are looking for rule violations when the rules are so complicated and numerous that no one could possibly be responsible for their contents. And now in Kentucky, they are not even going to send us updates but still hold us responsible for their contents. If that is not bad enough, if a case goes to review, it takes forever to get it paid.

On July 19, my office manager called regarding a problem with claims. An Administar supervisor told her that they were working on mail from April 7. My accounts receivable over 90 days for Medicare is $89,143.86. The bulk of this cost represents cancer treatment drugs for which I have to pay monthly. Medicare bureaucracy has no complete master list of covered and noncovered services. HCFA actually encourages its more than 60 carriers to make their own additional coverage determinations on a case by case basis. This makes billing akin to Russian roulette where you never know if you will be paid or be subject to fraud and abuse investigations.

The Medicare bureaucracy is forcing solo and small group practices to increase time spent on Medicare compliance and reduce time spent on patient care. I would like to briefly give you some examples of how these bureaucratic hassles result in substandard care for Medicare patients.

No. 1. In the early 1980's, I went to a conference where a physician from MD Anderson hospital in Texas presented work on CML. He reported that a drug, Interferon, had reverted the chromosome change commonly seen with CML back to normal. At that time, I started treating some CML patients with that drug. Just last year articles appeared in a peer review journal, and FDA recognized this as an indication for the drug. My patients had benefited from this treatment already for a number of years. Currently under the reimbursement rules for this state, these patients could not have been treated until last year. Oncology is a rapidly changing field; innovations must be rapidly available for patient use if we are to combat this dreaded disease.

No. 2. Neumega is a drug that prevents a complication of chemotherapy. In Kentucky, every billing for Neumega must be accompanied by the medical record and be subject to review. Therefore, I have to pay staff to copy records, send in claims, wait 90 days for the review and then maybe get paid. Please tell me how this micromanagement benefits anyone. The government subsidizes the education of physicians. Why not let them practice? Who is more qualified to determine if the patient needed the drug, the doctor or an insurance clerk-especially a drug that prevents a complication? How can you see prevention on a current record? I do not use this drug on Medicare patients.

Regarding oncology drugs, recently HCFA has said that beginning October 1, we will be reimbursed at 17 percent less than AWP (average wholesale price). Of that 83 percent the patient is responsible for a 20 percent co-payment. The first 6 months of this year my office administered $ 1,902,716.54 of drugs. We wrote off $528,882.36. Many of our patients are poor and cannot afford co-payments which might amount to hundreds of dollars for a single treatment. Many uninsured patients cannot afford to pay for these drugs.

It does not take much to figure out if I am reimbursed at 17 percent less than AWP, pay a 6 percent Kentucky sales tax, lose the 20 percent co-payment for bad debt, lose interest cost while waiting for payment, pay shipping, breakage, spillage and spoilage, and provide care for the uninsured I won't be in business very long—thus October 1 if this goes forth. Medicare patients may not be able to get treatments at my office. In a system that allows the government to pay $900 for a hammer, I don't understand why I am not allowed to make a profit on drugs.

In closing I would like you to consider how far HCFA has twisted the intent of congress as stated in section 1801 of the act that created Medicare—the act which forbids "any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided, or over the selection, tenure, or compensation of any officer or employee of any institution, agency, or person providing health services."

Chairman CHAMBLISS. Dr. Carloss, thank you very much, and we are going to even go a little bit out of order and ask you a few questions, knowing that you are going to have to leave, instead of asking questions to everybody at the end. I am a little bit disturbed by what you said, and it is a follow-on to what I have heard other

physicians say. One in particular that we had testify in Washington a couple of months ago, about the attitude of HCFA when they come into your office, or the attitude that you hear from them over the telephone as being one of intimidation versus one of wanting to reach a helping hand out to you to try to help you through this maze that you have to tread through. And I want to make sure that I am hearing that from you. Is it your feeling that, in general, physicians feel some intimidation from HCFA, both from a personal visit standpoint as well as in dealing with them through the volumes of the other regulations that are existing out there?

Dr. CARLOSS. That is difficult for me to answer because I very rarely am intimidated. [Laughter.]

But I will tell you, there is one thing that I am afraid of. And I am afraid of snakes. And the reason I am afraid of snakes is because I cannot see them always. And I know that they can attack me from unforeseen places. And that is somewhat of the fear that I have in dealing with the Federal Government. Not in Kentucky, but in other states in the union, physicians offices have been entered by armed agents when patients are present. You know, I just cannot imagine such a thing happening in my country, but apparently it has and has been reported widely.

This has not been reported to me as President of the Kentucky Medical Association. But I feel that physicians are intimidated by the unknown, because they do not know what the rules are, they cannot find out what the rules are. Let me give you an example. You know, I am giving some drugs that cost $9,000 a week. I would like to know if I am going to be paid for them or not because I am giving them in my office. And if I am not getting paid for them, I am paying for them.

Oncologists have a very high overhead. And running, as you say, millions of dollars worth of drugs through the office. So we have a directory, and we can look under in the directory, the directory is pretty far behind as far as oncology treatments go. So we will call the Administar people and we will say, we have a patient and they have this disease and we would like to give them this treatment. Will you cover that? And they say, well, we should cover that, but of course, what we tell you on the phone is not an absolute guarantee that we will cover it. And you just go ahead and give it to them and send it in, and we will send it to review.

So I am giving this drug once every 2 weeks and it is going to review, and a review lasts 90 days before they even start to look at it, by their own admission, lasts 90 days. So then they come up after they finally review and they say, well, we do not believe it is indicated because you do not have three peer review journals and it has not been approved by the FDA for this, so we are not going to pay for it.

So now—and I can actually show you charts of patients who have gotten drugs under unusual circumstances, that had failed other treatments, had gotten drugs, had responded to the drugs and are in complete remission, and Medicare is telling me that they are not going to pay me for the drug.

Now you know, the reason that I am going to have trouble practicing medicine under this kind of regime is because I cannot walk in that room and say, Mrs. Jones, Medicare told me today they are

no longer going to pay for your drug, so I cannot give it to you, and you are going to die. I cannot do that. So we are giving these drugs currently in my practice at a loss for—until we get reviewed. And then if we are turned down, and then if we are working on a patient, then we are still giving them and my partner and I are paying for them out of our pocket, or trying to get the drug company to give them to us free, which they are reluctant to do because they think that, if a person has some sort of coverage, the coverage ought to pay for them.

So that is the kind of intimidation that I feel. It is not that I am—I am not really worried that the Gestapo is going to come kick down my door tomorrow, although they have in other states. But I am worried about things that I do not know and do not understand, and I am worried about providing quality care for my patients.

Chairman CHAMBLISS. Some of what we have heard with respect to intimidation, I want to ask this to all other panelists also, is just the fact that there are so many civil penalties on the books out there that you can do everything you think is right in filing a claim, and yet if you should happen to use the wrong code, which I understand is sometimes easy to do, that you subject yourself to civil penalties. So the rest of you may be thinking about that.

Is what you are telling me with respect to a difference of interpretation by HCFA in Kentucky versus the way they may interpret medical necessity or whatever determines coverage in, say, Indiana, is that basically just from a—trying to determine what the definition of medical necessity is or does coverage depend on something else in different jurisdictions?

Dr. CARLOSS. Coverage depends upon the ruling of the covering carrier in the jurisdiction. Kentucky and Indiana may not be the best example because they are the same carrier, Administar covers Kentucky and Indiana. But I can tell you that I have patients that winter in Florida that have gotten the treatment in Florida that have come back to Kentucky and have not been able to get the same treatment until I had gone through the entire appeals process. So there is a great variation from state to state and from carrier to carrier.

As to what you said about the coding, you know, the coding is fantasy land. I think that you have already heard testimony from the American College of Physicians that, when a patient sees—is seen by a physician in his office and the coding process takes place, that over 6,000 determinations go into determining the correct code. In my office, if it is hard, we code it a little higher than we do if it is not hard.

Now HCFA actually has a ruling, and I have tried to find a copy of this but I could not go through the 100,000 pages. But they have a ruling that, if a doctor has more training and a patient comes and it is an easy answer, so if you, as a Congressman, you have heard lots of testimony and you were able to solve a difficult problem quickly because you had all the background information and training, that would not actually be worth as much to HCFA as if you were off the street and had to make the decision, and it took you longer and you made a less good decision. That is probably not the right way to say it, but doctor of less experience would actually

get paid more for making the same diagnosis than a subspecialist would get paid, under the coding system.

But you know, I can tell you the honest truth, I do not code the things in my office to any great extent. I have the nurses help me with the coding in the office. My job is to see patients. I hate other things, and I am a very obstinate person. If things are easy, we put down a low code. If things are hard, we put down a high code.

Now I got in trouble once for that because a lot of things seemed easy to me that year and I put down a lot of the low codes, and I actually received a letter that I was going to be fined because that I had submitted too many low codes. [Laughter.]

Chairman CHAMBLISS. You were not charging the government enough?

Dr. CARLOSS. Exactly, that is right, I was not charging them enough. And actually there was a fine stated, and I was helped by some of my representatives in Washington so that I did not actually have to pay the fine.

Chairman CHAMBLISS. And that is exactly the form of intimidation that I had referenced to that we have heard about.

Let me just mention very quickly, and then I want to turn it over to Dr. Fletcher, but we have been involved with trying to provide some assistance to one of the problems that you spent a good deal of time on there, and that is this issue of you being compensated for the drugs administered to your patients, and I know you are familiar with the fact that the administration has now come out and they are going to change the rule in the middle of the stream and say that we cannot use the red book anymore, and that they have gone to any number of discount drug catalogs, apparently, and come up with the fact that we are reimbursing you at too high a rate when, in fact, we are reimbursing you at what the red book rate is. And it may be a little bit higher, but we are shortchanging you on the other end.

And everybody knows the way that game has been played, and it has been sanctioned by Medicare, and now all of a sudden they are coming back and saying, we are going to cut you back to another 17 percent, I believe, on the reimbursement rate for those drugs.

We have sent a letter to Secretary Shalala, and it is a bipartisan effort to try to at least set back that October 1 date that we can have an opportunity to discuss this further, and make sure that, if we are going to reduce the reimbursement rate on the drugs that, at the very least, we allow additional compensation to you on the other end. Because what you say is, I know, exactly right. You can only go so far in administering drugs to Medicare patients that you are not going to be reimbursed for.

So I hope we are going to get a satisfactory answer out of that, and I am sure Dr. Fletcher will stay in touch with you with regard to the way we proceed on that, and the reaction we get from Secretary Shalala.

Dr. CARLOSS. Thank you.

Chairman CHAMBLISS. Dr. Fletcher.

Mr. FLETCHER. Thank you, Chairman Chambliss. And Dr. Carloss, we appreciate your distinguished service as President of the KMA as well as years of service to patients in western Kentucky,

cancer patients. And so it is an honor to really have you. And I appreciate very informative testimony.

Some of the things you brought up I think stress the importance, you mentioned patients' difficulty, particularly uninsured or low-income patients, seniors on fixed income, that are not able to afford those co-pays. And I think it certainly stresses the importance of prescription drug coverage and a more comprehensive drug coverage for our Medicare patients. And we have worked very hard for that in the Budget Committee.

Let me say, even this year, we have passed budget—in our budget 200—well, actually, we passed more than that, it ended up being about $250 million for women with breast and cervical cancer that have no insurance or are under-insured, so that we can insure every woman actually across the country is able to get the treatment when they are diagnosed with those diseases. So I share your concern.

And somewhat, you know, as you listen to this, you kind of wonder, boy, this sounds so ridiculous sometimes as to how they administer things. Is it really that bad? And yet, my personal experience confirms what you have said, as well as the testimony we have heard previously.

Let me ask you just one thing, how much staff would you say, or increased staff costs have you seen over the years of your practice, just to try to comply with the coding, the regulations and making sure that you keep those folks from barging into your office when you are trying to care for patients over something that may be a minor mistake or a coding mistake, as you mentioned?

Dr. CARLOSS. In our office, I have one full-time senior employee who does nothing but deal with those types of issues. And the majority of my practice is Medicare-related. You know, Medicare does not just apply to the elderly. Frequently, if you get a disease that I take care of, you get Medicare disability. And so my practice is skewed more to Medicare than other people. You know, I am practically an employee of the government, I think about 76 percent of my practice is Medicare or Medicaid. But I have not been able to get on the Federal employees' health benefits. [Laughter.]

Chairman CHAMBLISS. It ain't that good. [Laughter.]

Dr. CARLOSS. You just be glad you live in Georgia, Congressman.

Mr. FLETCHER. Dr. Carloss, let me ask you, if the change in regulation is decrease—17 percent decrease in reimbursal for outpatient pharmaceuticals, let me say the President in his budget, both years, particularly last year, was going to decrease reimbursals even more on oncology outpatient treatment, which is what you are talking about. We fortunately killed that because that would have had a tremendous impact. He was going to cut I think Medicare and those reimbursals, it was like $18 billion.

But if it gets to the point where you cannot economically give treatment in your office that costs substantially less than giving it in a hospital, what are you going to do, and are you going to have to hospitalize these patients to give treatment in order to try to secure payment so that they can get the treatment, life-saving treatment many times, that they need?

Dr. CARLOSS. That is exactly what I will do, is that I will admit the patients to the hospital, as long as I am allowed to do that.

Now as you are well aware, the Medicaid program in the State of Kentucky does not reimburse for drugs as high as—Medicaid does not reimburse as high as Medicare does for the drug. It is a small number of people, but recently in this State, they decided that doctors had to pay a 6-percent sales tax in addition to the price of the drug.

Now when you add that 6 percent sales tax in, that makes a list of about 20 drugs that it actually costs me money to provide the drug. I actually lose money on the drug. Now we are kind of slow in my office, we are just now catching on to this, and we are admitting all those people to the hospital.

Mr. FLETCHER. So that probably costs multiple times what it would if you gave it as an outpatient, where you could—you do not have the cost of the facility, the hospital day or whatever it requires there.

Dr. CARLOSS. It costs somebody. It eventually costs the taxpayer, one way or another. But I have been told that one way HCFA is looking at this is if they forced all of these people into the hospital, they would come under a DRG, and they would actually save money by forcing people into the hospital and inconveniencing all the Medicare patients. Now I do not know if that is official policy, but when I met with you in Washington, I also ran into a HCFA person that night who mentioned that that might be a goal.

So it might cost the government less in one hand, but I—it is going to hard for me to say this without insulting anybody, but the government is a one-step process. I have been an advisor to HCFA regarding peer review. I have worked on HCFA committees. And you know, when I see patients, I have to think five or six steps down the road, and I know that you all in Congress have to think many steps down the road. But when it appears to me that, in my experience with the government, they can only think one step ahead. If we do this, this will happen. What they do not consider that, for every action, that there is a whole series of reactions that go on.

Mr. FLETCHER. Well, I appreciate it. And I was surprised to find out this year that this State charges 6 percent on cancer treatment.

Dr. CARLOSS. Yeah, I was surprised by that, too.

Mr. FLETCHER. And I do not know if they do that in Georgia, but I certainly think we need to call on the Governor of this State and the State Legislature to take a look at this and rescind that. That seems to me the opposite message of what you are sending, I think. We have a new cancer prevention center at the University of Kentucky, we are putting a lot of emphasis, we have the third highest rate of cancer. And now we are taxing cancer. And I think we need to look very seriously about it in this State, about rescinding that tax.

Dr. Carloss, if there was one thing—and I know that is hard to do—but one thing we could do or take back with us from your testimony today that would be the most urgent thing to change, what would it be, in your opinion?

Dr. CARLOSS. The population in this United States cannot exist without Medicare. We owe our senior citizens, of which I am rapidly becoming one, the best treatment that there is available, under a simplified system. And that may cost some money. But we need

to make sure that medical benefits are distributed equally to the population of the United States. People that life in Florida are no more American than people that live in Kentucky. They have provided no more service to their country, and their families and their communities, and they do not deserve any more special care than people in Kentucky.

If you are going to have a Federal program, you are going to have to have one set of rules that apply to everybody in the entire country, and they have to be administered fairly.

Mr. FLETCHER. We appreciate your testimony, and I yield back, Mr. Chairman.

Chairman CHAMBLISS. Thank you very much, Dr. Carloss.

We have no particular order to go in, but I think we will start, Mr. Fraraccio with you, and just proceed down the line. Dr. Reynolds, we will come to you next and go right on down.

STATEMENT OF ROBERT D. FRARACCIO, CHIEF EXECUTIVE OFFICER, CLARK REGIONAL MEDICAL CENTER

Mr. FRARACCIO. Thank you, Congressman. Is this microphone working OK?

Good morning. My name is Bob Fraraccio, and I am the CEO at Clark Regional Medical Center. I have held this position since June 1993. Clark Regional is a freestanding, not-for-profit community hospital located in Winchester just 15 miles east of Lexington. The hospital opened in 1917 and is licensed for 100 beds.

I appreciate the opportunity to speak this morning to the Task Force on Health about the Federal regulatory burden on hospitals, and I would like to focus my remarks on three areas. First, the sheer volume of regulations; second, the lack of sufficient planning prior to their implementation; and finally, the inconsistency with which these regulations are administered.

Without a doubt, the health care industry is the most regulated industry in the country. In addition to Medicare, hospitals are subject to regulations from numerous other agencies including Medicaid, OSHA, EPA, CDC, Center for Disease Controls, and the IRS, just to name a few. Dr. Carloss just mentioned that Medicare had regulations that totaled 117,000 pages. The information I received says that that number is in excess of 132,000 pages. And these rules are extremely complex and costly for hospitals. One example would be how HCFA has delegated to its fiscal intermediary the method for determining the medical necessity for outpatient testing, and as you know, most hospitals see about 60 percent of their revenue from outpatient sources. So it affects a high volume.

The vehicle to make this determination for necessity is a publication called the Local Medical Review Policy or LMRP. The LMRP may used for surgical procedures, laboratory tests, radiology tests and respiratory tests. In short, almost all outpatient diagnostic testing requires LMRP. In order to be reimbursed, hospitals are required to collect ICD-9 codes, diagnosis codes for the requested services. The vast number of physicians do not routinely provide specific ICD-9 codes when ordering tests for the simple reason that the test itself is usually needed to make the diagnosis.

Nonetheless, Clark Regional and other hospitals have been forced to implement the LMRP process which results in long delays

for patients requiring simple tests, while we spend inordinate amount of time and money tracking down physicians for the appropriate codes.

In some cases, the hospital is not paid at all since Medicare rejects the general ICD-9 codes. If the information cannot be obtained in a timely manner, an advance beneficiary notice, or an ABN, is issued to the patient stating that, if Medicare does not pay for the service, the patient becomes responsible for payment. The patient then has the option of refusing treatment or risk additional out-of-pocket expense.

In addition to costly delays, the LMRP creates a major public relations problem. You can imagine that patients can be extremely upset with these types of situations, and they take their frustrations out on the hospital and the physicians, but certainly not the fiscal intermediary nor HCFA itself.

The next area I would like to address is the lack of planning when implementing new regulations. Through the Balanced Budget Act of 1997, Congress sought to simplify outpatient reimbursement by requiring HCFA to implement a prospective payment system. Hospitals support Congress's effort for an outpatient prospective payment system that is simple, predictable and fair. Unfortunately, between the enactment of the law and the drafting of the regulatory language, the new system is anything but simple, predictable and fair.

The ambulatory payment classification system, which took effect on August 1 of this year is more complex than the inpatient prospective payment system implemented in the early 1980's, known as DRGs. It is most likely the significant—the most significant comprehensive and complex program ever implemented by HCFA, yet the final regulations for APCs were issued in mid-April of this year, leaving the hospitals a mere three or three and a half months to prepare for such massive changes.

Despite repeated requests on the part of the American Hospital Association for HCFA to delay implementation of the regulations until providers had a better opportunity to prepare for the changes, HCFA insisted on implementing this new program, even though HCFA's training manuals and materials were inaccurate, misleading and lacked detail information that hospitals needed to properly comply with its directives.

If past experience is any indication, we can expect that HCFA will follow with correction notice after correction notice, thus complicating and hindering hospitals' ability to implement changes in a timely and appropriate fashion, while at the same time increasing their risk of losing reimbursement for outpatient procedures.

And the last area I would like to talk about briefly is the inconsistency of regulatory interpretation. Throughout the years, HCFA, through its fiscal intermediary, has consistently interpreted many of its regulations in an inconsistent manner. A critical example for Clark Regional deals with the disproportionate share payments. In recognition of the additional costs incurred by hospitals treating a disproportionately high share of indigent patients, Federal law requires that the Medicare program make additional payments to such disproportionate share hospitals. Hospitals with 100 beds or more, and at least 15 percent Medicaid utilization qualified for

these additional payments. Clark Regional is licensed for 100 beds and had been receiving disproportionate share payments for several years.

In June 1997, Medicare's intermediary, Administar, notified Clark Regional that it would no longer receive disproportionate share funding due to a different interpretation of the Medicare regulations. Subsequently, the intermediary reversed its position stating that we would, indeed, continue to receive those funds, and shortly thereafter reversed itself a second time, denying payments of those funds.

In addition, Administar chose to reopen closed reports, closed cost reports retroactively to 1992 and take back payments that had already been made to Clark Regional Medical Center. This amount totaled to $2.5 million, a staggering amount for a hospital the size of Clark Regional. HCFA's rationale was that Clark Regional failed to meet the 100-bed threshold due to the fact that when a patient is considered an observation patient, as opposed to an inpatient, the hospital's bed count dropped below 100. HCFA's argument claims that using an existing bed to temporarily observe a patient, changes the size of the hospital.

Presumably, according to HCFA, the hospital size changes yet again when that same patient in that same bed becomes an inpatient. In making its argument, HCFA is actually contradicting its own guidelines. Those guidelines make clear that observation beds are not to be excluded from the hospital bed count. The hospital appealed this matter to the Provider Reimbursement Review Board, or the PRRB. This Board is appointed by HCFA and is composed of experts in the field of reimbursement. It is empowered to conduct hearings and rule in a manner that, "affords great weight to the interpretive rules, general statements of policy and rules of agency, organization, procedure or practice established by HCFA."

On September 2nd, 1999, the PRRB released a decision fully favorable to Clark Regional Medical Center. The Board held that the beds at issue met all the program requirements to be included in the bed size calculation to determine disproportionate share eligibility. On November 8, approximately 2 months later, 1999, the HCFA Administrator unilaterally reversed the decision of the PRRB. The Administrator's decision did not even attempt to address the aspects of HCFA's own guidelines, stating that changes in day-to-day use in beds did not change the bed counts, and that the bed counts should only change when the size of the facility changes.

Subsequently, Clark Regional filed a lawsuit contesting the Administrator's decision in the United States District Court for the Eastern Kentucky District. In addition to having to pay HCFA—repay HCFA the $2.5 million, the hospital has incurred significant legal expense for the PRRB appeal, and continues to incur significant legal expense preparing for the trial which is expected to take place later this fall. All the while, HCFA has held our money which could have been used to make improvements in patient care services.

In Kentucky, Clark Regional and Pattie A. Clay in Richmond are the only two hospitals that have been impacted by this disproportionate share ruling. Throughout the country, we have been able to

find approximately 12 other hospitals in the same situation, contesting a total of approximately $30 million. While the dollars involved for each individual hospital are significant, it is a relatively small amount of money for HCFA in the overall scheme of things. Yet HCFA refuses, at least in our case, to heed its own panel of experts.

However, when the disproportionate share issues came up recently in the State of New York, where many more dollars were at stake, HCFA sought to continue disproportionate share payments to the New York State hospitals. Certainly the amount of money involved with New York State hospitals is significantly more than the amount of money involved with the 12 hospitals across the entire country.

HCFA's inconsistency in interpreting its own guidelines continues to cause extreme frustration and wreak financial havoc on our and other health care institutions.

In conclusion, I would like to state that the hospital's first priority is to provide high-quality patient care. A small percentage of these voluminous regulations that we are discussing this morning contribute to our efforts to provide that quality care. The rest simply drain resources away from that goal. These burdensome regulations continually place a financial strain on the providers who are already reeling from the drastic provider cuts included in the 1997 Balanced Budget Act.

We all agree that the health care industry should be regulated to some extent. There are valid reasons why HCFA and other regulatory agencies should monitor hospital activities. However, the strain of numerous agencies issuing thousands and thousands of pages of conflicting and unnecessary rules, instructions and laws is hurting the health of our nation's hospitals and putting their financial viability at risk.

Programs such as Medicare and Medicaid were designed to make health care more accessible to our senior and less fortunate citizens in this country. Sadly, the continued promulgation of unreasonable and ill-conceived regulations would jeopardize the provider's ability to provide quality care, and ultimately perhaps reduce accessibility for beneficiaries. Ironically, these programs may very well hurt the people they were intended to help.

I appreciate you listening to my comments and the opportunity to speak with you this morning. Thank you.

[The prepared statement of Robert D. Fraraccio follows:]

PREPARED STATEMENT OF ROBERT D. FRARACCIO, CHIEF EXECUTIVE OFFICER, CLARK REGIONAL MEDICAL CENTER

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I appreciate the opportunity to speak this morning to the Task Force on Health about the Federal regulatory burden on hospitals. I would like to focus my remarks on three areas.

1. The sheer volume of regulations.
2. The lack of sufficient planning prior to their implementation.
3. The inconsistency with which these regulations are administered.

VOLUME OF REGULATIONS

Without a doubt the healthcare industry is the most regulated industry in the country. In addition to Medicare, hospitals are subject to regulations from numerous other agencies including Medicaid, OSHA, EPA, Center for Disease Control, and the IRS-to name a few. For Medicare alone hospitals are subjected to more than 132,000 pages of Medicare rules. These rules are extremely complex and costly for hospitals.

One example would be how HCFA has delegated to its fiscal intermediary the method for determining the medical necessity of outpatient testing. The vehicle for this determine is a publication called the local medical review policy (LMRP). LMRP may be used for surgical procedures, laboratory tests, radiology tests, and respiratory tests. In short, almost all outpatient diagnostic testing requires LMRP. In order to be reimbursed hospitals are required to collect ICD-9 coded diagnoses for the requested services. The vast number of physicians do not routinely provide specific ICD-9 coded diagnosis information when ordering tests for the simple reason that the test itself may be needed to make the diagnosis.

Nonetheless, Clark Regional and other hospitals have been forced to implement the LMRP process which results in long delays for patients requiring simple tests while we spend inordinate amounts of time and money tracking down physicians for the appropriate ICD-9 codes. In some cases the hospital is not paid at all since Medicare often rejects the general ICD-9 codes.

If the information cannot be obtained in a timely manner, an Advance Beneficiary Notice (ABN) is issued to the patient stating that if Medicare does not pay for the service, the patient becomes responsible for payment. The patient then has the option of refusing treatment or risk additional out of pocket expense. In addition to costly delays the LMRP creates a major public relations problem. You can imagine that patients can become extremely upset in these types of situations and they take their frustrations out on the hospital as well as the physicians, but certainly not the fiscal intermediary nor HCFA itself.

LACK OF SUFFICIENT PLANNING PRIOR TO IMPLEMENTATION

The next area I would like to address is lack of planning when implementing new regulations. Through the Balanced Budget Act of 1997 Congress sought to simplify outpatient reimbursement by requiring HCFA to implement a prospective payment system. Hospital support Congress' effort for an outpatient prospective payment system that is simple, predictable, and fair. Unfortunately between the enactment of the law and the drafting of the regulatory language, the new system is anything but simple, predictable, and fair.

The ambulatory payment classification (APC) system which took effect August 1 of this year, is more complex than the inpatient prospective payment system implemented in the early 80's. It is most likely the most significant, comprehensive, and complex program ever implemented by HCFA. Yet the final regulations for APCs were issued on April 2000 leaving hospitals a mere 3 months to prepare for such a massive change.

Despite repeated requests on the part of the American Hospital Association for HCFA to delay implementation of the regulations until providers had a better opportunity to prepare for the changes, HCFA insisted on implementing this new program even though HCFA's training material was inaccurate, misleading, and lacked detailed information that hospitals needed to properly comply with its directives. If past experience is any indication, we can expect that HCFA will follow with correction notice after correction notice, thus complicating and hindering hospitals ability to implement changes in a timely and appropriate fashion while at the same time increasing their risk of losing reimbursement for outpatient procedures.

INCONSISTENCY OF REGULATORY INTERPRETATION

Throughout the years, HCFA through its fiscal intermediary has consistently interpreted many of its regulations in an inconsistent manner. A critical example for Clark Regional deals with disproportionate share payments. In recognition of the additional costs incurred by hospitals treating a disproportionately high share of indigent patients, Federal law requires that the Medicare program make additional payments to such disproportionate share hospitals.

Hospitals with 100 or more beds with at least 15 percent Medicaid utilization qualify for these additional payments. Clark Regional is licensed for 100 beds and has been receiving disproportionate share payments for several years.

In June 1997 Medicare's intermediary, Administar, notified Clark Regional that it would no longer receive disproportionate share funding due to a different interpretation of the Medicare regulations. Subsequently, the intermediary reversed its posi-

tion, stating that we would indeed continue to receive those funds, and shortly thereafter reversed itself for a second time denying payment of those funds. In addition, Administar chose to reopen closed cost reports retroactively to 1992 and take back payments that already had been made to Clark Regional Medical Center. This total amounted to $2.5 million dollars, a staggering amount for a hospital the size of Clark Regional.

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In Kentucky, Clark Regional and Pattie A. Clay in Richmond are the only two hospitals that have been impacted by this disproportionate share ruling. Throughout the country we have been able to find approximately 12 other hospitals in this same situation contesting a total of approximately $30 million dollars. While the dollars involved for each individual hospital are significant, it is a relatively small amount of money for HCFA in the overall scheme of things. Yet HCFA refuses, at least in our case, to heed its own panel of experts. However, when disproportionate share issues came up recently in the State of New York, where many more dollars were at stake, HCFA sought to continue disproportionate share payments to New York State hospitals. Certainly the amount of money involved with New York State hospitals is significantly greater than the amount involved with 12 hospitals across the entire country.

HCFA's inconsistency in interpreting its own guidelines continues to cause extreme frustration and wreak financial havoc on our and other healthcare institutions.

CONCLUSION

In conclusion, I would like to state that hospitals' first priority is to provide high quality care to our patients. Only a small percentage of these voluminous regulations contribute to our efforts to provide that quality care. The rest simply drain resources away from that goal. These burdensome regulatory rules continually place a financial strain on providers who are already reeling from the drastic provider cuts included in the 1997 Balanced Budget Act.

We all agree that the healthcare industry should be regulated. There are valid reasons why HCFA and a host of other regulatory agency should monitor hospitals' activities. However, the strain of numerous agencies issuing thousands and thousands of pages of conflicting and unnecessary rules, instructions, and laws is hurting the health of our nation's hospitals and putting their financial viability at risk.

Programs such as Medicare/Medicaid were designed to make healthcare more accessible to our senior and less fortunate citizens in this country. Sadly, the continued promulgation of unreasonable and ill-conceived regulations will jeopardize the providers' ability to provide quality care and ultimately reduce accessibility for bene-

ficiaries. Ironically, these programs may very well hurt the very people they were intended to help.

I thank you for the opportunity to come before the Task Force this morning.

Chairman CHAMBLISS. Thank you very much, Mr. Fraraccio.

And I jumped the gun just a little bit, I want to give Dr. Fletcher an opportunity to introduce all of our panel members before we get to each one of them.

Mr. FLETCHER. Let me go back with Robert Fraraccio, and we thank you for your testimony and for coming. You are the Chief Executive Officer of Clark Regional Medical Center in Winchester, served there since June 1993. Before that, served as Chief Executive Officer of Montgomery Regional Hospital, a 150-bed facility located in Blacksburg, Virginia. He has also served as assistant administrator in Bluefield Community Hospital, Bluefield, West Virginia, and Johnston-Willis Hospital in Richmond, Virginia.

He received his master's degree in hospital administration from the Medical College of Virginia in 1974, and this past year, Mr. Fraraccio has served as Chairman of the Kentucky Hospital Association. We thank you for your testimony and for coming here.

Let me introduce Dr. Barbara Reynolds, a physician serving as the Medical Director of the Emergency Department at Frankfurt Regional Medical Center. She graduated from Washington University School of Medicine with an M.D. degree, undergraduate in Connecticut College, Washington University School of Medicine where she did a research fellowship, the Departments of Surgery and Gastroenterology, the general surgery at Barnes Hospital, Washington University, and internship and general surgery, she completed that there as well.

Additionally, let me find that, I think you are President-elect of the Kentucky Chapter of American College of Emergency Physicians, and we certainly would welcome you here.

Mr. William E. Stauter works at Sayre Christian Village Nursing Home. He is the Administrator/Chaplain since January 1998 to the present. Prior experience with the Christian Benevolent Association, Director of Pastoral Services. There additionally, Mount Healthy Christian Home, Cincinnati, Ohio, was the Administrator there from 1990 to 1997. Worked also with Woodland Lakes Christian Camp, 1972 to 1983. Graduated from Cincinnati Baptist—Bible College, rather, and Seminary University of Illinois, College of Commerce and Business Administration, and certainly we welcome you here with Sayre Christian Village, and we look forward to hearing your testimony.

Mr. Lennie House is the owner and President and CEO of Nurses Registry and Home Health, the largest home health agency in Central Kentucky with over 200 employees and operations in 16 counties. Mr. House has been a strong advocate for home health care, and its indisputable benefits for patients and their families and brings many years of experience to the subject. He has been involved, participant in, a witness to all of the ups and downs of the home health field over the past 15 years. He is married to Vickie S. Fell-House, has been executive director of Nurses Registry and Home Health for many years. Has two daughters, and they are residents of Georgetown, Kentucky. We welcome you and look forward to hearing your experience, too.

I am not sure I have got—let me make sure I have got the rest of the CVs up in front of me here. I introduce Dr. Charles Shelton who is a physician and doctor of osteopathy. He is with the Lexington Psychiatric Group, a general adult psychiatrist, inpatient-outpatient consulting psychiatry, specializing interests in forensic and geriatric psychiatry. He was at the University of Kentucky Department of Psychiatry, he was the chief resident in 1993 and 1994. Did his residency at the University of Kentucky. Additionally, is on the active medical staff here at St. Joseph Hospital, been consultant medical staff at Central Baptist, as well as an active medical staff at Charter Ridge and Lexington Hospital, and River Hospital in the past in Huntington, West Virginia. From 1999 to the present, he has been Chairman of Behavioral Health Services, St. Joseph Hospital, and also on the medical executive committee at St. Joseph Hospital, and we certainly appreciate yours, and look forward to your testimony, too.

And we welcome Robert Hudson. Robert J. Hudson is vice president of Fiscal Services at Pattie A. Clay Hospital, Richmond, Kentucky. He is a graduate of the University of Kentucky with a B.S. in accounting. After serving in the military, he worked 6 years at the University of Kentucky Medical Center and has been at Pattie A. Clay Hospital for 20-plus years. In the early 1990's, he served as the president of the Kentucky Chapter of the Health Care Financial Management Association. We look forward to hearing your testimony as well.

Mr. Chairman, I yield back.

Chairman CHAMBLISS. Thank you very much, Dr. Fletcher. It is certainly a distinguished panel, and one we look forward to continuing to hear from. And Dr. Reynolds, we will now turn to you.

STATEMENT OF BARBARA J. REYNOLDS, M.D., PRESIDENT-ELECT, KENTUCKY CHAPTER, AMERICAN COLLEGE OF EMERGENCY PHYSICIANS

Dr. REYNOLDS. Good morning, Chairman Chambliss and Dr. Fletcher. And I want to thank you for holding this hearing here in Kentucky and for asking for representation from the Kentucky Chapter of the American College of Emergency Physicians.

Emergency physicians provide a unique role in health care in the United States. America's emergency departments are the nation's health care safety net. Because of this unique role and the constraints inherent in our practice of emergency medicine, HCFA's burdensome rules and regulations have had a particularly detrimental effect. All the regulations affecting physicians, and many of those affecting hospitals, impact the practice of emergency medicine.

We will highlight three specific subsets of HCFA regulations that have significantly impacted emergency physicians. These are the evaluation and management documentation guidelines, EMTALA, and accusations of fraud and abuse.

Firstly, regarding documentation guidelines, these are constantly-changing regulations. HCFA has issued rules for physician documentation in 1995 and in 1997. In addition, in 1999, in conjunction with the AMA CPT editorial panel, another set of rules were submitted to HCFA. These 1999 rules, however, were never

issued because they were felt to be too complex. HCFA is now in the process of drafting yet another version of the evaluation and management guidelines. Currently, either the 1995 or the 1997 guidelines are considered acceptable for billing purposes.

Needless to say, there is a lot of uncertainty in which rules to use, and this is confusing for everyone. A considerable amount of time must be spent in learning the various rules and how to comply with them. Consequences of not complying are great. Not only can non-compliant charts be down-coded and thereby decrease physician and hospital reimbursement, but doctors and hospitals may be subject to significant fines and penalties as well.

Doctors as well as hospitals and billing entities spend enormous amounts of time learning how to comply with the rules and regulations. The documentation guidelines and many other regulations create intense frustration for doctors for several reasons. First, the rules and regulations do not improve patient care, and often detract from it by making doctors focus on overly-burdensome charting requirements, when they should be and want to be focusing on caring for their patients.

Second, most time spent learning the rules is often wasted because the rules change almost as soon as they are learned. Thirdly, the time spent learning to comply with these unnecessary regulations could be better spent learning about advances and updates in medical knowledge. The limited time we have for continuing medical education is instead taken up with trying to learn about HCFA's latest rules and how to comply with them.

There is interference of the doctor/patient relationship. Because documentation requirements must be met in order to charge for the various levels of care, doctors are spending time counting elements of the chart instead of taking care of patients. For example, if a doctor cares for a patient with a life-threatening medical problem, such as a heart attack, he or she would normally charge a level 5.

However, in order to receive reimbursement at a level 5, the review of systems section of the charge must show that ten or more systems of the body were discussed with the patient. This means, for instance, that a doctor must ask a patient a lot of unnecessary and irrelevant, and frequently annoying questions. For instance, a doctor would need to inquire whether a patient was having problems with their skin, bone and joints, eyes and ears or mental health. For a patient with a serious medical condition such as a heart attack, these are usually irrelevant, and frequently annoying. However, should the doctor fail to do this, the chart will be down-coded to a level 4 or possibly a level 3. This could amount to a decrease of several hundred dollars per patient. Needless to say, a doctor will spend time meeting these unnecessary requirements when they should be at the patient's bedside.

This wasting of time with unnecessary requirements is definitely problematic in the emergency department where we are under constant pressure to work as quickly as we can, and often are making critical decisions with patients who are seriously ill or injured where every second counts. The last thing that should interfere with our efforts to take care of our patients is unnecessary charting regulations. In the book, "Time to Heal," author Kenneth Ludmerer, M.D. emphasizes that a key element in the decline of

quality medical care in this country relates to the lack of time that physicians now have with their patients. Although physicians recognize the need to provide a medical record that is complete, and justifies the medical complexity and decision-making that is taking place, the current regulations do not provide for this and actually work against both the doctor and the patient, especially in the emergency department.

We have increased and not decreased costs for the patients because of these regulations. The complexity of the rules means that the extra people that must be hired by physicians and hospitals to ensure compliance with these rules which have become so burdensome that there are now additional entire full-time equivalents that are hired for these roles. These include coders, billers and lawyers. The cost of employing these people is passed on to the patients.

Secondly, I would like to address the rules of EMTALA. This has basically become an unfunded mandate for emergency physicians. As emergency physicians, we are required by law to see all patients who present to the hospital for medical care. As directed by EMTALA, all patients must receive a medical screening exam and be stabilized. This HCFA obligation applies to all patients, not just Medicare beneficiaries. Emergency physicians provide this care without concern for the patient's insurance coverage or ability to pay. Because of this, we have become the nation's health care safety net by providing care for patients who cannot afford to go elsewhere.

Most doctors' offices require some form of payment up front for their medical care. Because emergency physicians cannot do this, those who cannot pay often come to the emergency department for their medical care. The cost of caring for patients in the emergency department is great, and it often goes uncompensated. Many patients pay much less than the cost of their services, and frequently nothing at all.

Although emergency physicians strongly support our role as providers of the health care safety net, we do not understand why it has been legislated, in effect, that we work for free. I am not aware of any other segment of society that is required by Federal law to perform any work or service for which there is no reimbursement.

If we are required by law to do a job, adequate reimbursement should follow. Since it does not, the end result is that either other patients are charged more so that expenses can be met, or hospitals and doctors will lose so much revenue that hospitals will be forced to close and doctors will leave their practices. This is not idle speculation. Emergency departments and/or hospitals are closing at a steady rate in all areas of the country. When a hospital closes, everyone loses.

The unfunded mandate presents a threat to the health care safety net. We have already seen this across the nation in emergency department overcrowding that occurs in areas where patients have no other access to health care. Waiting times to see a doctor are not consistent with safe medical care, and many people have suffered from the delays and mistakes that are unavoidable in these circumstances. Worst of all is a patient arriving at a hospital with

a life-threatening emergency only to find the doors closed and no one there to help them.

Congress must address this problem and provide funding for essential services provided by emergency physicians. Congress must also require HCFA to recognize the true cost of providing emergency care.

Next I would like to address new regulations known as advance beneficiary notices. This creates a conflict of interest. HCFA regulations have become so complex that they have now created new regulations that are in violation of their old ones. New requirements by HCFA state that lab tests cannot be ordered without a diagnosis that justifies the test. However, in the emergency department, we are usually doing the test in order to obtain a diagnosis. Often there is no old chart to review and the patient is unable to give any history due to the seriousness of their medical condition.

In cases where there is no diagnosis prior to ordering the tests, HCFA how requires that a patient sign an ABN, or advance beneficiary notice, stating that they will be responsible for the charge. What is created here is a situation where physicians must either violate EMTALA by seeking insurance information and proof of ability to pay prior to completion of the medical screening, or we must violate HCFA requirements by ordering the tests without a diagnosis. It is simply not possible to satisfy HCFA requirements for lab tests in the emergency department without violating HCFA—or rather, EMTALA by asking for inappropriate information and/or delaying care.

In addition, HCFA's recently issued Medicare Hospital Outpatient Prospective Payment Systems Regulation requires the hospital outpatient department to provide a Medicare beneficiary, or an ABN, prior to delivery of services. This requirement conflicts with previous guidance issued by HCFA and the OIG. In November 1999, OIG and HCFA issued a special advisory bulletin on the patient anti-dumping statute. The OIG and HCFA stated that a hospital would violate EMTALA if it delayed a medical screening exam or necessary stabilizing treatment in order to prepare an ABN and obtain beneficiary signature. When it is not possible for doctors and hospitals to comply with one rule without violating another, we have a problem.

Thirdly, concerns regarding fraud and abuse. The complexity, contradiction and overall confusion HCFA has created make it almost impossible to avoid errors in coding and billing. However, the assumption is that inaccurate coding and billing is fraud. Some fraud and abuse may occur in medicine, just as in any segment of society.

We believe that in medicine, this pertains to a very small minority of doctors. The overwhelming majority are honest and very hard working. Physicians and their billing staffs are overwhelmed by the number and complexity of regulations, and even those who have a full-time job interpreting the rules do not know them all or agree on how to interpret them. With over 100,000 pages of Medicare rules and regulations, many of which are vague or contradictory, it is no wonder that mistakes are made. However, instead of educating physicians and their staffs, HCFA chooses to assume that

doctors are guilty of fraud and to actively pursue enforcement initiatives.

The truth is that the vast majority of doctors are honest and are struggling to understand and comply with an impossible system. The fear of audits, prosecution and fines of many thousands of dollars has had a devastating effect on physician morale. In addition, we have to cope with more patients, sicker patients, unnecessary paperwork, decreased time with our patients and decreased reimbursements. It should come as no surprise that physicians are leaving the practice of medicine.

In conclusion, government regulations have become so complex and burdensome that doctors can no longer practice medicine. All we want to do is take care of our patients. We want to function as physicians, not lawyers, accountants or lawmakers. As emergency physicians, we want to ensure access to emergency care for everyone who feels they have an emergency medical condition, and to secure the health care safety net. Rules and regulations that waste our time and interfere with our ability to care for our patients must be eliminated.

Adequate and fair reimbursement must be secured for services that we provide. And freedom from fear of prosecution for fraud and abuse must be ensured in the honest practice of medicine.

Thank you for holding these hearings and for the opportunity to submit this testimony for the record.

Chairman CHAMBLISS. Thank you very much, Dr. Reynolds. You raised some very interesting questions.

And now we will move on to Mr. Stauter.

[The prepared statement of Barbara J. Reynolds follows:]

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Emergency physicians provide a unique role in healthcare in the United States. America's Emergency Departments are the nation's healthcare safety net. Because of this unique role and the constraints inherent in our practice of Emergency Medicine, HCFA's burdensome rules and regulations have had a particularly detrimental effect. All of the regulations affecting physicians and many of those affecting hospitals impact the practice of Emergency Medicine. We will highlight three specific subsets of HCFA regulations that have significantly impacted Emergency physicians. These are the E/M Documentation Guidelines, EMTALA and accusations of Fraud and Abuse.

1. DOCUMENTATION GUIDELINES

A. Constant changing of regulations. HCFA has issued rules for physician documentation in 1995 and 1997. In addition, in 1999, the AMA's CPT editorial panel submitted another proposal to HCFA. The 1999 rules were never issued by HCFA because they were felt to be too complex. HCFA is now in the process of drafting yet another version of the E/M guidelines. Currently either the 1995 or 1997 guidelines are acceptable for billing purposes. Needless to say this constant uncertainty and changing of the rules is confusing for everyone. A considerable amount of time must be spent teaming the various rules and how to comply with them. The consequences of not complying are great. Not only can noncompliant charts be downcoded and thereby decrease physician and hospital reimbursement, but doctors and hospitals may be subject to significant fines and penalties as well. Doctors as well as hospitals and billing entities spend enormous amounts of time learning about how to comply with rules and regulations. The documentation guidelines and many other regulations create intense frustration for doctors for several reasons. First, the rules and regulations do not improve patient care and often detract from it by making doctors focus on overly burdensome charting requirements when they should be, and want to be focusing on caring for their patients. Second, the time spent learning the rules is often wasted since the rules change almost as soon as

they are learned. Third, the time spent learning to comply with these unnecessary regulations could be better spent learning about advances and updates in medical knowledge. The limited time that we have for continuing medical education is instead taken up with trying to learn about HCFA's latest rules and how to comply with them.

B. Interference in Doctor-Patient Relationship. Because documentation requirements must be met in order to charge the various levels of care, doctors are spending time counting elements of the chart instead of taking care of patients. For example, if a doctor cares for a patient with a life threatening medical problem such as a heart attack, he or she would normally charge a Level 5. However, in order to receive reimbursement at a Level 5, the Review of Systems section of the chart must show that 10 or more systems were discussed with the patient. . This means that the doctor must ask the patient a lot of unnecessary and irrelevant questions. For instance the doctor would need to inquire whether the patient was having problems with their skin, bones and joints, eyes and ears or mental health. For the patient with a serious medical condition such as a heart attack, these are usually irrelevant. However, should the doctor fail to do this, the chart will be downcoded to a level 4 or even a 3. This can amount to a decrease of several hundred dollars per patient. Needless to say, doctors will spend time meeting these unnecessary requirements when they could be with their patients. This wasting of both physician and patient time is especially problematic in the Emergency Department where we are under constant pressures to work quickly and often take care of critically ill or injured patients for whom every second counts. The last thing that should interfere with our efforts to care for our patients is unnecessary charting regulations. In "Time to Heal" author Kenneth Ludmerer, NM emphasizes that a key element in the decline of quality medical care in this country relates to the lack of time that physicians now have with their patients. Although physicians recognize the need to provide a medical record that is complete and justifies the medical complexity and decision making that has taken place, the current regulations do not provide for this and actually work against both the doctor and patient, especially in the Emergency Department.

C. Increased not decreased costs for patients. The complexity of the rules means that extra people must be hired by physicians and hospitals to insure compliance with the rules. These extra people include coders, billers and lawyers. The cost of employing these people is passed on to patients.

2. EMTALA

A. Unfunded mandate. As Emergency physicians, we are required by law to see all patients who present to the hospital for medical care. As directed by EMTALA, all patients must receive a medical screening exam and be stabilized. This HCFA obligation applies to all patients, not just Medicare beneficiaries. Emergency physicians provide this care without concern for the patient's insurance coverage or ability to pay. Because of this we have become the nation's healthcare safety net by providing care for patients who cannot afford to go anywhere else. Most doctors' offices require some form of payment "up front" for medical care. Because Emergency physicians do not do this, those who cannot pay often come to the ER for their medical care. The cost of caring for people in the Emergency Department is great and often goes uncompensated. Many patients pay much less than the cost of the services and frequently nothing at all. Although Emergency physicians strongly support our role as providers of the healthcare safety net, we do not understand why it has been legislated, in effect, that we work for free. I am not aware of any other segment of society that is required by Federal law to perform any work or service for which there is no reimbursement. If we are required by law to do a job, adequate reimbursement should follow. Since it does not, the end result is that either other patients are charged more so that expenses can be met or hospitals and doctors will lose so much revenue that the hospitals will be forced to close and doctors will leave their practices. This is not idle speculation. Emergency Departments and/or hospitals are closing at a steady rate in all areas of the country. When a hospital closes, everyone loses. The unfunded mandate presents a threat to the healthcare safety net. We have already seen this across the nation in the Emergency Department overcrowding that occurs in areas where patients have no other access to healthcare. Waiting times to see a doctor are not consistent with safe medical care and many people have suffered from the delays and mistakes that are unavoidable under these circumstances. Worst of all is a patient arriving at a hospital with a life-threatening emergency only to find the doors closed no one there to help them. Congress must address this problem and provide funding for the essential services

provided by emergency physicians. Congress musts also require HCFA to recognize the true costs of providing emergency care.

B. Advanced Beneficiary Notices create conflict of interest. HCFA regulations have become so complex that they have now created new regulations that are in violation of their old ones. New requirements by HCFA state that lab tests cannot be ordered without a diagnosis that justifies the test. However in the Emergency Department we are usually doing the test to obtain a diagnosis. Often there is no old chart to review and the patient is unable to give any history due to the seriousness of his medical condition. In cases where there is no diagnosis prior to ordering the tests, HCFA now requires that a patient sign an ABN stating that they will be responsible for the charge. What is created here is a situation where physicians must either violate EMTALA by seeking insurance information and proof of ability to pay prior to completion of medical screening or we must violate HCFA requirements by ordering tests without a diagnosis. It is simply not possible to satisfy HCFA requirements for lab tests in the Emergency Department without violating EMTALA by asking for inappropriate information and/or delaying care. In addition, HCFA's recently issued Medicare Hospital outpatient prospective payment system regulation requires hospital outpatient departments to provide a Medicare beneficiary and an ABN prior to delivery of services. This requirement conflicts with previous guidance issued by HCFA and the OIG. In a November 1999 OIG/HCFA "special advisory bulletin" on the patient antidumping statute, the OIG and HCFA stated that a hospital would violate EMTALA if it delayed a medical screening exam or necessary stabilizing treatment in order to prepare an ABN and obtain a beneficiary signature. When it is not possible for doctors and hospitals to comply with one rule without violating another, we have a problem.

3. FRAUD AND ABUSE

The complexity, contradictions and overall confusion HCFA has created make it almost impossible to avoid errors in coding and billing. However the assumption is made that inaccurate coding and billing is fraud. Some fraud and abuse may occur in medicine just as in any segment of society. We believe that in medicine, this pertains to a small minority of doctors. The overwhelming majority are honest and very hard working. Physicians and their billing staffs are overwhelmed by the number and complexity of the regulations and even those who have a full time job interpreting the rules do not know them all or agree with how to interpret them. With over 100,000 pages of Medicare rules and regulations, many of which are vague or contradictory, it is no wonder mistakes are made. However, instead of educating physicians and their staffs, HCFA chooses to assume doctors are guilty of fraud and to actively pursue enforcement initiatives. The truth is that the vast majority of doctors are honest and are struggling to understand and comply with an impossible system. The fear of audits, prosecution and fines of many thousands of dollars is having a devastating effect on physician morale. In addition we have to cope with more patients, sicker patients, unnecessary paper work, decreased time with our patients and decreased reimbursements. It should come as no surprise that physicians are leaving the practice of medicine.

CONCLUSION

In summary, Government regulations have become so complex and burdensome that doctors can no longer practice medicine. All we want to do is take care of our patients. We want to function as physicians, not lawyers, accountants, or lawmakers. As Emergency physicians we want to insure access to emergency care for anyone who feels they have an emergency medical condition and to secure the healthcare safety net. Rules and regulations that waste our time and interfere with our ability to care for patients must be eliminated. Adequate and fair reimbursement must be secured for the service we provide. Freedom from fear of prosecution for fraud and abuse must be insured in the honest practice of medicine.

Thank you for holding this hearing and for the opportunity to submit testimony for the record.

STATEMENT OF WILLIAM E. STAUTER, ADMINISTRATOR, SAYRE CHRISTIAN VILLAGE NURSING HOME, INC.

Mr. STAUTER. Chairman Chambliss, Dr. Fletcher, I thank you for the opportunity to be here today and to share in the panel.

I need to tell you a little bit about my perspective. We represent a nursing home here in Lexington. That is a little different from

hospitals and doctors, but we certainly tie together with hospitals and doctors. Sayre Christian Village Nursing Home, which is also known as Moberly Manor, is 109-bed church-related, non-profit facility. All of our beds are duly certified for Medicare and for Medicaid. We have been serving the community for 16 years as a part of a village known as Sayre Christian Village.

On campus with us are two apartment buildings for independent seniors. The first one is known as the Baunta Building, which is a HUD subsidized facility which provides direct rent payment for low-income seniors. Friendship Towers, the other building, is a market-rate apartment building. As a part of our campus arrangement, folks who live in those apartments have priority admission when they need to come to the nursing home for any reason.

Because we have a good organization, we have two apartment buildings with over 100 residents in each building, we have a good reputation in the community, and we have a good link with our supporting churches in the area, the independent Christian churches, we find ourselves in that interesting position where we are always full in the nursing home.

When hospitals have someone who needs nursing home placement, they call us to inquire, and we inform them often that we have no vacancy. So our facility is not full of high-care Medicare residents. Rather, we find ourselves serving about a 4-percent Medicare population in our facility. The bigger problem for us is the issue of Medicaid, which is also a HCFA program, but we have 75 Medicaid recipients, typically, in our facility, 70 percent of our population is Medicaid. Our residents, about 45 percent of them come from our sponsoring churches, about 35 percent of them come directly from our apartments. So there is that very good tie.

Two issues I would like to speak to today to are reimbursement, one, and the other being regulations. I am going to give you a rather simple overview of this. HCFA oversees these two programs, and these recent reductions we have heard about through the prospective payment system have also affected the nursing homes in a significant way.

In the past we were reimbursed on the basis of cost reports that we submitted annually. So we were submitting our costs and being reimbursed on that level. That system has changed now for nursing homes in that we are told what the rate will be to care for a particular resident, a particular kind of resident, based on their care needs, based on an average for the cost of that care in the past. Now that payment comes to the nursing home, and the nursing home pays for the ancillary services—such things as laboratory services, x-ray services, oxygen and physical therapy and pharmacy—and we keep what is left to cover our expenses. So we find ourselves often, in the Medicare arena at least, scrambling to cover our expenses because we are getting less and less money for our services.

We hear of individuals who cannot find placement in a nursing home because the nursing home has figured out they simply cannot afford to provide the kind of care that that person needs at that reimbursement level. An example would be a resident who needs to have regular kidney dialysis where they would be transported to a dialysis unit and then returned to the nursing home. The nursing

home is responsible for the ambulance transport back and forth, and for the payment of the dialysis unit. And the reimbursement for those services is such that there is virtually nothing left to cover the expenses of feeding that resident and providing the bed and so on.

The timing of the implementation of the prospective payment system also had an impact on us. Even though we only have 4 percent Medicare generally, when the system was put in place, we were moved really much too quickly from the old system—the computer system I am speaking of here, which worked—to a new system which had to be developed rather quickly because of HCFA deadlines. So when we went to the new system, Administar simply was not able to process claims. And we went for a period of about 5 months not being able to get any payment for any of our Medicare claims.

And then when the system finally was opened up to us, we had to process all of the 5-month-old claims and get them cleaned up before we could go to the next month and begin looking at the 4-month-old claims. So this slow-down in our reimbursement really did have an effect on us. We budget basically to break even, we do not budget to make any money. But when you do not receive all the revenue you have coming, it does have a major impact on your operation.

The most significant issue we face in the nursing home is the Medicaid reimbursement. We are delighted to say that the Medicaid program in Kentucky has been revamped and a new system of reimbursement was put in place as of January 1. But prior to that, the anticipated revenue, based on our expenses, basically was not happening. In the time when we were competing for nurse aides, basically—that is our most obvious level of employee—competing for nurse aides with many other nursing homes and hospitals, and fast-food restaurants and places like Wal-Mart and K-Mart who were paying more money than we could afford to pay, we had to raise rates of pay in order to maintain and attract staff to give decent care.

When we submitted our cost report to Medicaid, they said, your wages are way out of line, we cannot afford to pay that. We submitted the proper Schedule J in Kentucky, which is a request for an exceptional payment because of unusual circumstances. That was denied 2 years in a row.

The result of that is, for our Medicaid patients, we were reimbursed at a rate that was $23 per patient per day less than our actual cost. Under the new system, that is much improved. We are now only receiving $10 a day less than it costs for us to provide care for those Medicaid residents.

When you think about that, you think about per day per patient so you can understand what it means, but if you lose $23 a day per Medicaid patient, and you have 75 patients in the facility, you are losing $1,700 a day. You are losing $50,000 a month. You are losing $600,000 a year. Now we offset that in other ways. We charge private pay people more than their fair share, and the private pay people are actually subsidizing the Medicaid patients in our facility. Under the new system, where we only lose $10 a day—

and I emphasize only lose—we lose $750 a day now. We lose $22,000 a month, we lose $270,000 a year on these folks.

How do we cover this revenue shortfall? This is a question we asked. We have chosen in our facility not to cut back on patient care. We have not eliminated any staff, we have had to make cuts in our expenditures that have been costly and have affected our operation significantly, but I can state unequivocally that patient care in our facility has not suffered. We chose to borrow money to be able to make our expenses. And from about Christmastime 1998 through 1999, we borrowed right at $300,000 in order to pay our expenses.

The new Medicaid reimbursement system is helping us, we are breaking even, maybe even gaining a little bit, but nothing like what it is going to take to pay back $300,000. We are in the process right now of developing our budget for next year, and the question is, how much more do we have to charge our private pay folks to subsidize the Medicaid folks? Another way of stating that is, what would happen to the Medicaid folks if we could not accept them? There are a number of facilities who are not participants in the Medicare/Medicaid program. Their annual survey or annual licensure is a much more simplified process than the process we go through when we have Medicare/Medicaid certified beds. The inspection process is much more complicated.

There are folks who are saying, if we cannot break even on these folks, maybe we ought to get out of that business. And they are attempting to get out of the Medicaid/Medicare business. There are not enough private pay residents out there to keep all the nursing homes full, and even if we opted out of the system, present regulations say we cannot just put Medicaid folks out on the street. We have to find a place for them, and they have to be willing to go.

So the practical effect of that is, if we decided not to serve the Medicaid population, we have to serve the Medicaid population anyway until they no longer need nursing services, which in many cases means for the rest of their life.

We understand and appreciate the government's need to monitor expenses. We all need to do that. But when we cut back spending at the Federal level at the expense of nursing home facilities and others, we are just passing the problem to another area. We regularly hear of nursing homes filing for bankruptcy. The trade literature says that over 10 percent of the nursing homes in the United States are presently receiving bankruptcy protection. And the news on a regular basis reports additional facilities that are going into bankruptcy. That is a concern.

The second area I want to address is the area of regulations, and I am not going to go into a lot of detail, we have already heard a good bit of that.

But when I began working in long-term care some 17 years ago, I was surprised to hear that long-term medical care, as an industry, is the second-most regulated industry in the United States, second only to nuclear power plants. We were not saying that proudly, saying, look at us, wow, we have lots of regulations. We were complaining that we were burdened with this crushing weight of regulations.

And since that time, in response to our plea, we have received additional layer after layer after layer of regulations. These drive up our costs and make our administration of our facilities very complex, very difficult.

One option that is not realistically available to us is to simply cut back on the care we provide our residents. If we participate in the program, we must meet their standards. And the program that determines these standards also determines how much pay we will get, and they are saying we cannot afford to pay you what it costs you to operate because your facility's operation is so expensive.

We might look at the state surveyors who come in for our annual survey and certification licensure inspections. Surveyors are increasingly becoming more thorough, to the point of being nit-picky. One of the problems is that the Federal folks, the HCFA folks, have what they call look-behind surveys. If they come into our facility after the state surveyors have been here and find something, we are in trouble because we did not do it right, but the state surveyors are in trouble because they did not find it. So they do not leave any stones unturned.

The number of surveyors on survey teams gets more and more every year. The length of the stay in the facility gets longer every year, and the process has changed in its attitude. HCFA has put in place civil money penalties, fines when we do not do something just right, as an attempt to make everybody meet their standards. The process has clearly changed from a collaborative effort, where we are trying to provide good care and make sure that that is done, to a punitive program, an adversarial relationship, where we fear the surveyors coming in because they are going to do something bad that will hurt our operation.

We often complain about the record-keeping that we are required to maintain. One example might help you to understand that. As a part of the PPS program, I think all at once it came along, we now have to transmit a minimum data set on every resident on a regular cycle, when they are admitted, a few days after that, quarterly, any time there is a significant change, we have to submit a minimum data set report, an MDS report, by computer, electronically, to a central location where it is reviewed.

We were not doing that on a computer. Most facilities in Kentucky were not, so we had to find computer software that would do what we needed to do. We had to buy hardware to accomplish that, and then we had to earmark staff to make sure that it was done right. We were told very bluntly up front, your reimbursement is going to be based on what is in that report, so you want your report to be right.

So we designated two RNs to run this system, and we found out rather quickly that that will not work because RNs have days off, there are holidays, there are vacations, there are times when they were sick, so we have to have backup staff trained to fill in for them when they are not there.

Do you have a guess what an RN costs for a year? Two RNs and backup RNs, plus the computers plus the room to put the computer in and all the work that they do, that is an additional layer of expense to us. It did not eliminate anything, we still have to do all the other things, we keep the charts at the nurse's stations, keep

all the medical records up to date there, but we have now a duplicate system tied in to the computer.

And it is interesting that, if one of those codes that is sent in—a code might be, for instance, that a one says they walk without assistance, two might mean they need some help, three might mean they cannot walk at all. Those codes, when they are put in the record, just because of the volume of those records, you can make a mistake. The attitude coming down from HCFA is, any mistake must be fraudulent, not just an honest mistake, and the attitude is something that I am greatly concerned about.

Additionally, the MDS system says, tell us everything that is going on in the life of every person in your facility, so that before the surveyors come out they know everybody who has decubitus ulcers, they know everybody who has had excessive weight loss, they get all these reports computerized and sorted out, they come in our facility and go right to the room of the person who has had a problem. It seems to be that they are just using our own information against us to punish us for reporting what is going on in our facility for reimbursement.

Some facilities we talked about are opting out of the program. One of the reasons why I think people might be opting out, either facilities out of the program or individuals opting out of the business and doing something else for a living is the attitude that is increasingly seen, at least coming out of Washington, as hostile to nursing homes.

A recent HCFA study was reported in an article in the Herald Leader here in Lexington. It was an Associated Press article, so the Herald Leader did not write it, and I am not criticizing Herald Leader in any way. The article states that, many of the nation's nursing homes are so understaffed, they may be endangering the welfare of the patients. The headline on the article was a quote from Senator Chuck Grasley from Iowa, and it simply said, Nursing Home Woes Turn Stomach. And they were describing an incident where a resident had skin break-downs and weigh loss and some major problems.

And they were saying basically all nursing homes are like that. They are full of people who are in it to defraud the government, they do not care about giving decent care. I want to say that that is not true. Those of us who are in this business care very deeply for our patients. We want to care for our patients. One of the problems is the regulations drive our costs up to the point where we do not make enough money to cover our costs, and we need to address that issue.

State surveyors used to be called consultants. I remember the first time, brand-new in a nursing home, I met with the survey team, and I called them inspectors. And they quickly told me they were not inspectors, I could call them surveyors, I could call them consultants. We are in this together, we are here to help you. One of the three greatest lies, I guess, I am from the government I am here to help you. [Laughter.]

The surveyors, the consultants worked with us to help us solve problems. These folks go from facility to facility to facility. They know what is going on. And if we have a problem and we have not

figured out how to do it, they can say, ABC Nursing Home did this or that, and that really worked, you might try that.

I remember clearly the day the team leader of a survey team said to me, we are no longer consultants. We are no longer here to help you, we are here to find deficiencies, we are here to write citations. If you need help, hire a consultant.

I just think that change has really affected the nursing home operation. Quality care for our residents ought to be our common goal and we ought to work together for that.

The implications, I think, of all of this are ominous to me. The pendulum swings, we know that. Something has changed, the pendulum swings, it will come back. And this pendulum will come back. My question is, how many nursing homes will go out of business before it comes back to a more reasonable place? Let us remember that any changes that are made at the Federal level have an impact on lots and lots and lots of people all across the country. They affect our industry, our ability to survive first, our ability to maintain adequate staffing, our ability to provide good patient care. I hope we can work together to provide the resources and achieve a balance between the quality of care we can provide and the cost of providing that care so that our organizations can become stable and solid and able to meet the needs of our residents on a long-term basis.

Thank you.

Chairman CHAMBLISS. Thank you very much, Mr. Stauter. And we will move on to Mr. House.

[The prepared statement of William E. Stauter follows:]

PREPARED STATEMENT OF WILLIAM E. STAUTER, ADMINISTRATOR, SAYRE CHRISTIAN VILLAGE NURSING HOME, INC.

PATIENT CARE ISSUES AND HCFA

Sayre Christian Village Nursing Home, Inc., also known as Moberly Manor, is a 109 bed, church-related not-for-profit facility. All our beds are dually certified for Medicare and Medicaid. We have been serving the community for over sixteen years as part of a village operated by our parent organization, Christian Benevolent Outreach, Inc. This village is C.B.O.'s only operation. Sayre Christian Village also includes a HUD subsidized senior apartment building (The Baunta Building) and a Market rate senior apartment building (Friendship Towers). Over one hundred residents live in each of these buildings.

About forty-five percent (45 percent) of our nursing home residents are members of Independent Christian Churches, our sponsoring church group. Some thirty-five percent (35 percent) of our nursing home residents lived in our apartments prior to their admission to the nursing home. In accepting new admissions, we give priority to our apartment residents and then to Christian Church members.

Because of the apartment buildings on campus, our close ties with our sponsoring churches, and our excellent reputation in the community, we maintain nearly 100 percent occupancy. When hospitals inquire about admitting higher care patients, we often cannot accept them because no bed is available. Thus, Medicare residents represent only 4 percent (4 percent) or less of our nursing home population. On the other hand, our census includes some seventy-five (75) Medicaid recipients. They make up about seventy percent (70 percent) of our total population.

HCFA activities have a strong impact on our operations. They can be divided into two major categories.

I. REIMBURSEMENT

HCFA (Health Care Financing Administration) is the Federal agency which oversees two major programs, Medicare and Medicaid. These two programs represent a significant portion of the revenue to nursing homes.

Recent reductions in Medicare payments have taken their toll on the financial operation of all nursing homes. A major change was the recently implemented Prospective Payment System. In the past, we were reimbursed for actual costs based on reports filed by each facility annually. Under PPS, the nursing home now receives payment for the total care of the patient based on past average costs. We pay for the "outside" services such as labs, x-ray, oxygen, therapy, and pharmacy and keep what is left to cover our expenses. In many instances, this results in the nursing home ending up with less money to cover its expenses. We hear of individuals who cannot find placement because nursing facilities cannot afford to provide the care. Kidney Dialysis is a prime example of a long term procedure where the nursing home will lose money.

The timing of the implementation of the PPS system also caused us some financial hardship. We were moved too quickly from the "old" computer system which worked, to a "new" system which did not work initially. Our reimbursement for Medicare residents was delayed as much as 5 months. This was a temporary problem, but it did have significant impact on our operation. As a facility, we budget to "break even" financially. Such delays are painful.

The most significant financial issue we face is Medicaid reimbursement. Because we are a benevolent organization, we desire to provide services to people in our community regardless of their ability to pay. Because we serve a HUD facility where residents have low income, we may have higher than normal Medicaid usage in our facility.

We have seen an improvement in the Medicaid system in Kentucky with the implementation of a new system as of January 1, 2000. We are grateful that the industry was able to have significant input in the development process. We can now report that we receive only $10.00 per day less than our actual costs to care for a Medicaid resident. Prior to the implementation of the new system, we were losing as much as $23.00 per day per resident.

We talk about Per Patient Day revenues and expenses in order to understand what is happening. We must recognize that to lose $23.00 per day for seventy-five residents is to lose $1,700.00 day, $50,000.00 a month, $600,000.00 a year. When our reimbursement is improved to cause us to lose "only" 10.00 per day, we understand that we now lose "only" $750.00 day, $22, 000.00 a month, $270,000.00 a year to care for indigent residents.

How do we cover this revenue shortfall? We have chosen not to cut back on care provided to our residents. I can state unequivocally that resident care has not suffered in our nursing home. We chose, instead, to borrow $300,000.00 during 1999 to stay in operation. We are now preparing our budget for next year. Will we charge our private pay residents more than their fair share to cover the shortfall from our Medicaid population? Will we be able to raise additional support from our constituency? It should be obvious to all that we cannot continue to lose money every month and stay in business.

The Boren Amendment (1980) guaranteed reasonable and adequate Medicaid reimbursements to efficiently and economically operated facilities. Unfortunately, it was repealed in 1997. I strongly urge its reinstatement.

We understand and appreciate that the government has a major concern with their expenditures. Cutting back on spending sounds good until we realize that nursing homes across the country now must do their jobs while receiving significantly less revenue. We regularly hear reports of nursing homes filing for bankruptcy. Nationally, about 10 percent (10 percent) of all nursing homes have filed and new reports continue to arrive.

II. REGULATIONS

When I began working in long term care some seventeen years ago, I was surprised to learn that we are the second most regulated industry in the country, following nuclear power plants. Since that time, the regulations have regularly been increased. Layers upon layers of new regulations drive up our costs and make our operations very complex and difficult to administer.

One option which is not realistically available to us is to cut back on the care we provide our residents. It is paradoxical that, while our funding is being reduced, we are being held to ever higher standards. In order to participate in the Medicare and Medicaid programs, annual certification surveys are conducted by the state. The state surveyors are themselves subject to Federal look-behind surveys. The threat of backlash from the Federal level causes state surveyors to be extremely thorough in their inspections. The number of inspectors on each survey team is increasing, and the number of days spent in facilities is also greater over time. The institution

and expansion of fines for deficiencies is used to assure compliance with regulations. The process has clearly changed from collaborative to punitive.

We often complain of the burden of record keeping in long term care. An example may help you to understand our plight. Not long ago, we were required to begin transmitting resident data (MDS—Minimum Data Set) by computer to a central agency where evaluation and monitoring could be done. Our reimbursement is based on these transmittals, so accuracy is extremely important. In order for us to comply with this requirement, we had to make a major study to find computer software that would meet our needs, then make a significant purchase of computer hardware. To operate the system, we assigned two full time Registered Nurses to learn the system and to operate it. Additional staff of this quality (and cost) have been trained to cover for vacations and illnesses. This extra program did not eliminate any paperwork, but it certainly added to our operating costs.

Additionally, the MDS system is a massive Federal program to identify what is going on in each facility. Information from this system is the starting point for future surveys, giving them very specific information about "problems" within the facility which must be addressed.

Some facilities who have been participants in Medicare and Medicaid are opting out of those programs. Nursing homes who do not to participate in these programs are inspected annually for state licensure, but the survey process for them is much simpler. Even when facilities chose to opt out of Medicaid, they find it difficult to discharge Medicaid residents if they desire to stay. So, they provide care at less than their costs for an extended period of time. We must ask what would become of the indigent if many facilities decided to opt out of Medicaid?

The attitude coming from Washington seems to be increasingly hostile toward nursing homes. A recent HCFA study, according to a newspaper report in the Lexington Herald-Leader, states that "many of the nation's nursing homes are so understaffed they may be endangering the welfare of the patients." The lead for the article states "Nursing homes' woes 'turn stomach'", quoting Sen. Chuck Grassley, R-Iowa.

State surveyors used to serve as consultants. They worked together with nursing homes to identify and solve problems. I remember clearly the day a survey team leader told us they were no longer able to help us solve problems. They were in our facility simply to identify problems and issue citations. If we needed help, we could hire consultants. We believed then and now that the state surveyors are in a excellent position to offer significant help. Quality resident care should be our common goal.

IMPLICATIONS

The implications are ominous. Those of us who really want to provide quality care for our nursing home residents understand that the pendulum swings. Sometimes it swings too far, but it always returns. Let us remember that any changes at the Federal level can have significant impact on the industry and our ability to survive, to maintain adequate staffing and to provide good patient care. May we work together to achieve a balance between quality of care and costs of operation so we can maintain solid and stable organizations. Only then can we serve our population well.

STATEMENT OF LENNIE G. HOUSE, CHIEF EXECUTIVE OFFICER, NURSES REGISTRY AND HOME HEALTH

Mr. HOUSE. Mr. Chairman, Dr. Fletcher, I would like to thank you very much for allowing me to speak on my firm, company and industry.

We have been through many, many changes since the inception of the Balanced Budget Act of 1997. From the change of a cost-based system to a for beneficiary limit cost system, home care saw 40 percent of their agencies close the doors. Prior to the implementation of the Balanced Budget Act, home health expenditures were budgeted for 5 years at $136.6 billion. When the Balanced Budget Act was presented to Congress, the goal was to save 16.1 billion. HCFA now estimates that the 5-year spending will reach only 58.4 billion. This is a cut of 78.2 billion for a percentage of 57.2 percent to the originally-presented budget. This is a far cry from the prom-

ised reduction of 16.1 billion. And yet our biggest challenge still lays before us.

The prospective payment system, known as PPS, is scheduled to take effect October 1, 2000. As we have been anxious to move into this new payment system, the fact remains that the final PPS regulations have caused a great deal of concern to us and to our beneficiaries. HCFA had the opportunity to transition the PPS system in over a 4-year period. Instead, they decided to transition all agencies in over the same period which begins October 1, 2000.

As of July 3rd, the final regulations have been published. This allows agencies 2 months to initiate software, billing, clinical, financial and other changes to meet the needs and demands of the PPS system. This is literally an impossible task, and will probably be the demise of many, many agencies.

The PPS plan allows for projected expenditures for this year of 11.3 billion. Because of the influx of baby-boomers needing home health care, projected expenditures should not be reduced from the proposed amount of 17 billion. The PPS plan also calls for a 15 percent cut to home health expenditures scheduled in the fiscal year for 2001. Combined with a low reimbursement payment rate of 60 percent for initial claims and a 40 percent catch-up at the end of the 60-day episodic period, this, quite frankly, as a cost—cash flow is practically impossible.

All of the above is cause for alarm. The PPS plan also does not give agencies any administrative or judicial review with a physical intermediary on PPS issues. And to my knowledge, this is a first. We have no rights. Providers should have the right to appeal, we should have the right to challenge the payments, reimbursement and denial of care of our beneficiaries.

Surely Congress did not intend for HCFA to cut 57 percent just for home care providers in the Balanced Budget Act of 1997 when the reduction was only intended to be 11 percent over 5 years. If our concerns are not heard, our patients will not be able to receive home care benefits due to home health agencies closing their door and inadequate payment for high-acuity patients. Our elderly population, our parents, our grandparents will be forced to leave their homes and obtain health care from hospitals, nursing homes and other more costly alternatives to home care. This threatens to destroy the infrastructure of home care, which is the only barrier to the high cost of institutional care.

I ask that you restore funding to the home health benefit for PPS and to eliminate the bundling of services or supplies, the 15 percent additional cut that is scheduled for the fiscal year of 2001, and set an episodic reimbursement rate of 80 percent for the initial with a subsequent claim being paid at a rate of 20 percent. I think with your help, your understanding and support, home health agencies might be able to survive in this new environment, but I very seriously urge you to take into consideration the unbelievable obstacles that we have. To go back and summarize, we have 2 months to meet the demands of PPS.

As recently as this morning, before I came to testify at this hearing, we are still struggling to find a computer system that will allow us to bill and keep track of our receivables. Because of the nuances in the payment, there is no software out there at this

time. I have tried every major vendor from Cimeon Central. We have a outside vendor that we bill through sometimes called CDP. They cannot supply it. So we are literally at a loss to bill an account for our receivables. Two months is not enough time for a home health agency to prepare what it took HCFA 3 years to put the plan together.

Thank you very much.

Chairman CHAMBLISS. Thank you very much, Mr. House. And I am told by technicians that we are getting a little feedback on the microphones so if you all will be sure and pull it closer to your mouth as you speak, I think we will avoid that feedback.

We will move on now to Mr. Hudson.

[The prepared statement of Lennie G. House follows:]

PREPARED STATEMENT OF LENNIE G. HOUSE, CHIEF EXECUTIVE OFFICER, NURSES REGISTRY AND HOME HEALTH

Thank you for allowing me to speak on behalf of Nurses Registry and Home Health and the home health industry. We have been through many changes since the inception of the Balanced Budget Act (BBA) of 1997. From the change of a cost based system to a per beneficiary limit cost system, home care saw 40 percent of agencies close doors. Prior to the implementation of the BBA, home health expenditures were budgeted for 5 years at $136.6 billion. When the BBA was presented to Congress, the goal was to save $16.1 billion. HCFA now estimates that the 5-year spending will only reach $58.4 billion. This is a cut of $78.2 billion or a cut of 57.2 percent of the original budget. This is a far cry from the promised reduction of $16.1 billion.

And yet our biggest challenge still lies before us. For you see, the Prospective Payment System (PPS) is scheduled to take effect October 1, 2000. As we have been anxious to move into this new payment system, the fact remains that the final PPS Regulations have caused a great deal of concern to us and to our beneficiaries. HCFA had the opportunity to transition PPS in over 4 years. Instead they decided to transition ALL agencies in over the same period of time (October 1, 2000). As of July 3, the final regulations have been published. This only allows agencies 2 months to initiate software, billing, clinical and financial changes for PPS. This is an impossible task and will be the demise of some agencies.

The PPS plan allowed for projected expenditures for this year of $11.3 billion. Because of the influx of baby boomers needing home health, projected expenditures should not be reduced from the proposed amount of $17 billion. The PPS plan also calls for a 15 percent cut to home health expenditures scheduled in fiscal year 2001, a low reimbursement payment rate of 60 percent for initial claims and 40 percent at the end of 60 days and then 50 percent for all subsequent claims. PPS also includes the bundling of non-routine medical supplies from Part B suppliers. All of the above is cause for alarm. The PPS Plan also does not give agencies any administrative or judicial review with the fiscal Intermediary on PPS issues. Providers should have the right to appeal and challenge the payment, reimbursement and denial of care of the beneficiaries.

Surely, Congress did not intend for HCFA to cut 57 percent just from home care providers in the Balanced Budget Act of 1997 when the reduction was only supposed to be 11 percent over 5 years.

If our concerns are not heard, our patients will not able to receive home care benefits due to home health agencies closing and inadequate payment for high acuity patients. Our elderly population, our parents, our grandparents will be forced to leave their home and obtain healthcare from hospitals and nursing homes, a much more costly alternative to home care. This threatens to destroy the infrastructure of home health, which is the barrier to the high cost of institutional care.

I ask that you restore funding to the home health benefit for PPS and to eliminate bundling of supplies, the 15 percent additional cut scheduled for Fiscal year 2001 and set an episode reimbursement rate of 80 percent for initial and subsequent claims with 20 percent at the end of the episode.

I believe with your help, we can care for our elderly in their home for many more years to come. Thank you very much.

STATEMENT OF ROBERT J. HUDSON, CHIEF FINANCIAL OFFICER, PATTIE A. CLAY REGIONAL MEDICAL CENTER

Mr. HUDSON. Thank you, Mr. Chairman and Dr. Fletcher, for the opportunity to address you regarding the problems with administering the delivery of health care under Medicare and other regulations.

It is estimated that hospitals are subject to 132,000 pages of regulations. I do not think you have heard that today yet, but I will tell you that. Hospitals and providers have to apply these rules and regulations to the 200,000 claims that are submitted daily, and on an annual basis, that amounts to 72 million claims per year. In 1997, close to 12 million Medicare beneficiaries received acute care services, and for hospitals to be reimbursed for these services, they must follow the maze known as the Medicare inpatient hospital billing system.

Complying with this Medicare billing maze is no small task, as you can imagine. It requires a specialized computer system that needs to be purchased, it has to be maintained, and you have to have the personnel that is knowledgeable in the system, as well as the regulations. Matter of fact, I estimate on Pattie A. Clay's part that we spend, on an annual basis, about a little less than $100,000 on the system, system maintenance and training of personnel, just on the inpatient side.

The Health Care Finance Administration has contracted with 43 Medicare Part A fiscal intermediaries, and 28 Medicare Part B. Needless to say, the consistency in instructions can vary from intermediary to intermediary, and a good example in this point is the delegation of the medical necessities to the 43 local fiscal intermediaries for the Part A. The vehicle that is used is the local medical review policy, and a good example of it is would be that there could be something that is diagnostically performed in Ohio that is covered and something in Kentucky that is not covered, or vice versa. And to make it a little bit more difficult, physicians do not work under the same policy. So they could be doing something in their office that is medically necessary but would be not medically necessary in the hospital, or vice versa again.

Pattie A. Clay currently generates about 18,000 in Medicare charges each month that do not meet the Kentucky medical necessity criteria. Again, these tests could be medically necessary outside Kentucky. For the most part, these charges are generated in the emergency room or on observation patients. And as you previously heard, the ABNs just cannot be done in the emergency rooms at all. Yes, we could take the time to train the physicians on the medical necessity, but personally I would rather have the physicians keep up on their medical knowledge instead of the reimbursement knowledge. So we totally ignore—we do not ignore it, but we inform them, and—but we do not ride them related to that. They have to treat the patients.

Pattie A. Clay also has a committee that works on and reviews medical necessity. I serve on that committee. One of the things that we have to balance is medical necessity and the standard of care. For example, a very healthy patient may need a surgical operation. However, the person may have smoked for 40 years. The standard of care would be that the patient would have a chest x-

ray and an EKG. This is not medically necessary. If something happened during the surgery, we would definitely have a legal situation on our hands.

In addition to Medicare regulations, hospitals have to contend with Medicaid, OSHA, EPA, Center for Disease Control, IRS and there is 29 other organizations that issue some type of rules, regulation or instructions to the hospitals. It is very, very easy to imagine the conflicts and the confusion in the various rules.

Just last week, on August 1, HCFA implemented the outpatient prospective payment system. To do so, they used a patchwork of 13 different payment formulas. Medicare outpatient reimbursement is complicated and administratively costly for hospitals and, I would think, for the Medicare program as well. The coding requirements far exceed the inpatient prospective payment system known as DRG. And matter of fact, it is at least three times as complicated as the inpatient side. And we are talking about, on the inpatient side at Pattie A. Clay, the bill is maybe let us say $6,000 on the average, outpatient bill would be less than $500. Yet it is going to take three times the administrative hassle to code that chart. It is unbelievable.

Again, this requires a special computer system, the inpatient side would not work with it so you have to maintain it, you have to train your personnel.

Without getting into the detailed complexities of the outpatient prospective payment, I would like to point out about three things. One, the huge benefits for the APCs and implementing them was that it was going to benefit the Medicare beneficiaries in their copayments. That is a partially true statement, but in the State of Kentucky, it is going to hurt the Medicare beneficiaries. The copayment is based on a national average of charges. Since Kentucky is a low-charge State versus the State of New York, that is going to end up that the copayments are going to be larger for Kentucky versus the person up in New York, which also places greater risk on the facility, because now we have to collect that copayment.

APC system delays, and I am not talking about the delay on HCFA. To put the system in, it is really—the vendors that you have to contract with to obtain the software had a very, very difficult time. The system went in August 1, and yet the software vendor—and we are talking the primary or one of the primary software vendors—could not deliver the software to the hospitals until the fourth week of July. No training, here is the diskette, install it, we will catch you as soon as we can.

HCFA cannot process a claim until August the 14th, yet we have to, as of August 1, start the process. August 14th, they do not know if the system will work or not, yet we are subject to submit a perfect claim at that particular point in time.

Thirdly, the fiscal intermediaries do not receive adequate training, at least that is what it appears to me. I asked for a number of pieces of information weeks ago, and believe it or not, the day it ended up on my desk was August 1, dated July 26th. So the trainers who we count on were not even trained properly associated with it.

The other thing, on the heels of the outpatient prospective payment, we have the upcoming provisions to comply with the Health

Insurance Portability and Accountability Act. And the estimates I have on the cost of implementing that program nationally is, over a 5-year period of time, is 3.8 billion to a large sum of $43 billion. So we do have that cost coming in down the road, too.

Complying with the growing number of rules and regulation has a high administrative price tag. And HCFA's most recent comparison of wages, medical records or health information and administration cost centers showed the largest increases from 1996 to 1997. Pattie A. Clay takes corporate compliance seriously, as does the industry. To do so has a price tag.

For example, to validate coding on a patient's chart, we have to contract with somebody to do that. We cannot do it internally. But also you have to educate employees on the importance of corporate compliance and what to do if an issue arises. And again, you have specialized programs that are used to perform certain edits to protect you from fraudulently billing or fraudulently submitted a claim.

Pattie A. Clay, as well as other hospitals, their objective is to provide high-quality care to the patients. That is our first goal. Only a small percentage of the vast amount of regulations contribute to that effort. Simply the rest really drains from the resources. In 1997, the Balanced Budget Act cut $116 billion from the 1999 to 2002 projected Medicare spending, according to the Congressional Budget Office. It was estimated at that time 50 billion of it would come the hospital inpatient side on Medicare, and about 10 billion coming from the Medicaid side.

The recent projections are that the cuts are not 116 billion, but they are 232 billion. And on the hospital side alone, that the savings about way over $75 billion. I would suggest that at least returning back the excess over the intended cuts. The impact on the financial cuts on Pattie A. Clay is what I assume to be similar to other facilities. Specifically new programs are placed on hold, old programs are evaluated and re-evaluated. Replacement of equipment, both clinical and non-clinical, is delayed, and system procedures are reviewed and modified. Not all of these are necessarily bad, but some of them do have long-range impact.

It is really funny when you are evaluating old programs, that kind of a thing. Pattie A. Clay has a pulmonary rehab program, which is used pretty much by the Medicare population. We also have a home—we also have a nurse midwife practice that really treats the indigent patients. When we implemented the pulmonary rehab department, the selling point was it was going to keep people out of the hospital. You were taking the COPD patient that basically you could count on being in the hospital four times a year, it would keep them out of the hospital. And I thought, yeah, yeah, that really will work. Three years down the fact, it does work. The problem of it is, we lose on that program under reimbursement. And if they were on the inpatient side, we would make money off of it. But the real thing of it is, if you are providing the community service and promoting health, you need the pulmonary rehab.

On the nurse midwifery practice, there is absolutely no way to make money. We established that 10 years ago. We have nipped it back best we possibly can, but if you want to provide prenatal care to the ladies, you have to have that program, and that is in con-

junction with the Health Department. But we lose money on it. And the only way to make it up, I guess, and the other thing that you do is you form a foundation hopefully to get charitable contributions to offset some of it.

Another aspect of the BBA is the payment updates are below the market index. This occurs at the time when the cost of prescription drugs have increased dramatically. As a matter of fact, the average cost of a new drug is $71, more than twice the average price for previously existing drugs. It also occurs at a time when the Food and Drug Administration will soon approve new blood screening techniques to make our blood supply safer. However, this will increase the cost of a pint of blood by $40 or $50.

I, along with the other hospitals, request that the BBA relief package include the following top priorities, one for Medicare and one for Medicaid. Under the Medicaid program, strongly support the repeal of the Medicare inpatient update reductions set for fiscal year 2001 and 2002. Providing hospitals with a full inflation update is very, very essential.

On the Medicaid side, we strongly support protecting Federal disproportionate share allotments by freezing reductions at the fiscal year 2000 level, and providing for growth in both fiscal year 2001 and 2002. And that payment is very essential for the nation's growing uninsured population.

I would be remiss, I guess, speaking of DSH, if I did not mention that I am one of the two hospitals here related to the appeal related to—this is on the Federal side—the disproportionate share payment. It occurred the same time as Clark County. We are appealing together, and the complexities of the rules, it seems so ridiculous that you have to appeal what is a bed, you know. It should not be that complicated, it should be cut and dried.

To us at Pattie A. Clay, that meant $5.2 million. And it is very, very interesting it happened to us, what, 3 years ago, and we are just getting phone calls from the State of Washington where they are being impacted on that interpretation. So the rules have not been applied consistently across the country at all.

The two initiatives I mentioned earlier, the restoring of the updates and protecting the disproportionate share allotments, represent our top priorities. It is not an all-inclusive list. We urge you as you begin your BBA relief package, that you do so solely from funding from the surplus. However—and hopefully we will not receive any more lower payment.

We agree that the health care industry should be regulated, but there should be coordination between agencies. We should not have rules that appear to be issued in vacuums with no regard to fiscal consequences or compliance.

I know I can speak for the hospitals across the State, as these apply to both large and small. Hospitals are ready and willing to continue to work with HCFA and other agencies to improve the way rules and regulations are developed and implemented. We pledge to do so, not just make the regulatory system better, but make the system better for our patients and community.

I thank the committee for allowing me to talk and I will be glad to answer any questions.

Chairman CHAMBLISS. Thank you very much, Mr. Hudson, and we will move on to our final witness, Dr. Shelton.

STATEMENT OF CHARLES SHELTON, LEXINGTON PSYCHIATRIC GROUP

Dr. SHELTON. OK. Thank you so much. I appreciate the both of you allowing me to testify at this hearing.

As a psychiatrist in private practice, I would like to take a few minutes to discuss my views on the impact of regulation on delivery of psychiatric services to Medicare recipients. Now I am going to break it up into three pertinent issues: first being parity; second being prevention; and then the third being the inclusion of a drug benefit.

Now parity, we have all heard that mental illness does not receive the parity that other medical illnesses receive. Two issues I see that are significant regarding the parity issue include patient accessibility. Patients that are not able to access care are, in essence, going to have a perpetuation of their illness.

The other thing that the limited access brings about is enhancement of the stigma that is already attached to psychiatric illness. It is a considerable problem. It is not uncommon for me to hear of individuals who cannot access psychiatric care. Just the other day, one of my neighbors who lives three houses down from me came seeking some advice from me. She had been separated from her husband, she cannot find a provider on her list. She is asking me who she can see and who are the adequate providers, or who would be good for her to see?

This is concerning. This causes frustration for the afflicted individual, and as a result lends toward an exacerbation of their illness. When an individual cannot get in to see a psychiatric provider for three to 4 months, or they cannot find a provider in and around their locality, it is very frustrating.

Now granted, primary care physicians can take care of many of these illnesses, they do an excellent job. But there are approximately a third of these patients who are resistant and who are refractory to using one medication, and as a result fall out of the auspices of being adequately treated under the primary care physician.

The second issue involves reimbursement. Now if we take into account the 80 percent allowable that all physicians must agree to in terms of reimbursement for Medicare, keep in mind that psychiatrists are only reimbursed at 62.5 percent of that 80 percent allowable. This is also a significant problem. It is causing concerns for me because I am seeing a number of things happen as a result of the lack of reimbursement.

First and foremost, we are seeing numbers of psychiatrists who are opting to drop out of the Medicare program. If you take into account the reimbursement, in addition to the excessive documentation that is required to offset the potential for fraud, it is not a cost-effective endeavor for many psychiatrists.

The second thing that is happening is many psychiatrists are opting to get out of the inpatient venue. What is happening is we are seeing more and more psychiatrists opting not to do inpatient work. Let me give you an example within this own institution what has happened in terms of our inpatient psychiatrists. Six years ago

when I began practice here, we had 15 psychiatrists on staff. OK, we all took call and it averaged out to approximately two nights of call per month. Now that was do-able, that was something that we could sustain, we could go ahead and care for the indigent population and not have that adversely affect our patient practices, or our private practices, that is.

Now over the course of time, one by one, psychiatrists began leaving and they canceled their inpatient privileges. We got down to a situation with four psychiatrists that were taking call. So I am now on call for this institution one in four nights, and it is very difficult for us to take care of these individuals, especially when we have a rate, an indigent rate here in this hospital that may border 30 percent or greater for those that are self-pay. So reimbursement is leading to individuals—and also the lack of parity that reimbursement falls under, it is leading to individuals with psychiatric illnesses not getting appropriate care.

The other concern that I see is prospective medical students. When they go to make a career choice, many medical students are bypassing psychiatry as a career. They see the lack of parity, they see the lack of reimbursement, and they choose to go into other areas.

What I am seeing—OK, what my concern as a psychiatrist is that we are going to see more and more prevalence and incidence of psychiatric illness and less and less of an ability to treat these illnesses. So unless something is done, psychiatric illness is going to become epidemic at some point. The lack of parity lends toward increased incidence and prevalence of psychiatric illness which, in turn, lends toward increase in morbidity and mortality of not only psychiatric illness but also of physical illness, and also lends toward increased costs.

Now if we look at my role as a psychiatrist here in this institution, I am admitting patients, especially Medicare patients whom are older, whom are medically compromised and whom also have psychiatric illness. So I am admitting patients to this institution, and I am making complex medical decisions regarding these patients. Not only do I have to assess them from a psychiatric standpoint, I also have to have a good grasp of their medical problems. As an attending physician on our psychiatric unit here, I have got to be able to treat their medical problems. So in essence, I feel that, as a psychiatrist, I am making medical decisions that are, in essence, no different from my internal medicine colleagues. Yet the reimbursement to psychiatrists remains less.

Let me give you another example. ECT, or electro-convulsive therapy is a treatment—is the only procedure that psychiatrists do nowadays. Many of you may not be aware, but it is very effective, it is our—in terms of treating depression, it is the most efficacious treatment that we have. As with all procedures, Medicare has taken the lead in thrusting procedures to be done on an outpatient basis. This mandate precludes many of my patients from getting ECT because ECT is done in a series. We do not just do one treatment, we do treatments Monday, Wednesday and Friday, typically, and we do anywhere from five to six treatments in a series.

So if I have a patient from eastern Kentucky who requires ECT, and I tell them that they have to do the ECT on an outpatient

basis, are they going to be able to come to Lexington and provide themselves with shelter and food while they do the treatments on an outpatient basis? Not many of them can do it. And as a result, we have seen one of our most efficacious treatments, the frequency that we are doing it is going down.

Let me give you another example as to what we are seeing in terms of reimbursement for this outpatient ECT. If I have a patient that comes in for outpatient ECT, I have got to do a history, I have got to know the patient, I have got to do a physical examination on them. The psychiatrist—and let me make this clear—the psychiatrist, not the anesthesiologist, makes a determination as to which drugs and what specific dosages are used in order to put the patient to sleep for the treatment.

I then have to go back and do the treatment, and I have to take a significant amount of risk. Now ECT basically causes quite a bit of strain on the cardiovascular system, or on the heart and lungs. And so if you have a medically compromised patient, you take quite a bit of risk. So for one outpatient ECT, I have about 1 hour to an hour and a half of time involved, plus a significant amount of risk and liability.

Now what does Medicare reimburse me for that time as a psychiatrist? Anyone have an idea? OK. I am reimbursed at the rate of about $41.42 for that time. Now the anesthesiologist, on the other hand, who puts the patient to sleep—and keep in mind, I make the recommendations for the doses of the medications, and what specific medications that we use, and the anesthesiologist, on the other hand, is reimbursed anywhere from $300 to $400, his typical fee. Is this fair? I ask you to render your decision.

So as a result, many psychiatrists are opting to get out of treating Medicare patients and are not doing inpatient psychiatry anymore, which is sad, because many individuals, when they get to the point where their depression or other psychiatric illness is severe, need inpatient care.

OK. My second issue involves prevention. Now with the inception of Medicare in 1965, the average life expectancy was 70. OK, so Medicare had to provide benefits for individuals on the average of 5 years. Over time, with the advent of medical technology, we have seen a dramatic increase in life expectancy. As a result, we have seen an increase in the cost of caring for our older population. In my mind, this necessitates implementing prevention as an adjunct to offset treatment costs. In other words, we need to implement prevention modalities. Now I would like to applaud HCFA, because there has been the provision for a number of preventive services. OK, these include screenings for cervical cancer, for colorectal cancer, for mammography. We are doing screenings for bone density now, we are doing diabetic self-management, to name a few. OK. So HCFA, I think, is going in the right direction in terms of prevention.

But I would like to let you know that we can screen effectively for depression. A depression screening is very inexpensive, it is user friendly, and it is accurate. And it typically involves asking the patients five to ten to 15 questions. This can be done by any health care provider, and in my opinion would lend toward identifying depression, other psychiatric illnesses early, lending toward

treatment and the long-term consequence would be decreased costs, and also it would lend toward decreasing the disparity that we are seeing amongst the psychiatric illnesses.

Now the last thing that I think everyone here is aware of is the drug benefit. It is very disconcerting to me when I have treated a patient in this hospital, I work very hard to get their depression better. And then when they come back to see me in the office, or they call me and they convey to me that, Doc, I had to stop the medication. And of course, I am going to inquire as to why, and the number one answer that I get is due to cost.

Now many individuals are going to view their medical illnesses or their medical maladies as being more life-threatening than their psychiatric illness, for instance, depression. So typically what would happen, if you have an elderly individual who is on a fixed income, they are going to choose to stop their psychiatric medications over their other medications for their blood pressure, say for instance.

I have also heard stories of individuals having to eat cat food because they have to spend money to buy their medications that keep them alive. It is very sad when we cannot afford to provide medications for our citizens.

Now one of the things—another interesting thing that I just read that really hit home with me is that if we take into account the cost of medication—now costs of medications have gone up dramatically. Let me give you a few figures here. In 1992, the average cost for medication for Medicare recipients was $552. In the year 2000, the costs are estimated at $1,205. By the year 2010, it is estimated that the costs will go up to $2,810 per year. OK, the costs are prohibitive.

Now the thing that we have got to keep in mind also is that individuals that are Medicare recipients that do not have a drug benefit as well as those that are uninsured are the only individuals that pay the full retail cost of medications. You can bet that my HMO is not paying the full cost for my medication due to the fact that they have got bargaining—you know, collective bargaining by virtue of purchasing medications in large volumes. And if a drug benefit could be instituted, the government could use purchasing in volumes to offset costs. So this is something that is definitely needed. We do need drugs. What we see is that patients will—can get their medications on an inpatient basis, they are typically not taking medications or they cannot afford them on an outpatient basis. This in essence is increasing morbidity and mortality, and as a result increases costs.

The cost of the drug benefit plan in the short term is going to be very expensive. In my opinion, especially for psychiatric illness, in the long term, the drug benefit plan would save money.

Thank you very much.

Chairman CHAMBLISS. Thank you very much, Dr. Shelton. And we have run over our time already. And I want to make a couple of comments and allow Dr. Fletcher to do so before we take some quick comments from the audience.

Just so our folks that are representing our hospitals will know, we have previously heard some testimony from some hospital administrators about some particular problems relevant to the ques-

tionnaire that is required to be answered every time a Medicare patient comes into the hospital, and also from a problem concerning the required length of record keeping that Medicare puts on you. I know of no other Federal agency outside of HCFA that requires that medical—that any sort of records be kept for 10 years. And we have made a written request of HCFA to examine both of those areas, and have received some favorable response from them already. But we are hoping we are going to see an immediate change in that and begin down this road of trying to reduce some of those burdensome regulations that they have got placed on you.

And just as a comment to what you just alluded to, Dr. Shelton, you are exactly right. We know that we have got a problem in this country from the standpoint of having some individuals who are Medicare beneficiaries and have a very meager income on which they have to live on each month, and at the same time they have a very high drug bill. It is not just in the area of psychiatry, it is obviously in other areas also. And we need a drug plan that will take care of those individuals who have a low income and a very high drug bill. The government needs to step in and provide them a helping hand.

Other individuals who have a higher income but also a higher drug bill need a helping hand from the government. And Dr. Fletcher and I have been working very diligently to try to come up with a plan along with our other colleagues in the House, as well as in the Senate, that will be of benefit to all Medicare beneficiaries. And unfortunately, we have not seen much cooperation from our colleagues on the other side. This is an election year, they see an opportunity to seize on this as a political issue, and it just ought not to be. It is kind of like every one of you all have alluded today to the fact that we have got problems with HCFA.

We have got problems in the Medicare and the Medicaid systems. And what gets lost in all of this dialogue and all of these burdens that are placed on you is what is best for the patient? And that is exactly what we have got with reference to the prescription drug benefit that ought to be dealt with in a way in looking out for what is best for the patient, not what is best for the politician. And unfortunately it has gotten to be a political issue.

But we are going to deal with it, and we are going to deal with it fairly, we are going to deal with it adequately so that we make sure that all of our Medicare beneficiaries do receive a helping hand from the Federal Government.

I want to thank all of you all for your comments. And before we open it up to comments from the audience, I want to turn to Dr. Fletcher for any questions or comments you have got, Ernie.

Mr. FLETCHER. Well certainly, I concur, Mr. Chairman, and appreciate the testimony. We have covered a whole lot of ground and it does take quite a bit of time. But I think you have given us a tremendous amount of information. Looking at some of the things we can summarize, first on the prescription drug, you are absolutely right. If we use some negotiations, buying in larger quantities, it is estimated that the bill we passed out of the House for prescription drugs by the CBO, that it would reduce the cost to seniors walking in by up to 39 percent. And that is a substantial difference and a substantial savings, as well as offering coverage

for low-income and those with high drug cost, and covering all seniors.

Some of the things I have written down here just briefly, because I want to get to some statements there. Quality, and my concern is, HCFA has not focused on the patient but rather has focused on the money, and focused on making sure, it looks like, developing a relationship that is adversarial rather than collaborative, as I think Mr. Stauter pointed out. And that is something that I do not think needs to exist. I think HCFA needs to be an organization, from what we hear, that works alongside providers with the patient's interest at heart.

Obviously there are financial concerns and constraints that we all have to operate in. But quality of care, I have found often, is the most efficient and cost-effective care in most cases. You mentioned, Mr. Hudson, about your COPD, chronic obstructive pulmonary disease program, and the savings of that, and it disturbs me, the same way with outpatient colonoscopy and other things, we do not have a system that increases efficiency, and yet at the same time, we have got HCFA coming in and assuming that all providers are guilty until proven innocent. And that is a problem.

Efficiency, it is not working well. Equity, the payments here were about $365 a month a few years ago when I was negotiating for Medicare-Plus Choice, versus 600 in Florida or New York. Why the disparity? And we need some equity in reimbursal as well as regulation, and I think that would be helpful.

The future, I am very concerned. We have had—if he is still here, I do not know if Frank Miller had to leave. He probably did, from the University of Kentucky. I am concerned about what Medicare and HCFA has done with our graduate medical education. Because as some mentioned, and I think Dr. Reynolds, you mentioned, physicians or young individuals now are not looking at going into medicine, and are we going to attract? We have had early retirements of physicians because of the burdensome practice of medicine. And I am very concerned about the future when we deal with reimbursement for graduate medical education as well as the complexity of delivering health care and the hassles that physicians go through, and other providers. We are not going to attract the best and the brightest if we do not make some changes, and I think that is critical.

Access also is obviously very important. So I appreciate the testimonies you all have given, and Mr. Chairman, I yield back the time.

Chairman CHAMBLISS. Dr. Fletcher, thank you.

Mr. Fraraccio, let me just say to you, you raised one issue regarding this appeal to the PRRB. And we have got one of our committee staff lawyers here, and Les, I want you to look into this issue. I do not understand why we have got the PRRB set up with an appellate process for you to go through if we are not going to use that as a binding body, the decision-making process being a binding body. And Les, I want you to take a look at that and let us see what that says, if it is set up by law or if it is set up by regulation, and why that decision is not binding on those folks. I am sure if you had lost that decision, it would have been binding as far HCFA is concerned. Somehow I think that is the case.

At this time, we want to throw it open to any comments or questions from anyone in the audience. As I say, we are a little short on time, but you folks have been very patient and we appreciate very much you being here. We have got a traveling microphone, and if anybody has a question or comment, if you will raise your hand, we will get the microphone to you.

Dr. BRISLIN. Thank you. I am pharmacist John Brislin with Pharmacists Consultation Services here in Lexington. I am a consultant, work with hospitals, home health agencies, home infusion pharmacies and even physicians to improve the efficiencies and marketing of their practices.

My biggest concern is the issue which has already been appropriately brought up about average wholesale prices of drugs. And we now have the Department of Justice across the board, dictating from their own survey what prices they will pay for reimbursement to home health agencies, home infusion pharmacies and pharmacists, and this, to me, seems totally backwards. And there will be home infusion pharmacies and home health agencies and other providers who go out of business, and these poor patients will have to go back into the hospitals, which ultimately will cost State Medicaid programs and the Federal Medicare program many millions of dollars that are unneeded.

Thank you.

Chairman CHAMBLISS. Well, I think Dr. Carloss alluded to one of those problems with respect to what is going on in the area of oncology. And we are addressing that with a rifle shot, and we hope that will shake up some folks over there and maybe we can ensure that we can continue to encourage people to receive treatment at home where they are oftentimes better served, and get the proper reimbursement rate there, not just from the standpoint of wholesale drug prices, but in other areas also that Mr. House alluded to with respect to reimbursement rates in home health care.

Yes, ma'am.

Ms. HENKLE. My name is Karen Henkle, I am Executive Director of the Kentucky Home Health Association.

To follow up on your comment there, there is one aspect of the Balanced Budget Act and the prospective payment system that Mr. House mentioned that has lots of problems. And in fact, some of the HCFA reps and FIs are doing training today on that implementation that is due in October. The bundling of all the costs of nonroutine medical supplies for a home health patient is now to be a part of that episode payment. And this means that if a physician has been caring for a patient and ordering those supplies, maybe someone whose routine catheterization or some other chronic illness, once they are now under a home health plan of care, the home health agency is going to be responsible for all of those medical supplies. And if a Part B provider, a pharmacy, an HME provider supplies those and submits a claim, that is going to be rejected.

We are concerned that we are facing both a tremendous PR issue and problems in coordination of services, but the reimbursement scheme has not been designed to adequately reimburse the home health agencies for that. I think there is probably a total of about $15 added to the payment rate to cover supplies. And anyone inter-

ested in looking at the cost of room care supplies for those patients, it is tremendous. This issue has got to be addressed.

HCFA themselves say this is their interpretation based on what they think the law says, but it is going to be a disaster come October 1 for individuals who require home health care, but yet who have substantial needs for non-routine medical supplies.

Mr. FLETCHER. Let me ask you, make sure we understand that clearly. In other words, the bundling, if all the supplies that are needed, even though it may be a supplier outside—well, obviously an outside supplier, has there been any provisions made for how reimbursement will be made to those or will the home health agency itself have to negotiate some sort of contract and reimbursal with the supplier?

Ms. HENKLE. The bottom line is that, for those non-routine supplies which HCFA, under the home health benefit, says are covered, the home health agency costs are supposed to be covered within the episode payment. However they pay for those. And so it is up to them to either purchase those items from a supplier, get a good wholesale price, a group purchasing contract, or to work out arrangements with local suppliers in order to reimburse them.

They can negotiate whatever kind of working arrangement or contract is done, but it has all got to be ultimately within the bounds of what they are receiving payment for. And right now, in many cases, the costs for some kinds of supplies will exceed the overall reimbursement that that agency will receive for that patient.

Mr. FLETCHER. Let me ask you a question specifically. Say you have got a patient who needs wound dressing, and you are going out and say you are going out and you are doing it at a certain frequency. It looks like this sort of payment would certainly encourage you to decrease the frequency of wound dressings, for example, which may, many times, probably would not be at the best interest of quality care to the patient. And yet we are putting on a pressure here of cutting corners, and at the same time HCFA comes around and is going to be inspecting and demanding that the wound care is adequate and all these things. It seems very counter productive.

Do you have any idea of how the industry is going to deal with this pressure economically, because if it does not cover the cost, it will encourage decreased wound dressings or in and out caths, or whatever they need.

Ms. HENKLE. I think an excellent point, Dr. Fletcher, and you are exactly right. The bottom line is going to mean that agencies are going to review their admission criteria very carefully, and they are going to be selective about the patients they admit. And so physicians who have patients who have perhaps decubitus or perhaps because of their immune system they are not healing from surgical wounds, the agencies are going to be forced to say, we cannot afford to accept that patient, because it is going to require for 2 weeks, three times a day, dressing changes with substantial cost of supplies, and then we decrease that.

You are right. If they choose to accept those patients, they are going to be challenged to provide those in as few visits, teaching the families. Sometimes this may be an aged family member who is being taught to change—if they are sterile dressings, of course,

that is not a choice, it is going to greatly complicate the care that individuals who have those intensive care needs receive.

Mr. FLETCHER. Is this going to include, say, administration of antibiotics for a particular infectious disease that are much more efficiently delivered at home, say, that are needed for a long period of time? Would the bundling include that or is that not going to fall out of that criteria?

Ms. HENKLE. If they are items—and of course, the drugs, some of those drugs are paid for. But those are paid for separately, it is not part of that episodic——

Mr. FLETCHER. What about the IV administration, the tubing and things?

Ms. HENKLE. Some of the materials and supplies, if they are now considered a DME item, and there is a fee schedule item, those would be covered under that fee provision. And that is another thing. There is questions about which items are non-routine medical supplies, which are DME items, which are covered under the home health benefit, which are covered under the carrier part B, and sorting out all that detail. The opportunity for making errors and for mistakes is tremendous. But it is greatly going to compromise the services and materials that are available for many of these folks who desperately need it.

Mr. FLETCHER. Thank you. And I find that very disturbing.

Chairman CHAMBLISS. There is time for maybe one other comment or question. Yes, sir.

Mr. HEITZENREITER. Yeah, I am Jim Heitzenreiter from Martin Wallace Hospital. And one of the concerns I have is, as we listened to all the testimony this morning, the one thing that I do not think has been addressed is we know, which is coming down the road, will be a prescription drug program. And I am not hearing anything addressing the cost of the—to the hospitals and to everybody for the cost of the drugs. That is going to be able to regulate and control the costs coming from the pharmaceutical companies. They are out there free, doing whatever they want to do, and then we are going to be restricted, and they are going to tell us, this is the X amount of money we will pay you, and this is how you are going to do it. But that is not restricting what our supplies are going to be. Our disposable supplies keep going up, they go up irregardless of what we can increase our rates and collect with the reimbursement—with the reduction in reimbursements over the last few years.

So my concern is that we address this, that we do not open the floodgates to make the pharmaceutical companies and medical suppliers rich by having a program that allows them to collect the money that they want to charge, and yet we are restricted on what we can do. So it is a real concern as we develop the programs coming up in the future, of how we are going to control even what our costs are going to be, even if we get partial reimbursement or reimbursement for that.

Chairman CHAMBLISS. Well, you have raised an excellent point, and I wish Ernie and I had the answer to that this morning. We have discussed this, in discussing our drug proposal that we ultimately passed on the floor of the House. In fact, our colleague, Tom Coburn, who is an OB/GYN in Oklahoma, raised this issue along

with Gil Gutknecht from Minnesota, after having done a significant study on the fact that—and come up with an answer with reference to the fact that you can buy the same drugs in Mexico and Canada cheaper than you can buy them in the United States today, and they come on the market quicker in those countries than they come on the market today.

And the obvious reason why that is the case are the serious regulations and hoops that we require our drug manufacturers to jump through. Now that is part of the problem. That is not the total reason why drugs are coming on the market quicker outside the United States and why they are less expensive outside the United States.

But you get into a very gray area if you try to mandate to anybody what they can charge for a service. We get back to the Clinton Health Care Plan of 1993, where there was going to be a mandate on what hospitals could charge and what physicians could charge. We all believe in the free and open market, but by the same time, we have seen the cost of drugs go up—somebody alluded to it earlier that the cost of a new drug coming on the market, coming into the hospital or the doctor's office today is $71, or increase of $71 over what it was a short time ago.

There has got to be an answer somewhere to how we can control that. Now we have tried to reduce the regulatory burden on pharmaceutical companies, and other companies. For example, farm chemicals is another area where this has impacted the State of Kentucky, just like it has impacted my State from an agricultural perspective. There are just too many regulations that burden manufacturers on the books right now that cause that ultimate retail price to go up more than what it should. And we are struggling with that. We are struggling to find a way to do that.

But you make an excellent point because, frankly, one thing that we have found is that when the government gets involved, from a payment standpoint, and the end seller of a product has the assurance that the Federal Government is going to pay for it, prices always go up even more. And we have got to ensure that does not happen. We do not want to put price controls on, obviously, but we have got to try to figure out some way to slow down that increase. And it is very troublesome to us.

Mr. FLETCHER. Let me make a comment to that, because we—recently we passed, actually three pieces of legislation. Gil Gutknecht's bill that—and Tom Coburn worked on that—referred to which directed the FDA, encouraged the FDA to look at prescription drugs that are sold overseas at a reduced cost, and look at the possibility of reimportation. Pharmaceuticals, obviously, were not real fond of that. There was a couple of amendments that looked at that.

But we do have—I mean, there is price controls and subsidies in other countries that reduce the cost of drugs to about half, for example, in England, to what our patients pay here in the United States. We can reduce it up to 39 percent outpatient, and you are talking about inpatient—outpatient, by negotiating with PBMs, the pharmaceutical benefit managers that buy in bulk rate and negotiate.

But we have to look at several things. One, we are subsidizing the world in our pharmaceutical research here, about $24 billion goes into that, because we pay higher cost of drugs, and yet other countries certainly benefit from that. There are some other countries that use other taxes to support more research, and so they subsidize some of the research, but we, by and large, do the bulk of the international research.

I think we need to look at, you know, the international market, and make sure that we can see if there is not better ways of equity, more competition to bring prices down. There is two choices: Increase competition and make sure that we look at what we are doing internationally, as well as being able to contract in a better way with pharmaceuticals. The other choice is price controls. And we develop a lot of new medications, cancer, for example, that are doing some wonderful things. And if we get price controls that inhibit research and development, we are not going to be able to cure a lot of the disease that I think morally we are obligated to continue our search in doing.

So it is a tough problem, but it does need addressing, and there is a lot of attention to it because it is going to bust the budget if we do not.

Chairman CHAMBLISS. Well, let me once again thank all of you all for being here. I particularly want to thank our witnesses for your testimony this morning, and let me assure you that we are going to take your testimony back to Washington and incorporate it into the thoughts and ideas and legislation that is going to be forthcoming. We know this is a serious problem. You have reiterated what we have heard from some other folks, but you have also pointed out some new problems to us that we were not aware of that we have got to address.

A lot of it money, a lot of it just involves reimbursement. But there are obviously a multitude of other things that have to be done and we are going to look at those other problems in addition to just reimbursement.

And I will have to tell you that we are embarking on some new territory here. This is the first time that the Budget Committee has created task forces, and we are one of six task forces that have been created to do oversight of Federal agencies. And Ernie and my area happens to be the health task force, but we are also looking at defense and any number—agriculture and any number of other areas out there.

And John Kasich and I came up with this idea of sort of creating these subcommittees last year, and we are real excited about this. And Ernie and I are not going to be able to solve all of the problems within this task force in the short period of time, but we are laying a foundation that we look forward to carrying forth into the next Congress and in future Congresses, where we can come back down here to Lexington and say, look, you remember in August of 2000, we talked about this problem, and here is what we did. We took this back to Washington, and we ultimately made some corrections and we made some changes that hopefully will make life better for you, both from a practitioner's standpoint and a health delivery standpoint, as well as from a beneficiary's standpoint on the other end of it.

That is our goal, and we cannot do this without input from you folks, and I just cannot tell you how much we appreciate you all being here and giving us your thoughts and your ideas, how much we appreciate you folks coming in and listening as well as participating in the discussion.

Once again, I want to say to St. Joseph's how much we appreciate them hosting us. They have been very gracious to give us this time in their auditorium this morning, and to Ernie and all your folks, your staff here that have been so gracious and hospitable to us, we appreciate you very much. And we invite all of you to come to Macon, GA, on Monday, because we are going to have another hearing like this. And we will show you some more good southern hospitality down there.

So thank you very much, and our hearing will be concluded.

[Whereupon, at 12:36 p.m., the Task Force was adjourned.]

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