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MEDICARE

Communications With Physicians Can Be Improved

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Accountability * Integrity * Reliability

Contents

Abbreviations

BFE	business function expert
BPR	budget and performance requirement
CMS	Centers for Medicare and Medicaid Services
CPE	contractor performance evaluation
CSR	customer service representative
FAQ	frequently asked questions
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
LMRP	local medical review policy
PM	program memorandum
PRIT	Physicians' Regulatory Issues Team

GAO

Accountability * Integrity * Reliability

United States General Accounting Office
Washington, DC 20548

February 27, 2002

The Honorable Jim Nussle
Chairman
Committee on the Budget
House of Representatives

The Honorable Nancy L. Johnson
Chairman
Subcommittee on Health
Committee on Ways and Means
House of Representatives

The Honorable Saxby Chambliss
House of Representatives

Medicare, serving nearly 40 million beneficiaries, is the nation's largest
health insurer and second largest federal program. Unlike other federal
programs that make expenditures under the direct control of the
government, Medicare constitutes a promise to pay for covered medical
services provided to its beneficiaries by about 1 million providers. Given
this open-ended entitlement, it is essential that appropriate and effective
rules and policies be specified so that only necessary services are provided
and reimbursed. To accomplish this, the Congress and the Centers for
Medicare and Medicaid Services (CMS)[1]—the federal agency within the
Department of Health and Human Services (HHS) that administers
Medicare—have promulgated an extensive body of statutes, regulations,
policies, and procedures regarding what shall be paid for and under what
circumstances. CMS, which relies on the assistance of about 50 claims
administration contractors[2] to operate the Medicare program, is charged

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[1]On June 14, 2001, the secretary of Health and Human Services announced that the name of
the Health Care Financing Administration (HCFA) had been changed to the Centers for
Medicare and Medicaid Services. In this report, we will refer to HCFA where our findings
apply to operations that took place under that organizational structure and name.

[2]Medicare consists of two parts—A and B. Contractors that process Part A claims—those
covering inpatient hospital, skilled nursing facility, hospice, and certain home health
services—are known as fiscal intermediaries. Contractors processing Part B claims—
covering physician services, diagnostic tests, and related services and supplies—are
referred to as carriers.

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with communicating this information to medical providers, including physicians, so that they can bill the program properly.

Recently, physicians and their representatives testified at congressional hearings that their participation in Medicare is becoming increasingly burdensome. Among other things, they reported being inundated with large volumes of complicated, unclear, and inconsistent information from the Health Care Financing Administration (HCFA) and its carriers about Medicare program requirements. They also expressed concern that, because rules change frequently, their understanding of billing rules may be obsolete and incorrect, which could lead to inadvertent billing errors.

This report responds to your request, which recognized both the need for HHS, and particularly CMS, to routinely communicate regulations, instructions, and guidance to physicians, and the concerns of physicians regarding the quality of the materials they receive. Specifically, you asked us to examine several aspects of Medicare communications, including (1) the quality of Medicare information provided to physicians by HHS, and CMS and its carriers, (2) the quality of CMS's management and oversight of carrier communications, and (3) current CMS efforts to enhance the communication process.

To understand physicians' concerns regarding Medicare communications, we first solicited the views of individual physicians from several specialties and representatives from relevant professional organizations. As part of this effort, we obtained the cooperation of seven physician practices of varying sizes that provided us with information on the volume and type of Medicare communications they received during a 3-month period. These practices were located in different areas of the country and received information from different carriers. They also provided us with excerpts from documents they received and shared their views on the usefulness of the information they received during that time frame. In addition, we interviewed officials at several carriers and HCFA. We also

met with officials at other HHS agencies to discuss their communications with physicians participating in the Medicare program.[3]

On the basis of this information, and because the vast majority of Medicare communications are issued by carriers on behalf of CMS, we focused on the information carriers provide to physicians. We then conducted an evaluation of the quality of the three main methods carriers use to provide information to physicians—bulletins they publish and mail to physicians, telephone call centers that respond to physician questions, and Internet Web sites to serve participating physicians. Specifically, to assess bulletins we reviewed recently issued bulletins from 10 carriers to determine whether they organized material in ways that would help readers locate information. We evaluated the timeliness and completeness of these bulletins by examining them to determine when certain CMS-issued memorandums, which were relevant to physicians, were included. To assess the quality of information provided to physicians calling carriers with questions, we telephoned 5 of the 37 provider assistance call centers with frequently asked questions (FAQ) taken from carrier Web sites. With CMS's assistance, we scored the completeness and accuracy of these responses. We also visited 3 carrier call centers to observe their operations and to study the carriers' approaches to monitoring the performance of the customer service representatives who are responsible for responding to physician inquiries. To assess carrier Web sites we examined 10 such sites to determine if they complied with requirements established by CMS, as well as to assess whether the information presented on those Web sites was accurate, complete, and timely. We did not evaluate communications issued by all Medicare carriers; our findings are limited to those carriers we reviewed and cannot be projected to other carriers.

To evaluate the quality of CMS's management and oversight of carriers' communications activities, we identified relevant requirements that CMS imposes on carriers regarding their communications with physicians. We also examined CMS's allocation of key resources devoted to communication activities. In addition, we observed CMS officials conduct

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[3]In addition to CMS, other HHS agencies generate information and guidance that are relevant to certain physicians or specialties that may affect their care of Medicare beneficiaries. For example, the Food and Drug Administration publicizes information on recalls of drugs or medical devices. The Centers for Disease Control and Prevention issues disease prevention guidance and manages a national surveillance system for approximately 60 infectious diseases. The Office of Inspector General issues Medicare-related fraud alerts and compliance guidance for specific provider types, including physicians.

an on-site performance evaluation of one carrier's call center. To identify CMS's efforts to improve Medicare communication to physicians, we spoke with officials from CMS, carriers, medical associations, physicians and their practice administrators, and reviewed related documentation. We identified recent initiatives CMS has undertaken to improve physician communications and also explored its plans for future enhancements.

Appendix I contains more information regarding the scope and methodology of our work. A more detailed description of our review of carrier call centers is contained in appendix II. Appendix III summarizes the amount and types of information the seven physician practices received from both governmental and nongovernmental sources from February 1, 2001, through April 30, 2001. CMS provided comments on a draft of this report. These comments are reproduced in appendix IV.

Our work was conducted from December 2000 through January 2002 in accordance with generally accepted government auditing standards.

Results in Brief

Information given to physicians by carriers is often difficult to use, out of date, inaccurate, and incomplete. Medicare bulletins that carriers use as the primary means of communicating with physicians are often poorly organized and contain dense legal language. They are sometimes incomplete, failing to include information about upcoming program changes, and are not always timely in communicating CMS-issued information. Similarly, carriers' other principal means of communicating information to physicians—toll-free provider assistance lines and Web sites—also proved to be problematic in terms of accuracy and completeness. Customer service representatives rarely provided appropriate answers to questions, answering only 15 percent of our test calls completely and accurately. In addition, only 20 percent of the carrier Web sites we reviewed contained all of the information required by CMS, and many lacked common features that allow Web sites to be used effectively, such as site maps and search functions. Although all carriers issue bulletins, operate call centers, and maintain Web sites, each carrier develops its own communications policies and strategies. This approach results in a duplication of effort as well as variations in the quality of carrier communications.

Although CMS is tasked with assuring that carriers are responsive to physicians, the agency has established few standards for carriers to meet in their physician communications activities. CMS provides little technical assistance to help carriers develop effective communication strategies.

CMS officials told us that they do not have enough staff to effectively monitor and assist carriers in their communications with physicians. Neither CMS carrier oversight nor self-monitoring by the carriers is comprehensive enough to provide sufficiently detailed information that could either pinpoint specific communications problems or identify poorly performing carriers.

CMS is working to improve its physician communications in a number of ways. For example, the agency announced that it would consolidate new instructions and regulations and issue them on a more predictable schedule to help lessen the burden of frequent policy changes that physicians have no way to anticipate. CMS is also enhancing its education programs for both physicians and carrier staffs and expanding its efforts to obtain physician feedback. In addition, CMS is improving its national Web site and intends to develop a single Web-based source of information for physicians. These and other improvements are potentially valuable; however, many are in the early stages of planning or implementation, and we could not assess their ultimate effectiveness.

We are making recommendations to the CMS administrator to further improve the timeliness, consistency, and quality of Medicare communications to physicians. CMS agreed that it needs to improve these communications and described some of its ongoing and planned improvements.

Background

The complexity of the environment in which CMS operates the Medicare program cannot be overstated. CMS manages Medicare, the nation's largest health insurer, in a challenging and complex environment in which medical providers and beneficiaries form a vast network of stakeholders with differing priorities. The agency is charged with developing regulations and policies that implement the statutory provisions of the Medicare program. The program is operated by CMS with the assistance of approximately 50 carriers and fiscal intermediaries—generally health insurance companies—that annually process about 900 million claims submitted by nearly 1 million providers and private health plans. Medicare is estimated to have spent nearly $240 billion in fiscal year 2001 for services provided to approximately 40 million elderly and disabled beneficiaries.

In order to receive reimbursement from Medicare, CMS requires physicians to submit claims that identify the services they have performed by using the agency's national uniform procedure coding system. Like

other Medicare providers, physicians are responsible for billing Medicare correctly for services performed and informing beneficiaries of the level of Medicare coverage at the time of service. To do this they need reliable information on Medicare coverage, claims coding and documentation requirements, claims submission instructions, program changes, and carrier policies.

CMS communicates information describing its billing requirements, as well as other relevant regulations and policies, to physicians primarily through its carriers. The carriers communicate with physicians in several ways. They send physicians bulletins periodically to update them on new rules and program changes, provide toll-free lines to call centers so physicians can obtain answers to questions, and maintain Web sites that include postings of, among other things, new Medicare developments and carrier-sponsored training. CMS and its carriers also sponsor a variety of provider education activities, such as workshops and on-line training courses, to help familiarize physicians with billing rules and other aspects of the program and to update them on program changes.

Physicians have become increasingly vocal about the timeliness and quality of the Medicare information CMS and its carriers provide. For example, last year, in congressional testimony, physicians and their representatives reported frustration because carrier communications are often unclear and do not always provide them with advance notice of program changes. They also charged that, when they seek clarification, carrier personnel often give them incorrect answers to their questions.

CMS establishes carrier requirements, including some related to communications, in its annual budget and performance requirements (BPR). For example, the BPRs require carriers to communicate with physicians about local medical review policies (LMRP)[4] and claims submission procedures. CMS is responsible for monitoring the performance of its carriers to ensure that they accurately and efficiently fulfill their requirements and properly implement Medicare policies. Much of CMS's oversight is accomplished through its periodic evaluations of

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[4]LMRPs specify under what circumstances a carrier will or will not provide Medicare payment for a type of service. LMRPs are developed by carriers to reflect their interpretation of Medicare coverage and to enhance or clarify national Medicare guidance. Because carriers may differ in how they assess the reasonableness and necessity of services provided, one carrier might pay for services that would not be paid for by another carrier.

carrier performance. In addition, the agency also requires carriers to routinely submit evidence of their own self-monitoring activities.

Carrier Communications Are Often Difficult to Use, Out of Date, Inaccurate, and Incomplete

Medicare information provided by carriers for physicians is often difficult to interpret and use, out of date, inaccurate, and incomplete. Our analysis of the three main methods that carriers use to communicate information to physicians—printed bulletins, provider assistance call centers, and Web sites—revealed problems with all three types of communication.

Carrier Bulletins Can Be Difficult to Use and Lack Current Information

Carrier bulletins contain important information for physicians but present this information in formats that may be difficult for them to use. In addition, critical information, including changing program requirements, may be late in reaching physicians who need to take steps to implement these changes.

CMS relies heavily on carrier bulletins—which each carrier is required to issue at least quarterly—to give physicians official notice of their responsibilities and requirements under Medicare law, regulations, and guidelines. Carriers have discretion regarding the bulletins' format and organization, but they are required to reprint certain CMS-provided information verbatim. For example, carriers receive and reproduce CMS-issued guidance—known as program memorandums (PM)—which convey details about upcoming program changes scheduled to become effective in the next few months.

Our review of bulletins issued from March through July 2001 by 10 randomly selected carriers[5] showed that there are several aspects of the bulletins, including their organization and length, which hinder their usefulness. As a result of carriers' freedom to develop their own bulletins with little direct CMS guidance, there was considerable variation in the organization and format of the bulletins we reviewed. While bulletins issued by 6 of the 10 carriers organized information by subject matter or

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[5]Carriers vary in how frequently they issue bulletins. The carriers we sampled issued from two to five bulletins each during the 5-month period.

specialty, the others provided only an alphabetical key word index instead of a table of contents to assist the user. Providing only a key word index makes it difficult to identify information relevant to different physician practices. Some carriers that serve physicians in several states issued a single bulletin for all their states. Some of these bulletins had information for each state contained in a separate insert or section. Other, less helpful, multistate bulletins only noted state differences within individual articles, requiring physicians or their staffs to scan each article to determine whether it was relevant and applicable to their practices. In addition, the bulletins were typically over 50 pages in length and several exceeded 80 pages, making them lengthy documents to search.

In several instances, bulletins were late, or provided little advance notice, in communicating HCFA-issued program changes to physicians. To test the timeliness of carrier bulletins in communicating information, we selected four PMs that HCFA issued from February through April 2001 concerning program changes that physicians would need to be aware of in billing for certain services. We then reviewed the bulletins issued from March through July by the 10 carriers we sampled, to determine when the four PMs were included in the carriers' bulletins. In 11 instances, PMs were either not communicated through carriers' bulletins until after their scheduled implementation dates, or they did not appear at all in the bulletins we reviewed, as shown in table 1. In 11 additional instances, bulletins communicated the memorandums less than 30 days prior to the implementation date, giving physicians little advance notice to help ensure their compliance with Medicare rules.[6] Overall, 6 of the 10 carriers did not communicate at least one of the four PMs before its scheduled implementation.

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[6]CMS has no standard for the amount of advance notice providers should receive before program changes are implemented. However, it does require that providers receive a 30-day notice before fee schedule or other payment changes are to take effect.

Table 1: Timeliness of 10 Carriers' Publication of Program Memorandums (PMs)

PMs (topic and number)	Number of carriers that included the PMs in their bulletins			Number of carriers that had not included PM in the bulletins as of 30 days after implementation
	At least 30 days before implementation	Less than 30 days before implementation	1 to 30 days after implementation	
Claims for drugs and biologicals, PM: B-01-10	10			
Coverage for verteporfin,ᵃ PM: AB-01-37	6	2	1	1
Levels of physician supervision required for diagnostic tests, PM: B-01-28	1	3	5	1
Billing codes for splints and casts, PM: AB-01-60	1	6	3	

[a]Verteporfin is a light-sensitive drug used in laser treatments of the eye.

Source: GAO analysis, based on PMs obtained from CMS and bulletins obtained from selected carriers.

Carrier Call Centers Often Provide Inaccurate and Incomplete Information and Lack Standard Policies and Sufficient Resources

Customer service representatives (CSR) at carrier call centers we tested rarely provided appropriate answers to questions we posed. Eighty-five percent of the responses we received from CSRs from 5 carrier call centers were inaccurate or incomplete.

To assess the accuracy of responses provided by CSRs, we made 61 calls to the provider inquiry lines at call centers and asked three questions from the FAQ pages on carriers' Web sites concerning the appropriate way to bill Medicare in circumstances commonly encountered by physicians.[7] When calling, we identified ourselves as GAO representatives and asked the CSRs to answer our questions as if we were physicians. CSR responses were recorded verbatim and submitted to a Medicare coding expert at CMS along with the text of the questions and answers used. We used the following questions when making our calls:

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[7]Although carrier officials told us that the majority of physicians' calls concern the status of claims, we were not able to ask for information about specific claims due to concerns about beneficiary confidentiality.

1. If a physician provides critical care for 1 hour and 15 minutes, how should the services be reported? Should code 99292 (for an additional 30 minutes) be reported? Should the reduced services modifier be used?

2. What is the proper way to bill for an office visit on the same day as a surgical procedure?

3. Can code 99211 be reported if a nurse in the physician's office provides instruction on self-administering insulin?

Appendix II provides the answers that appear on the Web sites.

The results of the test, which were validated by the coding expert, showed that 32 percent of the answers were inaccurate, 53 percent were incomplete, and only 15 percent were complete and accurate. These results are illustrated in table 2. There was little variation among the carriers in the overall accuracy and completeness of their answers.

Table 2: Summary of the Accuracy of Responses by Question

	Inaccurate response	Incomplete response	Accurate and complete response	Nonresponse[a]
Question 1: Critical care coding	8	6	6	1
Question 2: Office visits and surgical procedure	6	10	3	1
Question 3: Nurse providing instruction	5	15	0	0
Number of call center responses	**19**	**31**	**9**	**2**
Percentage of call center responses	**32%**	**53%**	**15%**	**N/A**

[a]Nonresponses omitted from the sample.

Source: GAO analysis of carrier call center responses.

Many physicians we spoke to expressed frustration that CSRs will not always provide information on how to properly code certain claims. Carrier call centers had varying policies about providing physicians with specific coding information. Knowing the appropriate code for a medical service is essential to properly billing Medicare. Although CMS does not

have a policy preventing them from doing so, managers at the carrier call centers we visited reported that it is not their policy to provide information to callers on how to code a specific claim. Carriers reported that they are reluctant to provide specific codes because the CSRs lack the medical expertise to appropriately make coding judgments, and they do not have the physician's clinical documentation at the time of the calls to understand the procedure or service in context.

During our test of call center accuracy, we noted that CSRs followed different procedures regarding coding-related inquiries and frequently did not adhere to the carriers' stated policy. While in 19 cases the CSRs provided neither a code nor referral to a source of coding information, specific codes were given in 24 instances. Specific referral to a bulletin issue or to a regulation number was given in 16 other cases, but for 7 of these cases the information was too vague to enable someone to locate the coding rules. Even when the referrals to information sources were accurate, physicians told us that being directed to other carrier publications does not respond to their need for readily accessible interpretation of Medicare regulations.

Our visits to 3 call centers also revealed that there is no uniformity or standardization across carriers in the types of technological resources available to CSRs. For example, 1 call center we visited had an on-line searchable database of LMRPs that facilitated quick retrieval of the appropriate information by the CSRs. Representatives at the 2 other call centers used hard copy bulletins or bulletins posted on their Web sites in a nonsearchable format. CSRs without easily searchable tools told us that they relied heavily on their more experienced colleagues, in the absence of more authoritative sources, for answers.

The lack of technological resources at call centers can affect centers' abilities to monitor the performance of their CSRs. One call center we visited was able to record calls from providers and the computer screens accessed by CSRs to determine whether their responses were accurate and complete, while the other two call centers could only record the telephone calls. Two call centers we visited were able to electronically observe each CSR's phone line activity to track the length and origin of calls; however, another call center had no electronic information and could only monitor lines and identify the type of caller by listening to the calls as they took place.

Carrier Web Sites Not Easy to Use and Often Did Not Meet HCFA-Mandated Requirements

Most of the 10 carrier Web sites we reviewed did not contain features that would allow physicians to quickly and directly obtain the information they needed. The Web sites frequently lacked logical organization and navigation tools and search functions that increase a site's usability and value. Only 4 of the 10 Web sites we examined contained site maps. Only 6 contained search functions and in two instances, the search functions did not work. Three sites had neither search functions nor site maps, making them difficult to navigate to access information. Furthermore, the Web sites often contained out-of-date information. Nine of the 10 sites included the required schedule of upcoming workshops or seminars but 5 of these sites were out of date. Only 1 site contained a potentially useful "What's New" page, but the page contained a single document of regulations that went into effect 8 months prior to the date of our Web site review.[8]

Although HCFA's 2001 BPRs contain specific requirements for carrier Web sites, most of the sites we reviewed did not meet all of these standards. Only 2 of the 10 sites complied with all 11 of the BPRs' content requirements,[9] as shown in table 3. In addition, other requirements, such as a federally mandated privacy statement outlining the type of information the site collects on visitors and a section containing FAQs were not consistently met. Five Web sites contained the privacy statement, and 5 contained a link to FAQs.

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[8]We did not review HCFA's own Web site during our review. In 2001, a consultant to the agency completed a needs assessment and design plan for the Web site, and the agency is working to improve the site's usability.

[9]Additional BPRs, not related to Web site content, focus on copyright guidelines for billing codes developed by the American Medical Association.

Table 3: Compliance with Fiscal Year 2001 BPR Content Requirements by 10 Carrier Web Sites

HCFA Web site requirement	1	2	3	4	5	6	7	8	9	10	Total carriers meeting requirement
				Carrier							
Recent bulletins	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	**10**
Compatibility with multiple browsers	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	**10**
Schedule of training sessions	☐		☐	☐	☐	☐	☐	☐	☐	☐	**9**
Link to HCFA.gov	☐	☐	☐		☐	☐	☐	☐	☐		**8**
Link to HCFA's Medicare Learning Network[a]	☐		☐	☐		☐		☐	☐	☐	**7**
Search function		☐	☐		☐	☐	☐		☐		**6**
Privacy policy published			☐	☐		☐			☐	☐	**5**
FAQs			☐	☐		☐		☐	☐		**5**
Link to Medicare.gov	☐	☐	☐			☐			☐		**5**
E-mail support				☐		☐			☐	☐	**4**
Register for events						☐	☐		☐		**3**
Percentage of BPR requirements met	55	46	82	64	46	100	55	55	100	55	

Legend: ☐ indicates that the Web site met the HCFA standard.

[a]The Medicare Learning Network is a Web site featuring information on training resources for physicians.

Source: GAO analysis of carrier Web sites.

Although CMS has set standards for carrier Web sites, each carrier independently develops its own Web site. This has resulted in duplication of effort and variations in the usability and complexity of the information provided.

CMS's Management and Oversight of Communications With Physicians Are Insufficient

CMS is ultimately responsible for managing and overseeing carrier performance to ensure that carriers supply physicians with consistent and accurate information. However, the agency's standards and technical assistance to guide carriers in physician communications activities are not sufficient to produce consistent, high-quality products and effective communication strategies. The lack of standard approaches to communication by carriers makes consistent oversight more challenging for CMS. Neither of the two principal oversight tools used by CMS—contractor performance evaluations (CPE)[10] and carrier self-monitoring

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[10]Teams of CMS staff annually conduct CPEs, reviewing the performance of some contractors in selected functions.

and reporting—provide enough information to reveal problems carriers may have in providing quality communications.

CMS's Communications Management Lacks Sufficient Standards and Resources

CMS has established few standards to guide carriers' primary communication activities, including publishing bulletins, providing telephone assistance to callers, and establishing and maintaining Web sites. The BPRs only require carriers to issue bulletins at least quarterly. There is no substantive guidance regarding content or readability.[11] Carrier call centers are instructed to perform "quality monitoring" no more than 10 times a quarter for each CSR, but CMS's definition of what constitutes accuracy and completeness in call center responses is neither clear nor specific. For example, CMS defines accuracy as not being inaccurate—as opposed to providing necessary and complete information to allow physicians to correctly bill the program. In the case of Web-based communication, the BPRs contain few requirements about the clarity or timeliness of information. Instead, they generally focus on legal issues—such as measures to protect copyrighted material—that, while important, do not enhance physicians' understanding of, or ability to correctly implement, Medicare policy.

CMS officials acknowledged that physician communications have received less support and oversight than other aspects of carrier operations and attributed this, in part, to a lack of resources. CMS's regional offices, which are most directly responsible for carrier oversight, provide assistance to carriers through business function experts (BFE) whose principal method of oversight is participation on CPE teams. A CMS official told us that there are not enough BFEs to provide direct technical assistance to all carriers in all areas of communication. Furthermore, a lack of budgetary resources limits BFEs' travel to carrier sites. One regional BFE we interviewed handles four functional areas, including provider education and provider phone inquiries, for 6 separate Medicare carriers. The BFE interviewed noted that little hands-on technical assistance is provided. Despite the fact that bulletins are a key means of physician communication, and Web sites are growing in importance, some regions have not been allocated any BFEs for these functions. Moreover, no region has a full-time equivalent staff member dedicated to these

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[11]As of fiscal year 2001, the only BPR requirement relating to content was that bulletins must include a statement that they should be shared with all health care practitioners and managers of the provider staff.

critical forms of communication, leaving carriers to solve problems independently.

CMS's efforts to assist carriers in sharing successful approaches are also limited. The agency's annual conference for call center managers provides a forum for sharing information and strategies. However, similar opportunities do not exist for carrier staff members working with bulletins and Web sites. CMS collects and posts on-line a carrier *Best Practices Handbook* relating to provider communications and education, but as of January 2002, the information had not been updated in a year. Further, the handbook contains little detail about how to implement the strategies for improving communications.

The lack of specific standards, sufficient technical assistance, and best practice guidance creates an environment in which, as one CMS business function expert said, each carrier must develop its own communication strategies, resulting in duplication of carriers' efforts and variations in the quality of their service to physicians. At the time of our review, CMS did not have any efforts that would be implemented in the near future to develop more standardized carrier communications to physicians.

Monitoring of Carriers Is Not Sufficient to Ensure Quality and Accuracy in Physician Communication

HCFA has not traditionally undertaken comprehensive evaluations of the quality or usefulness of carriers' bulletins or Web sites. For 21 years, the agency has conducted on-site evaluations to directly monitor carriers' performance in a variety of areas. However, the agency is just beginning to focus CPEs on provider communications. In 2001, it expanded the focus of its call center CPEs to include call centers that serve providers, including physicians. Previously, these reviews had been limited to beneficiary call centers.

We observed one CPE team as it evaluated the operations of a provider call center. This team focused mainly on performance standards that address procedures, such as how long a caller is kept on hold or whether the CSR had given an appropriate greeting, rather than whether information provided was complete and accurate. In order to evaluate the carrier's performance in monitoring its CSRs, the CPE auditor listened to 10 prerecorded calls that had been evaluated by the carrier at an earlier date. However, the CPE auditor did not access the claims information to evaluate whether the information being provided to the callers was correct. While assessing procedural performance is important, helping ensure that callers receive the correct information is essential.

In addition to CMS's evaluation of call centers through CPEs, the agency requires carriers to evaluate the performance of their call center CSRs. Carriers must monitor up to 10 calls for each CSR each quarter—amounting to about 90 of the more than 30,000 provider inquiries received by a given carrier each quarter. Carriers we visited agreed with one call center industry expert[12] that this level of monitoring is far short of what is necessary to thoroughly evaluate quality. Accuracy and completeness are a relatively small component (40 percent of the total score) in the overall performance evaluation of a CSR. The remaining components focus on CSR attitude and helpfulness.

CMS's oversight beyond the CPE process and carrier self-monitoring consists principally of CMS staff reviewing carriers' self-reported data, with little direct feedback from the regional BFEs. Carriers submit monthly reports summarizing certain call center data, such as how long callers were kept on hold and the number of calls abandoned. They also submit quarterly activity reports on communications. The reports include items such as the number of provider training sessions offered and the questions most frequently asked by providers. Feedback from CMS is geared toward correcting specific problems, such as lengthy caller waiting times, rather than identifying ways to improve performance on a broader scale.

CMS is Making Efforts to Improve Physician Communications

Through the feedback it has received from the physician community, CMS is aware of a need to improve Medicare communications. It is working to issue new Medicare rules and regulations on a more consistent and predictable schedule, expand information resources available to physicians, and obtain more physician feedback relating to Medicare policies and communications. However, most of these efforts are in early stages of planning or implementation; therefore, we could not assess their ultimate impact.

In June 2001, CMS announced plans to reduce the burden on providers of frequent and irregularly occurring Medicare program changes by issuing and communicating regulations on a more consistent schedule. CMS plans to institute a new, Web-based quarterly compendium of program changes, including all regulations that it expects to publish in the coming quarter, as

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[12]This expert was a featured speaker at HCFA's 2001 Telephone Customer Service Conference.

well as references or electronic links to regulations published in the previous quarter. By doing so, CMS hopes to make physicians aware of program changes and provide them with sufficient lead time to implement them. The compendium was originally to be introduced in October 2001, but according to a CMS official, as of January 2002 the compendium's format was still being developed.

CMS is attempting to improve the consistency of information that carriers provide to physicians and has both short-term and long-term projects under way. Currently, the agency is establishing a new on-line training program for carrier call center CSRs, and over the past year it has provided in-person training to carrier staffs. Installation of satellite dish technology at Medicare carriers was recently completed so that CMS could broadcast training to carrier staffs. In addition to these shorter-term initiatives, agency officials told us that they are developing some longer-term projects to enhance carriers' communications. For example, they are developing a standard template for carrier bulletins. In 2001, CMS also awarded a contract for the design of a standardized computer system that would be used by CSRs at all carrier call centers to improve CSRs' access to information as they respond to telephone inquiries. A CMS official told us this will be tested first at a durable medical equipment contractor this spring, but had no estimate of when it would be installed at carrier sites.

CMS is also addressing information that it provides directly to the physician community. In November 2001, CMS mailed the physician edition of *Medicare and You 2002* to physicians participating in Medicare, which was the first issuance of a physician-oriented version of their annual *Medicare and You* beneficiary handbook. This physician information includes a summary of recent Medicare program changes, an overview of physician concerns that CMS is currently addressing, and guidance on contacting carriers or CMS for claims submission and billing information. The agency is also focusing on improving its national Web site. Plans include installation of a new navigational system to make information on CMS's Web site more accessible and consolidation of all information relevant to providers in a single Web-based source—a project that will take several years to complete.

In recent years, CMS has also increased efforts to obtain feedback from physicians regarding communications and training. In response to the physician community's concerns, the agency established the Physicians' Regulatory Issues Team (PRIT) in 1998. PRIT has collaborated with the physician community to identify Medicare requirements, procedures, and communications that cause the most problems for physicians, and is

working to address the most significant of them. In July 2001, the administrator of CMS announced the formation of "open door" policy committees, including one focused on physicians, consisting of top CMS staff members and provider group representatives that would meet regularly to discuss regulations that are troubling to providers. Finally, in the fall of 2001, CMS sent out two surveys to obtain the views of physicians and other providers on their Medicare education needs and their experiences with CMS's program integrity efforts.

Conclusions

The scope and complexity of the Medicare program make complete, accurate, and timely communication of program information vital to physicians who need up-to-date knowledge of Medicare requirements in order to serve their patients and bill correctly for the services they provide. Although CMS has delegated this responsibility to carriers, our work demonstrates that physicians cannot rely on carrier bulletins, call centers, or Web sites to meet their information needs. In addition, CMS's lack of standard requirements for carrier communications results in carriers developing their own approaches to convey information, leading to duplication of effort and varying degrees of timeliness, accuracy, and completeness.

CMS has initiated a number of efforts, although some are just getting underway, to improve the way its carriers communicate with physicians and, in doing so, has acknowledged that improvements are needed. However, these efforts focus on the individual methods of communication and do not consider more fundamental matters such as whether the current, and almost complete, reliance on carriers to communicate with physicians is in the best interest of the program. We believe it is important for CMS to initiate a more comprehensive and standardized approach to physician communications through coordination, leadership, and management of CMS's carrier-based communications. This approach should focus on communicating timely, accurate, and complete information in formats that physicians find easy to use. It should include meaningful performance standards for carrier communications, enhanced requirements for carrier self-monitoring, effective monitoring and feedback by CMS's staff, and more substantive periodic CPE reviews of carrier communications.

Recommendations for Executive Action

In order to improve its assistance to, and oversight of, its Medicare carriers' physician communications efforts, we recommend that the administrator of CMS adopt a standardized approach that would promote the quality, consistency, and timeliness of Medicare communications while also strengthening CMS's management and oversight. Specifically we recommend that CMS take the following actions:

- Assume responsibility for the publication of a national bulletin for physicians, in addition to issuing a quarterly compendium of regulations. Carriers would be responsible for preparing supplements to CMS's national bulletin regarding local medical policy issues.
- Establish new performance standards for carrier call centers that emphasize providing complete and accurate answers to physician inquiries. Carriers' monitoring of their carrier call center operations should also be expanded to assure that these performance standards and policies are followed.
- Set standards and provide technical assistance to carriers to promote consistency, accuracy, and user-friendliness of all carrier Web sites, which should be limited to local Medicare information and should be designed to link to CMS's Web site for national program information.
- Strengthen its contractor evaluation and management process by relying on expert teams to conduct more substantive CPE reviews on all physician communications activities.

Agency Comments and Our Evaluation

In written comments on a draft of this report, CMS agreed that improvement is needed in its communications with physicians participating in Medicare and recognized that providing them with the best possible information is integral to successfully serving Medicare beneficiaries. CMS described its current efforts to develop a comprehensive customer service plan and elaborated on several efforts to improve communications that the agency currently has under way. For example, CMS pointed out that it is enhancing its services to physicians by establishing a new program to disseminate information at professional conferences and by instituting its "Open Door Forums" where physicians can meet with CMS officials and share their views on Medicare program rules. We have reprinted CMS's letter in appendix IV. CMS also provided us with technical comments, which we incorporated as appropriate.

In addressing our first recommendation to assume responsibility of a national bulletin for physicians, CMS pointed out that it is taking steps to "nationalize" information contained in these bulletins. It said it is already including articles of national interest regarding Medicare issues in carrier

bulletins. CMS also said it is planning a National Provider Bulletin Project to study the practicality of establishing a national source for the information included in these bulletins as well as potential changes to the publication and distribution process.

In response to our second recommendation that new performance standards be established for carrier call centers, CMS described a variety of initiatives it has under way to help enhance the quality of these communications. CMS agreed that providing timely, correct, and consistent answers to physicians' questions is imperative. The agency stated that it has instituted a new program of performance standards that features more effective oversight and evaluation and that includes new quality call monitoring procedures. Although this new plan appears to contain key components of an effective communication strategy, CMS's description of this effort does not contain sufficient detail for us to fully assess its usefulness. We believe such a plan ultimately needs to incorporate specific performance measures for which the carriers could be held accountable. Although CMS indicated it plans to devise ways of objectively measuring carrier performance, it said that it does not yet have such measures in place.

In response to our third recommendation to set standards and provide carriers with additional technical assistance to enhance carrier Web sites, CMS outlined the requirements that carriers must meet. CMS indicated it was satisfied with carriers' performance in this area, pointing out that an examination of Web sites was part of this year's annual CPE reviews. According to CMS, none of the carriers have been deficient in their compliance with CMS requirements, and CPE reviewers found most of the Web sites to be user-friendly. Although these CPE reviews may not have detected deficiencies at carrier Web sites, as we have noted most of the Web sites we reviewed did not comply with some of CMS's requirements. CMS has agreed to reexamine its Web site monitoring efforts.

Regarding out fourth recommendation, CMS agreed that utilizing expert teams to conduct CPE reviews would be the best means of ensuring substantive evaluations. However, CMS said that it believed that implementing our recommendation would require the agency to establish a team of dedicated review staff, which would not be feasible given the agency's available resources. Although CMS said it could not implement our recommendation at this time, it indicated that it will nonetheless try to continue building the expertise of its review staff. According to CMS, many of the staff members that performed these reviews last year will

perform them this year as well. In addition, CMS said it will continue to provide relevant training to these staff members.

Officials of the American Medical Association and the Medical Group Management Association also reviewed a draft of this report. In oral comments, officials from both organizations said they generally agreed with our findings and recommendations and offered technical comments, which we incorporated as appropriate.

We are sending copies of this report to the secretary of Health and Human Services, the administrator of CMS, and other interested parties. We will make copies available to others upon request.

If you or your staffs have any questions about this report, please call me at (312) 220-7600. An additional GAO contact and other staff members who made major contributions to this report are listed in appendix V.

Leslie G. Aronovitz
Director, Health Care—Program
 Administration and Integrity Issues

Appendix I: Scope and Methodology

To develop an understanding of physicians' concerns about the Medicare communications they receive, we obtained the cooperation of seven physician practices. These practices were of varying sizes, were located in different geographic regions, and were served by three different Medicare carriers. Each practice agreed to send us the Medicare-related information that it received during the 3-month period from February 1 through April 30, 2001. Besides participating in this communications collection effort, representatives from these practices shared their views on the quality of the information they received during this period. We also discussed these matters with representatives from the following 10 professional associations:

- American Academy of Family Physicians,
- American Academy of Professional Coders,
- American College of Emergency Physicians,
- American College of Physicians-American Society of Internal Medicine,
- American Health Information Management Association,
- American Medical Association,
- Health Care Billing Managers Association,
- Health Care Compliance Association,
- Medical Group Management Association, and
- Professional Association of Health Care Office Managers.

Because the majority of Medicare communications to physicians are issued by carriers on behalf of CMS, we focused on the three main methods these carriers use to communicate with physicians—carrier bulletins, carrier provider assistance call centers, and carrier Web sites. We did not review communications from every Medicare carrier. Our findings are limited to the carriers we reviewed and cannot be projected to other carriers. The scope of our work did not permit us to examine provider education efforts such as seminars and training sessions except in the form of documents submitted by physician practices and conversations with agency and carrier officials. In addition to assessing the quality of carrier communications, we also reviewed the agency's oversight of physician communications and its plans to improve these communications. Finally, we interviewed officials from other agencies within HHS to discuss their communications with physicians participating in the Medicare program.

Quality of Carrier Medicare Communications

To evaluate the quality of carrier bulletins, we randomly selected 10 carriers and reviewed the bulletins they issued from March through July 2001. We reviewed the bulletins from the standpoint of whether their

format and organization facilitated a reader's ability to locate information. To test the bulletins' timeliness and completeness in communicating required information, we identified approximately 40 PMs—issued by HCFA from February 1 through April 30, 2001—that addressed program changes relevant to physicians. We then selected four of these memorandums and reviewed the bulletins issued by the sampled carriers to determine when, or whether, the memorandums were published.

To evaluate the accuracy and completeness of responses given on carrier-operated provider inquiry lines, we made calls to five call centers operated by 3 carriers for a total of 59 usable responses (two nonresponses were eliminated from the sample). We selected call centers operated by the 3 carriers that serve the geographic areas where the seven physician practices participating in our data collection were located. The three test questions were selected from FAQs posted on carrier Web sites, to represent common physician billing concerns. The questions and answers are listed in appendix II. Our methodology was to ask each of the three questions, four times, at each of the five call centers, for a total of 12 test calls to each center and 20 test calls for each question. Calls were placed at different times of day and different days of the week from early May through June 2001.

HCFA officials were aware of our test. Call center managers were also informed that their CSRs would be receiving test calls from us. When calling, we identified ourselves as GAO representatives and asked the CSR to answer our question as if we were physicians. Prompts were only given if the CSR probed for more specific information or gave conditional responses that depended upon different circumstances. In those situations, we asked the CSR to provide the correct answer for each set of circumstances (such as, whether the office visit was related or unrelated to the surgical procedure). Following the response, we asked the CSR if there was any additional information he or she would like to provide. CSR responses were recorded verbatim and submitted to a Medicare coding expert at CMS along with the text of the questions and answers used. The coding expert verified our results using the following criteria.

- Correct and complete: The answer provided enough information to correctly bill, including (1) a correct explanation of how to apply the billing policy and (2) correct billing codes or a referral to specific documentation that provides coding information.
- Partial or incomplete: The answer referred to material, but (1) did not provide assistance in interpretation or warn about special circumstances

that would affect billing, or (2) provided interpretation but no directions to specific documentation, or (3) was correct but not complete.
- Incorrect: The answer contained fully or partially incorrect information, such that a physician might incorrectly bill or not file a claim for a billable service.
- Nonresponse: The CSR refused to answer the question. (Nonresponses occurred because CSRs would not answer questions for callers who were not physicians.)

To test the usefulness of carriers' electronic communications with physicians, we randomly selected 10 carrier Web sites for review. We investigated Web sites to determine whether they were in compliance with the content requirements for electronic media as detailed in HCFA's 2001 budget and performance requirements and in the contractor Web site standards and guidelines posted on the agency Web site. To identify best practices for effective, user-friendly Web sites, we interviewed four individuals familiar with Web site development, including the Web master for HHS and two private Web designers. We used information from these sources to evaluate the 10 carrier Web sites for their accessibility, privacy, format, content, ease of navigation, organization, contact information, appearance, and use of graphics.

HCFA Oversight of Physician Communications

We identified HCFA requirements for carrier bulletins, call center operations, and carrier Web sites, and discussed the agency's oversight and monitoring of carriers' communications with both headquarters and regional office officials. We researched call center standards used in private industry through conversations with an industry expert and the manager of a large call center, and visited three carrier call centers to discuss technology, standards, best practices, and support from HCFA. We also observed carrier call centers' monitoring of calls for quality at the three call centers we visited. In addition, we observed a contractor performance evaluation—the agency's independent review of "at-risk" contractor activities—conducted at one of the carrier call centers in our review.

Improving Medicare Communications

Throughout this review, as we met with HCFA and carrier officials and representatives of the physician practices participating in our communications collection, we solicited their views on problems with the Medicare communications process and potential best practices. Agency officials also identified their current and planned efforts to improve its process for communicating with Medicare providers. In addition, we

discussed related issues in our conversations with representatives from professional associations.

Other HHS Agencies' Communications to Physicians

HHS is the principal federal department responsible for protecting the health of Americans and providing other essential health services. Although the focus of our work was Medicare communications that originated with CMS, we were also asked to identify the quantity and type of communications that physicians receive from other HHS agencies. Based on our review of background information and discussions with HHS officials, we identified nine HHS offices and agencies, other than CMS, as potential sources of information or instructions for practicing physicians. These include the Office of the Secretary, Office of the Inspector General, Agency for Healthcare Research and Quality, Centers for Disease Control and Prevention, Food and Drug Administration, Health Resources and Services Administration, Indian Health Service, National Institutes of Health, and Substance Abuse and Mental Health Services Administration.

We contacted officials in these offices and agencies and reviewed information available through their Web sites to determine whether they issued instructions or requirements that affected practicing physicians. Compared to CMS, the other HHS agencies we contacted issue relatively few requirements for practicing physicians and rarely communicate instructions or information directly to the physicians, as does CMS through its Medicare carriers. Generally, officials we contacted indicated that these agencies rely primarily on posting information to their Web sites to communicate with the medical community and the general public. Many of the HHS agencies also offer subject-specific e-mail notification of new Web postings to physicians and others who register to receive this service. Some agencies have newsletters or publications to which physicians and others can subscribe or they provide specific information upon request.

Appendix II: Call Center Accuracy Test Questions

The questions and answers we used to test the accuracy of carrier call center responses to physician inquiries are shown in table 4.

Table 4: Questions and Answers for Test of Carrier Call Centers

Question	Answer
If a physician provides critical care for 1 hour and 15 minutes, how should the services be reported? Should code 99292 (for an additional 30 minutes) be reported? Should the reduced services modifier be used?	Code 99291, Critical care, first hour. Should be used to report the services of a physician providing constant attention to a critically ill patient for a total of 30 minutes to 1 hour on a given day. If the total duration of critical care provided by the physician on a given day is less than 30 minutes, the appropriate evaluation and management code should be used. In the hospital setting, it is expected that the level 3 subsequent hospital care code (99233) would most often be used.
	Code 99292, critical care, each additional 30 minutes. Should be used to report the services of a physician providing constant attention to the patient for 15 to 30 minutes beyond the first hour of critical care on a given day.
What is the proper way to bill for an office visit on the same day as a surgical procedure?	If the office visit is unrelated to the surgical procedure, separate payment can be allowed by applying the "25" modifier to the office visit procedure code. Medicare will not pay separately for a visit on the same day as a minor surgery or endoscopic procedure unless other significant, separately identifiable services are performed in addition to the procedure. If other significant evaluation and management services are performed on the same day, the physician may bill for the visit with modifier "25."
Can code 99211 be reported if a nurse in the physician's office provides instruction on self-administering insulin?	Yes. If a physician's employee performs a limited service, a physician may use this code to report services that may not require personal performance.[a] The definition of code 99211 is as follows: office or other outpatient visits for the evaluation and management of an established patient that may not require the presence of a physician. However, this code should not be reported in addition to other evaluation and management services performed by the physician on the same day.

[a]CMS advised us that the following sentence should be inserted for this answer to be accurate: "All of the requirements for an 'incident to' service must be met."

Source: Frequently asked questions and answers posted on carrier Web sites.

Appendix III: Results of Communications Collection from Seven Physician Practices

To identify the quantity and sources of Medicare information received by physicians, we enlisted the assistance of seven physician practices to collect communications that related to their practices and were received during the 3-month period from February 1 through April 30, 2001. A 3-month period was selected so that practices would receive at least one carrier bulletin. HCFA representatives and participating practices reported that the period selected was typical in relation to the release of Medicare regulations and information. The participating physicians represented both urban and rural practices and were located in four states served by three carriers and three HCFA regional offices. They also varied in size and specialty and included

- a 600-physician multispecialty group;
- a 450-physician teaching hospital-based group;
- a 43-physician network of small internal medicine/family practice groups;
- a 10-physician internal medicine, obstetrics/gynecology, and pediatric group;
- a 4-physician multispecialty group;
- a 4-physician internal medicine group; and
- a 4-physician ophthalmology group.

The practices collected and submitted full copies or excerpts of practice-related communications received by mail, fax, or e-mail, or downloaded from the Internet, regardless of the source, during this period.[1] We asked the practices to omit certain items from their collection due to lack of relevance or privacy issues. Material the practices were asked to include and exclude from their submissions to us is shown in table 5.

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[1] In the case of the three largest practices, we collected documents from only some of their departments. Due to the size of some of these documents, we often received excerpts containing the front page, table of contents, and a description of the document.

Table 5: Summary of Communications Included and Excluded by Physician Practices

Communications included	Communications excluded

• Written communications containing information that the physician, or his or her practice, was required to comply with
  a) to participate in or submit claims to Medicare, other federal or state programs, or private payers; or
  b) to legally operate his or her practice.
• Written communications that the physician was not required to comply with, but had to review in order to determine that compliance was not required.
• Information that was not compliance-related but was relevant to the practice, such as professional journals, newsletters or public health alerts.
	• Internal practice communications or communications with patients.
	• Statements and correspondence as part of the routine claims processing cycle, including claims denials and documentation requests.
	• Marketing and advertising information.
	• Information on conferences or educational opportunities (other than compliance training).
	• Communications from agencies such as the Internal Revenue Service; the Occupational Safety and Health Administration; or other federal, state, or local government entities that have no direct bearing on medical practice.
	• Subpoenas, demand letters, or similar legal communications.

We collected 947 documents from the physician practices. Based on the table of contents or section titles of these documents, we categorized them as (1) directly related to Medicare, (2) unrelated to Medicare but involving some other requirement relevant to the physician practice, and (3) information relevant to the physician practice that did not include any requirement the practice needed to act upon. We also classified communications by their source, including HCFA or its carriers, other HHS agencies, state and local government agencies, insurance companies and managed care plans, and all other sources, such as professional journals, newsletters, or other information sent to physicians. We could not independently verify that the physician practices submitted all relevant communications they received, nor could we reliably distinguish between communications that the practice requested and those that were unsolicited. Most of the documents submitted by the practices had some Medicare content, indicative of the pervasiveness of the Medicare program. Frequently appearing topics included Medicare fraud and abuse, Medicare coding issues, contractor audits, and the Medicare appeals process.

The information that was submitted by the seven physician practices shows that while Medicare-related information accounts for much of this material, a relatively small portion of the documents came from HCFA, its carriers, or other governmental sources. About half of the documents we received from the physician practices contained mostly Medicare information. We found that a relatively small amount of all documents—about 10 percent—was sent by HCFA or its carriers. Material from other HHS agencies accounted for less than 3 percent of all documents the physician practices collected. The majority of the information came from

other organizations, such as consulting firms and medical specialty or
professional societies.

Table 6 shows the source and subject of all documents collected and
submitted by the participating physician practices.

**Table 6: Percentages of Medicare Communication Subjects and Sources Collected by Seven Physician Practices from
February 1, 2001 through April 30, 2001**

| | Subject of the Communication | | | |
Source of communication	Medicare Information	Practice information not related to Medicare	Information not required for Medicare or medical practice	Total[a]
HCFA	9.9	0.2	0	10.1
All HHS other than HCFA	1.5	0.8	0	2.3
All government other than HHS (federal, state, and local)[b]	0.3	2.3	0.5[a]	3.2
Private insurance	0.1	6.2	0.1	6.4
Private sector other than insurance	36.0	19.1	22.8	78.0
Total[a]	**47.8**	**28.7**	**23.4**	**100**

[a]Some columns and rows do not equal the total percentage shown because of rounding.

[b]Category includes local public health department warnings and proposed legislation at all levels of
the government. Category does not include communications from agencies such as the Internal
Revenue Service, the Occupational Safety and Health Administration, or other federal, state, or local
government entities that have no direct bearing on medical practice.

Source: GAO analysis of 947 documents collected from seven physician practices.

The number of Medicare-related documents and number of pages
submitted by each practice was generally related to the size of the
practice. This was true both of documents from HCFA and from the
private sector. Three of the smaller practices sent us fewer than 5
documents that they received from HCFA. In one case, the 3 documents
submitted by a small practice totaled 217 pages. The largest practice, a
multispecialty clinic, sent 57 HCFA documents totaling 704 pages. A small
rural practice sent 3 private-source documents totaling 12 pages, while the
multispecialty clinic sent 148 documents totaling 1,174 pages. The number
of documents received by a practice may be influenced by the practice's
breadth of specialties and participation in professional organizations.

Appendix IV: Comments from the Centers for Medicare and Medicaid Services
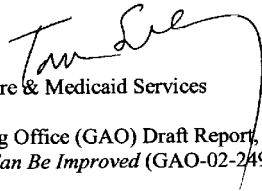
DATE: FEB 2 5 2002

TO: Leslie G. Aronovitz
Director, Health Care—Program
General Accounting Office

FROM: Thomas A. Scully
Administrator
Centers for Medicare & Medicaid Services

SUBJECT: General Accounting Office (GAO) Draft Report, *Medicare: Provider Communications Can Be Improved* (GAO-02-249)

Thank you for sending the above-referenced report for comments. We appreciate GAO's efforts to identify areas for improving the Centers for Medicare & Medicaid Services' (CMS) communications with Medicare providers. We agree that improvement is needed in this area for the agency. Providing the best possible information to physicians and other providers and suppliers is integral to successfully serving our Medicare beneficiaries.

The CMS is currently examining its customer service strategy and is formulating a comprehensive strategic plan in this area. Once the full potential of this plan is realized, we believe the concerns raised by GAO will be significantly diminished. We are grateful to GAO for its timely report as it will serve to strengthen our strategic planning effort.

Before commenting on the specific recommendations outlined in the GAO report, we would like to outline some activities we currently have underway, and some ideas we are exploring for the future.

The CMS is enhancing and expanding its outreach, education, and overall service to physicians, providers and suppliers by building on its current education and customer service systems with a renewed spirit of openness, mutual information sharing, and partnership. Several national programs have been established to more effectively communicate directly with physician and provider organizations and to enhance their relationship with the Medicare program.

The following list of activities delineates some of the most important education measures CMS has recently undertaken (some during and/or after GAO conducted its review) in its spirit of responsiveness to the needs of physicians, providers and suppliers:

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- We provide Medicare contractors with in-person instruction and a standardized training manual for them to use in educating physicians, providers, and suppliers on new CMS policy initiatives (e.g., new prospective payment systems). These programs provide consistency and help ensure that our contractors speak with one voice on national issues.

- Via our Satellite Learning Channel, which we launched in November 2001, we provide Medicare contractors with the latest information on contemporary topics of interest. We recently completed the installation of a network of satellite dishes at all contractor call centers to improve our training efforts with contractor customer service representatives.

- We now have a program for monitoring the training sessions conducted by our contractors so that we can obtain feedback from providers and work collaboratively to find new ways of communicating with them.

- We are in the process of re-evaluating Medicare contractor bulletins and other communications with providers, and have taken steps to standardize and make more consistent the information contained in contractor bulletins by developing national information articles on significant Medicare policies.

- Over the past year, CMS has made it a practice to make available a list of Web-Based, frequently asked questions (FAQs) for major Medicare program initiatives, which are publicly available to all providers over the Internet.

- We have established electronic listservs on priority initiatives that have enabled us to keep thousands of subscribers informed about the latest Medicare changes. We expect to continue these practices for future significant initiatives, as well as investigate the feasibility of developing a new system to capture, compile, and index FAQs.

- We provide a variety of resources, such as Reference Guides, FAQs and Computer-Based Training courses, online at the Medicare Learning Network homepage, www.hcfa.gov/MedLearn.htm. MedLearn provides timely, accurate, and relevant information about Medicare coverage and payment policies, and serves as an efficient, convenient provider education tool.

- We recently established a National Physician and Provider Organization Exhibit Program designed to disseminate information from CMS to physicians and providers at various professional conferences held throughout the country.

- Eleven Open Door Forums were established in August 2001 for virtually every physician and provider type that participates in the Medicare program. Regularly held listening sessions are being conducted throughout the country to allow us to

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hear directly from physicians and health care providers about what it's like to live
and work every day under the rules we develop.

- Strengthening of the operational support of the Practicing Physician Advisory
Council, which plays a key role as a Federal Advisory Committee Act-compliant
advisor body, is assisting CMS in identifying issues challenging practicing
physicians.

- This year we are establishing plans for a customer satisfaction survey and
focus group program in order to advance our initiative for obtaining
physician/provider/supplier input to their customer service needs.

In tandem with our efforts to improve physician and provider education, we are focused
on improving the quality of our provider customer service. Last year, our Medicare
contractors received 24 million telephone calls from physicians and providers, and we
know it is imperative that the contractors provide timely, correct, and consistent answers.
One significant step towards service improvement is our recent move from toll to toll-
free telephone answer-centers at all Medicare contractors.

We agree with GAO about the importance of accurate and consistent answers to provider
inquiries and this past year we implemented a new program of performance standards,
including more effective oversight and evaluation. We have quality call monitoring
procedures, contractor guidelines, and performance standards in place to ensure that
contractors know what is expected and so that we can be satisfied that the contractors are
meeting/exceeding our expectations. We also want to know about the issues and
misunderstandings that most affect provider satisfaction with our call centers so that we
can provide our customer service representatives with the information and guidance to
make a difference. We are exploring various feedback mechanisms and contractor
profiling to obtain this information.

Because our physician and provider education, outreach, and customer service activities
are relatively new, we do not yet have outcome measures to demonstrate that what we are
doing is effective. While we are implementing tools to measure the impact of our
interventions (e.g., a Quality Call Monitoring Scorecard and Customer Service
Representative standards), we will not be able to objectively measure the effect of those
interventions until we are farther down the road. We believe, however, that we are doing
the right things and are optimistic that these activities will improve our communication
with physicians and other providers and suppliers.

We appreciate GAO's recognizing that our resources are limited. Many of the
observations and suggestions contained throughout the report represent initiatives CMS
would gladly undertake if it had the resources to do so. We are doing a lot with the
resources we have and will continue to seek additional resources. In the meantime, we
continue to examine ways to use our existing resources in creative ways, such as

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making greater the use of the Internet, other e-commerce tools, and other media, as a way
of improving the ways in which we share information with, and receive information
from, physicians and other providers and suppliers.

Physicians and other providers play a crucial role in caring for Medicare beneficiaries,
and their concerns regarding the program's regulatory burden must be addressed.
Enhancement of our communication and education efforts is essential to the success of
Medicare, and we believe it will ultimately reduce the level of physicians', providers' and
suppliers' frustration with the Medicare program, as well as increase beneficiaries'
options and satisfaction.

GAO Recommendation

Assume responsibility for the publication of a national bulletin, for providers, in addition
to issuing a quarterly compendium of regulations. Carriers would be responsible for
preparing supplements to CMS' national bulletin regarding local medical policy issues.

CMS Response

The CMS is very interested in making the information that is furnished to physicians,
providers and suppliers as useful, clear, and understandable as possible. To this end,
CMS has taken steps to "nationalize" information contained in contractor bulletins and
newsletters sent to physicians, providers, and suppliers. The CMS often has developed
national information articles on significant Medicare policies, programs, or issues. These
articles are carefully written to be lucid and comprehensible and to effectively
communicate with the target audience. These national articles are distributed to all
Medicare contractors who are instructed to publish them in their next provider bulletins.

Additionally, for fiscal year (FY) 2002, CMS is planning a National Provider Bulletin
Project. The project will be used to determine the practicality of establishing a national
source for the information and material included in provider bulletins while also allowing
for the communication of local contractor concerns. The effort will also evaluate the
publication and distribution process for the bulletin.

GAO Recommendation

Establish new performance standards for carrier call centers that emphasize providing
complete and accurate answers to physician inquiries. Carriers' monitoring of their
carrier call center operations should also be expanded to assure that these performance
standards and policies are followed.

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<u>**CMS Response**</u>

As previously stated, we agree with the need to focus on improving the quality of our provider customer service. Last year, our Medicare contractors received 24 million telephone calls from physicians and providers, and it is imperative that the contractors provide timely, correct, and consistent answers.[1] We have several initiatives underway to address this need:

- <u>**Contractor Performance Evaluation (CPE) Reviews.**</u> We have performance standards, quality call monitoring procedures, and contractor guidelines in place to ensure that contractors know what is expected and so that we can be satisfied that the contractors are reaching our expectations. For the FY 2001 period and for the first time, Medicare contractors' physician and provider telephone customer service operations were reviewed against these standards and procedures separate from our review of their beneficiary customer service. During these weeklong CPE reviews, we identify areas that need improvement and "best practices" that can be shared among our other Medicare physician and provider call centers. As a result of the reviews, performance improvement plans will be instituted when needed, and CMS staff in our Regional Offices will continue to monitor the specific contractor throughout the year. Separate from the CPE reviews, the Medicare Contractor Consortium Management Officers, responsible for each contractor, perform regular reviews throughout the year, including a check on the contractors' provider customer service.

- <u>**Desktop Initiative.**</u> We have begun a modernization program that gives the Medicare contractor customer service representatives, who handle physician/provider inquiries, state-of-the-art desktop tools to enable improved responsiveness in handling telephone inquiries and combine this technology upgrade with the development of standardized resource materials and training for those customer service staff.

- <u>**Quality Call Monitoring (QCM) Procedures.**</u> We have recently formed Central Office/Regional Office/contractor workgroups to review the contractor performance standards, QCM scorecard, QCM criteria chart, and the monthly telephone data reporting processes, and make changes to tailor them to the needs of physicians, providers and suppliers. The QCM workgroup made significant changes in the wording of monitoring criteria and in the weighting of segments of the scorecard to increase its relevance for monitoring provider calls. The scorecard was tested throughout October and early November 2001, and was implemented on a national level beginning December 2001. There are two separate overall scores for the QCM. The first addresses "soft skills" (common to all customer service

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[1] Coding questions, such as those presented to Contractor Customer Service Representatives by the GAO auditors, are not the typical and frequent questions received by the call centers. Of the 24 million calls we received in FY 2001, the vast majority of those, based on CPE reviews of call monitoring processes, are handled accurately, completely, and courteously.

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operations), and the second addresses "accuracy/completeness." This allows for more directed coaching sessions and service improvement.

- **Creating Call Center Profiles.** In FY 2001, we visited eight of our largest Medicare contractors to collect information on their operations, their use of technology, their performance data, their most frequently asked provider questions, and their training needs. We subsequently collected similar information from all of the remaining Medicare call centers via an online profile. The profiles have been analyzed to identify additional training needs and other improvements we can make at our contractors. These improvements will be implemented through a Customer Service Training Plan (see below).

- **Creating a Customer Service Training Plan.** Based upon the call center profiles we have gathered, we have drafted a Customer Service Training Plan to address the training needs of our Medicare customer service representatives. This training plan will bring uniformity to the contractor training, and improve the accuracy and consistency of the information that representatives give to physicians and providers across the country. Our first training effort will focus on the Correct Coding Initiative. Customer service representatives will be trained on the language and concepts of coding issues so that they can properly direct physicians and providers to the best sources of information or make sure that the appropriate technical expert responds to the caller in a timely fashion. We plan to offer this and other training via a satellite network.

- **Holding Telephone Customer Service Conferences.** In March 2001, we held our first National Telephone Customer Service Conference for Medicare contractor call center managers and our Central and Regional Office staff. The conference emphasized our goal of improved customer service and served as a forum for exchanging ideas on best practices. Our next conference is scheduled for July 2002.

- **Conducting Monthly Call Center Meetings.** We currently hold monthly conference calls with contractor call center managers and CMS Central and Regional Office staff to identify problems, give contractors additional information, and resolve issues.

- **Analyzing Baseline Performance Data.** Medicare call center managers were required to report data from October 1999 through May 2001 (and monthly thereafter), on a variety of performance measures. We are analyzing these data to determine contractors' relative performance and the impact of the installation of toll-free lines on contractor workload and performance.

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GAO Recommendation

Set standards and provide technical assistance to carriers to promote consistency,
accuracy, and user-friendliness of all carrier Web sites, which should be limited to local
Medicare information and should be designed to link to CMS's Web site for national
program information.

CMS Response

As GAO indicates, CMS has established requirements for the features and content of
Medicare contractor Web sites used to furnish physicians, providers and suppliers timely
and understandable Medicare program information. These requirements are contained in
the annual Budget and Performance Requirements for fiscal intermediaries and carriers,
and in the Statement of Work for Durable Medical Equipment Regional Carriers. For FY
2002, all Medicare contractor provider/supplier Web sites must contain the following:

- all bulletins/newsletters;
- a schedule of upcoming events (seminars, workshops, fairs, etc.);
- ability to register for contractor-sponsored events via the Web site;
- features which permit providers to order and receive copies of bulletins;
- a quarterly listing of provider frequently asked questions;
- search engine functionality;
- e-mail based support/help/customer service;
- a "What's New" or similarly titled section;
- an ability to link to other provider interest sites and
- an area designated as the Medicare Learning Network which will contain
  promotional material supplied by CMS as well as link to CMS's MedLearn and
  Best Practices Web sites.

Additionally, all Medicare contractor Web sites must comply with CMS's "Contractor
Website Standards and Guidelines."

These Medicare contractor Web sites were examined as part of this year's annual CPE. In
all of the CPE reports received to date, none has cited any contractor provider Web site
for being deficient from CMS requirements. In fact, most reports indicate that the
provider Web sites were generally clearly presented, user friendly and contained an
abundant amount of easily retrievable Medicare provider information. However, we
appreciate the findings from GAO and we will reexamine our monitoring efforts to make
certain our guidelines are being followed.

For FY 2002 CMS has instructed its Medicare contractors to establish and maintain
electronic mailing lists listservs for physicians, providers and suppliers. These listservs
will be used to notify registrants via e-mail of important and time sensitive Medicare
program information, upcoming provider education and training events, and other

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announcements or messages necessitating immediate attention. Contractors will also use their listservs to notify registrants of the availability of contractor bulletins on their Web sites.

GAO Recommendation

Strengthen its contractor evaluation and management process by relying on expert teams to conduct more substantive CPE reviews on all provider communications activities.

CMS Response

Performing CPE is part of our strategy to achieve consistency in the communications we have with physicians and providers while also serving as a tool to hold contractors accountable for the service they provide. The FY 2001 was the first year we performed CPE reviews for provider education and customer service activities, including provider inquiry telephone lines. Teams consisted of Central Office and Regional Office staff working in the provider education arena, many of whom participated in the development of the standards used to evaluate contractors' performance in their provider communication activities. We acknowledge that expert teams of reviewers would be the best tools for ensuring substantive evaluations. However, we also believe that establishment of expert teams for review of provider communications would require CMS staff dedicated to the conduct of reviews. Given the work faced by the Agency and the resources available, CMS is not able to have a dedicated review staff at this time. We will, however, continue to provide training and increased review experience to staff that are available to conduct reviews.

Results from the first year's reports provided us with baseline information on the activities performed by the contractors in relation to the priorities of the Agency. Modifications have been made to the protocols being used this year to better focus on the vast array of activities used to communicate with physicians and providers. The expertise of the teams continues to build as many of these same staff are performing CPE reviews again this year.

Appendix V: GAO Contact and Staff Acknowledgments

GAO Contact	Geraldine Redican-Bigott, (312) 220-7678
Staff Acknowledgments	Donald Kittler, Victoria Smith, Christi Turner, and Margaret Weber made key contributions to this report.