THE REGULATORY MORASS AT THE CENTERS FOR MEDICARE AND MEDICAID SERVICES; A PRESCRIPTION FOR BAD MEDICINE

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THE REGULATORY MORASS AT THE CENTERS FOR MEDICARE AND MEDICAID SERVICES: A PRESCRIPTION FOR BAD MEDICINE

WEDNESDAY, JULY 11, 2001

HOUSE OF REPRESENTATIVES,
COMMITTEE ON SMALL BUSINESS,
Washington, DC.

The Committee met, pursuant to call, at 10:05 a.m. in Room 2360, Rayburn House Office Building, Hon. Donald Manzullo [chairman of the committee] presiding.

Chairman MANZULLO. The Small Business Committee will come to order. Good morning.

This is the Committee's second hearing to examine the regulatory problems at the centers for Medicare and Medicaid services, CMS, formerly known as HCFA. I will not recognize the new name until I am convinced that HCFA is the a new organization with a new operating philosophy. So I will not use the new name anymore. At that point when I no longer use HCFA, then the reforms we are seeking will have been implemented.

In the previous hearing the Committee heard about the deluge of paperwork that health care providers towered under in the effort to provide service to the injured and the informed. Today's hearing will address the regulatory morass swamp in health care providers and potential solutions to the draining of that swamp. [Laughter.]

It is like Pogo in that swamp down there? [Laughter.]

Are you doing okay? We are having some fun today, are we not? You bet, you bet. The Committee's next hearing at the end of this month we expect to hear from Thomas Scully of the head of HCFA, and Sean O'Keith from the Office of Management and Budget, about administrative actions that they can take to resolve the problems identified by the Committee.

The health care provider renders service to an eligible Medicare beneficiary and should be reimbursed at a rate that enables the health care provider to stay in business. That seems like a simple proposition. However, sometimes simple tasks are rendered unduly complex by excessive federal government procedure. In the case of Medicare, the simple proposition of reimbursing providers for services rendered now covers more than 130,000 pages of federal laws, regulations and informal guidance. The U.S. Court of Appeals, Judge Leon Higginbothim, once noted about Federal Milk Marketing Orders, "It is difficult to imagine a case intertwined with greater confusion and delay and a problem which but for the administrative process was not extremely complex." Well, what does

that mean? It means you cannot understand it. Today's hearing will demonstrate that Judge Higginbothim's statement can be applied with equal, if not greater, force to the operation of the Medicare program.

The regulatory morass of HCFA has spawned a hydro-headed monster feared by all and accountable to no one. This morass cannot last because the diversity affects the ability of small businesses to provide adequate health care to beneficiaries. I am interested in navigating through this, and I would like to thank Mr. Toomey and Ms. Berkley for their leadership on this issue. The ultimate beneficiaries will be patients and taxpayers because higher quality care will be offered at a lower overall cost to the economy. And I will recognize the Ranking Member of the Full Committee, the distinguished gentle lady from New York, for her opening statement.

[Mr. Manzullo's statement may be found in the appendix.]

Ms. VELAZQUEZ. Thank you, Mr. Chairman.

Today we continue our examination of the Health Care Financing Administration system, known today as the Center for Medicare and Medicaid Services. During our last hearing, this Committee examined the main burdens CMS imposes on health care providers. Foremost among these are onerous and often contradictory paperwork requirements that doctors must go through simply to receive payment for services. Even more disconcerting, doctors can face unannounced audits for unintended errors. In addition, doctors are forced to pay the difference in disputed agency billings up front, before the dispute is resolved—effectively, they are considered guilty until proven innocent. Tragically, these impositions discourage doctors from caring for the most needing among us—the aged, and the poor.

Today, Mr. Chairman, we focus on solutions to these problems. The Medicare Education and Regulatory Fairness Act, proposed by my colleagues Congresswoman Berkley and Congressman Toomey, goes far to overcome these challenges. First, this bill will reduce the administrative burden on doctors by easing complex billing requirements and creating an expedited system for dispute claims resolution. Second, doctors will get advance notice for any audit, so they are not caught by surprise when CMS comes knocking. Lastly, this bill bars up-front repayments in fee disputes, requiring the agency to prove the doctor has committed an error, rather than the other way around. This legislation addresses many of the inequities created by the most recent reforms, enforcing the fair play we expect from our government.

Nevertheless, I hope we will be careful as we move forward. Unintended or unexpected consequences of our reform proposals could divert energy and funds away from the primary mission of CMS, which is to compensate fairly the doctors who provide services to the poor and elderly. For example, our attempt to level the playing field between doctors and CMS should not limit enforcement efforts against fraud or abuse. As a recent news report has suggested, there are still some people out there trying to bilk CMS for their own profit.

In loosening the grip CMS has on providers, we need to avoid a return to our earlier system, which was rife with chronic mispayments or improper payments. CMS has reduced payment

error rates from 14 percent in 1996 to 6.8 percent in 2000—and we can encourage them toward their goal of a five percent error rate set for next year.

Finally, the driving force for our reform remains the continued viability of Medicaid and Medicare. Thankfully, through strong fiscal discipline and good success in reducing fraud and errors, the Medicare Trust Fund will remain solvent through 2025. We can continue and improve on that success.

To conclude, Mr. Chairman, CMS provides a vital service to those who most need medical are; our poor and our elderly. We will work together to build a system where doctors do not fear caring for their patients while we fight waste, fraud and abuse.

Thank you.

[Ms. Velazquez's statement may be found in appendix]

Chairman MANZULLO. Thank you very much.

We have two panels. Our first panel consists of two members, Congresswoman Shelley Berkley from Nevada, and Congressman Pat Toomey from Pennsylvania.

Congresswoman Berkley, please.

Ms. BERKLEY. Thanks.

Chairman MANZULLO. And I am going to put on the five-minute clock. Normally members ignore red lights and green light, but let's take a stab at it anyway. Thank you.

STATEMENT OF THE HONORABLE SHELLY BERKLEY, A CONGRESSWOMAN FROM THE STATE OF NEVADA

Ms. BERKLEY. Thank you, Chairman Manzullo, Ranking Member Velazquez, and Members of the Committee for this opportunity to speak before you today.

Let me begin by telling you how pleased I am that the Small Business Committee is studying this problem of the regulatory burden in the Medicare system. I do not have to tell you that many health care providers are in fact small business people. Many of them have small practices with only a few staff members.

They are finding it increasingly difficult, sometimes impossible, to keep up with the constantly changing regulatory obligations of the Medicare system. And to give you some idea of what they are contending with, I have with me the books that most doctors will tell you represents the core of their medical education when they are in medical school, and I have in front of you five cases of Medicare regulations that the doctors after they graduate medical school after having mastered what is in these books, then they have to master what is in those crates. It is not very balanced, I would say.

Asking a small practice, or any practice for that matter, to deal with that massive amount of paperwork is unfair, unnecessary, and counterproductive. Finding a way to reduce this burden can mean the difference between helping small practices stay open, particularly in rural areas, or watching them shut down one by one.

In order to help this important segment of the small business population, the Medicare regulatory burden must be addressed. And I want to share with you how I became involved in this.

I received a telephone call from a friend of mine telling me about a problem that a fellow doctor was having. Apparently he had attended a HCFA seminar in Las Vegas and got into a debate with

a HCFA representative who was talking about the different regulations. And in the exchange, from what I understand, it got very heated. Then, of course, the seminar ended. The doctor went home.

Two weeks later he received a letter from HCFA advising him of an impending audit. He is absolutely certain that the reason that he got this letter was for retribution for having spoken out about some of the regulations that were being proposed, or initiated I should say.

What happened to this doctor should not happen in America to anybody. HCFA came in. They totally disrupted his practice for months after months after months. His practice ground to a standstill while the auditors took over his office, went through hundreds of thousands of dollars of billings.

A year later he received a letter, after almost the destruction of his practice, saying that he owed $900. There was never any question of fraud, never any question of abuse. What there was was a difference in the coding, and after hundreds and hundreds of thousands of billings being gone through by HCFA, totally disrupting the man's practice, they told him he owed $900, and it was terribly, terribly unfair.

As I helped my constituent, I found myself wading deeper and deeper into the amazing amount of paperwork, regulation and explanation that health care providers must deal with on a daily basis. As time went on, I began to hear one story after another from hardworking providers who have had increasing problems working within Medicare.

One letter I received from a constituent is particularly compelling. It was sent to me by a doctor who has fought his way, unsuccessfully, through the regulatory process. He writes, "Although I have spent my entire 30-year career dedicated to the care of my patients, I will be forced to retire. There is no way for me to express the pain and anguish that I feel at the prospect of this happening. At this point I can think of nothing else to do except to ask for your help. How can this be happening in our country?" It is time to do something to protect our nation's community of law-abiding physicians from overly burdensome federal acts so that they can remain in the Medicare program, treating and caring for our nation's older Americans.

This need is precisely the reason why Congressman Toomey and I introduced the Medicare Education and Regulatory Fairness Act, MERFA, last March. This important legislation seeks to provide regulatory relief to health care providers in the Medicare system. The bill achieves this goal by reforming some of the practices of CMS, clarifying current regulations and providing education about Medicare regulations to providers.

MERFA responds to the problems health care providers face by reforming the audit practice to limit random audits, make the practice of returning overpayments to CMS more fair, and limit the use of extrapolation. MERFA provides basic rights concerning appeals and delays recovery of overpayments until the entire appeals process has been completed.

MERFA also creates several effective education functions to ensure that billing and documentation errors are minimized. Finally, MERFA requires CMS to make sure that new documentation

guidelines for physician services are pilot tested before implementation.

Physicians and other health care providers do not want to spend valuable time on paperwork. They know there is some that must be done, but they more importantly want to save lives, ease sickness and serve their patients. MERFA will help them do that. Medicare needs to be user friendly, a user friendly system for both patients and providers. This bill is a step in that direction.

Once again, I want to thank you for testifying and thank you for an opportunity appear in front of you. Thank you very much.

[Ms. Berkley's statement may be found in appendix]

Chairman MANZULLO. Well, thank you. I presume you do not want those documents made part of the record.

Ms. BERKLEY. In the interest of not overburdening with regulation, no.

Chairman MANZULLO. Thank you.

By the way, statements of all witnesses and members of Congress will be made part of the official record without objection.

Congressman Toomey.

STATEMENT OF THE HONORABLE PATRICK J. TOOMEY, A CONGRESSMAN FROM THE STATE OF PENNSYLVANIA

Mr. TOOMEY. Thank you, Chairman Manzullo. It is a pleasure to be here to testify today before the Committee. I want to thank you, Mr. Chairman, also Ranking Member Velazquez, and my fellow Committee members. Perhaps in light of the fact that I am member of this Committee, you will go easy on me during questioning.

Mr. Chairman, first, I would like to thank you for one other thing, and that is your longstanding leadership on the need to reform Medicare for health care providers and the patients that they serve. I would also like to thank my fellow Committee members, many of whom are co-sponsors of this legislation. Representative Berkley and I introduced MERFA just four months ago, and today we will be announcing that we have over 220 bipartisan co-sponsors. Medicare reform for providers is indeed an issue whose time has come.

As we heard in this Committee's hearing on May 9, health care providers of all kinds are suffering under excessive paperwork and regulations. In my view, Medicare's burdensome regulations are a symptom of the fundamental structural flaw in the program. As long as the federal bureaucracy attempts to dictate the circumstances under which it will allow, and the price it will pay for thousands of different individual medical procedures, Medicare will always be a maze of regulations and will not provide the effective, efficient medical insurance that our senior citizens deserve. Ultimately, we need to transform Medicare into a market-based system in which patients are also consumers. Patients should be in control of the money that is being spent on their behalf.

Now, H.R. 868, the Medicare Education and Regulatory Fairness Act, is not nearly that ambitious. Fundamental, comprehensive reform of Medicare will take more of a consensus and more time. But, in the meantime, health care providers need relief now, and that is what our bill does. Congress needs to step in and restore some balance between HCFA and the health care providers. And

if we do not step in, HCFA's practices will have serious detrimental effects on the quality of our seniors' medical care.

I would like to outline what I believe are several unintended consequences of some of HCFA's current practices. First, a number of HCFA's practices are counterproductive. In an effort to try to lower the cost of health care, HCFA attempts to reduce fraud by imposing enormous paperwork burdens on all health care providers, including the overwhelming majority of whom are honest and would never commit fraud. Paradoxically, this burden actually increases the cost of providing health care for senior citizens. Second, HCFA's practices can be counterproductive when they reduce the amount of time health care providers have to spend with their patients. Third, seniors' medical records have become more of a way for physicians to communicate with Medicare bureaucrats than as a way to communicate with their colleagues. As Dr. David Whitson will testify in the next panel, sometimes these documents are no longer even clinically useful medical records. Rather than being medical records, they have become billing records. Fourth, and perhaps most disturbing, is the perverse incentive for health care providers to deliver ordinary care—the service that will not raise eyebrows at HCFA—not necessarily the best care. For health care providers, the risks and costs of defending against HCFA are so great that it produces an incentive for them to bill Medicare for common services, which means providing patients with common services, even when the best care might call for more intensive or just different services. Finally, the shear complexity and associated costs of compliance are so great that solo and small group practices often simply cannot afford to comply.

So what does MERFA do to correct these unintended consequences? MERFA reforms how HCFA issues new regulations and policies, for one. It ensures health care providers have a modicum of due-process rights when there is a dispute with HCFA, and it allocates administrative funding for the specific purpose of educating providers about proper billing and documentation. Our goal is to ease some of the regulatory burdens that health care providers face so they can spend more time with their patients and less time dealing with HCFA bureaucrats.

Here are a few examples of some of the specific reforms in MERFA:

MERFA will clarify that health care providers only need to comply with the regulation issued by HCFA when it is finalized, and that a regulation cannot be applied retroactively;

it allows providers the option of entering into a repayment plan for overpayments rather than HCFA automatically offsetting future payments;

it prevents HCFA from unilaterally recouping an alleged overpayment while an appeal is still pending;

it would allow providers up to one year to return overpayments without penalty or audit if they discover the mistake before HCFA does;

it requires funds to be used to educate providers about property documentation and billing. It creates a safe harbor so providers can voluntarily submit claims for education purposes without fear that that would trigger an investigation; and

it would require HCFA to pilot test new Evaluation and Management Guidelines before mandating them for all physicians nationwide.

I would like to point out that there are some new sheriffs in town—George W. Bush as President and our own Don Manzullo as Chairman of the Small Business Committee—provide the leadership that has made regulatory reform popular in Washington, and we need to make sure that health care providers do not miss out on that spirit and that momentum.

A majority of House members now recognize the need to rein in some of HCFA's excesses. In the administration, Secretary Tommy Thompson and Administrator Tom Scully have made encouraging remarks. There are over 60 health care provider groups in support of our bill, and with the Small Business Committee's help, we can make HCFA reform a reality for our health care providers and the patients they serve.

Thank you very much.

[Mr. Toomey's statement may be found in the appendix.]

Chairman MANZULLO. Thank you for that excellent testimony.

Congresswoman Berkley, if you want, you can give me the name of these people at HCFA that harassed your constituent, and we will write the story. We will put it up on web site, on the Small Business Committee web site.

Ms. BERKLEY. I will check with the doctor. The one doctor in particular was so intimidated by what transpired that he has kept an amazingly low profile, and I have invited him to participate with me, and quite frankly, he is fearful of going public with his story for fear of additional retribution. But I will share this with him and see if he would not be more willing to go more public.

Chairman MANZULLO. In the next panel, you will listen to a fearless one, who is my chiropractor, who took in the entire system and——

Ms. BERKLEY. He would have to be fearless to be your chiropractor. [Laughter.]

Chairman MANZULLO. That was pretty good.

I do not have any questions. I am a co-sponsor on your bill. I wish you God speed on it, and I trust that we can do something with this organization. I had an incident yesterday. I was on the phone for 15 minutes with a HCFA carrier. The difference between Social Security where the people are in direct contact with people who work for the agency, and we have a relatively—in fact, a very good relationship.

And the problem with HCFA is that it is one-step removed from these contracting organizations. But there is a lady who is dying of liver cancer who wanted to get—her husband wanted to get a lift chair, and for 30 days he had been arguing with a woman at one of these carriers who insisted that she was not going to violate the privacy and wanted an incompetent woman to sign a privacy release.

And I got on the phone and I argued with her for 15 minutes, and I finally said, "Who is your supervisor?" "Well, they are not available."

I said, "Would you like to come before my Committee on a subpoena?" I said, "I am not kidding."

I have had it with these incompetent bureaucrats that waste all of our money instead of helping people.

And, finally, it go to, she gave me the name of the executive of the organization, and he called and he was extremely apologetic because I finally got to a person who understood that a person who is incompetent cannot even sign an X, because if you move their hand for them, then you are guilty of a felony. And all that because they had no idea what they were doing, and fortunately it was an isolated incident with this one particular organization, but it is stories like that that build up and build up.

Mr. Toomey, I would add another name to the new sheriffs in town besides George W. Bush and myself, and that is my distinguished ranking minority member, Mrs. Velazquez. At times she may appear to be very tame.

Ms. BERKLEY. I wonder who her chiropractor is. [Laughter.]

Ms. VELAZQUEZ. Thank you, Mr. Chairman.

I have been historically—well, first of all, thank you for being here and we will work together with you in easing the burden of paperwork regulations and regulations.

But, Ms. Berkley, all those books that you have, those are regulations?

Ms. BERKLEY. No, no, these are the—these are the textbooks——

Ms. VELAZQUEZ. Oh.

Ms. BERKLEY [continuing]. Of medical school.

Ms. VELAZQUEZ. Oh, okay.

Ms. BERKLEY. Those are the regulations.

Ms. VELAZQUEZ. And those are the regulations.

So how do you—can you tell me how do you think those regulations got there in the first place?

Ms. BERKLEY. I think the—the only thing I could think of is that through the years, through additional regulation upon regulation upon regulation, they just grow and grow.

I suspect that much of what is in that cart—the container—probably contradicts what is in that container. And if I could share an anecdote.

When I was first running for Congress, I started—my husband started courting me, and we were dating during my campaign. He is a doctor. He is a nephrologist. He used to bring—now this may not sound very romantic, but he used to bring HCFA regulations on our dates for me to read.

And I am an attorney by profession, he is a practicing physician for many years, and he would show me these regulations that I could not make any sense out of. And you know, they keep getting promulgated and promulgated and expecting physicians and health care providers to not only digest the information, which is often contradictory, but to master it and to follow it until the next regulation comes, which may contradict the one that they are operating under, with no education, no opportunity to learn the new regulation before it is implemented. So I think a lot of the—many parts of MERFA addressed that particular problem as well.

Ms. VELAZQUEZ. Yes, but the point that I just would like to make, if you allow me, is that, look, all those regulations that have been promulgated and that are reflected in those regulations are a result of the Health Insurance Portability and Accountability Act

of 1996, the Balanced Budget Act of 1997, the Balanced Budget Act of 1999, the Medicare/Medicaid Benefits Improvement and Protection Act of 2000.

Passed by who? By us, Congress.

Ms. BERKLEY. Yes.

Ms. VELAZQUEZ. So we have to go to the root of the problem here, and it is not just HCFA, but also we need to recognize that this is a result of congressional mandates that we passed here in Congress.

Ms. BERKLEY. I do not disagree with you, and I think what Congressmen Toomey pointed out is quite accurate, the unintended consequences often of what is done in Congress, this is the unintended consequence.

Ms. VELAZQUEZ. Thank you.

Ms. BERKLEY. Thank you.

Chairman MANZULLO. Congresswoman and Physician Christian-Christensen.

Mrs. CHRISTIAN-CHRISTENSEN. Thank you, Mr. Chairman, and I want to welcome my colleagues also this morning, and I want to thank you for the second in a series of hearings on HCFA. I think this Committee has a unique and very important perspective to bring to the issue of HCFA and the reform as it affects our small business health care providers.

Like you, Mr. Chairman, I feel that a new name is not a new agency make, and I am awaiting real reform before I really adopt the name of Center for Medicare and Medicaid Services as well. Having been victimized myself by this agency, I am really proud to be a co-sponsor of your bill. We welcome the bill. I think it makes a real effort in addressing some of the issues and frustrations that physicians have been facing, and some of which we will hear about on the next panel.

I think, among those reforms are the pilot testing. So many times our carrier would inform us of some new reg, and by the time we got used to it, it is changing, or it just wasn't working. So I think that pilot testing is very, very important.

The repayment plan, it should not have taken legislation to have—to make that happen. It just makes good sense in the spirit of cooperation because, as even HCFA will tell you, most of the areas where they find discrepancies are not really deliberate fraud and abuse. They are mistakes. So it should not have had to take us, but we are glad that you are doing it.

And I hope that—your bill is drafted, but the copy you showed me earlier this morning about the one particular. I took care of a lot of patients who were coming from low-income levels, and even the co-payment was difficult for them to meet. And I will admit here that—even though it is on the record—that many times I just forewent the co-payment. Of course, I lived in absolute fear that I would be called up for the $2 or $5 or whatever it was, and be sanctioned and maybe be denied the ability to take care of Medicare patients. So I hope, Shelly, it is retroactive, and it covers any allowances that I have made.

I just wanted to ask one question. [Laughter.]

One of the purposes of MERFA is to make Medicare carriers and the intermediary audit process more equitable and increase Medi-

care education efforts. What is HCFA's and OIG's official position on this bill? Have they offered one? And has the private insurance agents industry offered an official position?

Mr. TOOMEY. Not surprisingly, the OIG is not terribly supportive of this bill. They have made a series of observations, some of which we believe are valid considerations that ought to be taken into account. Others, we think are not. And, frankly, as we move forward in this process, both Ways and Means and Commerce have jurisdiction and what we ought to do, and I believe what they are doing, both of those committees, is taking input from those folks and balancing their concerns with the legitimate concerns of the providers.

I will say in informal discussions with the new administrator of HCFA, he was very, very sympathetic to the intent. He observed that there might be some technical things that need to be adjusted as a practical matter, but that he was very open to this effort to end. I think that is going to be very helpful.

Mrs. CHRISTIAN-CHRISTENSEN. Thank you. I have no further questions. Again, thanks for being here and thanks for the bill.

Chairman MANZULLO. Congresswoman Kelly.

Ms. KELLY. Thank you, Mr. Chairman.

Inasmuch as I just got here and have not heard the testimony, I am not going to ask any questions. I know where to find these two individuals at a later moment when I do have questions. Thank you.

Chairman MANZULLO. Thank you.

Congressman Baird.

Mr. BAIRD. Thank you, Mr. Chair. Thank you for convening this hearing and to the sponsors. I am also proud to be a co-sponsor.

I went to a little hospital called Morton General, way up in the hills, and they had been audited that very year. Activity had been found that they had 12 instances of overbilling, double billing, not overbilling. And I thought they should receive a award for their efficiency, 12 out of an entire year, and instead they got menacing and threatening letters. So I applaud this bill and that is part of why I co-sponsored it.

One quick question, and then—a specific detail question. In some of the summaries, it talks about providers covered in the bill, including physicians. It is my understanding that many other providers, including my own profession of psychology, face similar challenges, and I trust that they would also be protected under the provision of MERFA. Is that the intent?

Ms. BERKLEY. It is our intent to be as inclusive as possible. And if there were any omissions of a health care provider, part of the profession, we are urging them to please to contact either one of our offices, and we will incorporate them.

Mr. TOOMEY. And if I could just add, I completely agree with Representative Berkley, and we have manifested that with letters to the relevant committee chairs, that this should include all health providers.

Mr. BAIRD. Terrific. I would like to follow up and make sure we get some others included.

One sort of philosophical question, but it is important. I think the Chair raised an interesting point, the difference with dealing with formerly HCFA folks versus Social Security.

In this intermediary, the so-called hired guns, there is somewhat of a paradox in that that is the very model of privatizing government services, which is—I am not trying to be partisan here, but that has been sort of the mantra of the majority party now, and yet it is that very privatization that in some cases has made it more difficult for us to deal with them.

And I just wonder if there are comments from the sponsors of the bill about that.

Mr. TOOMEY. We could probably have a discussion that would go on for a very long time on this topic.

I think that the word "privatization" can, of course, mean many, many different things to different people. Having a private corporation to perform the functions within a very highly bureaucratic government structure may not necessarily provide great relief.

However, I think if we move in the direction of empowering patients to make the decisions about the kind of insurance product they would have, the kind of coverage they have, and diminish the control that the government has, that, I think, would be extremely helpful.

Mr. BAIRD. I appreciate that point. I think my concern is in the nature of trying to root out waste, fraud or abuse, we have basically created consultative gun slingers—these bounty hunters—that go out, and they effectively act like that towards practitioners, and the practitioners who have been on the receiving end have said essentially you have created a virtually unaccountable organization to investigate well-intended practitioners with virtually no consequences.

If we have a problem with Social Security, I think they are pretty receptive to us calling us and pulling their chain a little bit. Or frankly, what I do with Social Security, if I call them up, oftentimes I say good work when they do a good job——

Chairman MANZULLO. That is right.

Mr. BAIRD [continuing]. Because so oftentimes they do excellent work and we need to commend it. But I am greatly concerned about this whole issue. I hope your bill addresses that in part. But I think separately this Committee or this body might want to evaluate whether it has been such a successful experiment to have these consulting bodies.

I yield back my time. Thank you, Mr. Chairman.

Chairman MANZULLO. I appreciate that very much. We are in the process of obtaining some of these contracts between HCFA and the providers, and I am interested to see the so-called performance contracts, where they work on a cut of the money that they get from the providers.

If any do not want to send those to me voluntarily, we will just issue a subpoena duces tecum. They can bring them to Washington and put them on my desk.

Mr. TOOMEY. I applaud you, Mr. Chairman.

Chairman MANZULLO. So that is the role that we are going to take on this.

I appreciate it very much.

Ms. BERKLEY. Thank you.

Chairman MANZULLO. And let us know what more we can do on your bill.

Ms. BERKLEY. Thank you.

Chairman MANZULLO. Thank you. Let us have the second panel, please.

Okay, we have our second panel in place. You are going to share a microphone. We are going to start from the left and go all the way down this side here.

Our first witness is Dr. Michael Hulsebus. Dr. Hulsebus is from Byron, Illinois, which is not too far from Egin, Illinois, and his father, Bob Hulsebus, pioneered chiropractic in the State of Illinois. He was one of the early pioneers, and Mike is here with his brother, Roger Hulsebus. The boys come in pairs to watch each other.

And I am very proud to be their congressman. I would just state that they set the example of whenever a provider has a medical problem, a problem with HCFA, to immediately contact a member of Congress because we can do a lot of things here in Washington to help them out.

So our first witness will be Dr. Hulsebus. The light in front of you will be green is go, yellow, you have got a minute to go, and then red. We will try to keep everybody's testimony to about five minutes so we have plenty of time for questions.

Michael.

STATEMENT OF MICHAEL HULSEBUS, HULSEBUS CHIROPRACTIC

Dr. HULSEBUS. Thank you, Mr. Chairman and members of the Committee. As you stated, my name is Michael Hulsebus.

Chairman MANZULLO. Hang on a second. Are you having a problem with those—Michael, why do you not start over with your statement.

Dr. HULSEBUS. Okay. Well, thank you, Mr. Chairman and members of the Committee. My name is, like he said, Michael Hulsebus. I am a doctor of chiropractic from Rockford, Illinois.

I appreciate the opportunity to address this Committee as it reviews the actions of the Health Care Finance Administration and it's dealing with the chiropractic profession. I am also speaking here on behalf of the American small business operators who must deal with a growing mountain of red tape and procedure wrangling to survive. It would seem in the best interest of the free enterprise system to simplify the processes dealing with small businesses, whose operators need an assist.

I am glad to tell my story, but dismayed to think it is not unique.

While there was an end to my situation, I know there are other chiropractic and health care professionals who have been forced out of the system because they could not assemble the forces necessary to fight this battle.

After the Health Care Financing Administration removed Blue Cross and Blue Shield from administering Medicare in 1999, it then retained several contractors across the United States, including Wisconsin Physicians Service for services, who administers the program in my home state of Illinois. Since then there has been a clear pattern of targeting the chiropractic profession from elimination from the program.

This happened even though the Office of Inspector General issued a report in September 1998 saying the chiropractic profes-

sion is not an area of major concern, and the limited resources of this program would be best served by focusing on other and more costly benefits.

In post-payment reviews, like the one I went through in 1999,the carriers issue a demand for records, along with threat of expulsion from the program. Then they contact an analysis of the records to determine whether the treatments are "medically", not chiropractically, necessary or whether treatments constitutes maintenance care. If determined to be not medically necessary or to be maintenance care, the claims are rejected.

Throughout this review process, the chiropractor is subjected to potential claims of criminal fraud, of a quasi-criminal nature. The physician is provided minimal options from the outset, none of which recognize the fundamental principle with the Constitution that every citizen is innocent until proven guilty.

In the usual course of the post-payment review process, the physician is provided with three options:

Number one, admit guilt, and pay or agree to pay; number two, admit guilt, but seek the reexamination of the charts; or deny guilt, and be required to produce the records of every Medicare patient cared for by the clinic, subject them to review by the consultant and face the ultimate consequences.

The ultimate consequence could be expulsion from Medicare program or possible criminal sanctions.

Under the regulation, it is the physician, in conjunction with the patient, who is primarily responsible for the determination of the necessity and duration of care, including the existence of a subluxation, which the chiropractor is uniquely qualified to determine. However, Health Care Financing Administration and the provider have arbitrarily limited the number visits that will be compensated.

Chiropractic methodology and patient input had been largely ignored. Making this even more complicated the previous admitted failure to properly communicate with the profession as to what is required under the guidelines, and what documentation is necessary.

Since March 1999, when I first received a demand for documentation, I have been forced to engage in unjustified and substantial amount of work, efforts and expense, all to defend myself against alleged overpayments which were ultimately allowed after a costly two-year review process.

Among my concerns at this points are the following: The methods—utilized for the identification of chiropractics for post-payment review, and the apparent efforts to target the chiropractic profession, in post-payment reviews and the adoption of guidelines that further restrict the scope of acceptable services, and the varied interpretation of policy from state to state and—consultant—and to consultants.

The admitted failure to properly communicate and educate the profession——

Chairman MANZULLO. Michael, why do you have a sip of water there.

Dr. HULSEBUS. Sure. The admit failure to——

Chairman MANZULLO. Settle down a little bit. We will give you a little bit more time.

Dr. HULSEBUS. Sure. No problem.

The admitted failure to properly communicate and educate the profession as to the guidelines and requirements imposed. My experience with the review process has been contravention of the Congressional intent and the directives that created the Medicare program. The processing and punishment rather than the creation ways to meet the goals of the program.

With the new guidelines now in place, it would be expected that the situation will not improve without your intervention.

And I want to thank you very much for everything you have done, and I appreciate that, and I will entertain any questions.

[Mr. Hulsebus's statement may be found in the appendix.]

Chairman MANZULLO. Thank you for your testimony.

Congressman Toomey, do you want to introduce your constituent, the next witness?

Mr. TOOMEY. Mr. Chairman, thank you very much. I would like to do that.

I am very grateful that Dr. David Whitson has taken time out of his practice and his busy schedule to be with us today. I would like to introduce him to the Committee.

Dr. Whitson is a constituent of mine from Allentown, Pennsylvania in the Lehigh Valley where he was born and raised, educated, and has practiced as a solo family practitioner since 1975, and I can assure my colleagues from personal experience, as well as the words of many friends back home, that Dr. Whitson is well known, not only for his medical expertise, but the compassion and genuine personal concern that he has always shown for his patients.

Dr. Whitson is also kind enough to serve on a Health Care Advisory Council that I formed, and he has given me very valuable input on health care issues, in particular. It was any suggestions that he had made and the input that he had given with regard to Evaluation and Management guidelines that helped us to draft MERFA in the form that it has.

So I am very grateful for all of his help, grateful that he is with us today, and I would like to introduce Dr. David Whitson.

STATEMENT OF DAVID W. WHITSON, M.D., P.C., MEDICAL OFFICES OF DAVID WHITSON, ALLENTOWN, PA

Dr. WHITSON. Thank you, Congressman Toomey.

Chairman MANZULLO. We look forward to your testimony.

Dr. WHITSON. Thank you. I would like to thank you, Chairman Manzullo, Ranking Member Velazquez——

Chairman MANZULLO. Excuse me, Doctor. Could you pull the microphone a little bit closer, the other microphone. Thank you.

Dr. WHITSON. I would like to thank you, Chairman Manzullo, Ranking Member Velazquez and the other Committee members for the opportunity to testify.

Most cancers start slowly and stay quietly hidden until they insidiously infiltrate an organ, a system, and then the entire person. Eventually when they have grown to sufficient power and size,

they start their terrible destructive, destructive, crippling and often fatal course.

Ladies and gentleman, there is a cancer growing in the health care system in the United States, and in my opinion, it has the power to cripple and destroy the best medical care available in the world.

The cancer began at the seemingly innocent attempt to control costs for senior citizens when Medicare recruited physicians to participate in its program. Well-intentioned, it has mushroomed into a bureaucratic nightmare of paperwork, rules, regulations and reviewers whose job seems to be one of forcing physicians into decreased payments for their services cloaked under the evaluation and management guidelines. It is imperative that this cancer be controlled before our once proud medical system is crippled beyond repair.

Mine is the story of living the American dream. From modest beginnings with considerable hard work and support derived from our government and other generous people I was able to achieve my dream, a solo family doctor, and have done so for 26 years.

But my dream is in grave trouble. For the last five years, the business aspect of medical practice has become a nightmare. Medicare has mandated, and almost all other insurance companies have happily followed suit, that I must document ridiculous and excessive information regarding each and every patient encountered to the brink of absurdity.

The feeling, if it is not written down, you did not do it, has ruined medical recordkeeping, turned medical records into fodder for malicious attorneys chasing lawsuits, Medicare and insurance companies whose folks are seeking refunds, and changed the focus of the physician from the patient to the record. It has to stop.

It really doesn't matter economically what I do when I see a patient. It matters to the patient. But Medicare cares only about what I write down. If I examine a patient's eye, it is now inadequate to record the eye is normal. If I want proper reimbursement for the proper time and complexity of the exam and decisions I make, I must record almost every aspect of my exam and thinking process about why I think the eye is normal.

So my record must say, "Eyelid, normal cover; moves normally; surface of the eye has normal color, normal tearing and no evidence of injury; pupil reacts normally to changes in light and reactions normally when patient changes from looking near or farther away; front part of the eye appears quiet, suggesting no inflammation; lens is normal, suggesting no cataract or foreign body; back part of the eye is fine, showing no infallation; retina looks normal, including a normal nerve, artery, vein, and no evidence of detachment," et cetera.

I am stopping out of consideration for your time and the clock.

My point is if I know I ask the right questions of my patient and did a thorough eye exam on my patient, and I decide the eye is normal, my note in my chart that the eye is normal should suffice. I or another physician who might need to review my patient's chart should know it's normal. If on a second exam an abnormality is noted, we can safely assume it occurred in the interim.

Under current E&M guidelines, I must include all the details I elucidated into the chart. This confuses the chart. It makes mountain of reading for myself or another physician should we need to review it, and really adds no useful information. It simply adds words.

However, if one assumes the adage, "If it isn't written, it wasn't done," any malpractice attorney or Medicare or insurance reviewer wishing to down code the visit starts to drool if he looks and my record and see it is concisely saying "eye is normal."

Ladies and gentlemen, I am tired. I am being beaten down. I am a very good family doctor who wants passionately to practice medicine and I would greatly appreciate your help. The private insurers follow Medicate. The absurdity of the E&M coding nightmare has to stop. Physicians like me who love family practice need your help before we become extinct like all the mom and pop businesses in this country.

Huge corporations, who lack the tremendously valuable personal touch I feel is such an inherent assets to good medical care, will deliver medicine, rather than individuals who know and truly care about each person they see.

Physicians and patients are not interchangeable as insurance companies would have you believe. It takes a long time to build trust with patients. Once established, it makes a physician much more efficient and effective in helping that patient, but there is no code for the time that it takes to build that trust.

Congressman Toomey and his co-sponsors have attempted to initiate some positive reform. It is not enough, but it does represent hope for dedicated family physicians like me.

In reference to my opening remarks, I truly hope someday medicine can cure all cancers. It is also up to you to help the possibility of that cure. Medical practice in this country is in trouble. Before medicine can cure anything, we must use the necessary time, effort and legislation to cure medicine of the cancers that threaten its quality, its providers and its longevity.

Thank you for the kind attention.

[Mr. Whitson's statement may be found in the appendix.]

Chairman MANZULLO. Thank you very much, Dr. Whitson.

We are going to—there is a vote, we have to go vote and we will stand in recess until we return, probably about 10 or 15 minutes.

[Whereupon, a recess was taken.]

Chairman MANZULLO. Okay, we will reconvene our hearing.

Our next witness is Brian Seeley, who has grown up in the home medical equipment industry; works at a family business located in Cleveland. In 1988, Mr. Seeley purchased a small company in Ormond Beach, Florida. It has grown into two location, selling appliance in north-central Florida, and it is considered a full-time home medical equipment and service company.

Seeley Medical has 13 employees. He is a member of the board of directors for the Power Mobility Coalition where he works closely with industry leaders concerning reimbursement criteria access and product document.

We look forward to your testimony, Mr. Seeley.

STATEMENT OF BRIAN SEELEY, SEELEY MEDICAL, INC., ORMOND BEACH, FLORIDA, FOR THE POWER MOBILITY COALITION

Mr. SEELEY. Thank you, and good morning, Mr. Chairman, distinguished members of the Committee.

As was stated earlier, I represent the Power Mobility Coalition, which is a coalition of supplier and manufacturers who provide power mobility equipment and services, such as motorized wheelchairs and scooters for beneficiaries nationwide. The PMC members represent well over half of the nation's power mobility market in all regions of the country.

According to HCFA's own Medicare data, more than 95 percent of all suppliers of durable medical equipment generate billings of less than $350,000 a year annually, and 99 percent generate less than five million annually.

While HCFA has overall responsibility for the Medicare program, many of its responsibilities related to reimbursement and medical policy have been delegated by the agency to the carriers. These are the four regional DMERCs around the country.

Unfortunately, the carriers have used this authority to create new policies, often in direct contrast to existing policy published by HCFA, developed by Congress. A deeper concern is that HCFA is aware that policies are not being adhered to by the carriers, and by omission are allowing these policies to stand. These actions and HCFA's lack of oversight of the carriers has lead to an erosion of the due process accorded to small businesses who choose to provide items and services to Medicare program beneficiaries.

Three examples of these violations of our due process I would like to cover today are the audits, extrapolation and appeals.

Medicare audits should be conducted base on good cause and adhere to established standards and guidelines. In fact, HCFA has told carriers, "subject providers only to the amount of medical review necessary to address the nature and extent of the identified problem."

But one of HCFA's carriers that oversees 17 states uses the number of power wheelchairs sold by suppliers in that region as the reason for an audit. If you sell more than seven chairs per month in that reason as a provider, you will be audited by that carrier.

This creates a chilling effect on the ability of small businesses to provide equipment and services to the patients who qualify for them.

Mr. Chairman, the development of new technology in the power mobility industry has made this equipment available to a larger number of disabled persons. It is now possible for beneficiaries to obtain smaller, more light-weight and maneuverable motorized wheelchairs for use inside a patient's home. This is not an instance of over utilization. This is an instance of technology.

The criterion used by HCFA's carriers is inconsistent with the policies set forth by Congress. Congress has established the Certificate of Medical Necessity, CMN, as a document which determines all medical necessity requirements for claims submitted to the Medicare system. When creating CMN forms, HCFA explicitly declared in writing, I quote, "These forms contain medical information necessary to make an appropriate claims determination." Yet

HCFA's carriers recently told suppliers in writing, and I quote, "CMN represents nothing more than a Medicare pre-payment tool, and CMN itself does not provide sufficient documentation of medical necessity."

The suppliers complied with the rules established by Medicare program, but they are punished by the carriers which applies new and arbitrary criteria after the equipment has been delivered to the patient and after the claim has already been paid.

An example of the lack of due process is the use of the extrapolation by HCFA's carriers in their calculation of so-called overpayments. Let me explain extrapolation.

A carrier may draw a sample of claims, sometimes it is as few as 10. All those claims are paid to the supplier. It is determined that 50 percent of them should not have been paid even though the patients' physicians certified the need for the equipment and the patient qualified for the equipment. We are talking about five claims.

That amount is then extrapolated to the universe of claims. If there 100 claims in that universe, a small business will owe repayment of 50 electric wheelchairs rather than just five. That can represent up to $350,000 to a small proprietor. To a company like mine, that would put me out of business.

The overpayment amount is due within 30 days of the carrier's determination, and even though the supplier wins, most, if not all, of the overpayment back on appeal the business is severely damaged. This process is creating hardships for dealers and has forced many businesses to face bankruptcy. This is unfortunate because, according to HCFA's own figures, 80 percent of the denials are reversed on appeal.

When a Medicare carrier audits the power mobility supplier, a carrier/reviewer will make a determination as to whether he believes the equipment is medically necessary. If the determination is negative, the reviewer who has never examined the patient reverses the determination previously made by the treating physician. The suppliers must then go through a lengthy appeal process.

I would like to thank you, Mr. Chairman, for providing the Power Mobility Coalition with the opportunity to bring these important issues to your attention, to the attention of the Committee. An audit process that targets class of suppliers rather than targeting abuse, extrapolations which can easily put a small supplier out of business, and a lengthy appeals process that withholds proper payments to supplier with an ultimate reversal rate of 80 percent.

We look forward to working with you to achieve reasonable solutions to these issues. Our entire industry and tens and thousands of disabled beneficiaries are counting on you.

Thank you.

[Mr. Seeley's statement may be found in the appendix.]

Chairman MANZULLO. Mr. Seeley, I would suggest that if you are having continuing problem with this—what the acronym used for the carrier?

Mr. SEELEY. The regional carriers, the DMERCs?

Chairman MANZULLO. The DMERCs, if you feel that they are acting in violation of the law, you send us a letter. I will ask that

the HCFA inspector general do an investigation. And if I believe that what they are doing is illegal, I am going to ask them to cancel the contract.

Mr. SEELEY. Thank you, Mr. Chairman. We will do that.

Chairman MANZULLO. That is what we have to do, every time there is a violation you bring it to our attention. We have within the Small Business Administration the Office of Advocacy that has a legal staff. We work with them. We have about a half a dozen lawyers on staff that are experts in the regulatory analysis. He does read regulations on Saturday night. [Laughter.]

Not so much a social life, but use our Committee. We work on a bipartisan basis. We were effective in canceling a contract when the Air force had decided they have 106,000 baseball caps made, and instead of giving—using it for procurement, they subcontracted with the Government Printing Office because they thought that hats were printed and not manufactured. And we called one individual and we stopped that contract. So we are not adverse to using any of our tools possible to raise as much hell possible, because you cannot afford to go to court with it, and that is why we are here to be your advocate. Okay?

Mr. SEELEY. I appreciate that, Mr. Chairman.

Chairman MANZULLO. Our next witness is Phillip Chase. Mr. Chase has been in the health care delivery business for over 30 years, including both owner/operator as well as senior manager level position in one of the largest health care delivery systems in the country. He has a keen interest in health policy development and implementation, which has been a constant focus for him throughout his career.

We look forward to your testimony, Mr. Chase.

STATEMENT OF PHILLIP CHASE, THE CHASE GROUP, THOUSAND OAKS, CALIFORNIA, FOR THE AMERICAN HEALTH CARE ASSOCIATION

Mr. CHASE. Thank you, Mr. Chairman.

Chairman Manzullo, Ranking Member Velazquez, and members of the Committee, thank you for having the opportunity to appear before you this morning and share some insights in regards to effective reforms to the Health Care Financing Administration, now known as CMS.

As the Chairman spoke, I am Phillip Chase. I am here today on behalf of the American Health Care Association. The American Health Care Association is a nonprofit association representing 12,000 not-for-profit and for-profit health facilities for skilled nursing, assisted living, and subacute care, and facilities for the disabled.

Let me briefly speak of myself. I have 30 years of experience as the owner and operator of skilled nursing facilities in California. Currently, I am the administrator of the Center at Park West, a 99-bed skilled nursing facility. I know firsthand the financial problems of the nursing home profession as an owner, as well as the day-to-day problems as an administrator trying to negotiate around complex CMS regulations to provide high quality care to my client residents.

Before I begin my testimony, I want to say that from what my AHCA's representatives tell me in Washington, it is a new day at CMS, and with a new willingness to develop solutions to problems that face us. We are greatly encouraged by the statements of Secretary Thompson and by Administrator Scully.

What I am going to do today is identify some systems that we believe deserve your oversight and attention.

There is a dangerous storm now brewing over the long-term care horizon, Mr. Chairman. We have a demographic crisis that, if not addressed, will severely threaten the quality and availability of care for the wave of baby boomers who are about to enter in the long-term care system.

Financially, skilled nursing facilities are, at best, treading water. We are facing a staffing crisis of epidemic proportions in every part of the U.S. Our turnover rates exceed 80 percent annually and recruitment is nearly impossible. The staffing crisis is compounded exponentially by the regulatory system that forces caregivers to focus on extraordinary amounts of time on cumbersome paperwork at the expense of direct patient care.

This is a burdensome system and it leaves a highly negative impact on patient care by driving good providers and caregivers to leave their profession.

I am here today not to ask for less government—I am here today to ask for smarter government—government that works in the best interest of promoting and maintaining quality care for beneficiaries and work to create a positive and healthy environment for our caregivers.

Since the Institute of Medicine study in 1983 and the Nursing Home Reform Act of 1987, facilities have been forced to work closely with HCFA's regulation to try to understand how to negotiate through that process. The system of oversight that exists today—although well intended—grew uncontrollably, as you heard earlier, and has evolved into an ineffective bureaucracy that needs major reform.

Today, providers face a system of oversight that is entirely subjective and process-oriented, and focuses more on punishment, not on quality of care.

The system bears little resemblance to the OBRA '87 that was envisioned. The current environment is a type of "Catch–22" scenario in which the low number of citations is interpreted as poor oversight, while a high number of citations is determined to be poor care.

The Institute of Medicine study, December of 2000, reinforces this conclusion. Therefore, the question before us: What reforms or changes can CMS make that would be more significant to improve its environment?

They are of two types, Mr. Chairman. The first is the much-needed administrative changes in how CMS carries out it regulatory process; the second, to address the issue of financing in terms of Medicaid and Medicare.

With regard to the regulatory improvement, let me share with you a few insights.

The first I would ask you to consider is to allow a consultative environment. Currently the language within HCFA's orders to

state agencies is—there is a no collaboration policy. They are not permitted to collaborate with providers in terms of how to solve issues. We believe this is unfortunate. Their expertise and the nature of their job is seeing other providers and how they work gives them some opportunities to share with us successful programs and stories. So we believe that a change to the state operations manual where they could be consulted would be very useful in that regard.

The second is to allow providers to follow physicians' orders. We recently had a survey in my facility wherein a state surveyor actually told me not to follow physicians' orders. This obviously is not appropriate, and we are caught in the middle because the surveyor is telling us to act a certain way, yet our regulations and our ethics require us to follow physicians' plan of care.

The solution is to modify the CMS—I'm sorry—the State Operations Manual in a way that the surveyors clearly understand that physicians' orders should stand as the marking process in the care of our clients.

The third issue is to stop CMS from holding nurse aide training programs. If you have a survey citation in which you have patients deficient care, your training program for CNAs may be suspended. And because of the length of time it takes for you to get adjudication to a proper hearing as to the fairness of that particular deficiency, in the meantime you have lost your ability to provide the training program for much needed staff as I mentioned earlier.

Next, implement a fair and timely appeal process. Currently, providers who want to dispute citations they believe have been issued in error have first to appeal to the agency. That agency acts as the enforcer, the judge and jury, and often fails to render an objective ruling on a dispute. Only after the full administrative process has been pursued, the informal resolution process, the administrative law judge process, and finally the department appeals board, and then to the secretary can either the provider then go to the court system to seek a remedy. This is not very timely. It can be anywhere from a year to a year and a half before that process is completed, and very costly to me as a small business provider.

On the penalties that continue—one of the penalties that continue while I appeal this determination is this nurse aide training program, which is very vital to our sustaining our staff and maintain our level of care.

A further ramification of this is that, although I have no claims, my liability record in terms of provider of care to my clients, my premiums for liability has skyrocketed from two years ago where I paid $60 a day in 1999, to this year paying $550 a day. That is almost a ten times increase.

Chairman MANZULLO. How are you doing in time? You are a minute 30 over.

Mr. CHASE. Thank you, sir.

Chairman MANZULLO. Can you finish in 30 seconds?

Mr. CHASE. Yes, sir.

As a small provider, small business provider, the lengthy appeal process needs to be addressed and looked into.

The next issue that I want to bring to your attention is the removal of disincentives to provide. I was able to take over from an existing provider who was about to be closed down, and part of the

"cost" that I incurred was that I got stuck with his penalties and fines that he had experienced in his cooperation, and I as a successor in interest ended having to pay his fines and ended up having to pay for his cost settlement because I inherited his provider number.

Today the Medicaid system pays for about 70 percent of the seniors in our nursing homes across the country, about 1.4 million clients. CMS does have the ability to work with states in addressing that payment system in a way that we can bring that to a conclusion, bring that to a more positive resolution.

In conclusion, Mr. Chairman, I think we have the opportunity at this point to work with members of the Committee and the new administration to seek ways in which the patients' needs and their care can be properly addressed in order to provide small business opportunity to provide a quality environment to these clients.

Thank you.

[Mr. Chase's statement may be found in the appendix.]

Chairman MANZULLO. So it is the superfund law that applies to succeeding owners of long-term health care facilities?

Mr. CHASE. I have not gone to HCFA directly to ask for some reconciliation to these issues, and they have not——

Chairman MANZULLO. Do they have authority to do that, the tacking of the fines of——

Mr. CHASE. Yes, they do.

Chairman MANZULLO [continuing]. That they screwed up in the first place?

Mr. CHASE. It is a part of the provider agreement contract.

Chairman MANZULLO. What I would like you to do is to send me a letter; put in there that provider agreement, and then ask in your letter what statutory or regulatory authority HCFA has in order to slap you with the penalties that were incurred by your predecessor.

Mr. CHASE. Yes, sir.

Chairman MANZULLO. We will take that letter and we will send it to HCFA, and we will get an answer from them.

Mr. CHASE. All right, thank you for your help.

Chairman MANZULLO. Okay?

Mr. CHASE. Thank you.

Chairman MANZULLO. You bet. This is amazing. My mother was in a nursing home for a period of time, and I could commensurate with what she had to go through on it.

Our next guest is Norman, is it Goldhecht?

Mr. GOLDHECHT. Correct.

Chairman MANZULLO. Mr. Goldhecht is currently the Executive Vice President of Diagnostic Health Systems, DHS, located in Lakewood, New Jersey, where he oversees operations, billing and cardiac services. I guess the cardiac services are related to the operations of billing?

Mr. GOLDHECHT. That's true.

Chairman MANZULLO. Prior to joining DHS in 1985, Mr. Goldhecht worked for the Lovebright Diamond Company where his primary functions including invoice clients and tracking accounts receivables.

We look forward to your testimony, Mr. Goldhecht.

STATEMENT OF NORMAN GOLDHECHT, DIAGNOSTIC HEALTH SYSTEMS, LAKEWOOD, NEW JERSEY, FOR THE NATIONAL ASS'N OF PORTABLE X-RAY PROVIDERS

Mr. GOLDHECHT. Thank you, Mr. Chairman, and members of the Committee. I appreciate the opportunity to appear before you today. My name, as you mentioned, is Norman Goldhecht, and I serve as the Regulatory Chairman of the National Association of Portable X-Ray Providers, and I also operate a mobile radiology company in New Jersey. I am particular pleased to have the opportunity to once again testify before this Committee as my company serves many patients in the New Jersey and New York area who are constituents of the members of this Committee.

Mr. CHAIRMAN, I represent an industry predominated by small and micro businesses. Our companies provide services to our nation's elderly in a particularly safe, convenient fashion, as we, literally, provide care at the patient's bedside. Because the vast majority of our patients rely on Medicare, our industry is highly dependent upon HCFA and its regulatory processes and pricing.

The regulatory process and specific policies of HCFA are critical to our ability to provide our much needed services. It is for this reason that we are so grateful to this Committee for, again, seeking to ensure that the small businesses of America are appropriately considered when HCFA policies and procedures are reviewed.

I would additionally like to thank Chairman Talent, the immediate past Chair of this Committee for sponsoring legislation last year to assist our industry in providing quality care for the elderly and infirm. Although Chairman Talent, and fellow original sponsor, Chairman Crane, were unable to prevail in the much needed legislation, the NAPXP and all of its members greatly appreciate their efforts and the efforts of all the members and staff who assisted them.

The negative effects of HCFA policy are first felt and most keenly in our rural and less prosperous communities. American small business provides the most cost-effective and thus available service in far-flung communities and other less profitable areas. While our federal agencies are most likely to hear and understand the well-financed perspectives of big business interests, the needs of our citizens living in regions offering lower profits to the small businesses who provide the only service available are frequently ignored.

As I present our situation to the Committee, I must stress that our situation is grave. If we are unable to effect change upon the current HCFA policies, our industry will continue to shrink until only those patients fortunate enough to live in high density, high profit areas will find our services available. To the elderly patients in a facility in rural Illinois, or Colorado, or Texas, the need for an X-Ray or an EKG in February will require an ambulance ride to a hospital. There, the patient will be subject to all the of the waiting and discomfort we all associate with a trip to the hospital followed by another ambulance ride home. Contrast this with quality care offered in the comfort of the patients' rooms, surrounded by reassuring sights and sounds without concern of adverse weather conditions or road hazards.

Fortunately, this Committee has already provided an appropriate mechanism for improving for most of our policy problems. Passage of the Regulatory Flexibility Act should have dramatically decreased the number and scope and type of problems our industry has experienced at the hands of HCFA. Unfortunately, while RFA presents a clear mandate for small business impact analysis in the regulatory process, it is all too often ignored. HCFA's failings in this area are cited directly by SBA Chief Counsel Glover in his annual report on RFA Fiscal 2000.

If the NAPXP were to request one result from this Committee's actions, it would be that the RFA be vigorously employed and enforced.

I would like to list three areas where HCFA's policies have failed to serve our industry or the Medicare system.

Rural access: Portable x-ray providers service many skilled nursing facilities and homebound patients that reside in rural areas. The providers must travel considerable distances to and from these sites. Increasingly, our member companies are opting not to service these areas, and thus patients. We are, frankly, amazed that a policy which has the effect of creating a regional "wrong side of the tracks" disadvantage to millions of our nation's elderly is tolerated. By refusing to additionally compensate providers of rural services in response to their clearly higher costs and lower profits, HCFA is actively engaged in a policy which simultaneously denied equal patient care, and drives rural small business service providers out of existence.

E.K.G. transportation: Currently, portable x-ray providers do not receive any additional reimbursement to travel to and from a skilled nursing facility while performing an EKG. The 1995 GAO study of this situation showed an already disproportionate relationship between portable EKG services in rural versus urban settings. Which member of this Committee would wish to explain to their constituents that are receiving fewer diagnostic procedures simply because they reside in the wrong area of the country?

Consolidated Billing: The Prospective Payment System for SNFs mandated by the Balanced Budget Act has been very damaging to our industry. While our industry initially offered cautious support of this policy in the interest of improving fiscal health to the system as a whole, enactment has caused many of our worst fears to be realized.

Mr. Chairman, I recognize the challenges faced by the this hard working Committee in dealing with these often complex issues. Again, I, and all of the members of the NAPXP, pledge our support for the efforts and thank you for the opportunity voice our concerns.

I would be happy to answer any questions of the Committee.

[Mr. Goldhecht's statement may be found in the appendix.]

Chairman MANZULLO. I appreciate all of your testimony. There is a nursing home back in our district that got audited by HCFA, and they were cited and threatened with a fine because they did not serve parsley garnish on a plate even though it was on the menu, and also they served porkettes instead of pork chops for dinner.

Now, I was discussing with my colleague here that, you know, we pass the laws, but there must be a bunch of people out there that have nothing to do but to walk around and harass people. I do not even know what a porkette is. I guess that is what happens when you raise beef cattle. I don't know.

Dr. Hulsebus, the question I want to ask of you, you practice with your brothers; is that correct?

Dr. HULSEBUS. That is correct.

Chairman MANZULLO. And one of them is here.

Dr. HULSEBUS. Yes. Dr. Robert Hulsebus began practicing in 1949, and my father is a chiropractor, as we stated earlier, and we have a large practice in Illinois.

And when Medicare came in and—carrier, rather, and audited us, they said they randomly picked, they picked our chiropractic and some other chiropractic clinic down in Baulton, Illinois, by the name of Dr. Frank Beamus. We were all second generation chiropractors and we had large chiropractic facilities.

And when we were audited, we have always cooperated and always tried to communicate with the carrier to try to comply with everything they have asked us to do. We have asked for guidelines and tried to cooperate, and our chiropractors, myself included, are on boards and past presidents of state organizations, and we are very, very active.

And basically we are told by the carriers we couldn't talk to them. And we received letters from them and mandated payment.

Chairman MANZULLO. They would not sit down with you and explain to you what, if anything, you did wrong?

Dr. HULSEBUS. Not at all.

Chairman MANZULLO. And then they went after you and your brothers, and what is the total amount of fine that they wanted from——

Dr. HULSEBUS. Well, it is a quarter of a million dollars, and you have to understand that chiropractic care, the only paid benefit is that of chiropractic adjustments of the spine, which averages $35 a visit.

Chairman MANZULLO. So there is really one Medicare coding that that you could use; is that correct?

Dr. HULSEBUS. Correct.

Chairman MANZULLO. And that is to manipulate the spine?

Dr. HULSEBUS. Correct. Based on 80 percent of our care, roughly, not necessary. And it is the same care we have been doing to the patients for—ever since Medicare started.

Chairman MANZULLO. Now, we had these people come in our office in Rockford.

Dr. HULSEBUS. The program integrated people.

Chairman MANZULLO. That did not answer my letter for 90 days.

Dr. HULSEBUS. Right.

Chairman MANZULLO. And they came in the office in Rockford, and tell us what happened there.

Dr. HULSEBUS. Well, basically, we sat down with them and told them we would like to dialogue and have open communication, and they said they reviewed our claims and they had a non-qualified person, a non-chiropractor that is, review the claims. And they just said we just find the claim is not necessary.

And yet we had been audited by Blue Cross/Blue Shield before that, that said all the claims were payable. And we asked them how they came about their audit and how they came about their decision on whether it was necessary or not, and they said, well, they had a nurse, registered nurse review them and they also had the medical director.

Well, we asked them, "Well, did you review each claim? Did you look at the x-ray of each patient?" because in chiropractic it is mandated that each patient must have an x-ray to demonstrate the need of the care for supplementation.

And they said "No. We didn't look at the x-rays."

And I said, "Well, how can you determine whether care is necessary or not if you don't use the criterion material in order to determine whether it is necessary or?"

Chairman MANZULLO. And that is when we came to the conclusion they do not know the difference between x-rays and the X-files.

Dr. HULSEBUS. Exactly. It was just so ridiculous, the whole thing was. They never looked at anything. They made their claims in January and they did not——

Chairman MANZULLO. They went from $250,000 down to zero.

Dr. HULSEBUS. Down to—basically, we went from $250,000 to about $40,000 down to nothing. In the end, we prevailed on the whole thing, and all the care was necessary and everything was great.

Chairman MANZULLO. Right at the end you got them down to $1,500, and then you took that to the administrative law judge, and then won, and then HCFA wanted to appeal that.

Dr. HULSEBUS. Correct. We went in front of a judge and he looked at the whole thing, and said there is nothing in here that should not be paid. The carrier makes no sense in the way they did this, and there is no reason for this at all. He recommended total payment. And then they wanted to appeal it again.

And then your office stepped in, and asked what was going on and——

Chairman MANZULLO. Well, I think we did more than that.

Dr. HULSEBUS. Oh, yeah, I know you did a lot more than that.

Chairman MANZULLO. But the—if you had not had a relationship with a member of Congress——

Dr. HULSEBUS. Mr. Manzullo, we went to four different law firms. We spent a tremendous amount of money and we tried everything we could. You know what our research were, we do not even know what a post-hearing review is. There was no law firm that we could contact that could help us. And finally we went to yourself and asked for help and immediately—you know, you looked into it, and said there is something wrong here.

You tried to contact them, I can vouch for that, and they would not even cooperate with you. And the carriers totally would not cooperate with us, tell us what we were doing wrong. All we want to do was correct the problem, if there was a problem. We could not find out what the problem was, even through your office.

Chairman MANZULLO. And to this date, there still are no guidelines——

Dr. HULSEBUS. There are no guidelines.

Chairman MANZULLO [continuing]. From HCFA as to what is expected of the chiropractors.

Dr. HULSEBUS. And there are no guidelines, and we still do not know if what we do is right or wrong, and we just continue to try to provide the services that is best for our patients and try to go along with it. We do not know what to do.

Dr. HULSEBUS. I appreciate your coming. I guess the lesson learned here is that we have to educate members of Congress on how to go about to deal with HCFA, and educate the medical profession that they should contact members of Congress in order to—in order to have us represent you before HCFA.

What a story, huh? It is amazing.

Ms. Velazquez.

Ms. VELAZQUEZ. Thank you, Mr. Chairman.

Mr. Goldhecht, oftentimes regulations that are required by a regulated community were not only required by statute, but required within a certain time frame. In other words, the statute passed by Congress was the problem.

Do you believe that growing amount of CMS paperwork requirements are the result of congressional mandate?

Mr. GOLDHECHT. That is part of the problem that our industry faces. A lot of the requirements and audits that we received are related to paperwork that is somewhat out of our control.

For example, a lot of the procedures, when we performing, using Mr. Chase's example, Mr. Chase's facility, a nurse calls a facility—calls our facility or provider to order an x-ray to be performed. They get a physician order, and we go out and perform, and they will provide us with a slip.

Yet we are obligated to document all of that to make sure that is done properly. If the audit comes, they will come and audit us to make sure that their doctor or the doctor that is on their staff performed what he needed to do, which we have no affiliation with, no control with, yet we are going to be liable, and we are going to get audited and have to document all that.

But more so, some of the regulations that has recently been mandated are more troublesome. For example, in my testimony, the EKGs, the removal of EKG transportation, we basically are paid the same amount a physician is paid to perform an EKG. He performs it in his office. We perform it by traveling. We are not paid for that travel time. That expense is incurred, and the reimbursement that we get paid, what my company gets paid is a little bit less than $16.15. It is a major problem.

Ms. VELAZQUEZ. Thank you.

Mr. Chase, in the time that we have gone through the transitions of the BBA, BBIA, HCFA and BIPA, have you used the rule-making processing, and are you using the process to give you comments as to where you think there are problems?

Mr. CHASE. Yes, ma'am, we do. Our association is very active in dialoguing with the agency and providing our input brought on by providers in the field who are experiencing the real live issues and those these changes will impact us, and we do try to provide our perspective on those regulations.

Ms. VELAZQUEZ. And do you think the agency listens to your comments?

Mr. CHASE. Not as successfully as we would like. It has to be told a number of times over and over again before it appears to finally click with them. It is frustrating.

Ms. VELAZQUEZ. Mr. Goldhecht, in your experience, could you say that there is any major program, Medicare, Medicaid, private insurance, that stands out as being outstandingly better or worse than another in terms of providers?

Mr. GOLDHECHT. Unfortunately, no one is better than the other. Medicaid for our industry is probably the one. Medicare and the private—the private insurance companies usually suit to what Medicare deems reasonable. The problem is what is reasonable and what is not, especially when you talk about a micro industry like ours. It is just overlooked in general, and that is the biggest obstacle that we have.

Ms. VELAZQUEZ. Mr. Michael Hulsebus?

Dr. HULSEBUS. Yes.

Ms. VELAZQUEZ. Regarding the legislation that was sponsored by Mr. Toomey and Mrs. Berkley, what is the difference between the operations that apply to the appeals and coverage process and the provisions contained in MERFA?

Dr. HULSEBUS. I am not sure if I understand your question correctly.

Mr. CHASE. Like, for example, should we be giving the agency time to promulgate the BIPA regs before we start reforming the system again?

Dr. HULSEBUS. Again, I am not real clear on your question.

Ms. VELAZQUEZ. If anyone will comment on that.

Dr. WHITSON. I think part of what they are trying to do, what Congressman Toomey's bill is trying to do is basically stop—if an agency like Medicare finds me in violation and finds under an audit that I have done some things that they want to down code, they can then extrapolate that to a large amount of money, and demand that money from me within 30 days or it starts bearing interest, and then fine me even more.

Part of the new regulations, I think that is in the new bill, would be that they would not be able to do that until I have had a chance to appeal it and I could indeed, if I were found negligent in my recordkeeping, I could take up to a year to repay that rather than basically have the ability to put me out of business, which they have at this point, even before I appeal it.

Ms. VELAZQUEZ. Okay, Mr. Chairman, I do not have anymore questions.

Chairman MANZULLO. Thank you.

Mr. Toomey.

Mr. TOOMEY. Thank you, Mr. Chairman, and if I can follow-up on the last question. I agree with the way that Dr. Whitson has characterized the legislation, but I would point out that our legislation is broad in its scope in that it only applies to the first audit, and the subsequent audit would not limit HCFA the way the first one would be audited, which is part of why I find it very hard to imagine why people would disagree with us.

I was hoping Dr. Whitson could just comment a little bit more about something that he touched upon during his testimony, and that is, is there any way that you could quantify for us, whether

it is in dollars or in personnel time or your own time or the number of staff you have, the entire burden that you face in dealing with the regulatory environment, and especially if you could sort of characterize that in terms of the effect that you see that having on solo family practitioners.

Do you see it having an effect on the number of solo practitioners in the Lehigh Valley where you practice medicine? And do you see it having an impact on the future of these small practices that so many patients so very much want to have?

Dr. WHITSON. I see it having—I see it having a huge impact. I am becoming a dinosaur. I cannot think of very much other solo family practitioners in the Allentown area, and there used to be a lot of us.

I now get things in the mail like this all the time. I got two yesterday. I used to enjoy going to medical conferences. I enjoy going, but I used to enjoy it more because now a lot of the medical conferences are about coding. They are about documentation and coding guidelines.

Yesterday, coincidentally, which is not an usual day, I got two. This one says, "Certified professional coder Boot Camp." Okay, I can go for three days, and this is dedicated to the business of medicine.

Ladies and gentlemen, Congressmen and Congresswomen, I continually want to be a better physician, but I do not want to be a better coder. Unfortunately, I am in a situation that if I do not do that I am the target. I have not done what my colleague here has done, and ask for help from Congressman Toomey, and perhaps I should have because I have been rather outspoken in my dislike of managed care.

I have viewed health maintenance organizations as wealth maintenance organizations basically for insurance companies, and I think insurance companies have now been placed squarely between patients and doctors. Because they are placed between doctors and patients, it really does not enhance the care I can give them. It simply enhances what I have to give the insurance companies, and that is more and more reports.

I can remember the good old days, I hate to sound that old, when the regulations were not that bad, and to take it to an extreme example, if we think about the three by five cards that the old family doctors used to use that are so often made fun of, I am not so sure we have not gone to the complete opposite extreme.

The good old family doctor who knew each and every patient, he had that history, but he had it right up here in his memory, and he knew that patient personally. So when he saw something and put down a couple of words about what that office visit was about, the next time he saw the person he knew why he came in the last time, and he knew what he should be concerned about this time.

Now, if I want to dictate into my record, I cannot write it, I have got to dictate it because I have got to put much too much down. I still want to dictate pertinent things. I want to know what was wrong with the person, what I might be concerned about, but also in my notes I want to put down if the person's husband is sick, or if something is really important in that person's life because it will impact on their medical care.

The insurance companies could care less. For them I must dictate, as in my initial testimony, all the line by line, item by item things that really I know are normal and the patient knows are normal, but I have got to document for the insurance company or the insurance company will say I never should have gotten paid 40 or 50 dollars for that visit. I should have gotten paid $15 for that visit, and that would not pay my office overhead.

Some doctors are starting to use templates. It is scary. They can have them in their palm computers or they can have a big computer system if it happens to be a big corporation with a lot of doctors, and a lot of them have even set their computers to default to normal findings.

So when they see a person, they can just flip the mouse and it checks everything in all the review systems or medical things that should have been examined, and that does not prove they were examined, but it will certainly stand up very well if they are subject to an audit.

I think this is a tremendous problem for the little guy, for the independent practitioner. In the past five years I have had my first malpractice claim that was over my head for two and a half years, dismissed by a jury in 10 minutes, because of an attorney who used the coding or inadequate documentation that they thought was inadequate because of this silly rule that if you did not write it down, you did not do it, which is just incorrect.

And my concern is that Medicare—where Medicare goes everyone else goes. Malpractice attorneys, private insurers, Blue Cross and Blue Shield, I think it is having a tremendous deleterious effect. I doubt that there will be many solo practitioners or small practices left unless this is changed.

Thank you.

Mr. TOOMEY. Let me just say and then I will yield the balance of my time, Mr. Chairman, but I want to thank the witnesses all for their testimony. This has been extremely helpful. The Ranking Member made the point that many of the problems have grown out of legislation that Congress is guilty of. Others have grown out of regulations, I think, that is dreamed of its own. But together we have got to deal with this problem.

It is an absolute tragedy that we have allowed health care in the United States to get to the point where wonderful family practitioners like Dr. Whitson are basically being forced out of business or becoming employees of large groups or hospitals, or losing a very, very important and valuable choice for patients. We have got to bring this to an end.

I want to thank you all for your support for this legislation, and I yield the balance of my time.

Chairman MANZULLO. Thank you.

Dr. Christian-Christensen?

Mrs. CHRISTIAN-CHRISTENSEN. Thank you, Mr. Chairman.

I too want to thank our panelists for being here and for not only being here yourself but for giving voice to all of the hundreds of thousands of health care providers and all of the years of the frustration that we have faced with HCFA.

You have also not only been able to help us understand better what you face in dealing with HCFA, but you are preparing us for

our next hearing, which we will be questioning the HCFA officials, so we thank you for the preparation that you have been able to lay down for us for that hearing. I probably have maybe about two questions.

We recognize that Congress has created some of the problem, but how much of it can be addressed by more uniformity within the contractors and more monitoring of the contractors because it seems as though from one city, or one region to another what we have done has been interpreted differently and is administered differently?

How much do you think we can fix the problem by addressing the contractors, the contractees?

Mr. CHASE. I will start. Certainly in the survey certification process where the state agencies are out to review our compliance, if you look at the 50 states and how they operate directly under the guise of HCFA, there are regional interpretations that are so significantly different than what happens in one area versus the other. And our ability to use or to bring our point to bear is limited because we are dealing with only our particular licensing agency, and they answer only to HCFA, and we have to deal with them on an ongoing basis.

So the differences that occur and exist from region to region are very significant and they are frustrating for us. We worked very hard with Congress, firstly, and then with the agencies to develop reasonable and new regulations that is meaningful to the quality of care you will find in a facility and yet to have third party interpretations that are not consistent around the country is very, very frustrating and unfair.

Mrs. CHRISTIAN-CHRISTENSEN. Okay. Do you think the MERFA begins to address the collaboration issue?

I think that was also your issue, Mr. Chase, the collaboration issue?

Chairman MANZULLO. Donna, you are not on?

Mrs. CHRISTIAN-CHRISTENSEN. Oh, sorry. The collaboration issue, do you think that MERFA begins to address that issue?

Mr. CHASE. I think it is a first step. It allows us to at least recognize that there is an issue that we need to work with together on behalf of the clients that we both are concerned with. We do not want to be in this environment that currently exists. We want to be able to work together for the benefit of the client. They are the ones that both Congress, HCFA, and ourselves should be concerned and focused on, and that is not yet the case. Hopefully, this will give us the first step in that process.

Mrs. CHRISTIAN-CHRISTENSEN. Thank you. I really appreciate again all of you again for coming. I am revisiting all of my worst nightmares from practice, especially listening to you, Dr. Whitson, is it?

Dr. WHITSON. Yes.

Mrs. CHRISTIAN-CHRISTENSEN. As a family physician myself, but we really appreciate your being here.

Thank you. Thank you, Chairman.

Chairman MANZULLO. So you left the uncomplicated world of medicine to come to this easy place. [Laughter.]

Appreciate your questions.

Mr. Issa.

Mr. ISSA. Thank you, Mr. Chairman. And I apologize for missing a little bit of the testimony.

Chairman MANZULLO. Excuse me, Mr. Issa. You told me that several times.

Mr. ISSA. That's alright. You know, my grandfather's name was Dafanse Swanza Be Issa, so he decided to be big Dave Issa, and I have been living with this pronunciation for my whole life. I take almost any pronunciation, Mr. Chairman, especially from you. [Laughter.]

Getting to a lighter note, your testimonies. I think I heard a consistent pattern in the time that I have been here and reading through your testimonies, and it seems to encompass two things: One, you are not terribly keen about any HMO.—unless I misunderstood that. But there is a particular concern that the worst offender is the federal government when it tries to play HMO and/or health care provider.

Is there anyone that is not going to nod yes on that?

Okay, so assuming that is the case, we are looking at reform and helping you in this case, and, of course, Mr. Toomey's bill. It seems like in the case of HMOs, for the most part, patients that come to you, they and/or their employer have chosen that plan. In a sense the employee has decided to stick somebody between you and them to get a cheaper price. And we may not fully agree whether it is the employer or the employee, but between the two of them one of them has made that decision because in most cases they offer an HMO and a PPO and a POS, all of which you probably do not like, but you know, different flavors.

I guess my question would be, is there any real potential for the government ever to be the best of the health care reimburses or is it an inevitability that they are always going to be the worst? Perhaps what we should be looking at is not reforming, but to a great extent trying to privatize, trying to move the dollars to the patient and then let the patient make the choice.

And I put that out to you today in the hopes that you will come back and tell me is this viable? Is this a direction Congress should be looking, to put the dollars of the Medicare and Medicaid recipient back into their hands with the understanding that they are going to put it into some other plan, but a plan that would not be the federal government making the decisions. I would welcome any of your comments.

Dr. WHITSON. That is exactly the only way to answer this problem. I can remember years ago when the government first recruited physicians to join Medicare, and many of my older patients who then were going to be on Medicare would come and try to pay for their office visit, and I would say, "No, no, now this is going to be paid for by the government."

They would say, "No, we don't want that."

They were smarter than I was. Basically, what has happened is the patient has been taken out of the equation. Let the patients be the consumers. Let them have some financial stake and some financial risk in what care they decide to have.

A lot of my patients were forced into HMOs. They did not have a choice. Unfortunately, health care became a benefit of employ-

ment. As technology increased, some people think doctors charge too much. I think it was mostly technology. But as it increased, it became a very burdensome thing for the employers, and they wanted a cheaper way out. But they were not giving apples for apples. They were giving apples for oranges and patients were forced into that situation.

But I think the only way out is the federal government giving the choice back to people and giving them some financial incentive to make choices. Do not go where it is really expensive. Do consider what treatment options are best for you, and do consider what they cost, and then that will trickle down to the private insured's.

Mr. CHASE. Let me add from my perspective dealing with the senior community. My concern has always been that that would be the long-term goal, but in the short term, we have the existing world as we know it, and the Medicare program, as managed by HCFA, set up by Congress in terms of the benefits to the beneficiaries, in my view is more fair to the client beneficiary than is the managed care system.

Managed care system by definition is pay at a reduced rate by the government to the third party administrator, and then he has got to pay for his salaries and staff and advertising, promotions, et cetera, to the net cents available to—as you provide care, it is probably 65 cents on the dollar, where Medicare at least keeps the dollar whole and promulgates that service down to the continuum.

So in dealing with seniors, I always encourage them to maintain their Medicare status because I believe they have a better shot at receiving a quality outcome than they do associate with managed care as their attempts to be more efficient in the process.

Mr. GOLDHECHT. To further back up that point, the Medicare process as it is today as far as the skilled nursing facility, which my industry deals with, it is a much better system for that patient as it exists right now. The HMO that has tried to manage those patients has failed terribly, and specifically with our industry, they have not reimbursed certain codes because they just felt like they didn't need to, and this puts us in precarious situation because we are contracted with the nursing home to perform services to their residents regardless of their insurance.

If that patient has an insurance that does not recognize some of our codes, we have to perform the service anyway. If a private insurance company all of a sudden decides, well, you know, we are not going to pay for this code, and we say, well, if you do not pay for it, you will have to put that patient on ambulance, they know we are going to go anyway because we have a contract with the facility. So therefore we are in a situation between the patient, the facility and the service.

So unless there are these intrinsic things that, and this is just one example as our industry adhere to this, there is going to be massive fallout.

Mr. ISSA. I want to thank you. With respect to the Chairman's time, can I allow another answer?

Chairman MANZULLO. Sure.

Mr. ISSA. Please.

Mr. SEELEY. I was simply going to make the point, Congressman, that is a difficult question from my industry's perspective to an-

swer. When I deal with the agency in my community as well, and when comparing HMOs, for most of the HMO plans, I have been contracted with HMOs to Medicare, I would say in concept——

Chairman MANZULLO. Would you excuse me just a second.

Dr. Hulsebus has to catch a 1:30 in Baltimore. And Mike, it is nice seeing you, but you should leave now.

Dr. HULSEBUS. Okay. [Laughter.]

Thank you.

Mr. ISSA. Thank you, Doctor.

Chairman MANZULLO. We know Rockford is not a straight shot. We will see you later. Thank you.

Mr. ISSA. Yes, Brian.

Mr. SEELEY. The only problem exists that if the Medicare system we are given the opportunity that is on paper to work the way it should be, the way we are told it should be. If HCFA would oversee its intermediaries the way Congress has instructed them to oversee, it might be a pretty darn good system. The problem is that on the intermediary level for our industry they act autonomously. HCFA knows they act autonomously. There is no consistency so we do not know how the system actually is working or should work.

Mr. ISSA. Well, I appreciate your comment. One odd thing when you notice that many were working at reforming the existing system, as a freshman who is going to be here for awhile, I am looking and saying, you know, I do not have the power to reform the system. I will go with my leadership and help them. But over the next several years I hope we will see you all again in the effort to find bigger, final solutions, if they exist, even if they are outside the box. And judging from the ascendancy of my Chairman, with a lot of hard work, I could end up chairing—what is it, eight years, six years?

Chairman MANZULLO. I do not know if you want that. [Laughter.]

You know, there is something else to this place besides legislation. What the Hulsebuses did because of their tenacity is they took on the entire system, and HCFA said that there were no longer torture chiropractors nationwide. You saw his demeanor. He can barely talk about it, and I can barely talk about it myself. But these are people that are trained to heal. And those boys were tortured so much, that that became a cause celebre for me. The reason I'm asking you is to get letters to us. Get them to Barry Pineles. He's an expert on regulatory reform. He'll work with the Democrat minority staff. And if we go after these abuses one by one, that could set a standard for different areas.

So, sometime I think that the law is the last thing you want to do. You pass laws to add more regulations. If we could find the abuse and uncover them one by one, we'll do that. That's why we're here. Ms. Velazquez.

Ms. VELAZQUEZ. Yes, Mr. Goldhecht, I have one more question. What has been the effect on your industry of implementation of the prospective payment system?

Mr. GOLDHECHT. How much time do we have today? [Laughter.]

There are two major flaws that happened to our industry that has directly related. One is that in lieu of getting paid directly from part B, we are now paid from the SNF. The SNF have there own

problems with their payments, but as it flows down to our level, they have negotiated prices with us that are below the HCFA fee schedule and in some cases, below what our costs are.

In doing so, it has put a pressure on us. We have gone to HCFA many times and told them, "you are putting us in a precarious situation", here we are as a part A patient, we are doing this service for below cost and next door, the bed next door, there is a part B patient, and we are performing a service at the Medicare fee schedule. That is clearly a violation of kickback laws.

They turned this to OIG and OIG says it is HCFA problem and we go around the revolving door.

The second problem that is probably just as big, if not bigger, is that there is no prompt payment from SNF to any kind of vendor. They get paid from HCFA. They don't have any obligation to pay the provider timely. And in those several contracts that exist, HCFA's response to us is, well, that is a private relationship between you and the SNF, and I tend to disagree that we perform the service. They have collected the funds. Surely it is our funds. We have just—they are the vehicle for us to get it, and that is probably the biggest obstacle.

Ms. VELAZQUEZ. Mr. Chase, as a nursing home owner, how current are you paying—are you paying these providers and how quickly do you get these payments out?

Mr. CHASE. We try to stay within about 90—between 90 and 120 days. The issue is Congress showed some wisdom here, as you know, in April the PPS system was adjusted and that was some relief. And as that cash flows begins to become a reality in our bank accounts, I think we can make a concerted effort to be more appropriate and more timely in that payment. But the PPS system was a tremendous hit to the profession. About 20 percent of my colleagues across the country are in Chapter, and a certain number of others certainly are near being in Chapter because of the public program and what PPS did.

And, finally, your wisdom in April, and hopefully you will have an opportunity here this year or next to continue that payment because there is a cliff on that fix that you put in place last year. It expires at the end of September of 2002, and we need Congress's support to continue that cash flow so that we can be a fair partner to our ancillary key members so we can provide that quality care and product to our clients.

Ms. VELAZQUEZ. Thank you. No more questions, Mr. Chairman.

Chairman MANZULLO. Thank you. For the record, could somebody—was it you, Mr. Goldhecht, that used the word "SNF"

Mr. GOLDHECHT. Yes.

Chairman MANZULLO. Could you——

Mr. GOLDHECHT. Skilled nursing facilities.

Chairman MANZULLO. All right. Okay.

We are having this hearing involving the HCFA people in about two weeks. I would ask any of the groups that you would like us to ask a question of them—oh, I see a lot of pens going down—to get those in writing, get those to both staffs. We will take a look at them. It gives us ideas as to questions to ask, and it will be very interesting to hear. We have great expectations for Mr. Scully—I do not know why he would take that job. [Laughter.]

But I admire him because he has gone into, I think, the worst managed agency in Washington, with an attempt to clean it up. We have talked to some of the people at HCFA. There are some marvelous physicians over there that are working very, very hard to try to do something, really dedicated public servants that have got into it because they were tortured by the system, and a lot of my colleagues have been tortured by that system. So we are looking forward to a great hearing.

And again, I want to thank you for the tremendous testimony, traveling a good distance to come down here. I do not know who is taking care of your practice, David, as a sole practitioner. But again, thank you very much.

This hearing is adjourned.

[Whereupon, at 12:25 p.m., the committee was adjourned.]

Congress of the United States

House of Representatives

107th Congress

Committee on Small Business

2361 Rayburn House Office Building
Washington, DC 20515-0315

Statement of Donald A. Manzullo
Chairman
Committee on Small Business
United States House of Representatives
Washington, DC
July 11, 2001

This is the Committee's second hearing to examine the regulatory problems at the Centers for Medicare and Medicaid Services (CMS) formerly known as HCFA. I will not recognize the new name until I am convinced that HCFA is a new organization with a new operating philosophy. In the previous hearing, the Committee heard about the deluge of paperwork that healthcare providers towered under in the effort to provide service to the injured and infirm. Today's hearing will address the regulatory morass swamping healthcare providers and potential solutions to the draining of that swamp. At the Committee's next hearing near the end of this month, we expect to here from Thomas Scully, the head of HCFA, and Sean O'Keefe from the Office of Management and Budget about administrative actions that they can take to resolve the problems identified by the Committee.

A healthcare provider renders service to an eligible Medicare beneficiary and should be reimbursed at a rate that enables the healthcare provider to stay in business. That seems like a simple proposition. However, sometimes simple tasks are rendered unduly complex by excessive federal government procedure. In the case of Medicare, the simple proposition of

reimbursing providers for services rendered now covers more than 130,000 pages of federal laws, regulations, and informal guidance. As United States Court of Appeals Judge Leon Higginbotham once noted about federal milk marketing orders, "it is difficult to imagine a case intertwined with greater confusion and delay on a problem which, but for the administrative process, was not extremely complex." Today's hearing will demonstrate that Judge Higginbotham's statement can be applied with equal, if not greater, force to the operation of the Medicare program.

Healthcare providers now suffer from regulatory oversight and second-guessing every time they see a patient or provide a piece of medical equipment. Rather than simply specifying that they have performed a physical examination or spinal manipulation, healthcare providers must record in excruciating detail the results of the examination or procedure for manipulating the spine. Why? Because the healthcare provider is concerned that an audit by a Medicare carrier might question the validity of the conclusion that the organ is normal or that the physician examined the organ. Similarly, durable medical equipment providers, despite utilizing HCFA-mandated certificates of medical necessity, are second-guessed about whether the equipment was medically necessary.

A healthcare provider that decides to challenge the second-guessing of the carrier enmeshes itself in a web of procedure from which only the brave or the lucky escape. There are multiple levels of review and the provider, if it can stay the course, will usually prevail. A provider's ability to challenge an irrational decision of a carrier should not rely on the financial resources of the provider to stay the course during an appeals process.

The problems facing healthcare providers are compounded by HCFA procedures for issuing new regulations. Frequently, HCFA fails to obtain input from the affected community

until after a regulation has been issued because HCFA does not believe it can do notice and comment rulemaking in a timely fashion. If the point of notice and comment rulemaking is to educate the agency on the problems of a regulation, how can the agency be educated when it issues and enforces a rule without public comment.

Since HCFA often issues its regulations without undertaking notice and comment rulemaking, HCFA also does not comply with the statutory requirement for assessing regulatory burdens on small healthcare providers mandated by the Regulatory Flexibility Act. HCFA can then issue regulations without assessing the impact of a reimbursement would have on the ability of a small healthcare provider to stay in business.

Providers wishing to challenge regulations cannot go directly to court. Rather, they have to convince HCFA that the original rulemaking decision was incorrect. Asking the Secretary to declare that a regulation he issued a year ago was wrong seems to me to be an exercise in futility – an exercise that almost no other entity regulated by the federal government must perform.

The regulatory morass at HCFA has spawned a Hydra-headed monster feared by all and accountable to no one. This morass cannot last because it adversely affects the ability of small businesses to provide adequate healthcare to beneficiaries. I am interested in navigating through the morass and would like to thank Mr. Toomey and Mrs. Berkley for their helmsmanship on this issue. The ultimately beneficiaries of draining the swamp will be patients and the taxpayers because higher quality care will be offered at a lower overall cost to the economy. Now I will recognize the ranking member of the full committee, the distinguished Gentlelady from New York, for her opening statement.

Congress of the United States

House of Representatives

107th Congress

Committee on Small Business

2361 Rayburn House Office Building

Washington, DC 20515-0515

Hearing on the Center for Medicare and Medicaid Services

2360 Rayburn HOB

July 11, 2001 10:00 a.m.

Statement by Rep. Nydia M. Velázquez

Thank you, Mr. Chairman.

Today we continue our examination of the Health Care Financing Administration system, known today as the Center for Medicare and Medicaid Services.

During our last hearing, this committee examined the many burdens CMS imposes on health care providers. Foremost among these are onerous and often contradictory paperwork requirements that doctors must go through simply to receive payment for services. Even more disconcerting, doctors can face unannounced audits for unintended errors.

In addition, doctors are forced to pay the difference in disputed agency billing up front, BEFORE the dispute is resolved – effectively, they are considered guilty until proven innocent.

Tragically, these impositions discourage doctors from caring for the most needing among us – the aged, and the poor.

Today, Mr. Chairman, we focus on solutions to these problems. The Medicare Education and Regulatory Fairness Act, proposed by my colleagues Congresswoman Berkley and Congressman Toomey, goes far to overcome these challenges.

First, this bill will reduce the administrative burden on doctors by easing complex billing requirements and creating an expedited system for dispute claims resolution.

Second, doctors will get advance notice for any audit, so they are not caught by surprise when CMS comes knocking.

Lastly, this bill bars up-front repayment in fee disputes, requiring the agency to prove the doctor has committed an error, rather than the other way around.

This legislation addresses many of the inequities created by the most recent reforms, enforcing the fair play we expect from our government.

Nevertheless, I hope we will be careful as we move forward. Unintended or unexpected consequences of our reform proposals could divert energy and funds away from the primary mission of CMS, which is to compensate fairly the doctors who provide services to the poor and elderly.

For example, our attempt to level the playing field between doctors and CMS should not limit enforcement efforts against fraud or abuse. As a recent news report has suggested, there are still some people out there trying to bilk CMS for their own profit.

In loosening the grip CMS has on providers, we need to avoid a return to our earlier system, which was rife with chronic mispayments or improper payments. CMS has reduced payment error rates from 14 percent in 1996 to 6.8 percent in 2000 – and we can encourage them toward their goal of a 5 percent error rate set for next year.

Finally, the driving force for our reform remains the continued viability of Medicaid and Medicare. Thankfully, through strong fiscal discipline and good success in reducing fraud and errors, the Medicare Trust Fund will remain solvent through 2025. We can continue and improve on that success.

To conclude, Mr. Chairman CMS provides a vital service to those who most need medical care: our poor and our elderly. We will work together to build a system where doctors do not fear caring for their patients while we fight waste, fraud and abuse.

Thank you very much.

Congresswoman
NYDIA M. VELÁZQUEZ
Representing New York's 12th Congressional District
Ranking Democrat, House Small Business Committee

FOR IMMEDIATE RELEASE
July 11, 2001

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Small Business Committee Proposes Medicare Regulation Relief

MERFA bill would provide procedural protections, reduce documentation hurdles

WASHINGTON – Democrats on the House Small Business Committee heard from small business health care providers compensated by the Medicare program today as part of the continuing process to reauthorize the *Paperwork Reduction Act*. This is the second in a series of hearings on how to lighten regulatory burdens and agency powers, resulting from statutory reforms to Medicare during the late 1990s, that hurt small business health care providers.

As part of the 1997 Balanced Budget Amendment, Congress imposed tough regulatory controls to streamline the Medicare system and reduce waste and fraud that had plagued the program. These controls forced medical providers to adhere to strict reporting requirements and imposed stiff sanctions against those who failed to do so. As a result, unfortunately, many health care providers left the system for fear of costly investigation - unintentionally hurting the poor and elderly persons depending on them for Medicare and Medicaid services.

To curb the new power of the Center for Medicare and Medicaid Services (CMS) (formerly the Health Care Financing Administration, or HCFA), the Committee heard testimony on the bipartisan Medicare Education and Regulatory Fairness Act (MERFA). This bill would restructure CMS procedures for investigating abuse while limiting actions against health care providers.

In particular, the bill would compel CMS to change the way audits are conducted and penalties are imposed. MERFA would end the CMS practice of surprise audits by requiring advance notice to providers. Additionally, MERFA would eliminate the requirement that doctors pay penalties before beginning an appeals process. Under current regulations, medical professionals are presumed guilty and must prove their innocence to CMS.

Lastly, MERFA proposes to reduce the paperwork burden earlier reforms imposed on health care providers to limit abuse. As caretaker of the $200 billion Medicare program, CMS has issued dozens of new rules to administer these Congressionally mandated reforms, and is now the sixth largest agency in total federal government paperwork burden. Increased regulatory requirements fuel concerns that patient care will suffer as health care providers spend more time simply complying with complex and contradictory documentation requirements than with their patients.

Members stress that reforming CMS is critical to the program's ability to continue to deliver quality services. They further believe that these changes must reflect a balance between reform and the continued solvency of Medicare.

Testimony of Rep. Patrick J. Toomey (R-PA)
Before the Committee on Small Business
U.S. House of Representatives

July 11, 2001

"The Regulatory Morass at the Centers for Medicare and Medicaid Services:
A Prescription for Bad Medicine"

It is a pleasure to be before Chairman Manzullo, Ranking Member Velazquez, and my fellow committee members. I hope you will be easy on me.

Mr. Chairman, I would like to thank you for two things today. First, thank you for providing Representative Berkley and me the opportunity to testify about H.R. 868, the Medicare Education and Regulatory Fairness Act (MERFA). Second, and more importantly, thank you for your leadership on the need to reform Medicare for health care providers and the patients they serve. You and Representative Collin Peterson led the call last year to investigate Medicare's burdensome regulations and you were an advocate of the bill Representative Berkley and I introduced last year. You are no "Johnny come lately" on this issue and we appreciate your support.

Representative Berkley and I introduced MERFA just four months ago and today we are announcing over 218 bipartisan cosponsors. Medicare reform for providers is indeed an issue whose time has come.

As we heard in the committee's hearing on May 9th of this year, health care providers of all kinds are suffering under excessive paperwork and regulations. Since that hearing, the Administration has announced it is changing the name of the Health Care Financing Administration (HCFA) to the Centers for Medicare and Medicaid Services (CMS). But, no matter what this agency is called, it is threatening our seniors' health care.

Medicare's burdensome regulations are a symptom of the fundamental structural flaw in the program. As long as a Federal bureaucracy attempts to dictate the circumstances under which it will allow, and the price it will pay for thousands of different medical procedures, Medicare will always be a maze of regulations and it will not provide effective, efficient medical insurance for our senior citizens.

Ultimately, we need to transform Medicare into a market-based system in which patients are also consumers. Patients should be in control of the money being spent on their medical care. Patients should decide for themselves – with their physicians – when,

where, and what kind of treatment they will receive – without having to get permission from a government bureaucrat.

H.R. 868, the Medicare Education and Regulatory Fairness Act (MERFA), is not nearly that ambitious. Fundamental, comprehensive reform will take much more consensus and time. But, in the meantime, health care providers need some relief.

Partly in response to Congress, HCFA has resorted to invoking exhaustive and sometimes even draconian practices when they perceive an error in coding or documenting. All of us are opposed to waste, fraud and abuse, and HCFA is under immense pressure to reduce it. But, differences in medical opinion are not fraud, they are not abuse, and many times they are not even waste. Congress needs to step in and restore some balance between HCFA and healthcare providers. If we do not step in, HCFA's practices will have serious, detrimental effects on the quality of our seniors' medical care.

I am going to outline what I believe are five unintended consequences of some of HCFA's practices.

First, HCFA's practices are often counterproductive. In an effort to try to lower the costs of health care, HCFA attempts to reduce fraud by imposing enormous paperwork burdens on all health care providers, including the overwhelming majority who are honest and would never commit fraud. Paradoxically, this burden can actually increase the cost of providing healthcare to senior citizens. It is a kind of tax that raises costs and reduces efficiency. In short, the cost of compliance can sometimes be greater than the savings from less fraud.

Second, HCFA's practices are also counterproductive by reducing the amount of time health care providers have to spend with their patients. As the chairman explained in our last hearing, HCFA has over 100,000 pages of laws and regulations. They have over 200 forms that generate 1.7 billion annual responses from health care providers. Even under the most ambitious estimates, these forms consume over 100 million hours every year that health care providers could have been using to treat patients.

Third, seniors' medical records have become more of a way for physicians to communicate with Medicare bureaucrats than as a way to communicate with colleagues. As Dr. David Whitson will testify in the next panel, sometimes these documents are no longer even clinically useful medical records. Rather than being medical records, they have become billing records. Physicians fear their words in notes may be scrutinized even years later and used against them in a medical malpractice lawsuit or a Medicare audit. Honest physicians should not have to live with that fear, and their medical records should be medically effective.

Fourth, and perhaps most disturbing, is the perverse incentive for health care providers to deliver ordinary care – the service that will not raise eyebrows at HCFA – not necessarily the best care. For health care providers, the risks and costs of defending against HCFA are so great that it produces an incentive for them to bill Medicare for common services, which means providing patients with common services, even when the best care might call for more intensive or just different services.

Finally, the shear complexity and associated costs of compliance are so great that solo and small group practices often cannot afford them. Therefore, physicians go into larger practices or hospitals, or refuse to take new Medicare patients. Either way, the result is fewer small businesses and fewer choices for patients.

What does MERFA do to help correct these unintended consequences? MERFA reforms how HCFA issues new regulations and policies, ensures health care providers have a modicum of due-process rights when there is a dispute with HCFA, and allocates administrative funding for the specific purpose of educating providers about proper billing and documenting. Our goal is to ease some of the regulatory burdens health care providers face so they can spend more time with their patients and less time dealing with HCFA bureaucrats.

Here are a few examples of the reforms in MERFA:

- Clarifies that health care providers only need to comply with a regulation issued by HCFA when it is finalized, and a regulation cannot be applied retroactively.

- Allows providers the option of entering into a repayment plan for overpayments rather than HCFA automatically offsetting future payments.

- Prevents HCFA from unilaterally recouping an alleged overpayment while an appeal is still pending.

- Allows providers up to one year to return overpayments without penalty or audit if they discover the mistake before HCFA.

- Prevent HCFA from using extrapolation during a provider's first overpayment audit. This is a process whereby HCFA assumes that one mistake on a filed claim is an indication that the same mistake has occurred on all filings to that point.

- Allows providers to appeal to HCFA on behalf of a deceased patient if no one else is available to make the appeal, such as on denied claims.

- Requires funds from the following sources to be used to educate providers about proper documenting and billing: 10 percent of funding in HCFA's Medicare Integrity Program, 1 percent of funding for Part A fiscal intermediaries, and 2 percent of funding for Part B carriers.

- Creates a "safe harbor" so providers may voluntarily submit claims for education purposes without fear of triggering an investigation.

- Requires HCFA to pilot test new Evaluation and Management (E&M) Guidelines before mandating them for all physicians nationwide.

Some critics have charged that these common sense reforms will threaten HCFA's ability to fight fraud in Medicare. These charges are not accurate. MERFA does not amend the False Claims Act – the law that HCFA and the Justice Department use to prosecute fraud allegations – and it does not change the way the Office of Inspector General performs its audits. Furthermore, we are working with the Ways & Means, and Energy & Commerce committees to clarify any misunderstandings.

In conclusion, I would like to point out that with new sheriffs in town – George W. Bush as President and our own Don Manzullo as Chairman of the Small Business Committee – regulatory reform is popular in Washington again. We need to make sure health care providers do not miss out.

A majority of House members now recognize the need to reign-in some of HCFA's excesses. Even the Administration in Secretary Tommy Thompson and Administrator Tom Scully has made encouraging remarks. With the Small Business Committee's help, we can make HCFA reform a reality for our health care providers and the patients they serve.

Congresswoman Shelley Berkley (D-NV)
before the
House Committee on Small Business
"The Regulatory Morass at the Centers for Medicare and Medicaid Services: A Prescription for Bad Medicine"
Testimony
July 11, 2001

- THANK YOU CHAIRMAN MANZULLO, RANKING MEMBER VELAZQUEZ, AND MEMBERS OF THE COMMITTEE FOR THIS OPPORTUNITY TO SPEAK BEFORE YOU TODAY.

- LET ME BEGIN BY TELLING YOU HOW PLEASED I AM THAT THE SMALL BUSINESS COMMITTEE IS STUDYING THIS PROBLEM OF THE REGULATORY BURDEN IN THE MEDICARE SYSTEM.

- I DON'T HAVE TO TELL YOU THAT MANY HEALTH CARE PROVIDERS ARE, IN FACT, SMALL BUSINESS PEOPLE. MANY OF THEM HAVE SMALL PRACTICES WITH ONLY A FEW STAFF MEMBERS AND THEY ARE FINDING IT INCREASINGLY DIFFICULT, SOMETIMES IMPOSSIBLE, TO KEEP UP WITH THE CONSTANTLY CHANGING REGULATORY OBLIGATIONS OF THE MEDICARE SYSTEM.

- TO DEMONSTRATE THIS POINT, I HAVE BROUGHT WITH ME TODAY THE STACKS OF REGULATIONS THAT PHYSICIANS AND OTHER PROVIDERS MUST DEAL WITH. ASKING A SMALL PRACTICE, OR ANY PRACTICE FOR THAT MATTER, TO DEAL WITH THAT MASSIVE AMOUNT OF PAPERWORK IS UNFAIR AND UNNECESSARY.

- FINDING A WAY TO REDUCE THIS BURDEN CAN MEAN THE DIFFERENCE BETWEEN HELPING SMALL PRACTICES STAY OPEN OR WATCHING THEM SHUT DOWN, ONE BY ONE. IN ORDER TO HELP THIS IMPORTANT SEGMENT OF THE SMALL BUSINESS POPULATION, THE MEDICARE REGULATORY BURDEN MUST BE ADDRESSED.

I FIRST BECAME AWARE OF THIS ISSUE BECAUSE OF ONE OF MY CONSTITUENTS--A DOCTOR IN LAS VEGAS, NEVADA. HE CAME TO ME BECAUSE HE WAS BEING AUDITED BY HCFA (NOW CMS) AND HE NEEDED HELP GETTING THROUGH IT. AS I HELPED MY CONSTITUENT, I FOUND MYSELF WADING DEEPER AND DEEPER INTO THE AMAZING AMOUNT OF PAPERWORK, REGULATION, AND EXPLANATION THAT HEALTH CARE PROVIDERS MUST DEAL WITH ON A DAILY BASIS.

AS TIME WENT ON, I BEGAN TO HEAR ONE STORY AFTER ANOTHER FROM HARD-WORKING PROVIDERS WHO HAVE HAD INCREASING PROBLEMS WORKING WITHIN MEDICARE. ONE LETTER I RECEIVED FROM A CONSTITUENT IS

PARTICULARLY COMPELLING. IT WAS SENT TO ME BY A DOCTOR WHO HAD FOUGHT HIS WAY, UNSUCCESSFULLY, THROUGH THE REGULATORY PROCESS. HE WRITES: "ALTHOUGH I HAVE SPENT MY ENTIRE THIRTY YEAR CAREER DEDICATED TO THE CARE OF MY PATIENTS, I WILL BE FORCED TO RETIRE. THERE IS NO WAY FOR ME TO EXPRESS THE PAIN AND ANGUISH THAT I FEEL AT THE PROSPECT OF THIS HAPPENING. AT THIS POINT, I CAN THINK OF NOTHING ELSE TO DO EXCEPT TO ASK FOR YOUR HELP . . . HOW CAN THIS BE HAPPENING IN THIS COUNTRY?"

IT'S TIME TO DO SOMETHING TO PROTECT OUR NATION'S COMMUNITY OF LAW-ABIDING PHYSICIANS FROM OVERLY-BURDENSOME FEDERAL ACTS SO THAT THEY REMAIN IN THE MEDICARE PROGRAM TREATING AND CARING FOR OUR NATION'S OLDER AMERICANS. THIS NEED IS PRECISELY THE REASON WHY CONGRESSMAN TOOMEY AND I INTRODUCED THE *MEDICARE EDUCATION AND REGULATORY FAIRNESS ACT (MERFA)*, LAST MARCH.

THIS IMPORTANT LEGISLATION SEEKS TO PROVIDE REGULATORY RELIEF TO HEALTH CARE PROVIDERS IN THE MEDICARE SYSTEM. THE BILL ACHIEVES THIS GOAL BY REFORMING SOME OF THE PRACTICES OF THE CMS (FORMERLY KNOWN AS HCFA), CLARIFYING CURRENT REGULATIONS, AND PROVIDING EDUCATION ABOUT MEDICARE REGULATIONS TO PROVIDERS.

MERFA RESPONDS TO THE PROBLEMS HEALTH CARE PROVIDERS FACE BY REFORMING THE AUDIT PROCESS TO LIMIT RANDOM AUDITS, MAKE THE PROCESS OF RETURNING OVERPAYMENTS TO CMS MORE FAIR, AND LIMIT THE USE OF EXTRAPOLATION. MERFA PROVIDES BASIC RIGHTS CONCERNING APPEALS AND DELAYS RECOVERY OF OVERPAYMENTS UNTIL THE *ENTIRE* APPEALS PROCESS HAS BEEN COMPLETED. MERFA ALSO CREATES SEVERAL EFFECTIVE EDUCATION FUNCTIONS TO ENSURE THAT BILLING AND DOCUMENTATION ERRORS ARE MINIMIZED. FINALLY, MERFA REQUIRES CMS TO MAKE SURE THAT NEW DOCUMENTATION GUIDELINES FOR PHYSICIANS' SERVICES ARE PILOT TESTED BEFORE IMPLEMENTATION.

PHYSICIANS, AND OTHER HEALTH CARE PROVIDERS, DON'T WANT TO SPEND VALUABLE TIME ON PAPERWORK. THEY WANT TO SAVE LIVES, EASE SICKNESS, AND SERVE THEIR PATIENTS. MERFA WILL HELP THEM DO THAT. MEDICARE NEEDS TO BE A USER FRIENDLY SYSTEM–FOR BOTH PATIENTS AND PROVIDERS. THIS BILL IS A STEP IN THAT DIRECTION.

ONCE AGAIN, THANK YOU FOR THIS OPPORTUNITY TO TESTIFY.

Testimony of Dr. Michael Hulsebus, Rockford, Illinois,
before the United States House of Representatives'
Committee on Small Business
July 11, 2001
Rayburn House Office Building, Room 2360
Washington, D.C. 20515-6315

Mr. Chairman and Members of the Committee:

My name is Michael Hulsebus. I am a doctor of chiropractic from Rockford, Illinois. I appreciate the opportunity to address this committee as it reviews the actions of the Health Care Finance Administration and its dealings with the chiropractic profession. I have an obvious concern for the effect the HCFA is having on chiropractors around the country, but I am also speaking here on behalf of America's small business operators who must deal with a growing mountain of red tape and procedural wrangling to survive. It would seem in the best interest of the free enterprise system to streamline and simplify processes dealing with small businesses, whose operators need an assist, and for whom expensive consultants are impossible to finance.

I am glad to tell my story, but dismayed to think that it is not unique. Similarly, while there was an end to this situation, I know there are other chiropractors and health care professionals who have been forced out of the system because they could not assemble the forces necessary to fight this battle. Therefore, let me say once again, how grateful I am to be invited to speak here for myself and for the thousands of others like me.

Right away, I want to list my concerns regarding HCFA review process, namely:

1. The **methods** utilized for the identification of chiropractors for post-payment review; and
2. The apparent efforts to **target the chiropractic profession** in post-payment reviews and the adoption of guidelines that further restrict the scope of acceptable services; and
3. The **varied interpretation** of policy from state to state and consultant to consultant; and
4. The admitted **failure to properly communicate** and educate the profession as to the guidelines and requirements imposed.

Before detailing those concerns, I want to offer some historical background.

The Medicare Program

When Medicare was initiated, the primary goal of Congress was to provide individuals of advanced age or limited resources the opportunity to obtain necessary care for physical ailments. The goal of the program was to provide for elderly and specified categories of individuals to have the ability to obtain necessary health care of most forms, including chiropractic. The intent was to seek to remedy various ailments, prevent disease, promote health and enhance the quality of life for these individuals.

In the development of the programs, Congress enacted various regulations setting forth the types of treatment covered, the actions required of the physician to participate and in the submission of claims for payment, and the circumstances under which treatment would be able to be continued. Additionally, provisions included within the regulations provided for the retention of contracted agents to administer the program throughout country. While provided with limited authority under the regulations, the agents mandate required adherence to the intent and scope of the regulations.

The Chiropractic profession was included within the Medicare programs from the outset. However, through the guidelines developed by the contracted agents, most often without meeting the prerequisites established by Congress, the extent of the level of participation of the profession has been significantly restricted. The applicable congressional regulations have not been amended insofar as the profession is concerned. Rather, it has been the agent's guidelines that have been developed so as to further restrict the participation of the profession.

An integral component of the program as created by Congress was that of program integrity. Program integrity may be best defined as the mandate that the intent of Congress be adhered to in all respects in the administration of the program and the evaluation of the treatment provided to recipients and the compensation of the participating physicians. As the program has developed, there have been substantial violations of this principle, both in the interpretation of the regulations, as well as their application.

Historical and Procedural Perspective

New obstacles for the chiropractic profession began in 1999 when the former contracted Medicare carrier, Blue Cross and Blue Shield was removed due to questionable actions on its part in the handling of the program throughout the country. To avoid the concentration of authority in one carrier, HCFA retained several contractors across the United States, providing each a specified territory.

With the dispersion of authority came actions taken by the individual carriers in seeking refunds from chiropractors based upon alleged overpayments. While the nature of the actions taken by the individual carriers differs slightly, a clear pattern has developed that reflects a conscious effort to target the chiropractic profession and, with the intent to eventually eliminate it from the Medicare program.

The Office of Inspector General conducted an analysis of the participation of the chiropractic profession within the Medicare program and published a report in September of 1998. The report, labeled a report on how to control chiropractic costs and participation, said that there existed a potential for there to be overcharges across the country of approximately $447 million over a period of five years. While this may seem significant, the report also said that total chiropractic expenditures were less than one percent of total Medicare costs. Additionally, while HCFA consistently cites the amount of potential overpayment, it fails to cite the conclusion within the Executive Summary which states that neither Medicare nor traditional carriers consider the chiropractic profession to be an area of major concern and the limited resources of the program would be best served by focusing upon other and more costly benefits.

In proceeding with post-payment reviews, the carriers issue a demand to the physician for the records of a specified list of patients. The correspondence includes not only the demand for production, but also, the threat that the failure to comply may result in the seizure of the records and expulsion from the program. In requesting the records, minimal information is provided as to the reason for the request or the nature of the review to be conducted. Once produced, the records are submitted to a retained chiropractic consultant charged with the duty to conduct an analysis of the information contained within the chart to determine whether they establish that the treatment provided was "medically," not chiropractically, necessary and whether the treatment constitutes maintenance care. If determined to be " not medically necessary or maintenance care," the claims are rejected.

Utilizing the percentage of the claims rejected among the sample group, the carrier then proceeds to extrapolate the alleged error rate among the entire Medicare population within the clinic

and issues the demand for refund based upon the results. Currently, alleged error rates range from 60 to 97 percent. The refund demanded is determined by applying the percentage to the total amount paid to the chiropractor for the period of time involved. The demand requires either prompt full payment, (which in one instance totals in excess of $97,000), or face the withholding of payments. The payments withheld are first applied to interest at the current rate of 13.5 percent for every 30-day period or portion thereof, and then the principal. Withholding of payments or payment of the total demanded and the application of interest is required even though the physician seeks his/her administrative remedies, which consist of a "Fair Hearing" before an employee of the contracted agent for HCFA. Thereafter, in the event of further appeal, the physician must seek a hearing before an Administrative Law Judge, a process which can take up to four years to complete.

Throughout this period, the chiropractor is subjected to potential claims of criminal fraud, of a quasi-criminal nature. The physician is provided minimal options from the outset, none of which recognize the fundamental principle within the Constitution that every citizen is innocent until proven guilty. In the usual course of the post-payment review process, the physician is provided three options:

Option One - Acceptance of Potential Projected Overpayment

1. Agree to refund the entire potential projected overpayment;
2. Loss of right to submit additional documentation;
3. Withholding of payments if not paid in full within sixty days;
4. The assessment of 13.25% on the balance unpaid after sixty days;
5. Admit fault;
6. Waive right to appeal and all additional rights provided under the Social Security Act;
7. No waiver by provider to institute additional audits.

Option Two - Acceptance of Capped Potential Projected Overpayment

1. Agree to refund the entire potential projected overpayment;
2. Retain ability to submit additional documentation that was in existence at the time of the service rendered;
3. Potential projected overpayment would be capped at the amount of the refund demanded;
4. Admit fault;
5. Waive right to appeal and all additional rights provided under the Social Security Act;
6. No waiver by provider to institute additional audits.

Option Three - Election to Proceed to a Statistically Valid Random Sample

1. Rejection of demand for refund;
2. Must submit documentation for all Medicare services for time period involved;
3. Loss of any ability to participate in a consent settlement;
4. Remain obligated to refund amount of actual alleged overpayment;

5. Retain all rights to appeal and as provided under the Social Security Act.

Although less severe forms of action are available to the carriers, they are rarely employed.

Medicare and Chiropractic

Both HCFA and the contracted agents are bound to adhere to the regulations of the Medicare program as established by Congress. While permitted some degree of latitude in the interpretation of the regulations, neither is permitted to circumvent nor restrict the intent or focus of the regulations. However, with respect to the chiropractic profession, this is not what has taken place.

Under the regulations, it is the physician, in conjunction with the patient, that is primarily responsible for the determination of the necessity of care, the specific forms of care to be provided and the duration of care. However, HCFA and the contracted carriers have arbitrarily limited the number of visits that will be compensated through the program. Post-payment reviews have shown that the input of the patient in the process has been totally ignored, and physicians must constantly live in fear of similar actions.

Making this even more complicated is the carriers' admitted failure to properly communicate with the profession as to what is required under the guidelines established by the providers, what documentation is necessary and will be deemed acceptable, the manner in which the guidelines have been developed, and the manner in which the guidelines will be applied. This is clearly seen when a national view of the program is taken. The various providers have issued differing guidelines and their interpretations also vary greatly. So now there are differing definitions for things like maintenance care and adequate documentation. This blurring of guidelines has occurred without any communication explaining the changes.

Regulations mandate that HCFA and the carriers obtain the input of the professions participating in the Medicare program relative to their interpretation, to the definitions to be applied to the profession and to any changes in guidelines. The chiropractic profession has largely been ignored in this process. In fact, several states are without a chiropractor on the Advisory Board. As a result, the guidelines for the profession have been largely the creation of members of the medical professions and the providers.

These actions certainly do not appear to be consistent with program integrity requirements established by Congress. While some may not consider them to be of significance, the actual impact is best seen in the review of specific instances where the provider has sought to take action with respect to an individual physician.

Recent Post-Payment Reviews

Two recent post-payment reviews exemplify the extreme nature of the actions of the providers that are occurring across the country. Both of these reviews involve Wisconsin Physicians' Service, (WPS), which is the contracted provider for the states of Illinois, Michigan, Wisconsin and, just recently, Minnesota.

Hulsebus Chiropractic Clinic

In March of 1999, I received a letter from Regina Milsap, Fraud Coordinator, for WPS. This letter demanded the production of the charts of 28 Medicare patients who had been treated in the clinic during 1998. The letter opened with a statement to the effect that the records must be

produced and that the failure to do so could result in the termination of participation status. The records were produced in compliance with this request. Similar demands were issued to each clinic with which I am affiliated.

Five months later, I received a letter indicating the results of the review, as to only my clinic. It stated that it was determined that a substantial number of services were 'maintenance care of a chronic spinal condition and not chiropractic manipulative treatment.' It further stated that an additional number of services were not properly documented, leading to additional rejections. Based upon the extrapolation of the percentage of alleged error as to the services actually reviewed to the entire patient population, a demand for refund in excess of $70,000 was made. Further, it stated:

> "We have made the determination that you were not 'without fault' in causing the overpayment. Therefore, we are not waiving your obligation to repay. We cannot find you without fault because the management of a medical or supplier practice that includes a large number of beneficiaries must understand the conditions governing which services will be covered and payable under Part B of the Medicare Program."

I was given the three options listed above, with the following statement:

> "Please send in your response to the options listed below within *thirty (60) days* from the date of this letter . . ." [Emphasis Added.] Attachment A.

In addition to the three legal options described above, the statement also indicated that, as the provider, WPS retained the right to expel the clinic from further participation, including the right to enter the clinic and physically seize the records and documentation concerning all Medicare beneficiaries.

Based upon this situation, I initially elected to proceed with Option Two, solely due to the threats imposed. Basically, the options require either the outright admission of fault or subjecting the entire practice to review by the same consultant who has already concluded that errors existed. At that time, I sought counsel and proceeded to develop a plan for the submission of additional information and documentation to establish that the alleged overpayments were false.

The plan included the review of all information submitted by an independent chiropractic consultant. This consultant also conducted personal interviews of the patients involved. Full reports were prepared and included the conclusions of the consultant based upon the documentation as well as, the information provided by the patient separately. The results of this review are detailed in the correspondence with Adam Magary, Legislative Assistant to Representative Donald Manzullo, dated Feb. 14, 2000. Attachment B.

As is indicated in that letter, and based upon the nature of the actions taken and potential impact thereof, intervention was sought from Rep. Manzullo and other members of Congress. Through this intervention, a meeting was held between myself, Dr. Roger Hulsebus and representatives of HCFA and WPS in February of 2000. This meeting resulted in the issuance of a statement by A. Michelle Snyder, Director, Office of Financial Management, HCFA, which identified the following errors on the part of WPS:

1. Improper requests for additional medical records from two of the clinics;

The imposition of withholding would result in a delay in payment according to HCFA guidelines. The current interest rate is 13.25 percent for every 30-day period or portion thereof. The original draft submitted in full payment has not been refunded. With objections being posed, no response has yet been received from WPS.

Frank C. Bemis, D.C.

A second example of the nature of the overbearing and improper actions that have been occurring in the Medicare Program is shown by the post-payment review conducted on Dr. Bemis and his clinic. Dr. Bemis has been a participant in the program since its inception. As with the Hulsebus Clinics, Dr. Bemis was forwarded a demand for the production of records in early 1999. A Fair Hearing was held on April 24, 2000.

The records of 29 patients were requested. In April, a letter identifying an "actual overpayment" of $7,562.18 was alleged together with a demand for refund. Having never been informed that there was any problem or deficiency in his care of Medicare patients prior to that time, both he and his staff made repeated attempts to obtain information from WPS. The WPS staff refused to respond to the questions and specifically stated that they had provided all of the information that they were required to and instructed them to not call the office again.

Obtaining no information as to what was required or what was allegedly wrong, Dr. Bemis proceeded to attempt to make his own determination. He sought the advice of other chiropractors, members of chiropractic colleges, attorneys and anyone he believed could provide some insight. With the request for a fair hearing, he also proceeded to prepare additional documentation on each of the patients, utilizing new forms that he believed might meet the unknown goals of WPS. In addition, reports were dictated as to each visit and service that was rejected.

Dr. Bemis has been forced to make a substantial investment in his belief that the services provided were both necessary and properly documented. Including the amount of the refund, the costs total $28,868.31. (See Attachment E.) It should also be noted that the refund was paid in order to prevent the imposition of interest, (at the rate of 13.75 percent, as opposed to the lower rate quoted for me), and the withholding of payments.

In preparation for this hearing, a request was made of WPS to provide the results of the review. Copies of the notes from the consultant were submitted. These notes, however, failed to clearly identify the manner in which the amount of the alleged overpayment was determined. Attachment F is an example of the notes that reflect the uncertainty as to whether a claim was approved or rejected. These notes also established a total lack of consistency in the conclusions. Where, in one instance a service was approved, it was denied in a virtually identical instance as medically unnecessary.

These problems were acknowledged by the Senior Hearing Officer of WPS in attendance at the hearing. In fact, she stated that the original records, together with the additional information prepared and submitted would be given to a different consultant to review. After the completion of that review, she will prepare her own conclusions. Thereafter, the process of further appeals will entail seeking relief before an Administrative Law Judge, a process which could take up to **four years** to complete. During that time, and for the last year, WPS has held the amounts paid by Dr. Bemis. With a favorable result of the appeal, monies will be returned to him, without interest.

Attachment E also contains a statement by Dr. Bemis as to the impact the process has had on him, personally and professionally. With no clear indication when this situation may be concluded, these effects continue. Additionally, there remains the issue of whether the new forms he has developed will be acceptable should there be an audit in the future. With the changing

solely upon numbers, as opposed to comparisons with other similarly situated physicians as patient population, size of practice, number of physicians in practice and other factors that carry greater significance in a proper statistical analysis;

3. The apparent efforts to target the chiropractic profession in post-payment reviews and the adoption of guidelines that further restrict the scope of services acceptable;
4. The identity and qualifications of the individuals employed as consultants, including the identification of potential conflicts of interest that exist, (e.g. a consultant maintaining an independent business relationship with the contracted provider as exists with one known consultant);
5. The fact that, in spite of there being a national policy as to the profession's involvement in Medicare programs, the interpretation of that policy varies from state to state and consultant to consultant;
6. The admitted failure to properly communicate and educate the profession as to the guidelines and requirements imposed;
7. The legitimate concern that what constitutes acceptable forms of documentation today will not tomorrow;
8. The fact that placement of a physician in a fraud and abuse investigation is not mandated nor necessary absent a specific showing of intent to defraud, which does not exist in any current proceedings noted herein.

Conclusion

Under federal regulations, the element of program integrity is of utmost significance. The actions currently underway establish the absence of integrity at all levels. They further establish the fact that the federal regulations have been ignored. Under those regulations, there exists no basis for an arbitrary limit on the number of chiropractic visits; it is the physician and the patient, based upon their reasonable expectation of benefit from the services, that are to determine what is or what is not maintenance care; and, the profession is to be permitted input into the development of revisions to guidelines, and not solely those that HCFA or the provider seeks to consult.

The past and current experience reflects the presence of an intent to substantially restrict and potentially eliminate chiropractic benefits under Medicare. The attachments hereto represent only a minimal fraction of the evidence supporting this. For a profession that constitutes such a small fraction of Medicare benefits paid and which the Inspector General has concluded is not an area of major concern, the actions represent an obvious onslaught, if not targeting, of the profession. These actions range from the unjustified quasi-criminal nature of the proceedings to actions such as refusing to accept a draft in full payment of an alleged overpayment pending appeal. Unfortunately, relief has been obtained only when members of Congress have become involved. There has been minimal cooperation from HCFA or the providers until force is applied.

This series of events is in contravention of the Congressional intent and directives that created the Medicare Programs. The actions seek punishment and not the goals of the program. With the new guidelines now in place, it must be expected that the situation will not improve. Rather, the profession must expect an increase in situations involving both pre- and post-payment reviews. The known violations of program integrity must be used to offset these actions and to provide both the physicians and the patients the benefits the program was created to serve.

House Committee on Small Business

"The Regulatory Morass at the Centers for Medicare and Medicaid Services:
A Prescription for Bad Medicine"

July 11, 2001

Prepared Remarks of Mr. David W. Whitson, M.D.

Most cancers start slowly and stay quietly hidden until they insidiously infiltrate an organ, a system and then the entire person. Eventually, when they have grown to sufficient power and size, they start their terrible destructive, crippling and, often fatal, course, while killing their victim. This can occur with amazing swiftness, or it can be an agonizingly slow process. Only when we identify the cause can we hope to initiate attempts at a cure. Often, sadly, we are too late.

There is a cancer growing on the health care system of the United States, and, in my opinion, it has the power to cripple and destroy the best medical care available in the world. The cancer began as a seemingly innocent attempt to control costs for senior citizens, when Medicare recruited physicians to participate in its program. Well intentioned, it has mushroomed into a bureaucratic nightmare of paperwork, rules, regulations and supervisory intermediaries whose job seems to be one of forcing physicians into decreased payments for their services, cloaked under the evaluation and management guidelines. It is imperative that this cancer be controlled, before our once proud medical system is crippled beyond repair.

Congressman Toomey and his co-sponsors have initiated an initial treatment in MERFA. It is not a cure. It will, however, decelerate the runaway nightmare of paperwork, confusion, audits and threats that have become part of every physician's practice.

Mine is a story of living "The American Dream." Grandson of a coal miner, and son of a coal hauler and immigrant mother, with some modest athletic abilities, adequate intelligence and very significant hard work, I was helped and worked through college and medical school to become my lifelong dream…a physician. A "Marcus Wellby" in the making, I dreamed of a solo practice where I could help individual people while knowing them personally and making a significant positive impact on their lives. The generosity of other people and my government facilitated that dream through scholarships and loans. For twenty-six years I have enjoyed that dream, and I sincerely believe I have made that difference in many of the lives of my patients. As a solo practitioner, I know almost every one of my patients as people, and I would consider over ninety per cent as friends. Medicine has been good to me and allowed me to educate my four children beyond college, and I am attempting to "give back" by volunteering to teach residents and younger health care providers in our hospital system.

But my dream is in trouble. For the last five years the business aspect of medical practice has become a nightmare. Medicare has mandated (and almost all other insurance companies have happily followed suit) that I must document ridiculous and excessive information regarding each and every patient encounter to the brink of absurdity. The feeling, "if it isn't written down, you didn't do it" has ruined medical record keeping, turned medical records into fodder for malicious attorneys chasing lawsuits, Medicare and insurance companies whose clerks are seeking refunds, and changed the focus of the physician from the patient to the record. It has to stop.

It truly doesn't matter what I do when I see a patient. It matters to the patient, but Medicare cares only about what I write down. If I examine a patient's eye, it is now inadequate to record. "the eye is normal." If I want proper reimbursement for the proper time and complexity of the exam and decisions I make, I must record almost every aspect of my exam and thinking process about why I feel the eye is normal. So my record must say: eyelid is normal color and moves normally, surface of the eye (sclera) has normal color, tearing and no evidence of injury, pupil reacts normally to changes in light and reacts normally when patient changes from looking near or farther away, front part of the eye (anterior chamber) appears quiet (suggesting no inflammation (iridis) and shows no sign of glaucoma, retina appears normal with a sharp optic nerve, normal blood vessels, no abnormality of the surface of the retina or macula(where macular degeneration can occur), etc. I am stopping out of consideration for your time. My point is, if I know I ask the right questions of my patient and did a thorough eye exam on my patient and I decide the eye is normal, my note in the chart that the eye is normal should suffice. I, or another physician who might need to review my patient's chart, should know it's normal. If on a second exam an abnormality is noted, we can safely assume it occurred in the interim. Under current E & M (evaluation and management) guidelines, along with the documentation guidelines, I must include all the details I elucidated into the chart. This confuses the chart, makes mountains of reading for myself or another physician should we need to review it, and, really, adds no useful information. It simply adds words. However, if one assumes the adage, "if it isn't written, it wasn't done," any malpractice attorney or Medicare or insurance reviewer wishing to down code the visit starts to drool if the medical record simply and concisely says, "eye is normal." Now please try to imagine extrapolating this to an entire office visit or complete physical exam. I hope it is obvious how excessively wordy and cumbersome this makes our medical records.

In order to accommodate these documentation and coding requirements, many physicians are using templates. These are preprinted sheets where the physician merely needs to check off all the various items involved in the eye exam (or complete physical.) In this situation, the medical record is now just a series of checkmarks. Some physicians have their computers default every item as normal unless they specify otherwise. Is this a good medical record? It is totally less personal and less useful, and, in my opinion, encourages false reporting. But it does comply with the documentation and coding requirements and may keep the physician out of trouble.

I enjoy attending medical conferences. I used to enjoy them more. Now every medical conference has sessions on coding, documentation, and legally protecting yourself, rather than concentrating on diseases, advances in medicine and becoming better physicians. Please

Congressmen and Congresswomen, understand that I, for one, continually want to be a better physician, not a better coder.

The past five years have been difficult for my dream and me. As with most physicians, in spite of working longer hours, my income is decreasing every year while my overhead keeps increasing. Four years ago I received the crushing certified letter regarding my first and only malpractice claim. I felt like a criminal. A nice, elderly lady lied about my phone advice that was fairly well documented in the chart…but a malicious attorney saw a glimpse of an opening so he dragged me through two and one half years of hell. When the case finally reached the jury (because I refused to settle…I had done nothing wrong), it took them ten minutes to find me "not negligent." But that life experience has left a scar. They made me feel like a criminal. Last year I endured a Medicare audit. Again, in the process, I was made to feel like a crook. When it was all done (an agonizing and threatening process for me with the definite threat of punitive financial and possible criminal consequences,) Medicare reviewers complimented me on my records and office practice. However, they still asked for about two hundred dollars back. Given the initial threat, I was delighted to pay it, but, in retrospect, how inappropriate it was. In my one physician office, they made me repay three flu shots. Medicare pays me three dollars for administering them and three dollars for the vaccine, which costs me two-and-one-half dollars. My nurse administered the shots. But I hadn't documented my order for my nurse to give the shots in the chart, so they disallowed the payments and I had to pay back. Now who do you suppose they thought ordered the shots?

In the past year I have been under a Blue Cross audit. They, on the other hand, are asking for considerable money back. There is no argument that I performed the services for which I billed, but they are arguing that I have inadequately documented my level of service, and of twenty nine charts reviewed, they have down coded twenty eight. The only one they didn't down code was a lab test. For this I needed to hire a very expensive attorney, and should I lose my appeal, I will essentially have no profit for the year. Ladies and gentlemen, I'm tired. I'm being beaten down. I am a very good family doctor who wants only to practice medicine. I did leave myself vulnerable to Blue Cross, because, while I realized Medicare required their absurd level of documentation, I was too busy practicing medicine to realize I also had to document that thoroughly for all the private insurers also. So I may just lose this appeal. I don't want your pity or condolences, but I would greatly appreciate your help. The private insurers follow Medicare. The absurdity of the E & M coding nightmare has to stop. Physicians like me who have a love and passion for Family Practice need your help before we become extinct like all the "Mom and Pop" businesses in this country. Huge corporations losing the tremendously valuable person touch I feel is such an inherent asset to good medical care will deliver medicine. Physicians and patients are not interchangeable, as insurance companies would have you believe. It takes a long time to build trust with a patient, and once established, it makes a physician much more efficient and effective in helping his or her patients. But there is no code for the time it takes to build that trust.

Congressman Toomey and his co-sponsors have attempted to initiate some positive reform. It isn't enough, but it does represent hope for dedicated family physicians like me. In my opinion there should simply be two visits: a regular visit and an extended visit. Lesser visits,

which scarcely reimburse for a physician's overhead, should be deleted. The coding guidelines could then be simplified allowing physicians to return solely to their chosen professions.

In reference to my opening remarks, I truly hope some day medicine can cure all cancers. I hope to be part of that cure. It is also up to you to help effect the possibility of that cure. Medical practice in this country is in trouble. Before medicine can cure anything we must use the necessary time, effort and legislation to cure medicine of the cancers that threaten its quality, its providers, and its longevity.

Thank you for your kind attention and for the opportunity to share my views.

THE POWER MOBILITY COALITION

United States House of Representatives

Committee on Small Business

Hearing
on

"The Regulatory Morass at the Centers for Medicare and Medicaid Services:

A Prescription for Bad Medicine"

Testimony of Brian Seeley
President and CEO
Seeley Medical, Inc.

On Behalf of the
Power Mobility Coalition

July 11, 2001

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House Committee on Small Business

"The Regulatory Morass at the Centers for Medicare and Medicaid Services: A Prescription for Bad Medicine"

July 11, 2001

Prepared Statement of Brian Seeley

Power Mobility Coalition

Mr. Chairman and Members of the Committee, my name is Brian Seeley. I am President and CEO of Seeley Medical, Inc., a supplier of home medical equipment and supplies serving patients in North-Central Florida since 1988. Seeley Medical has two locations and employs 13 people. I also serve on the Board of Directors of the Power Mobility Coalition ("PMC") and the Florida Association of Medical Equipment Services ("FAMES") and served as the FAMES President from 1997 to 2001.

On behalf of the PMC, I would like to thank the Committee for holding this hearing and appreciate the opportunity to present testimony concerning the procedural and regulatory problems facing small businesses in their dealings with the Centers for Medicare and Medicaid services ("CMS"), formerly known as the Health Care Financing Administration ("HCFA"). The PMC is a coalition of suppliers and manufacturers who provide power mobility equipment and services, such as motorized wheelchairs and scooters, to beneficiaries nationwide. PMC members represent well over half of the nation's power mobility market and our members are located in all regions of the country.

Suppliers of power mobility equipment and services, and other health care providers that serve Medicare beneficiaries, spend much of their time and effort interpreting and complying with Medicare's complex regulatory and procedural requirements. In addition to dealing with Medicare laws and regulations, PMC members must also deal directly with the Durable Medical Equipment Regional Carriers (DMERCs), the entities that are charged with administering payment on behalf of CMS. While CMS has overall responsibility for program management, many of the responsibilities related to reimbursement and medical policy have been delegated by the agency to the DMERCs. Unfortunately, the DMERCs have used this authority to create new policies, often in direct contrast to existing policy published by CMS. For example, the DMERCs often conduct random audits of suppliers of so-called "high utilization" items without adhering to published standards governing such audits, and use "overpayment" calculation methods such as extrapolation to recoup funds that have already been appropriately paid out by the Medicare program.

These actions, and CMS's lack of oversight of the DMERCs, have led to an erosion of the due process afforded to those who choose to provide items and services to program beneficiaries. In this context, we offer the following comments and recommendations.

AUDIT PROCESS

I. Medical Review and Audits Should Be Conducted Based on Good Cause

Medicare audits and medical reviews should be conducted based on good cause and should adhere to established standards and guidelines. Toward that end, CMS developed standards for the audit process in an August 7, 2000 Program Memorandum entitled the *Medicare Review Progressive Corrective Action* plan. These standards require that intermediaries/carriers should "***subject providers only to the amount of medical review necessary to address the nature and extent of the identified problem***."

The PMC applauds CMS for developing criteria to establish payment safeguards within the Medicare program. We have witnessed, however, an increasing number of audits and medical reviews being performed on suppliers without adherence to the standards established by the agency. Some of these audits stretch back more than four years without cause even though the agency prohibits such practice.

Many of the audits conducted upon suppliers are not based on an "identified problem" but rather are triggered on the use of a code for equipment for which utilization has increased. For example, the Region D DMERC, the Medicare Part B carrier overseeing 17 states spanning the entire Western part of the country, has developed a series of pie charts highlighting the top suppliers of power wheelchairs for 3 month periods. Each of the suppliers cited on these pie charts are subsequently targeted for an audit based solely on the "high utilization" of this equipment. What is troubling is the fact that the Region D DMERC's own pie charts demonstrate that the targeted suppliers are providing only between 6 and 8 wheelchairs a month to Medicare beneficiaries. 6-8 wheelchairs a month does not constitute high utilization in a Region spanning 17 states. Further, the information provided to industry by the Region D DMERC appears to be inconsistent. One chart used by the Region D DMERC cited the top supplier for the first quarter of 2000 as providing 32 wheelchairs while another chart used by the same DMERC for the same quarter of 2000 cited a company as providing 39 wheelchairs.

The Region D DMERC audit process is consistent with CMS/carrier policy of targeting companies that may specialize in a particular area and/or companies that have developed a reputation for providing quality service and care to Medicare beneficiaries. CMS's policy of targeting suppliers of a particular product creates a chilling effect on the ability of small businesses to provide equipment and services to patients who qualify for such equipment and services.

II. The Current Audit Process Should Account for New Technology in the Marketplace

The current process by which companies are being audited raises a broader issue concerning CMS's inability or unwillingness to acknowledge or recognize the importance of technological advancements in the health care field. Mr. Chairman, the development of new technology in the power mobility industry has made this equipment available to a larger number of disabled people. It is now possible for beneficiaries to obtain smaller, more lightweight and maneuverable motorized wheelchairs for use inside a patient's home. This new technology allows people to move about in small places (e.g., hallways, kitchens, and bathrooms) and complete their activities of daily living without being bed-bound or sent to nursing homes.

The National Council on Disability ("NCD") issued a May 31, 2000 Report to Congress, entitled "*Federal Policy Barriers To Assistive Technology*," addressing assistive technology. The Report defined "assistive technology" as "any item, piece of equipment or product system that is used to increase, maintain, or improve the functional capabilities of individuals with disabilities." The NCD stated in its May 31, 2000 Report that Congress should ensure that CMS revises the Medicare and Medicaid definitions and descriptions of "medical care," "medical necessity," and "durable medical equipment" "to broaden the range of assistive technology provided. Stated the NCD:

> The current definitions of durable medical equipment and medical necessity were enacted in the 1960's, when medical care was viewed with little or no consideration given to increasing an individual's functional status. This bias often severely restricts funding of assistive technology that improves functioning or helps prevent secondary disabilities.

CMS's targeting of companies based strictly on utilization fails to recognize the evolving health care marketplace and fails to appreciate the rationale for a particular product or service being provided to patients throughout our country.

III. Carrier Audit Determinations Should Be Consistent With Medical Necessity Standards Established By Congress and CMS

The CMS *Medical Review Progressive Corrective Action* plan states that "***after validating that claims are being billed in error,*** *target medical review activities at providers or services that place the Medicare trust funds at the greatest risk while ensuring the level of review remains within the scope of the budget for medical review.*"

Unfortunately, the criteria the carriers use to determine that "claims are being billed in error" are inconsistent with criteria already established by Congress and CMS. Current Medicare policy governing the use of power mobility equipment requires that a supplier submit, on behalf of a beneficiary, a certificate of medical necessity ("CMN") form signed and completed by the patient's treating physician, with each power mobility claim. Congress passed legislation in 1994 defining a CMN in the following manner:

> A form or other document containing information required by the carrier to be submitted to show that an item is reasonable and necessary for the diagnosis or treatment of illness or injury to improve the functioning of a malformed body member.

CMS worked with the medical community on the development of the CMN for power mobility equipment (as well as CMNs for other DME items) and received approval from the Office of Management and Budget for these forms pursuant to the Paperwork Reduction Act. When submitting the CMN forms to OMB for approval, CMS explicitly declared that the CMN forms are "needed to correctly process claims and ensure that claims are properly paid" and that "these forms contain medical information necessary to make an appropriate claims determination." In fact, the treating physician (or clinician familiar with the patient's condition) is required to complete the detailed medical necessity information on the CMN and certifies that such information is true and accurate.

The CMN process has been quite effective. The PMC sampled roughly 20,000 power mobility CMNs and discovered that over 75% of the patients failed to qualify based on responses to medical necessity questions established on the CMN form. Only the 25% of patients who have met the medical necessity requirements established on the CMN form were provided with power mobility equipment that was billed to the Medicare program.

Despite the legal/medical necessity significance of the CMN form as envisioned by Congress, CMS and the OMB, the DMERCs have often disregarded the information contained on the forms, particularly when conducting audits, to determine the validity of claims. On numerous occasions, power mobility suppliers have been assessed overpayments even though the equipment was provided pursuant to a properly completed CMN form signed and certified by the patients treating physician.

One power mobility supplier, a small business with revenues between 1 and 2 million a year, was assessed an overpayment of nearly $500,000. Upon making this overpayment assessment, the carrier informed the supplier in writing that the "***CMN represents nothing more than a Medicare pre-payment tool*** which has been abbreviated as much as possible to reduce physician paperwork." Another small power mobility supplier was assessed an overpayment of over $600,000 and informed by the carrier in writing that "***the CMN itself does not provide sufficient documentation of medical necessity***...Suppliers are not required, nor should they, sell equipment to unqualified beneficiaries merely because they have a physician's written order and a CMN."

In these cases, and in other similar cases throughout the country, the supplier had fully complied with the rules established by the Medicare program and yet were penalized based on new and arbitrary criteria developed by the carrier after the equipment had been delivered to the patient and after the claim had originally been paid. While these companies will most likely be vindicated during the appeal process, the damage to the company has taken place and the company's ability to survive has been impacted. As set forth above, the inability of CMS to effectively monitor the

performance of the Part B carriers results in an unfair burden and cost to small businesses who serve beneficiaries.

EXTRAPOLATION

An additional problem faced by provider/suppliers in dealing with the Medicare program concerns the arbitrary use of the technique of extrapolation to calculate so called overpayments. The DMERCs currently 'extrapolate' an overpayment over a 'universe' of beneficiaries, thereby enlarging any assessed overpayment.

To do this, a carrier is required to draw a "sample" of claims (often as few as thirty) from a universe of claims for that supplier a defined period of time. If, for example, the carrier reviewer determines that 50% of the claims should not have been paid (even though the treating physician has certified the need for the equipment), that non-payment amount is then "extrapolated" to the universe of claims. If there are a hundred claims in the universe, the small business will owe repayment for 50 electric wheelchairs ($250,000) rather than 15 wheelchairs ($75,000). The overpayment amount is due within thirty days of the DMERC reviewer's determination, and even though the supplier wins most, if not all, of the overpayment back on appeal, the business is severely damaged.

Extrapolation Should Not Be A Weapon Used Against Suppliers of Power Mobility Equipment

The indiscriminate use of extrapolation for costly, customized items of medical equipment such as electric wheelchairs, is creating hardships for dealers and has forced many businesses to face bankruptcy. Although CMS has the discretion to allow the supplier to pay back a large overpayment in installments, such payment arrangements are usually granted only for a twelve-month period, with interest of around 14% assessed on all outstanding "overpayments" even while they are being appealed.

The use of extrapolation saddles the small supplier, who is trying to provide a service in his/her community, with a large overpayment assessment, as well as additional costs including fees for representation and interest on any assessed "overpayment." In addition, the small supplier is required to pay back the government within thirty days. The small business who finds itself in this position will take little comfort in the fact that the ultimate reversal rate for these cases is, according to CMS's own figures, roughly 80 percent. That is because the business may very well not survive the next year or two of working through this CMS/DMERC controlled process. An appeal for relief to federal court is not possible until administrative remedies are exhausted.

MEDICARE APPEAL PROCESS

As previously highlighted, when a Medicare carrier audits a power mobility supplier, a carrier reviewer will make a determination as to whether the equipment is medically necessary. If the determination is negative, the reviewer, who has never examined the patient, reverses the determination previously made by the treating physician.

CMS/Carriers Should Be Prohibited From Recovering Past Overpayments If An Appeal Is Pending

The current system requires suppliers and providers to repay the government and then undergo a lengthy appeals process to win back monies to which they are entitled. The appeal process includes a lengthy course of review and it is not unusual for a supplier to wait one or two years for a claim to be completely adjudicated.

During the appeals process, the supplier continues to provide the equipment and service to the beneficiary — to do otherwise would force the supplier to forfeit its right to appeal. The appeals process typically results in payment to the supplier who provided equipment and service pursuant to the order certified by the physicians in compliance with Medicare rules. According to statistics cited in the September 1999 Report issued by the Office of Inspector General of the Department of Health and Human Services, entitled "*Medicare Administrative Appeals - ALJ Hearing Process*," 78 percent of DME appeals studied were "reversed at the ALJ level" and 81 percent of home health appeals studied "were reversed at the ALJ level."

With a reversal rate of roughly 80 percent, it does not seem fair that a company would have to forfeit the right to reimbursement without having the ability to adjudicate these disputed claims prior to repayment. Again, the supplier who wins a case is, under the current law, not entitled to interest on reversed claims even though there has been no break in service, or removal of equipment from, the Medicare patient.

COMPLIANCE WITH PROCEDURAL LAWS ESTABLISHED BY CONGRESS

To ensure clarity and consistency in the Medicare program, it is essential that CMS and the DMERCs comply with the procedural safeguards established by Congress. We would propose that Congress provide additional protection to small businesses that become subject to CMS/DMERC avoidance of these important procedural safeguards. As set forth below, the avoidance of such safeguards by CMS/DMERCs imposes an unfair burden on small businesses.

I. Compliance With the Regulatory Flexibility Act

The Regulatory Flexibility Act ("RFA") requires agencies to comply with the following:

- Whenever an agency is required to publish a general notice of proposed rulemaking for any proposed rule, the agency shall prepare and make available for public comment an initial regulatory flexibility analysis addressing the economic impact of the proposed rule on small entities.

- When an agency promulgates a final rule, after being required by law to publish a general notice of proposed rulemaking, the agency shall prepare a final regulatory flexibility analysis addressing the economic impact of the rule on small entities.

- When any rule is promulgated which will have a significant economic impact on a substantial number of small entities, the head of the agency promulgating the rule or the official of the agency with statutory responsibility for the promulgation of the rule shall assure that small entities have been given an opportunity to participate in the rulemaking for the rule.

Power mobility suppliers, as well as suppliers of many types of medical equipment, are predominantly small businesses. According to CMS's own Medicare data, more than 95 percent of all suppliers of durable medical equipment prosthetics, orthotics and supplies generate billings of less than $350,000 in Medicare revenues annually, and 99 percent generate less than $5 million. See Final Rule, entitled *"Medicare Program; Additional Supplier Standards" (October 11, 2000 Federal Register, 65 Fed. Reg. 60366).*

The CMS has avoided the requirements of the RFA when issuing rules impacting the supplier industry. Two recent examples include the following:

i. An interim final rule issued by CMS on January 7, 1998 (63 Fed. Reg. 687) entitled *"Application of Inherent Reasonableness To All Medicare Part B Services (Other Than Physician Services)"* has significant importance to the supplier community in that it established standards governing payment amounts for Medicare Part B services. CMS issued the IR rule without preparing an initial or final regulatory flexibility analysis and without providing small entities with an opportunity to participate in the rulemaking for the rule. The agency avoided compliance with the RFA based on a certification that the "[IR] rule will not, if promulgated, have a significant economic impact on a substantial number of small entities." The agency further added that although "we expect suppliers of Part B services, other than physician services, to be affected by this rule...we do not have sufficient data to predict exactly the nature of the impact of this rule or the magnitude of such impact."

ii. A proposed rule issued by CMS on October 25, 1999 entitled *"Medicare Program; Appeals of Carrier Determinations That A Supplier Fails To Meet The Requirements For Medicare Billing Privileges"* (64 Fed. Reg. 57431) would impact suppliers seeking to enroll within the Medicare program by establishing new requirements. CMS stated in the proposed rule that in calendar year 1997, "129,000 enrollment applications were

submitted to the Medicare carriers by suppliers seeking to receive billing privileges. We believe that a cast majority of these applicants were small businesses. Of those applications, 2,310 were denied." Despite the impact of the proposed rule on small businesses, CMS avoided compliance with the RFA based on the following statement: "we have determined that, and we certify, that this proposed rule will not have a significant economic impact on a substantial number of small entities."

II. Compliance With Rulemaking Requirements

Section 1871(b)(1) of the Social Security Act (referred to as the Medicare law) provides that CMS, prior to issuing a final regulation that establishes or changes a substantive legal standard governing the payment of services, must provide a notice of a proposed regulation in the *Federal Register* for a period of not less than 60 days for public comment. The Social Security Act does provide for certain exceptions including circumstances in which CMS determines that "good cause" makes the notice and public comment process impracticable, unnecessary, or contrary to the public interest.

We have two concerns regarding the avoidance of the rulemaking process by CMS: (1) the continued delegation of authority to the DMERCs allowing CMS to avoid rulemaking requirements set forth in statute (the DMERCs do not issue rules in the *Federal Register*) and (2) the questionable use of the "good cause" exception by CMS to avoid rulemaking requirements.

A prime example of these concerns occurred in the January 7, 1998 interim final rule issued by CMS, entitled "*Medicare Program; Application of Inherent Reasonableness To All Medicare Part B Services (Other Than Physician Services)*" (63 Fed. Reg. 687). The inherent reasonableness interim rule granted the DMERCs unprecedented power to modify payment rates and to adjust statute-based payment methodologies, thereby allowing future DMERC payment determinations to avoid the formal public notice and comment period. Further, CMS claimed that "good cause" existed to waive the rulemaking process and that issuance of an inherent reasonableness proposed rule would be "unnecessary" and "contrary to the public interest." Entities, including Medicare beneficiaries and patient advocacy groups as well as provider/supplier groups, were thus denied the right to participate in a formal rulemaking process.

III. Compliance With Paperwork Reduction Act

Mr. Chairman, we applaud the Committee for holding its hearing on May 9, 2001 hearing which explored the reporting and recordkeeping requirements imposed on health care providers by CMS. The PMC submitted testimony for the record addressing the significant paperwork issues facing suppliers in the Medicare program. What is noteworthy is the apparent disregard by CMS and the DMERCs of a law enacted by Congress — the Paperwork Reduction Act ("PRA") — and the resulting impact on businesses that participate in the Medicare program. In sum, suppliers are faced with significant overpayments and subject to new onerous paperwork requirements that are inconsistent with the principles set forth in the PRA.

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Mr. Chairman and Members of the Committee, thank you again for providing the Power Mobility Coalition with this opportunity to discuss these important regulatory and procedural matters. We look forward to working with you to achieve reasonable solutions to the issues highlighted above.

Testimony of

Phillip Chase

On behalf of the

AMERICAN HEALTH CARE ASSOCIATION

Before the

House Committee on Small Business

On

Reform of the

Centers for Medicare & Medicaid Services

July 11, 2001

Good morning Mr. Chairman. I'd like to thank you and the members of this Committee for inviting me here today to provide perspective on reform of the Health Care Financing Administration – now known as CMS. I am pleased to be here.

My name is Phillip Chase, and I'm here today on behalf of the American Health Care Association. The American Health Care Association is a non-profit association representing more than 12,000 non-profit and for-profit skilled nursing, assisted living, subacute facilities, and facilities treating the developmentally disabled nationwide.

Let me briefly tell you about myself. For over 30 years, I have been an owner operator of long term care facilities in California. I am the working administrator of the Center at Park West, a 99-bed nursing home in Reseda, CA. I know first hand the financial problems of the nursing home profession as an owner, as well as the day to day problems I have as an administrator trying to negotiate around complex CMS regulations to provide high quality care to my residents.

Before I begin my testimony, I want to say that from what AHCA's representatives in Washington tell me, it is a new day at CMS and we see a new willingness to develop solutions to the problems that face us. We are greatly encouraged by statements we have heard from Secretary Thompson and Administrator Scully. What we want to do today is identify system problems that we believe can be corrected.

There is a dangerous storm on the long-term care horizon, Mr. Chairman. We have a demographic crisis brewing that, if not addressed, will severely threaten the quality and availability of care for the wave of baby boomers set to retire in just a few years.

While the ever-growing demand for care begins to strain the long term care system, the supply of caregivers is dwindling to crisis levels -- and the oversight system currently in place serves to promote distrust of providers, demoralize caregivers, and scare families.

Financially, skilled nursing facilities are, at best, treading water. Liability insurance premiums are skyrocketing. We are facing a staffing crisis of epidemic proportions in every part of the United States. Turnover rates in our profession generally exceed 80%. Recruitment is nearly impossible. The staffing crisis is compounded exponentially by a regulatory system that forces caregivers to focus an extraordinary amount of time on cumbersome paperwork and complex, confusing regulatory requirements.

This burdensome system is having a highly negative impact on patient care by driving good providers out of the business. Caregivers who enter this profession today quickly find themselves spending more time on paperwork describing their care, and justifying their actions on behalf of patients -- than on actually delivering care.

I am not here today to ask for *less* government -- I am here today to ask for *smarter,* more *accountable* government – government that works in the best interest of promoting and maintaining quality care for beneficiaries and works to create a positive and healthy environment for our caregivers.

Since the Institute of Medicine (IOM) study in 1986 and the Nursing Home Reform Act of 1987 (contained in the Omnibus Budget Reconciliation Act of 1987), nursing facilities' daily operations have been inextricably linked to the Health Care Financing Administration (HCFA), now the Centers for Medicare and Medicaid Services (CMS). The system of oversight that exists today -- though well intended -- grew uncontrollably, and evolved into an ineffective bureaucracy in need of major reform.

Today, providers face a system of oversight that is an entirely subjective, process-oriented system that focuses on punishment, not quality improvement – and confrontation, not constructive collaboration that benefits patient and provider alike.

This system bears very little resemblance to what OBRA '87 envisioned. Providers are caught in a no-win crossfire: The current environment is a type of "Catch-22" scenario in which a low number of citations is interpreted as poor oversight, while a high number of citations is seen as poor care. Clearly the incentive for inspectors is to cite more deficiencies.

The subjectivity of the survey system makes it unpredictable. This means that no provider, even if they have done everything correctly, can predict whether they will receive citations on any given inspection.

The Institute of Medicine (IOM), in its December 2000 report "*Improving the Quality of Long Term Care,*" discovered that "forty concurrent surveys in ten states found that state surveyors were inconsistent in detecting problems related to outcomes of care…" and, "At the same time, states surveyors also cited some facilities for deficiencies that appeared to be a function of their high prevalence of seriously impaired residents rather than poor quality care."

In our view, a system that consistently fails to measure quality has little hope of improving it.

Therefore, the questions before us are: What reforms or changes can CMS make that would garner the most meaningful improvements? And, how can we ensure these reforms will provide continuous improvement in quality of care while protecting residents?

We urge you to adopt two types of reform of nursing home oversight:

- First, make the much-needed administrative changes in how CMS carries out its regulatory efforts.

- Second, address the issue of financing in terms of Medicaid and Medicare.

With regard to the regulatory improvements to the current system, the following are key areas in which changes could be made that would improve the quality and consistency of regulation, and that will also improve the quality of care we provide.

I have 6 recommended steps:

1. **Allow Collaboration -** Create a collaborative system so providers and regulators can work together to address problems. In such a system, providers would retain responsibility to fix problems, but surveyors would play a supportive role to help providers achieve improvements. Currently, when surveyors find a problem, they are not allowed to discuss possible causes, provide technical assistance, or to suggest solutions. This "no collaboration" policy is an obstacle to ongoing improvements in quality. This is directly opposite of the approach taken with other providers such as clinical laboratories. **Solution:** Guidance must be given to inspectors through the *State Operations Manual (SOM)* to encourage collaboration and compliance-assistance toward quality improvement.

2. **Allow providers to follow physician orders -** All too often, providers are cited for deficiencies for simply following the orders of the residents' physician. Nursing home inspectors will sometimes cite providers for giving medication as prescribed, but that the inspector might not understand is appropriate. This is the only instance in health care where less-skilled personnel are allowed to second guess the orders of physicians, and nursing home care providers get punished. This system has forced providers in the middle by being liable for following a physician's or a surveyor's order. We are requesting that providers not be caught in the middle and not be held liable for following a physician's order. This system has forced providers to choose between government fines and the well being of those for whom they care. Most of the time, they pay the fine and protect the resident, but this system must be changed. Providers need to be allowed to follow the patients' doctor's orders without fear of citation. **Solution:** Again, modify the *State Operations Manual* to provide specific guidance on surveyors and facilities lack of authority to overturn physical orders and the limitations of facilities influence over physicians.

3. **Prevent CMS from closing Nurse Aide Training Programs** – As I noted, we are currently operating with a severe shortage of nursing home workers. Even in this challenging environment, CMS is terminating the in-house nurse aide training programs for facilities with certain deficiencies or enforcement actions -- even if completely unrelated to the training programs themselves. Clearly this "punishment" only hampers the providers' ability to fix the problem and hire and train adequate staff to improve quality. **Solution:** Change policy so that termination of nurse aide training must only be an option when there is a deficiency directly related to the training program itself.

4. **Implement a fair and timely appeals process** - Currently, providers who want to dispute citations they believe have been issued in error must first appeal to the agency that issued the citation. An agency that acts as enforcer, judge and jury often fails to render an objective ruling on the dispute. This process is not objective, and more often than not, a decision is rendered against the facility. Failing to get a fair and objective hearing during the informal dispute resolution forces the provider to go through the administrative process that can take over one year to resolve. If appealed further to the next level, it can take another 4 months. I want to pause here for a moment and talk about the appeal process.

   Only after going through the full administrative review process-- informal dispute resolution (IDR) level, then through the Administrative Law Judge (ALJ)/Departmental Appeals Board (DAB), and then review by the Secretary, can the provider petition to be heard in federal court. Providers can spend years and valuable resources appealing through the administrative process before they can be heard in federal court. This is a great concern for long term care providers because they can face other penalties while waiting to have their cases adjudicated. A sample of 40 cases before the DAB from 1999 and 2000 shows that the average elapsed time between a provider's original request for hearing and the ALJ's decision is 1 year and 2 months. For decisions appealed beyond the original ALJ's decision to the appellate division, a sample of 15 cases shows that the average elapsed time between a provider's original request for hearing and the Appellate Board's decision is another 4 months.

   The irony is that if the provider has a challenge to the statutory authority or the constitutionality of a regulation or procedure, neither the time nor the money invested at the administrative level gives the provider any relief because ALJ's cannot rule on these types of claims. It also should be noted that some larger providers have spent hundreds of thousands of dollars in legal fees while incurring the costs of sanctions imposed, e.g. denial of payments for new admissions, and loss of nurse aide training program, while working through the administrative review process. Consequently, many providers cannot afford to exhaust the administrative process that could get them in to federal court to obtain relief on a statutory or constitutional claim. This is especially true of small providers, like myself.

   I mentioned earlier that we face serious penalties while we are waiting to have our cases heard in the administrative process. One of the penalties that continues while I appeal is the termination of my nurse aide training program which could be unrelated to the reason I might have received the sanction. I testified earlier about our workforce shortage and losing my nurse aide training program for any period of time takes away my ability to recruit staff and may compromise the quality of care my team is able to provide to residents without the staff we need. This is an example of the situation that CMSs' policies put me in. I am between a rock and a hard place

because I can either go through a costly appeal that jeopardizes the viability of my business or take the sanction that goes on my public record and the CMS website for the public to read and compounds my liabilities.

You see, even though I have no claims on my liability insurance, my premiums have skyrocketed from $60.00/bed in 1999 to $550.00/bed this year. And, I was only able to get this rate because I have a $50,000 deductible. Why is this happening? In California, Texas and Florida, lawsuits against nursing homes have reached crisis levels. So much so in Florida, that companies stopped writing liability insurance for providers in the state. Insurance companies are now reviewing a facility's survey history to compute its premium costs in anticipation that a bad survey could instigate a lawsuit. These premium increases are happening around the country regardless of claims history against a facility. Suing nursing homes has become a lucrative business in parts of this country. I can't allow any unjustified sanctions to remain on my record and give any grounds to further increase my insurance premiums. So I have to appeal the sanction. For the small provider, like myself, the lengthy appeal process hurts my ability to appeal sanctions that I feel are not justified. It is for this reason that I support the Medicare Education and Regulatory Fairness Act of 2001. This bill would provide a more just appeals process by expediting the appeals process. It would also allow providers to take issues that do not have facts in dispute, but are issues that challenge the constitutionality or statutory authority of a regulation directly to federal court and not bog down the appeals process. The legislation would also stop penalties such as removal of nurse aide training while I appeal a sanction. If I feel a sanction is unjustified, then I should have a timely appeals process to adjudicate that claim and this legislation will go a long way to helping providers in this regard. **Solution:** We must establish a timely and impartial system of appeal that will dispose of grievances in an equitable, efficient way, and quickly impose penalties that are warranted, while dismissing those that are not merited. CMS can also take steps to clarify that documents they use to survey facilities are not for use in civil litigation.

5. **Enlist Resident Assistants** - Allow additional caregivers to help meet residents' daily needs. Currently, CMS allows untrained volunteers to perform nursing-related tasks, but the paid staff of the facility cannot help dress, feed, or even move patients in a wheelchair -- even under direct RN supervision -- unless trained to become a full Certified Nurse Assistant. Secretary Thompson has recently announced that he will allow Resident Assistants to help transport residents. This is a very positive development from our point of view, and a step towards solving this problem. Legislation has been introduced in the House to address this issue through a demonstration program, and we urge passage of this bill. **Solution:** Support CMS's efforts to allow resident assistants to help transport residents and encourage CMS to take this initiative further.

6. **Remove disincentives to improving facilities** - Allow new owners to improve facilities without threats of closure due to previous problems. Today, a new owner who purchases a troubled facility inherits the track record, fines and enforcement

penalties of the previous owner. In some cases, facilities have been closed within months of the takeover due to compliance problems that were cited before the turnover. This policy discourages companies from taking over problem homes and improving care. The government should work towards helping to improve care for residents -- not prevent it. **Solution:** A positive step forward would be to allow a new owner to start with a clean slate and the opportunity to improve care when the sale themselves have been shown to be at arms length.

In regard to the second issue – financing our system of long term care – our elected officials should look more realistically at existing levels of investment, which we believe are insufficient. But, we also believe that CMS can address these problems.

Today, Medicaid pays for the care for almost 70% of the seniors and the disabled in nursing homes -- over 1.4 million people. States set the reimbursement rate and in California, the reimbursement rate for my geographical area is $105/day. An independent analysis shows that providers are paid approximately 10% below their costs. At this artificially low reimbursement rate, it is becoming increasingly difficult for providers to continue caring for Medicaid patients and providing high quality care. Of course, we're doing the best we can under the circumstances. Overlay the already low reimbursement, with the energy crisis that California is experiencing. My energy costs have risen 30-100%. In many states including mine, the Medicaid payment system is based on cost reports we file with the state. So, the energy costs I pay today won't be reimbursed by California Medicaid, or Medical as we call it, for another year after my cost report is settled. We need a Medicaid system that pays realistically and that can react to real world problems as they are happening.

Because this country does not have a comprehensive long term care policy, many people resort to impoverishing themselves so Medicaid can cover the cost of their nursing home care. If steps are not taken soon to assist states in paying real reimbursement rates to providers -- that actually reflect the costs of care -- our Medicaid financing system has the potential to implode.

How does CMS work to solve the financing problem? Because the federal government provides about half of each states' Medicaid funding, we ask that CMS assess this problem in a realistic manner -- and consider the demographic trends that will shape the future funding needs of the Medicaid program itself. We encourage the CMS to work closely with the nation's governors, as each also has responsibility for this problem.

On the Medicare side, CMS has an opportunity to address fundamental flaws in the way in which skilled nursing facility (SNF) Prospective Payment Rates (PPS) are updated. We would urge CMS to convene a working group to improve the SNF market basket update factor so that it more accurately reflects real cost increases to providers. The current market basket is inadequate to keep pace with cost changes of goods and services from year to year. For example, according to Guy King, former chief actuary at CMS, and based on CMS audited cost reports, cost increases incurred by SNFs increased

27.4% between 1995 and 1998. The SNF market basket provided 8.2% during that time. With labor and energy costs on the rise, it is time to develop an update factor that better reflects the real cost of providing high quality skilled nursing care.

When all is said and done, Mr. Chairman, we all have a personal stake in strengthening our nation's long term care system. Like you, and like all members of this Committee, we want to ensure the vulnerable patients of today and tomorrow are cared for in a manner consistent with the historical watchwords associated with our nation's system of healthcare: Quality and Compassion. I do want to emphasize what I said in the beginning of my testimony regarding the willingness of Secretary Thompson and Administrator Scully to work on the problems facing providers and to work to address them so that we are providing the highest quality of care possible. This is a new day at CMS and we are encouraged by what we have heard from the new administration.

We look forward to working with you all to ensure that care now, and care in the future, is as good as it can, and should be for every American, from every walk of life.

Thank you.

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Thank you Mr. Chairman and Members of the Committee. I appreciate the opportunity to appear before you today. My name is Norman Goldhecht and I serve as the Regulatory Chairman to the National Association of Portable X-Ray Providers (NAPXP). I am also an operator of a portable radiology company in New Jersey. I am particularly pleased to have the opportunity to, once again, testify before this Committee as my company serves many patients in the New Jersey/New York area who are constituents of members of this Committee.

Mr. Chairman, I represent an industry predominated by small and micro businesses. Our companies provide service to our nation's elderly in a particularly safe, convenient fashion, as we, literally, provide care at the patients' bedside. Because the vast majority of our patients rely on Medicare, our industry is highly dependant upon HCFA and its regulatory processes and pricing. Please note that I will refer to the Agency as HCFA in this testimony, in spite of the recent name change, as that is the name referenced by the committee in announcing this hearing and in my invitation to testify. The regulatory process and specific policies of HCFA are critical to our ability to provide our much needed services. It is for this reason that we are so grateful to this Committee for, again, seeking to insure that the small businesses of America are appropriately considered when HCFA policies and procedures are reviewed. I would additionally like to thank Chairman Talent, the immediate past Chair of this Committee and his able staff for sponsoring legislation last year to assist our industry in providing quality care for the elderly and infirm. Although Chairman Talent, and fellow original sponsor, Chairman Crane, were unable to prevail in much needed legislation the NAPXP and all of its members greatly appreciate their efforts and the efforts of all of the Members and staff who assisted them. Our industry relies on the continued oversight offered by this vital Committee and pledges to assist, in any way, your ongoing review of federal policies and processes as they impact American small business.

In presenting our views regarding the methodology by which HCFA develops and administers policies impacting our industry, I will outline some broad, procedural, practices which lead to specific policy problems, as experienced by our industry. I will then discuss several specific policies, which, resultant from the flawed developmental process, provide end-product examples of the need for policy development changes. These examples are, by no means, intended to cover the gamut of specific policy concerns our industry faces. Rather, these examples are presented in an effort to illustrate the effects of policy development procedures within HCFA, which fail to recognize small business realities and thus have a detrimental effect upon health care delivery in America. These effects, not surprisingly, are felt first and most keenly in our rural and less prosperous communities. As is so often the case, American small business provides the only cost effective, and thus available, service to far-flung communities and other less profitable areas. While our federal agencies are most likely to hear and understand the well-financed perspectives of big business interests, the needs of our citizens living in regions offering lower profits to the small businesses who provide the only services available are frequently ignored. As profit margins drop, big business gravitates to the higher density markets. In contrast, small business, due to factors including community involvement, a greater emphasis on personal service and a general unwillingness to

abandon patients due simply to the bottom line, remain to serve long after the profit hungry have fled. It is in this environment that the NAPXP Membership finds itself and it is in this environment that we seek your help. As I present our situation to the Committee, I must stress that our situation is grave. If we are unable to effect change upon the current HCFA policies, our industry will continue to shrink until only those patients fortunate enough to live in high density, high profit areas will find our services available. To the elderly patient in a facility in rural Illinois, or Colorado, or Texas, the need for an X-Ray or EKG in February will require an ambulance ride to a hospital. There, the patient will be subjected to all of the waiting and discomfort we all associate with a trip to the hospital followed by another ambulance ride home. Contrast this with quality care offered in the comfort of the patient's room, surrounded by reassuring sights and sounds without concern for adverse weather conditions, road hazards, etc.

Why would HCFA promulgate policies that have the effect of marginalizing small business? We know that, in addition to providing care to lower profit margin patients, small business also serves to maintain competitiveness through lower overhead, swifter adaptability to market changes, etc. We recognize the fact that much of the recent regulatory actions from HCFA are specifically designed to lower costs. Why then would HCFA promulgate regulations, which decrease small business provider competitiveness? We feel that a lack of small business understanding, much less support, is evident in the process. We see no evidence of effort on the part of HCFA to encourage or even enable small business interests to participate in health care delivery. This near total lack of consideration of the proven cost saving and quality assurance presented by small business competition speaks clearly of an expanded need for the House and Senate Small Business Committees, the Small Business Administration (SBA) and American small business itself, to work together to educate federal agencies such as HCFA to small business realities. Fortunately, this Committee has already provided an appropriate mechanism for just such an educational process. Passage of the Regulatory Flexibility Act (RFA) should have dramatically decreased the number and scope of the type of problems our industry has experienced at the hands of HCFA. Unfortunately, while RFA presents a clear mandate for small business impact analysis in the regulatory process, it is all too often ignored. HCFA's failings in this area are cited directly by SBA Chief Counsel Jere W. Glover in his January 2001, Annual Report on the Regulatory Flexibility Act, Fiscal 2000 (Attachment I). If the NAPXP were to request one result from this Committee's actions, it would be that RFA be vigorously employed and enforced. Rather than pursue the endless task of educating federal agencies to an acceptable level of small business awareness, we ask only that existing statute regarding fair treatment of small business be obeyed. The fact that passage of legislation such as this was possible says more than we are able regarding the plight of American small business.

To illustrate my point regarding the general lack of small business consideration found in recent HCFA regulatory actions, I would outline four separate policy areas, which are badly failing our patients and our industry. They consist of Rural Access, EKG Transportation, Consolidated Billing and Medicare HMOs. Each offers a unique example of flawed policy and resultant degradation of patient care due generally to the inability of small business to continue to provide services under the existing regulations.

Rural Access

Portable x-ray providers service many Skilled Nursing Facilities (SNFs) and homebound patients that reside in rural areas. The provider must travel considerable distances to and from these sites to offer these patients our needed and cost effective services. The cost effectiveness of our services has been documented. In 1995 the Center for Health Policy Studies prepared a cost report which found the average charge to Medicare for a typical x-ray performed by a portable service provider to be $86.76. This was contrasted by an average cost to transport the same patient by ambulance of $420.99. As these figures represent averages, it is logical to assume that the relative costs would become further disproportional in rural areas. Rather than promulgate policy which would encourage portable service providers to travel these distances and provide cost saving services, HCFA has ignored industry requests for a "rural modifier" or other reasonable means by which small businesses, frequently the only service providers available, might be induced to continue serving our rural areas. We know that, increasingly, our member companies are opting not to serve these areas and thus patients. We are frankly amazed that a policy, which has the effect of creating a regional "wrong side of the tracks" disadvantage to millions of our nation's elderly, is tolerated. By refusing to additionally compensate providers of rural services in response to their clearly higher costs and lower profits, HCFA is actively engaged in a policy, which simultaneously denies equal patient care, and drives rural small business service providers out of existence.

EKG Transportation

Currently, portable x-ray providers do not receive any additional reimbursement to travel to and from a SNF when performing a 12 Lead Electrocardiogram (EKG). This previously provided reimbursement was eliminated by HCFA in 1998. The current technical component reimbursement for an EKG is $16.49. This is the identical reimbursement provided a physician's office or hospital for this test. HCFA's blatant disregard for the travel/transport costs of portable providers in this instance is outrageous. Clearly, portable service providers incur additional costs to provide these exams. If HCFA does not recognize these costs for EKG, why then are they reimbursed for portable x-ray transportation? Obviously the costs exist as evidenced by the x-ray policy, but are ignored in the EKG policy. Why? The answer is as unacceptable as it is obvious. Money. Money saved by HCFA in failing to fairly compensate providers for health care services. Money spent by big business to influence policy to damage small business and drive down competition. Money unavailable to small business to fight the big business tactics and bring fundamental fairness to the process. This policy is an embarrassment to our nation and its health care delivery system. The 1995 GAO study of this situation showed an already disproportionate relationship between portable EKG procedures in rural vs. urban settings (Attachment II). The startlingly clear map of this dichotomy was based upon 1995 data. As the transportation reimbursement existed at that time, we can reasonably assume that the situation has worsened with its removal. Which Member of this Committee would wish to explain to their constituents that they are receiving

demonstrably fewer diagnostic procedures simply because they reside in the wrong area of the country?

Consolidated Billing

When I testified before this Committee last year, Consolidated Billing for Part B services was still scheduled to begin. I, and my fellow providers, am thankful that implementation has not taken place. We urge HCFA to stand by their recent decision to indefinitely postpone Part B Consolidated Billing. Additionally, we ask that Specialty 63 (portable x-ray) providers be exempted from Part A Consolidated Billing.

The Prospective Payment System (PPS) for SNFs mandated by the Balanced Budget Act (BBA) has been very damaging to our industry. The intent of PPS was to remove Medicare billing capabilities from our providers and place them with the SNFs. Increased competitiveness and efficiency were cited as reason for this move. While our industry initially offered cautious support for this policy in the interest of improving fiscal health to the system as a whole, enactment has caused many of our worst fears to be realized. Under PPS, SNF residents that are Part A patients must be billed directly to the SNF. The SNF then reimburses the provider for the service. This has allowed SNFs to seek large discounts (below any HCFA fee schedule). Our industry realizes the positive effects of competition; again, small business thrives upon it. However, unscrupulous SNFs have abused this situation to drive prices below costs. As all too many other industries have learned, big business can absorb higher debt level than small. The end result of this trend will be to dramatically reduce the number of providers in the market and thus allow the remaining few to increase prices without adequate competition to forestall them. Additionally, requiring Part A discounts as a cost of maintaining Part B business creates an unhealthy "kick back" atmosphere which has been consistently challenged as unethical, if not illegal, by HCFA itself. The simple solution would be to exempt Specialty 63 providers from PPS. This is also a reasonable step due to the vast differences between costs as incurred by physicians in their offices and portable providers with high transportation costs.

Finally, as SNFs face no prompt payment requirements, in sharp contrast with virtually every other federal government contract, they find it increasingly advantageous to simply hold our fees until they find it convenient to pay, if at all. Clearly small businesses are disproportionately unable to carry debt as compared to big business. This further creates a big business advantage and forces still more small providers out of the market. HCFA's failure to insert prompt payment language into the PPS system demonstrates an appalling lack of comprehension of the small business environment.

Medicare HMOs

A new and growing problem may be found in the increase in Medicare HMOs. As providers to SNFs, we are asked to perform services for patients who appear to have Medicare Part B coverage, but who actually are covered by a Medicare HMO. These HMOs do not always recognize the provider and will thus refuse to reimburse them for

services already performed. This occurs because the provider has no way of knowing that the patient is actually in a Medicare HMO until after the procedure. In most cases the patient retains the same Medicare number they were issued under Medicare Part B. Additionally, Medicare HMOs are not required to recognize HCFA fee schedules, further complicating the seemingly simple concept of a provider receiving fair compensation for services rendered. We call upon HCFA to better identify these patients and install a reasonable fee schedule so that service providers can be assured of compensation.

Mr. Chairman, I recognize the challenges faced by this hard working committee in dealing with these often-complex challenges. Again, I and all of the Members of the NAPXP pledge our support for your efforts and thank you for the opportunity to voice our concerns. I would be happy to answer any questions the Committee might have.

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Statement of Steven M. Mirin, M.D.
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To the House Committee on Small Business

On

"The Regulatory Morass at the Centers for Medicare
and Medicaid Services:
A Prescription for Bad Medicine"

Wednesday, July 11, 2001

The American Psychiatric Association (APA), the medical specialty society representing more than 38,000 psychiatric physicians nationwide, is pleased to submit this statement to the Committee on Small Business at its timely hearing on the management of the Medicare program by the Centers for Medicare and Medicaid Services (CMS, formerly HCFA). First and foremost, Mr. Chairman, the APA commends you and the Small Business Committee for your concern about our patients and profession by conducting today's hearing. APA would also like to strongly commend Representatives Toomey and Berkley for their tireless personal efforts to secure enactment of the Medicare Education and Regulatory Fairness Act (MERFA), H.R. 858. Enactment of H.R. 858 would help resolve many of the problems and concerns we will address in our testimony today.

We acknowledge at the outset that the task of day-to-day operational management of Medicare must be daunting. CMS – through Medicare, Medicaid, and the new children's health insurance program (SCHIP) – is the largest health insurance administrative entity in the nation. It will process almost a billion claims submitted by some three-quarters of a million physicians, non-physician health professionals, hospitals, and other health providers and suppliers. On the Medicare side alone, CMS is the insurance company for 39 million elderly and disabled beneficiaries.

The sheer size of the Medicare program alone is staggering. Nor is Medicare a static target. As you know, the program is subject almost every year to numerous legislated changes (335 in the Balanced Budget Act of 1997, according to CMS), including in recent years the development of extraordinarily complex system for paying physicians (i.e., the RBRVS-based fee schedule). Budget-driven priorities have led successive Administrations and Congresses to farm the statute for short-term savings necessitating complex changes in payment rules, or for longer-term changes in program administration (i.e., stepped-up efforts to target program fraud and abuse).

Each of these developments requires the promulgation through public process of new regulations and the development of a variety of complex instructions to CMS contractors (i.e., Medicare carriers and fiscal intermediaries) on how to administer claims on a day-to-day basis. Thus, it is small wonder that as the covered population and covered services have grown, and as the various mandates passed on to CMS by successive Congresses and Administrations have also grown, the Medicare program itself has become extremely complex and, from the perspective of the physicians represented by the American Psychiatric Association, increasingly unwieldy, unresponsive, and in many cases apparently hostile to the physicians who provide medically necessary care to our patients who are Medicare's beneficiaries.

On a general basis, APA as the national medical specialty for psychiatrists is increasingly hearing grave concerns from our physicians in the field that they and the patients they serve feel under siege by a Medicare administrative operation that is too-often unresponsive, insensitive, and hostile. We believe that much of the problem stems from the autonomous nature of CMS carrier operations.

As you know, Medicare covers services that are medically reasonable and necessary, entitles beneficiaries to these services, and requires appropriate documentation for claims filed. Medicare uses roughly twenty-four private contractors (the carriers) to administer claims filed under Part B of the program.

As contractors, carriers are subject to specific contractual requirements from CMS that govern their responsibilities. Despite the fact that Medicare is a federal program with supposedly uniform national coverage and payment criteria, carriers in fact are given considerable autonomy and flexibility in their administration of Part B. For example, carriers are left to develop their own local medical review policies (LMRPs). The LMRPs are primarily a program integrity tool to specify criteria to determine whether a service is covered and to set standards for determining whether a covered service is reasonable, necessary, appropriate. The LMRP is not supposed to restrict or conflict with national coverage policy.

Too often, however, the LMRPs provide the means for widespread variation between carriers in the treatment of claims common to all carriers. This is particularly true of psychiatric services, where services defined as reasonable and necessary for beneficiaries in one carrier jurisdiction are denied as not being reasonable and necessary in another. This results in two major distortions of what should be a national program. First, patient access to identical services varies from carrier to carrier. Second, documentation requirements imposed on physicians for identical services vary from carrier to carrier. Taken together, these two important problems can and do result in reduced access to care for our patients and increased hassles for psychiatrists.

General carrier-related problems and anomalies associated with psychiatric services include the following:

- Alzheimer's Disease Coverage: The Medicare Carrier Manual stipulates that Alzheimer's patients are entitled to psychiatric services. A number of carriers, however, have been routinely denying any psychotherapy services for patients with a primary diagnosis of Alzheimer's disease, no matter what stage of the progressively degenerative disease the individual patient is in or how minimal their cognitive impairment may actually be.

- Drug Management: Pharmacologic management (CPT-90862) is a service clearly covered by Medicare. APA review of carrier LMRPs shows widespread variation from the AMA's CPT manual that serves as the descriptor for the service.

- Family Therapy: This is another service clearly covered by Medicare, but APA members report that some carriers routinely deny all claims for the service, even when full documentation is provided.

- Review Triggers: Medicare's coverage of outpatient psychotherapy services is not subject to annual visit limits. Increasingly, however, carriers are developing LMRPs that subject all claims above a certain number (typically 20) to intensive review (in some cases 100% review). This creates a major administrative hardship for psychiatric physicians who often practice in a solo office environment and is a significant detriment to quality patient care.

Real-world examples of carrier specific issues include the following:

- In New York, the carrier, Empire, continues to routinely subject 100% of claims for CPT codes 90846 and 90847 (family therapy with and without the patient present) to prepayment reviews. This occurs *every* time these codes are submitted, even when Empire had approved the same service for the same patient by the same psychiatrist the month before.

- In Massachusetts, Maine, New Hampshire, and Vermont the carrier, NHIC, has been routinely denying medical family therapy claims, even though family therapy is clearly a benefit covered under Medicare. I note that psychiatrist appeals of the denials are usually decided in favor of the psychiatrists.

- In Arkansas, one of our members reported that his hospital had started a partial hospitalization program (PHP) at the urging of managed care organizations who told them frequently that patients were not critical enough for acute hospitalization but would be appropriate for partial hospitalization care if the hospital would establish a PHP. Less than a year after the hospital instituted its partial hospitalization program they were forced to shut it down because the Arkansas carrier decided to restrict all PHP care in response to fraud committed by a single mental health center in Arkansas that had contracted with an out-of-state company to manage their partial hospitalization program. While it certainly may have been appropriate to shut down the offending operation, it should not have resulted in the effective shutting down of every legitimate partial hospitalization program in the state as well.

- In Colorado, an APA member who provided medication management checks to nursing home patients -- and who had done so for many years without challenge -- was abruptly subject to 100% claims prepayment audits for a period of nearly 7 months without warning or explanation.

In addition to the carrier-specific anomalies cited above, there appear to be general problems in the ways in which CMS identifies potential problems within the Medicare program that adversely affect psychiatric services to patients. For example, we understand that CMS uses "BESS" data (Part B Extract and Summary System data) to flag anomalous code usage and notify carriers that code usage within their charge locality is at variance with national averages, and to instruct carriers to develop LMRPs to respond to the variance.

Yet there seems to be no effort made to determine why the variance exists. It may well be that physicians in one state are encouraged by the carrier to use one code, while those in another are encouraged by their carrier to use a different code. Or it may be that a few individual physicians or other health professionals are outliers, using a disproportionately large share of the codes within a carrier's locality. Thus, coverage policies affecting thousands of physicians and the patients they serve seem to be made on the basis of abstract statistical data analysis, not on the basis of a determination that a specific problem exists.

Psychiatrists' problems with Medicare are not confined to carrier interface. Under current law, Medicare beneficiaries are required to pay a discriminatory 50% copayment for outpatient psychotherapy services. As a result of the 1990 budget law, Medigap insurance policies are supposed to cover the 50% copayment, but 10 years later, we continue to hear from psychiatrists who are having difficulty in persuading Medigap insurers that they are in fact liable for coverage of the 50% copayment.

In another example of how CMS policy-making can have a sweeping impact on physicians, in July 1999, CMS (then HCFA) released an unannounced and complex new rule establishing a new "Patients Rights" condition of participation for Medicare and Medicaid

hospitals. Included within the patient's rights is a series of provisions governing the use of seclusion and restraint of patients in acute medical and psychiatric settings. These sweeping standards amount to the imposition of untested standards of clinical care by federal regulatory fiat.

Issued as an interim final rule, the seclusion and restraint standards were put in force on 30 days notice (i.e., they were enforceable as of August, 1999) without benefit of prior public comment or field testing. Two years later CMS has still not issued a final rule, nor has it responded to the thousands of comments from psychiatrists, other physicians, and hospitals, all of whom have pointed out major clinical problems with the interim final rule.

Despite the fact that the rule affects every Medicare/Medicaid hospital and imposes burdensome and sweeping patient care requirements that invariably will affect hospital staffing and require more intensive patient interaction per capita, the interim final rule asserted that costs associated with compliance would be minimal. This was palpably untrue, but no objective cost assessment was issued until the Small Business Administration found that (then) HCFA had violated the Regulatory Flexibility Act by failing to conduct a valid cost impact analysis and by failing to consider less costly alternatives for rural and other underserved locations, and until a Federal court ordered HCFA/CMS to produce a cost analysis.

In the meantime, the outgoing Clinton Administration issued a similar rule applicable to Medicaid patients under age 21 receiving services in psychiatric residential treatment centers. These rules were issued despite the fact that Congress itself had approved standards applicable to both hospital and non-hospital settings as part of the omnibus reauthorization of the Substance Abuse and Mental Health Services Administration included in H.R. 4365, the Children's Health Act of 2000. Likewise, the Joint Commission on Accreditation of Healthcare Organizations revised its own standards for the use of seclusion and restraint, effective January 1, 2001. Thus, in less than two years, psychiatrists and other physicians, hospitals, and other institutional providers have had to contend with two major federal regulatory initiatives, legislation enacted by Congress (for which regulations have still not been issued), and fundamental changes in JCAHO practice standards, all dealing with the use of seclusion and restraint.

In fairness, the Bush Administration inherited a regulatory morass on seclusion and restraint. We are heartened that Health and Human Services Secretary Thompson has, to the credit of the Bush Administration, amended the Medicaid psychiatric RTC standards in ways that offer some meaningful measure of common sense to this volatile and complex issue. We hope that HHS will work with us to reassess the standards already in place for Medicare hospital settings, and we commend Secretary Thompson and President Bush for what we hope are first steps in this area.

In the meantime, the Medicare hospital standards remain in force, despite widespread and thoughtful disagreement from expert clinicians, and despite compelling evidence that some hospitals may not be able to comply with the standards, thus risking decertification. At a minimum, the rules represent a substitution of the inflexible judgment of a bureaucrat for the independent clinical judgment of the physician responding to the needs of his or her patient.

Ironically, we believe that the rule will result in reduced access to needed inpatient psychiatric care, as hospitals may screen out patients with a track record that suggests the likelihood of restraint and or seclusion. Such patients will more than likely end up in the forensic system where they are much less likely to receive the care their mental disorders require. This will be the unhappy result of the establishment of clinical practice standards by bureaucratic fiat, and furthers CMS's image as unthinking, unresponsive, and capricious.

Finally, our members in the field tell us that a major problem with Medicare is a lack of responsiveness and accountability throughout the system. For example, carriers have told our members that Carrier Advisory Committee meetings are not subject to federal sunshine requirements, and thus that the CACs are under no specific obligation to open up their meetings to the concerned physicians and their representatives who are directly affected by CAC deliberations. In addition, there is widespread reluctance throughout the system to put information and interpretations about claims, particularly about denial policies, in writing. Thus, physicians are forced to rely on oral statements from carriers which cannot subsequently be used to justify future claims.

Mr. Chairman, to sum up, we believe that CMS has an unenviable and complex job of administering the largest health insurance program in the United State. Psychiatrists, as any group of physicians, are interested only in the provision of medically necessary care to our patients. We would welcome the opportunity to work in partnership with Congress and CMS to craft common sense solutions to Medicare's myriad operational problems with the object of improving patient access to care.

To that end, we make the following recommendations on behalf of our patients and our profession:

1. CMS should conduct a systematic review of carrier operations with an eye to removing widespread variations in coverage and review practices by carriers. There is no justification for one carrier to routinely reject services that another carrier routinely covers.

2. 100% claims review practices effectively constitute carrier harassment of physicians and should be halted. If there is a specific problem with a specific code, CMS and the carriers should work with local and national physician organizations to understand first if there is in fact a problem and second to craft a solution to the identified problem.

3. CMS should follow administrative procedures. We echo the AMA's recommendation that CMS should be required to conduct accurate regulatory impact and cost analyses and to fully account for the burden of complying with a proposed regulation before putting them in force.

4. CMS should conduct nationwide physician education workshops. If, as CMS suggests, there are widespread inadvertent claims submission errors, then it is logical that the errors stem from program complexity and lack of clear direction on how to properly file claims. Rather than assuming criminal intent, CMS should acknowledge the necessity for widespread cooperative education of physicians and other providers.

5. Carriers should be required to provide explanations of coverage decisions and interpretations in writing in an understandable form. If physicians request guidance from carriers on how to file claims and which codes to use, the information should be provided in writing when requested. Carriers should not be allowed to avoid responsibility for the advice that they give to physicians, nor should physicians be subject to sanctions and penalties for following carrier guidance.

6. CMS and the carriers should be instructed to reduce the adversarial nature of communications with physicians. Too often carrier communication with individual physicians is predicated on the assumption that the physician is trying to defraud the Medicare program. To the contrary, the overwhelming majority of physicians are simply trying to render medically necessary care to their patients and to be paid with a minimum amount of bureaucratic hassle for the services rendered.

We are heartened by recent communications between Ways and Means Health Subcommittee Chairman Nancy Johnson and Ranking Member Pete Stark and CMS Administrator Tom Scully about ways in which CMS can take administrative action to alleviate some of the problems we have discussed in this testimony. But we continue to believe that legislative action is necessary to ensure that Medicare carriers -- and CMS -- take action to address the regulatory morass that discourages physicians from sticking with the Medicare program.

As noted, APA strongly supports enactment of H.R. 868, the Toomey-Berkley "MERFA" bill now cosponsored by a majority of the House of Representatives. We believe that a codified establishment of greater due process requirements in post-payment claims audits, combined with greater efforts to education physicians about coding, documentation, and billing requirements, would send a clear message to CMS and its contractors that Congress is serious about redressing the hostile relationship that too-often exists between Medicare and physicians who are simply trying to get paid for providing medically necessary care to their patients. Enactment of H.R. 868 would be a major positive step in this direction.

APA also believes that the practice of issuing "interim final" rules in perpetuity must stop. As noted in our comments about seclusion and restraint, CMS has still not issued final rules clarifying numerous elements of the 1999 interim final rule, despite the fact that it received literally thousands of comments. APA continues to receive many inquiries from our members in the field about this complex and important patient care issue; our ability to respond is compromised by the failure of CMS to issue a final rule.

Mr. Chairman, thank you for the opportunity to present our views on this important topic. We commend you for holding this important hearing and look forward to working with you and the Committee to make Medicare regulatory reform and enactment of H.R. 868 a reality in the 107th Congress.