A Call for Medicare Reform of the Education and Payment Systems

by Christian G. Downs

For years providers have been frustrated by what they consider to be poor information and unclear instructions from Medicare and their carriers about billing and payment policies.

A case in point: Medicare offers to cover the routine care costs of clinical trials. The agency then issues a program memorandum notifying carriers to advise providers it will *not* pay for the drug under investigation. Providers bill for the routine care costs—chemotherapy administration and office visit—and submit the bill to the carrier. The carrier then rejects payment for the whole claim because the provider billed for chemotherapy administration without billing for the drug. "But," the provider says, "you told us not to bill for the drug!"

While this situation serves only as an example, a recent hearing on Capitol Hill confirmed the frustrations of many providers. In an exercise that occurs every day in provider offices and hospitals around the country, personnel from the U.S. General Accounting Office (GAO) explained how they performed a simple test by placing nearly 60 calls to five provider inquiry lines. The results were disconcerting, but not surprising.

Leslie Aronovitz, GAO's director of health care program administration and integrity issues, testified that: "Three test questions selected from the 'Frequently Asked Questions Section' of the carrier's web site concerned the appropriate way to bill Medicare under different circumstances. The results of the test, which were verified by a coding expert from the Centers for Medicare and Medicaid Services (CMS), showed that only 15 percent of the answers were complete and accurate, while 53 percent were incomplete and 32 percent were entirely incorrect."

Also at the hearing, GAO staff testified that the Medicare program suffered from a lack of competition in selecting contractors, a lack of adequate and economically sound performance incentives, and outdated and inaccurate or incomplete information on carrier web sites.

So, what can be done?

Discussion on a very broad level has centered on "privatizing" the Medicare system. Such action would allow insurance companies to compete for Medicare beneficiaries. While providers are not enamored with the Medicare billing and coding system, at the same time many realize that privatizing the whole system may take away what little due process providers currently have with Medicare.

At the other end of the spectrum, having government control over the whole system has problems. Many providers, who have experience working with the cumbersome Veterans Administration's payment system, can support this position.

A middle position may be staked out in the form of a bill introduced in August on Medicare reform and approved by the House Ways and Means Committee in October. The bill, the Medicare Regulatory and Contracting Reform Act (H.R. 2768), would require Medicare to centrally coordinate contractors' provider education activities, establish communications performance standards, and appoint a Medicare provider ombudsman. Moreover, the legislation would require Medicare to create a demonstration program to offer technical assistance to small providers, require competition for contracts, and mandate that contractors monitor the accuracy and timeliness of the information they provide. In fact, CMS, formerly known as the Health Care Financing Administration or HCFA, supports the reforms stated in H.R. 2768. (H.R. 2768 can be read at *www.house.gov*, and testimony is at *http://waysandmeans.house.gov/health/107cong/hl-10wit.htm.)*

CMS officials in June announced their own reforms that were similar to those proposed in the Medicare Regulatory and Contracting Reform Act. This action bodes well for the "concepts" discussed in each proposal for reform.

While these reforms sound prudent and appropriate, in Washington the devil is in the details. One concern with H.R. 2768, for example, is the idea called "extrapolation." Many providers are familiar with this technique. Auditors look at a small sample of claims, and then determine that an overpayment has been made. Then, instead of looking at all the claims, they simply extrapolate the finding to hundreds of claims per year over several years and demand repayment of tens of thousands of dollars without doing the due diligence of looking at the claims.

Another concern, and one that exists with any legislative proposal, is how will the agency interpret the law? In health care this is always a problem. For example, look at the regulation for self-injectables and the previously mentioned clinical trials memorandum.

Despite these concerns, as a concept H.R. 2768 is a step in the right direction. Providers have long needed reform of the Medicare education and payment systems. Let's hope Congress and CMS have the will.

Christian G. Downs is ACCC managing director of provider economics and public policy.