AIM

Alliance to Improve
Medicare

Improving Medicare Management *for Everyone*

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

A Report by the Alliance to Improve Medicare June 2001

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

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

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

Key AIM Principles

C Improve coverage through better coordination of care and health promotion and disease prevention efforts.

C Improve coverage choices by providing Medicare beneficiaries with the power to choose from a range of coverage options similar to those available to Member of Congress, federal employees and million of working Americans under age 65 who are covered by private plans.

C Improve coverage through increasing market competition and availability of basic, affordable coverage to Medicare beneficiaries.

C Provide access to prescription drug coverage as part of comprehensive, market-based modernization and improvement.

C Improve traditional Medicare's basic benefit package and provide the flexibility to make new health care innovations more accessible.

C Reduce Medicare's excessive complexity and rigid bureaucracy.

C Establish a solid foundation upon which to improve Medicare by ensuring appropriate and timely payments to health plans and

providers.

ALLIANCE TO IMPROVE MEDICARE

COALITION MEMBERS

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

Improving Medicare Management *for Everyone*

Improving Medicare Management Through Reducing Regulatory Burdens on Providers and Beneficiaries

Background

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

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

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

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

Report

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

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

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

SECTION ONE:

Medicare Modernization: Beneficiary Regulatory Concerns

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

Beneficiary Benefit and Compliance Concerns

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

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

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

particular service. (Medicare makes coverage determinations only after services are provided.)

Caseworkers responded that many beneficiaries are unaware of existing opportunities for assistance from such organizations as State Health Insurance Assistance Programs and other medical hotlines or simply lack access to opportunities such as the Internet and the www.Medicare.gov web site. Beneficiaries clearly need such information to be more easily accessible.

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

Recommendation: *Provide Prescription Drug Coverage* (Statutory)

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

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

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

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

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

SECTION TWO

Improving Medicare Management: Provider Regulatory and Compliance Concerns

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

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

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

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

Today, advances in areas such as DNA-based testing, microelectronics, tissue engineering and molecular imaging are transforming health care – and patients' lives. Frequently, cutting-edge medical technologies are supplanted by new breakthroughs in two years or less, yet Medicare can take 15 months to five years or more to make these advances available to seniors and people with disabilities. The recommendations below will help make timely patient access to 21st century medical technology a part of CMS's new mission.

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

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

Provider Regulatory Relief Recommendations

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

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

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

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

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

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

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

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

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

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

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

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

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

C M+C organizations across the country frequently receive different instructions and policy interpretations from the 10 CMS Regional Offices and the CMS Central Office. Regional Office Administrators and CMS Center Directors

report directly to the CMS Administrator. Regional offices and centers are not required to maintain program-wide consistency for instructions or policies.

For example, the CMS Central Office has issued model language for beneficiary communications and stated that use of the language by plans is discretionary: if a plan chooses to use the language as issued, it will not be subject to change by the Regional Offices and will receive expedited review. Contrary to Central Office instructions, however, some Regional Offices have *required* rather than permitted use of the model language and required plans to make changes in the Central Office model language in order to obtain Regional Office approval.

- CMS should adopt consistent policies for Part A and Part B. Examples of inconsistency include: advanced beneficiary notices (ABNs) and medical necessity determinations for Part A and Part B; Medicare secondary coverage determinations for Part A and Part B, including reference labs, etc.

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

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

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

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

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

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

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

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

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

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

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

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

  The complex and burdensome hospital cost-reporting process developed over decades, at a time when Medicare payments were, to a significant degree, based on their costs. Now that Medicare has largely eliminated cost-based payments for hospital services, the primary purpose of hospital cost reporting has disappeared, and thus the

process should be correspondingly reduced and simplified. By comparison, the cost reporting process for skilled nursing facilities was recently substantially simplified in the wake of their conversion from cost-based reimbursement to prospective payments. Hospitals are entitled to similar regulatory relief.

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

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

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

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

In order to improve efficiencies in payment, CMS needs to select a methodology for risk adjustment with a public comment period of no less than 18 months prior to implementation. The methodology must be financially sound and provide for an efficient system for data collection. Risk adjustment, in turn, needs to be phased in

over a 10-year period, beginning in 2004, in order to stabilize payments to plans. Current law calls for risk adjustment to have an 8-year phase-in, with 100% of payments risk adjusted in 2007. This schedule is not adequate to preserve stability in plan payments.

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

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

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

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

Recommendation: *Simplify Accreditation Procedures* (Administrative)

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

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

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

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

Plans that also wish to participate in quality improvement activities generated by

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

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

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

It is often impossible to obtain clear, timely and final answers from CMS on complex billing issues. Thus, providers must take a best guess at the answer, which leaves them vulnerable to second-guessing and charges of incorrect billing. Creating a formal process for obtaining answers to these types of questions would provide greater certainty and consistency, and reduce billing and payment errors. Receiving a written advisory opinion would also permit the provider to rely on the advice received. Many other Federal agencies have similar programs (e.g., the SEC, the IRS, the DHHS OIG) and they are enormously helpful.

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

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

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

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

for correcting overpayments.

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

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

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

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

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

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