The American College of Physicians–American Society of Internal Medicine (ACP–ASIM), representing the nation’s largest medical specialty, is pleased to provide the following comments to the Practicing Physicians Advisory Council (PPAC) on Medicare Integrity Program Contracting Initiatives and Proposed Regulations to Implement the Medicaid Managed Care Provisions of the Balanced Budget Act of 1997.

**Medicare Integrity Program Contracting Initiatives**

ACP–ASIM has concerns regarding the Health Care Financing Administration’s (HCFA) Medicare Integrity Program (MIP) contracting initiatives. Our comments on HCFA’s “Medicare Program; Medicare Integrity Program (MIP), Intermediary and Carrier Functions, and Conflict of Interest Requirements” notice of proposed rulemaking (NPRM) that appeared in the March 20, 1998 Federal Register spell out many of our concerns and recommended solutions. A copy of our comments on this NPRM are included under “Attachment A.”

ACP–ASIM objects to the use of proprietary commercial off the shelf editing software by Program Safeguard Contractors (PSC) under the MIP (or by existing contractors). While we understand that HCFA is under pressure to use proprietary, or “black box,” edits to save money, we point out that the appropriateness of these edits cannot be judged solely on their ability to generate savings by denying payments to providers. The Department of Health and Human Services Office of Inspector General (OIG) report, “Using Software to Detect Upcoding of Hospital Bills,” released August 12, 1998, questions the ability of commercial software to accurately detect over-billing. The report, which analyzed two off the shelf software products currently on the market to identify hospital upcoding, found that only about 20 percent of the Medicare billing cases that commercially available software identified as being upcoded were in fact upcoded.

HCFA’s PSC draft Statement of Work (SOW), discussed at its April 17, 1998 pre-solicitation conference, that outlines how PSCs will coordinate with other entities raises serious continuity concerns for physicians. The draft SOW states that a PSC will work with its “affiliated contractor,” the contractor responsible for claims processing, when hearing appeals on denied claims. identifying and determining overpayments, and providing customer service. The draft SOW stipulates that the affiliated contractor will serve as the initial point of contact to carry out these functions, while referring matters relating to program safeguard within each area to the PSC. ACP–ASIM questions the ability of the PSC and affiliated contractor to coordinate with each other in a seamless way that will not disrupt services that are essential to physicians. The
draft SOW’s guidance regarding overpayment activities illustrates the complexity of intended coordination efforts. Having affiliated contractors “identify claims processing, Medicare secondary payer, and other overpayments...the PSC identify and assess program safeguard overpayments...and the affiliated contractor collect all overpayments” has the potential to further complicate an overpayment recoupment process that providers already view as affording too little time to respond to a recoupment request.

We strongly support the PSC draft SOW provision that PSCs coordinate with professional societies. Allowing professional societies to participate in the development of contractor policies will result in better policies that are more likely to be accepted by affected physicians. National medical specialty societies should be involved in development of policies with the potential to affect a large number of physicians or a significant geographic area. National specialty society input can then be supplemented by local Carrier Advisory Committees (CACs), which the draft SOW states will continue to function under the MIP program.

In addition, it is imperative that HCFA keep the medical community, as well as all other interested parties, informed regarding its MIP contracting activities.

**Proposed Regulations to Implement the Medicaid Managed Care Provisions of the Balanced Budget Act of 1997**

Due to the fact that Medicaid fee-for-service (FFS) reimbursement is substantially below all other payers, and so low in fact that many physicians find the paperwork for submitting claims (and correcting/resubmitting rejected or denied claims) more costly than the amount paid by Medicaid, the number of physicians willing to see Medicaid patients has eroded to the point that State agencies can no longer assure access to services under FFS.

This has necessitated a substantial shift to managed care by State agencies, to assure their recipients have a guaranteed point of access to care. Free choice of provider, once an underlying tenet of both Medicare and Medicaid, is now, for the most part, a theoretical ideal under Medicaid that has evaporated along with the ever dwindling pool of Medicaid FFS providers.

So, for many Medicaid recipients, the local hospital emergency room (ER) has become the primary, and sometimes only, source of care, even when the care needed is neither urgent nor an emergency. This inappropriate utilization of ERs has costly consequences for the States—not only in terms of how much they pay hospitals for these “office visits”, but also because it means patients are being seen at later stages of an illness, which is always more costly than prevention and/or early intervention and treatment.

The situation noted above has increased the prevalence of and States’ reliance on Medicaid managed care, in many cases requiring burdensome waiver proposals and HCFA approval to implement. With the Balanced Budget Act of 1997 eliminating the need for such waivers,
ACP–ASIM is encouraged that States will now face a reduced administrative burden, freeing up resources they can use to better support managed care contractors. This is also likely to put States in a better position to evaluate managed care plans and help improve their performance.

Preserving Fee-for-Service and Maintaining the Safety Net

Although the Balanced Budget Act of 1997 provides States more flexibility to mandate that Medicaid eligibles enroll in managed care plans, ACP–ASIM believes it is necessary to preserve the FFS infrastructure and to maintain a safety net to ensure that the Medicaid population receives adequate care. There remains an absolute need for States to maintain and improve their FFS operations and providers, since not all recipients have access to Medicaid contracted managed care organizations (MCOs). This is true even in geographical areas where, previously under Section 1915(b) waiver authority, or now under the State Plan, most eligibles are mandatorily enrolled in MCOs—the usual case is mandatory enrollment for Aid to Families with Dependent Children (AFDC) linked eligibles, and voluntary enrollment for the Supplemental Security Income (SSI) population.

States such as California have striven to maintain enhanced services for specialized needs populations even when managed care has become the primary source of care in a given geographic area. Retention of safety net providers and their target populations has been addressed by either: (1) requiring Medicaid MCOs to offer contracts to these providers, (2) requiring Medicaid MCOs to enroll and serve these special needs recipients directly, with State capitation rates factoring in the higher than average FFS costs of these providers and their clients, or: (3) providing managed care exemptions for patients with special needs and/or those who were seeing specialists for selected conditions in order to complete their course of therapy.

In reference to (3) above, States can protect their FFS safety net providers and their special needs populations by exempting them from participation in the local Medicaid managed care system, and pay them enhanced rates under FFS (since their clientele generally demand more costly and complex services, and safety net clinics tend to be small, with low patient volumes that generally cannot achieve any economies of scale). This is a more difficult approach, since these patients still must be enrolled in the local managed care system for all their other covered services, requiring more resources to coordinate, track, and pay for their care.

Medicaid Provider Participation

We are concerned that the proposed regulation to implement Medicaid managed care provisions fails to provide incentives to physicians to participate in Medicaid managed care plans. We recommend that physicians be given an active role in the design and operation of Medicaid managed care programs organized and operated at the local level. This positive impact on physician participation and commitment has been the case with a number of Medicaid waivered County Organized Health Systems (COHS), where physicians play a pivotal, gatekeeper role in managing the care of their patients, and have a very significant say in how the COHS operates.
Notably, COHS's have the freedom to pay their participating physicians more than what is paid by the State agency, and can and do offer financial bonuses to physician case managers who keep their patients healthy and out of the hospitals. Further, physicians are attracted by the minimal paperwork and red tape in getting paid compared to the State operated FFS system, and the fact that COHS turnaround time on claims payment is typically faster than the State with less claims payment rejections and delays, and a local COHS staff person to contact to quickly allay problems.

COHS's give patients and physicians a sense of belonging, of being part of a system that is committed to service excellence, staffed by members of the local community, with full time, active beneficiary and provider relations departments. COHS's have the ability to tailor their services to local needs.

The lack of provider participation in Medicaid FFS continues to be problematic and still must be addressed. Dozens of HCFA waiver evaluations, as well as academic and National Governors Association (NGA) studies of physician participation in Medicaid, show that the primary reason for non-participation in Medicaid is the amount of red tape, overhead, delays, and frustration in obtaining timely Medicaid FFS reimbursement, with the low levels of Medicaid reimbursement, and difficulties working with the Medicaid population (missed appointments, poor treatment compliance) being significant but only secondary considerations.

Thus, ACP-ASIM recommends that States focus on ways of streamlining the processes by which physicians are paid under FFS, relieving them of as much of the paperwork burden as possible and, if possible, increasing reimbursement sufficiently to start attracting physicians and other providers back into Medicaid FFS (State streamlining of its FFS requirements and claims processing might be one source of savings that could be tapped to increase the FFS payment scale, as well as administrative savings that arise from switching from FFS to mandatory managed care--such as lowered claims processing costs, reduction of FFS monitoring/oversight staff). Another way States could attract physicians back to Medicaid is to pay them a monthly fee to serve as case managers.

ACP-ASIM thanks PPAC for the opportunity to comment on Medicare Integrity Program Contracting Initiatives and Proposed Regulations to Implement the Medicaid Managed Care Provisions of the Balanced Budget Act of 1997.
May 19, 1998

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Attention: HCFA 7020-P

Dear Ms. DeParle:

The American Society of Internal Medicine (ASIM), representing the nation’s largest medical specialty, is pleased to provide the following comments on the Health Care Financing Administration’s (HCFA) “Medicare Program; Medicare Integrity Program (MIP), Intermediary and Carrier Functions, and Conflict of Interest Requirements” notice of proposed rulemaking (NPRM) that appeared in the March 20, 1998 Federal Register.

ASIM agrees with HCFA’s assessment that the MIP has the potential to improve the efficiency of the Medicare program. ASIM is concerned, however, that MIP implementation, including the selection of MIP contractors, will cause disruptions in the services provided to physicians and patients. We are also concerned that fragmenting carrier functions could impose a significant administrative burden on physicians.

This NPRM fails to specify an adequate level of accountability for MIP contractors. There is no mention of transferring the current carrier performance criteria to MIP contractors when functions currently being performed by carriers become the responsibility of MIP contractors.

Our comments are intended to assist HCFA in ensuring a smooth transition for parties affected by the implementation of the MIP framework by improving all aspects of the functions it may delegate to contractors. Our comments appear under the headings listed in the NPRM. The notation in parentheses following the heading, for example (II. A. 4), indicate the exact section of the NPRM to which our comments pertain.

Medicare Integrity Program: Services to be Procured (II. A. 4)

Medical, Utilization, and Fraud Review (II. A. 4.a)

This section of the NPRM states HCFA’s belief that the ability to contract with outside entities afforded under the MIP allows it the “flexibility to invest in innovative strategies to combat fraud
and abuse.” However, the NPRM does not have a provision to allow physicians to review these strategies, particularly the various “black box” electronic claims processing technologies that MIP contractors could use to prevent erroneous payment for Medicare claims. ASIM has no tolerance for fraud and abuse, but is concerned with the potential for MIP contractors to use these “black box” coding edits.

“Black Box” Edits

ASIM is concerned that private entities with MIP contracts will purchase Commercial Off-the-Shelf Software (COTS) or develop similar “black box” coding edit systems. ASIM strongly believes that such a closed edit system is inappropriate. The Medicare Correct Coding Initiative demonstrates the need for a coding edit system that is open to peer review. ASIM and other medical organizations were able to identify numerous inappropriate coding edits in the Medicare correct coding system because it was made available for public review. Hundreds of these inappropriate proposed edits were later retracted or altered. The end result is that the claims payment system will be more accurate because it had been appropriately peer reviewed. If the Correct Coding Initiative was a closed system, then many inappropriate edits would have remained, which would have denied payment for appropriately provided services.

ASIM recommends that HCFA prohibit MIP contractors from implementing coding edits that have not been reviewed by practicing physicians. Misguided products are counterproductive as they disrupt billing and increase friction between Medicare and its providers. HCFA (and its contractors)’ zeal for combating fraud and abuse through innovative editing techniques must not inhibit physicians’ ability to bill and be paid for medically necessary services furnished to beneficiaries.

This section of the NPRM also fails to adequately address the following issues: (1) the standard established by the Health Insurance Portability and Accountability Act (HIPAA) of 1996 on intent to commit fraud and abuse; (2) prepayment claims review and prepayment medical frequency screening; (3) post-payment utilization review; and (4) contractor medical review personnel. HCFA should address these issues in the final rule.

1. HIPAA-Established Standard on Intent to Commit Fraud and Abuse

HIPAA of 1996 provides that physicians and other providers can be sanctioned for program abuse (covering such things as upcoding and billing for medically unnecessary services) under the civil monetary penalties of the statute only to the extent that the person “acts in deliberate ignorance of the truth or falsity of the information or acts in reckless disregard of the truth.”

Fraudulent activities that carry with them criminal penalties require that the person was "knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program, or to obtain by false pretenses any money or property under the custody of a health care benefit program."

The report language from the House and Senate conference committee that developed the final
language of the HIPAA states that Congress:

"does not intend to penalize the exercise of medical judgment of health care treatment choices made in good faith, and which are supported by significant medical evidence or held by a respectable minority of those providers who customarily provide the service. The Act is not intended to penalize providers simply because of a professional difference of opinion regarding diagnosis and treatment. A sanction is not intended for providers who submit claims they know will not be reimbursed as medically necessary services, but who are required to submit the claims because beneficiaries need to document that Medicare will not reimburse a service."

For example, a physician whose documentation fails to support the level of service submitted for an E/M service code is not guilty of fraud or abuse, unless he or she acted "in deliberate ignorance" or "reckless disregard" of the truth. Submitting a claim for a service that is later found to be medically unnecessary also doesn't constitute fraud or abuse without evidence of a deliberate or reckless disregard of the truth or a knowing and willful intent to defraud the program.

This section of the NPRM briefly discusses the review activities that will be performed by MIP contractors, but it fails to specify the standard that an entity conducting medical utilization, and fraud review should use to determine when to initiate a fraud investigation. The final rule should clearly state that MIP contractors will abide by the "knowing and willful" standard for fraud and the "deliberate ignorance" or "reckless disregard of the truth" standard for program abuse. Physicians are already concerned that they may be unfairly subjected to fraud and abuse investigations for simple coding errors and/or inadequate documentation because current carriers do not uniformly apply the standard of intent required by the HIPAA.

Since ASIM is concerned that the OIG may overstep its authority in penalizing physician practices without proving that physicians have acted in reckless disregard or deliberate ignorance of the truth," carriers or MIP contractors should be very cautious in referring cases to the OIG. The possibility of the imposition of severe civil penalties and assessments, and/or a possible five year exclusion from the Medicare and Medicaid programs may lead many physicians to settle with the OIG for lesser penalties rather than risk potentially larger penalties and to avoid going to court. ASIM is concerned about the possibility that physicians could be pressured into a costly settlement with the OIG, without the OIG actually proving that the physicians' activities constitute fraud.

HCFA must make the HIPAA-established standard for proving fraud and abuse clear to MIP contractors. Adherence to this standard will prevent physicians from unfairly being investigated and sanctioned while allowing HCFA to focus on true fraud and abuse.

2. Prepayment Claims Review and Prepayment Medical Frequency Screening

ASIM is opposed to prepayment review of evaluation and management (E/M) services, which
HCFA instructed its carriers to initiate in Fall 1997. We also object to any HCFA expansion of the scope of services subject to prepayment review of medical documentation.

Prepayment review of documentation is costly and time-consuming for both physicians and carriers. ASIM seriously doubts that savings generated by prepayment review will justify the resources that must be put into it. In its statement regarding the OIG's 1997 financial audit of HCFA before the House of Representatives Committee on Ways and Means, Subcommittee on Health, in July 1997, HCFA acknowledged that the substantive claims testing audit function conducted by the OIG, which must be performed by medical personnel from the contractor or Peer Review Organization, is costly and time-consuming. HCFA's statement continued, "...because of the significant expense involved in this type of review, the amount of overpayments might not be recouped, after the cost of review is considered."

ASIM recommends that HCFA refrain from instructing its contractors to initiate random prepayment review of claims that requires the provider to supply documentation to substantiate the claim before it determines whether or not to pay the claim.

3. Post-Payment Utilization Review

ASIM is skeptical of the benefits of a systematic increase in the number of claims subjected to post-payment utilization review (PUR). While an increase in the number of aberrant billing patterns or beneficiary complaints would be appropriate mechanisms to trigger a rise in the frequency of PUR audits, simply mandating an increase in the number of reviews is unlikely to bring positive results. In fact, while the percentage of claims reviewed decreased almost 50% from 1990 to 1996, HCFA's return on investment actually doubled—meaning that the same amount of aberrant billing patterns were found at different review levels. HCFA should refrain from instructing MIP contractors to conduct PUR on a specific number or percentage of claims.

ASIM believes that Medicare's billing regulations are already too complex. While each individual policy may appear to be reasonable, the responsibility of complying with the myriad of requirements, during the course of treating patients, is becoming increasingly difficult to bear. ASIM believes that simply increasing the scrutiny placed on physicians' claims for services will not strike at the root of the problem; instead, HCFA needs to fix the system that makes compliance exceedingly difficult even under ideal conditions. ASIM believes that the MIP provides HCFA a great opportunity to improve the PUR process. HCFA can improve the overall PUR process by incorporating our specific recommendations, discussed below, regarding various aspects of the PUR process into its MIP contracts.

Improving PUR Fairness

Certain principles, which may or may not be strictly adhered to by existing carriers, must be included in MIP contracts to ensure physicians are treated fairly. A good faith effort by HCFA to improve the PUR process will greatly reduce physician skepticism surrounding its use. Contractor personnel conducting reviews must be available to the physician submitting the documentation to discuss the results. MIP contracts should provide the audited physician with
due process and the right to review the post-payment audit sample with the actual personnel responsible for the review.

HCFA should also be more open with the protocols and materials used in PUR audit determinations. All regulations being enforced by the PUR personnel employed by the Medicare carriers should be published and publicly available.

Furthermore, the credibility of the PUR process is undermined if MIP contractors retroactively apply new policies to old claims in audits. HCFA should outlaw this practice in its MIP contracts.

Recognizing that coding for physician services is not an exact science and is often open to interpretation, physicians who disagree with the outcome of the audit performed by their contractor should have the option of having their documentation reviewed by an entity independent of the contractor, and entity such as a Peer Review Organization (PRO), when the amount in dispute equals or exceeds $1,000. PRO oversight of a contractor’s audit will help to settle disputes in an equitable manner and promote physician confidence in the PUR process. It would also elevate the often spoken and rarely demonstrated goal of PUR audits, which is to provide educational feedback. The PRO, whose focus is on improving the mainstream of care, should explain its decision to physicians requesting review. Additionally, physicians will be less inclined to think that the PUR process coerces them into accepting an overpayment settlement if they have an outlet that is independent of the contractor.

**Sampling Techniques**

The process of carriers extrapolating PUR audit results to a larger number of claims for similar services to determine overpayment amounts is inappropriate. Using statistical samples of office records is not a valid way of determining appropriateness of care in any individual case, and frequently the "problems" found by audits are due to inadequate documentation, not improper or "unnecessary" care. Sampling may be an appropriate technique for triggering more intensive review of individual claims, but denials or overpayment requests based on the extrapolation of statistical samples alone should be prohibited.

HCFA should instruct MIP contractors not to extrapolate findings from a statistical sampling to all claims submitted by a physician for similar services.

**Overpayment Requests**

Once a physician is notified of a repayment demand resulting from an audit, he or she is given 30 days to make that repayment, even if the physician appeals the audit’s result. MIP contractors should be prohibited from seeking repayment until the physician has exhausted all appeals and an accurate overpayment amount has been established. Also, there should be limitations on the annual interest rate being charged against physicians. Further, contractors should be obligated to pay interest at the same level to the physician for any repayment amounts recouped in error.
4. Contractor Medical Review Personnel

The "Medicare Integrity Program" heading in the "Background" section of this NPRM states HCFA's belief that fluctuations in Congressional funding from one year to the next made it difficult for the agency (and its contractors) to "attract, train, and retain qualified professional staff, including auditors and fraud investigators." ASIM agrees with HCFA that this stable source of funding will now allow it to maintain qualified professionals with the expertise necessary to make the proper decisions regarding medical necessity and adequacy of documentation. ASIM believes that HCFA should capitalize on the opportunity provided by improved funding for auditing activities by improving the skill level of contractor personnel under MIP. Upgrading contractor personnel quality, promoting fairness by having physicians review physician documentation of services, and improving the appeals process will help relieve physician skepticism toward Medicare's medical review process and allay fears that physicians will be unfairly investigated for fraud and abuse.

HCFA should also improve the Fair Hearing process that allows physicians to appeal adverse contractor determinations. Contractors should be required to utilize physician Hearing Officers who are licensed in the same specialty and in the same geographical area as that of the physician who requests a Fair Hearing. The contractor should also make the educational and medical credentials of the Hearing Officer known to the requesting physician prior to the Fair Hearing.

Education (II. A. 4.d)

Despite being perhaps the most important "service to be procured," as the NPRM states, this section is the least descriptive in the NPRM. This section does not mention any effort to educate the physician community regarding the MIP program. A January 9, 1998 program memorandum from HCFA to its current carriers instructs them to eliminate some essential services that they provide to beneficiaries and physicians to stay within their operating budgets. This action underscores our concern regarding the agency's lack of commitment to physician MIP educational activities. The January 9 memorandum reads:

"there will be significant cuts below many of the requested full year funding levels for Medicare Integrity Program Education and Training (PET) activities, as a result you will note only partial funding is being provided for current notice of budget approval."

Based upon this memorandum it is reasonable to deduce that HCFA will continue to neglect physician education and training as it transitions to using MIP contractors. HCFA must initiate a widespread and comprehensive effort to educate physicians about all aspects of MIP.

To achieve the MIP goal of reducing improper payments by reviewing claims, denying payment, and educating providers regarding proper billing, contractors must utilize the data it gathers from conducting reviews and share it with all providers in an educational manner. HCFA should instruct MIP contractors to provide broad feedback to providers based on reviews. For example,
a contractor could use the information it obtains from medical review of documentation for E/M claims to provide general educational feedback to the physician community on compliance with Medicare documentation guidelines.

Further, HCFA should mandate that MIP contractors be more proactive in explaining policy changes to preempt problems before they require claims to be manually reviewed. MIP contractors should hold educational programs to help physicians and their staffs meet ever changing regulations and requirements and convey this information to HCFA. Information about successful programs could then be shared by HCFA with all contractors.

**Developing Prior Authorization Lists (II. A. 4.e)**

ASIM supports giving MIP contractors the authority to create prior authorization lists to target potential fraud and abuse in the utilization of high cost durable medical equipment (DME), but only if this process does not result in delays in obtaining medically necessary services or an increase in the administrative burden placed upon physicians. HCFA should assure that MIP contractors minimize this regulatory burden on physicians. Further, physicians should not be required to provide more information than is currently required on the present DME ordering forms and prescriptions. The DME supplier should have the responsibility of submitting appropriate documentation to the preauthorization entity since it is the DME supplier that provides the equipment and is reimbursed for it. The supplier should be responsible for obtaining copies of records from the hospital, or from the physician chart if necessary, with the supplier also being obligated to pay a reasonable fee for those records.

Additionally, the supplier should follow the appropriate Medicare guidelines when recommending a particular type of DME; the supplier should indicate on the certificate of medical necessity or DME order-form both the cost of the supply item recommended by the supplier and appropriate information indicating the medical necessity of the DME item; the supplier should include the appropriate Medicare guidelines for ordering the recommended DME item with the order so that the physician can evaluate these factors when prescribing the DME item; if the DME order originates from the DME supplier, the supplier should attest that in their opinion the patient is in need of the DME item recommended.

DME preauthorization requirements that unduly burden physicians have the potential to discourage physicians from getting involved in DME prescription decisions. HCFA must also be careful not to create an unnecessary burden for patients waiting to receive DME equipment that requires preauthorization. A patient should not be unnecessarily detained in the hospital or a skilled nursing facility waiting for authorization of certain durable medical equipment needed to support the patient in the home setting. If preauthorization cannot be handled quickly and efficiently, it is likely that delays will increase costs to the Medicare program rather than reduce costs since hospital stays and inpatient stays at other facilities will be unnecessarily prolonged. Contractors should educate physicians, suppliers, and patients on their respective roles in reducing fraudulent and abusive DME ordering as well.
Medicare Integrity Program: Competitive Requirements (II. A. 5.)

This section of the NPRM touches on HCFA’s ability to renew a contractor contract without competition if the contractor meets or exceeds performance standards specified in the contract. It also articulates HCFA’s right to reassign a contract if the contractor chooses not to renew or if HCFA believes reassignment is in the best interests of the Medicare program. These specific proposed regulations—and the NPRM in general—fail to spell out how MIP contractors will be held accountable to HCFA (and its customers) for their performance. ASIM believes that HCFA must establish and publish performance criteria for MIP contractors. HCFA should build on the performance criteria currently in place for carriers, published in the September 7, 1994 Federal Register and contained in Section 2261 of the Medicare Carriers Manual (MCM). ASIM also recommends that HCFA incorporate the following into MIP contractor performance criteria:

(1) HCFA must ensure that its contractors are held accountable to established Medicare criteria and standards, especially in the areas of claims processing and customer satisfaction after carrier responsibilities for claims processing and payment safeguards (program integrity) are split under the MIP.

(2) MIP contractor performance criteria must include provisions that ensure the contractor is responsive to physicians and other providers. The current carrier performance criteria contain no mention of adverse actions against non-compliant carriers. HCFA must correct this oversight as it develops performance criteria for MIP contractors.

(3) HCFA should provide a mechanism for close surveillance and monitoring of the performance of the MIP contractors to assure their accountability to questions and concerns raised by patients and physicians about coverage and other issues.

(4) Contractors, whether carriers or MIP, should be penalized for failing to meet established criteria and standards.

(5) HCFA should solicit local physician input on the adequacy of carrier performance—for both claims processing and program integrity. Additionally, HCFA should be required to include specific requirements for services provided to physicians and other health care providers in its carrier performance standards. These performance standards should be provided to state medical societies and other medical organizations within the state and should include a procedure for bringing complaints about the contractor to HCFA’s attention.

Intermediary and Carrier Functions (II. B.)

The proposal to revise code of federal regulations (CFR) 421.200, “Carrier functions,” to state that a contract between HCFA and a carrier must specify the functions to be performed by the carrier is appropriate to avoid duplication of services between the carrier and the MIP contractor.

ASIM is concerned about the confusion that could result from allowing existing carriers to
perform "any or all of the MIP functions described in 421.304" if the carrier is continuing those functions under a contract with HCFA that was in effect on August 21, 1996, the date that HIPAA was enacted. Transferring all program integrity functions performed by MIP contractors in a geographical area will cause a disruption for physicians even under the best circumstances that would include an adequate transition period with significant physician education. Allowing carriers with contracts on August 21, 1996 to retain some MIP functions that ordinarily would be the responsibility of a new MIP contractor will effectively create a disjointed system where certain MIP functions can continue under an existing carrier and other functions under a MIP contractor. This type of system intensifies the need to for HCFA to make it clear to physicians as to which entity provides each function. ASIM recognizes HCFA’s need for leeway to assign each claims processing and integrity function to the entity--carrier or MIP contractor--that is best equipped to carry it out in that carrier/contractor area. However, ASIM believes that HCFA must ensure that physicians are fully informed regarding each entity’s responsibilities to minimize disruptions caused by transferring integrity duties from existing carriers.

ASIM recommends that the function in CFR 421.200 that states that a carrier contract may include, “upon inquiry, assisting individuals with matters pertaining to a carrier contract” be included in all carrier contracts. Carriers must be responsive to physicians as they may be determining payment amounts for services and collecting overpayments, in addition to processing claims. One of the most common complaints ASIM receives from its members relates to carrier unresponsiveness and inconsistent advice regarding billing matters. ASIM strongly recommends that HCFA strengthen and enforce its “claims processing” and “customer service” criteria published in the September 7, 1994 Federal Register and contained in Section 5261 of the MCM.

ASIM is concerned that these and other “carrier performance criteria” are not currently being adequately enforced. The numerous complaints we receive regarding carrier performance from physicians throughout the country leads us to believe that not all carriers are in compliance with these standards. Yet, to the best of our knowledge, each carrier that has recently dropped its Part B responsibilities has done so voluntarily. HCFA appears to refrain from using its right to choose not to renew a carrier’s contract. ASIM questions whether HCFA even disciplines its carriers that fail to meet performance requirements as the criteria contained in the MCM makes no mention of actions that will be taken against a non-compliant carrier. The criteria only state that “recognition will be given for improvements in performance (from the prior year) and/or maintaining highly efficient operations.”

ASIM also recommends that HCFA establish a mechanism to allow for physician input on carrier performance. This could be accomplished through the area’s Carrier Advisory Committee or in some other manner.

**Regulatory Impact: Discussion of Impact (V. C)**

**The Medicare Program and Health Insurance Trust Funds (V. C.1)**
ASIM concurs that the MIP can lead to more efficient and effective safeguard for the Medicare Trust Fund. HCFA should refrain from gauging MIP’s effectiveness solely on the return on investment (ROI) it generates, however. Focusing on the legislatively-mandated MIP functions of conducting medical, utilization, and fraud review; performing cost report audits; Medicare Secondary Payer activities; educating physicians; and developing prior authorization lists and performing them well may or may not translate into a higher ROI. As a MIP contractor identifies those committing fraudulent activities, prevents them from further defrauding the program, and corrects improper coding through education, its ROI is likely to actually decrease. Forcing MIP contractors to consistently improve their ROI is likely to inappropriately increase the regulatory burden on honest physicians. Accordingly, a MIP contractor with a higher ROI is not necessary performing well. HCFA must not use ROI as its primary indicator of a MIP contractor’s performance.

Medicare Beneficiaries and Taxpayers (V. C.2)

ASIM agrees with the concept of educating beneficiaries on how to identify and report suspected fraud and abuse. Targeted educational efforts, such as the “scam alerts” example mentioned in this section of the NPRM, are appropriate as they can help in combating true fraud and abuse. The benefit of less-focused beneficiary education is unclear. Broader efforts may even be detrimental to the anti-fraud cause by requiring contractors to investigate unsubstantiated fraud claims.

For example, carrier explanation of Medicare benefits (EOMB) letters that are sent to beneficiaries explaining that a physician provided a Medicare non-covered service can potentially lead to unwarranted fraud and abuse investigations. Carrier EOMBs sent to beneficiaries often read that the service(s) provided by the beneficiary’s physician “were not medically necessary.” This can confuse beneficiaries as the Medicare fraud and abuse statutes prohibit physicians from knowingly billing for a medical unnecessary service. ASIM recognizes that heightening beneficiary awareness of fraudulent and abusive activity is an important step toward weeding out fraud and abuse. However, inflammatory EOMB language resulting in unsubstantiated inquiries or allegations is counterproductive and unfair.

ASIM recommends that HCFA ensure that its beneficiary fraud and abuse education awareness activities target specific areas that are susceptible to fraud. Broad programs that result in unwarranted investigations will provide an undue regulatory burden on physicians that are unfairly identified and investigated.

Carriers and Intermediaries (V. C.3)

ASIM is pleased that HCFA recognizes the need to maintain physician input into carrier operations by continuing to use local carrier Medical Directors (CMDs) as liaisons to the physician community and through Carrier Advisory Committees (CACs). Providing a mechanism for physicians to have input into carrier and MIP contractor policy decisions is
essential to ensure continuity between physicians and Medicare contractors, which should serve to minimize the potential regulatory burden on physicians.

ASIM is encouraged that HCFA recognizes the value of a CMD as a peer liaison to the provider community. ASIM is concerned, however, that the increasing consolidation of Medicare contractors and the implementation of the MIP initiative will reduce direct access to CMDs on the local level. To ensure that this will not happen, HCFA must maintain a commitment to keep CMDs for each contractor in each state.

Maintaining and Improving the Carrier Advisory Committee Process

Implementation of the MIP provides HCFA with an opportunity to improve the CAC process. All changes to contractor local medical review policies (LMRPs) should be done in as open a manner as possible. The current 45 day comment period is too short for medical societies to make informed judgments and comments on policy changes. This is a problem particularly in rural states where the medical society staff may be limited. Carriers should provide a 60-day public comment period for all proposed policy changes.

Contractors should be required to send written justification of policy changes to all members of the CAC and make them available to the public on request. Just as HCFA is required to respond to comments made on its proposed rules, so too should carriers have to provide an explanation of why they have adopted a particular policy. In this manner, the medical and patient community will know why a particular course of action is being pursued by that carrier.

Educating physicians and their staffs about the policy change would further the goal of correct policy adoption and relieve carriers of administrative burdens resulting from physicians' misunderstandings of policy changes. Once a policy is made final, the carrier should release it to the medical community and conduct educational forums, when necessary, to ensure proper implementation of the new policy. Adequate notice (a minimum of 90 days) also must be given before the policy is effective.

Need for National Medical Specialty Society Input in Model Local Medical Review Policies

Working groups of CMDs, with oversight from HCFA, develop model LMRPs for services that HCFA perceives as overutilized. These model LMRPs are available to CMDs to implement through the CAC in their contractor area. ASIM proposes that HCFA change its policy of discouraging participation of national medical specialty societies in the development of model LMRPs. ASIM recommends a process that permits national medical specialty societies to review and comment on draft model policies before they are implemented locally through the CAC process. National medical specialty society participation in this process would enhance final model LMRPs, while keeping the national societies better informed so they can better educate their members regarding Medicare’s requirements.

Providers and Suppliers (V. C.5)
ASIM believes that HCFA has overlooked a potential adverse impact that the transition to MIP contractors may impose on physicians by assuming that this will fail to impose a regulatory burden on physicians. Smooth transitions to new contractors are the exception rather than the rule. Our concern is supported by the HCFA action that most closely mirrors the MIP framework of splitting claims processing and program integrity functions—the agency’s decision to contract separately for these functions in the nine states formerly covered by Aetna Life and Casualty. The transition to Blue Cross and Blue Shield of North Dakota (BC/BS ND) to process claims and to Transamerica Occidental for program safeguard activities has been rocky. In fact, the complex transition resulted in BC/BS ND sending an “apology” notice to providers in Fall 1997 because it denied and/or was late on paying many legitimate claims. Interrupted payments imposed severe hardship on many physicians. The problems are only now being fully corrected. HCFA must make every effort to avoid duplicating these mistakes as it issues claims processing and MIP contracts.

ASIM disagrees with HCFA’s assessment that the $10 million impact of having physicians make toll calls to regional contractors is insignificant. This assessment reasons that physicians’ costs will increase if their MIP contractor is out of their local calling area, but the cost is muted if their current carrier also assumes the MIP functions. ASIM questions this assessment because, as HCFA acknowledges, most carriers currently do not maintain a toll free number for physicians and many physicians are already outside their existing carrier’s local calling area. Additionally, an increasing number of physicians will be out of their carrier’s calling area as HCFA moves toward regional carriers.

In order to minimize the regulatory burden on physicians, HCFA should require that its existing carriers and its MIP contractors establish and maintain a toll free number for providers. The increased efficiency that would result from allowing physicians to reach a better trained staff via a toll free number would outweigh the financial costs.

ASIM concurs with the statement that physicians may experience an increase in the number of claims reviewed, but is skeptical of the assumption that the negative impact will decrease as physicians become more knowledgeable regarding what claims are appropriate. Random prepayment review affects all physicians. Increasing the frequency of post-payment reviews without targeting providers who are outliers also has the potential to force physicians to fulfill documentation requests regardless of their propensity to submit questionable claims.

ASIM is pleased that HCFA recognizes that the few providers who engage in fraudulent activities tarnish the reputations of all physicians, and that mass media’s focus on the most egregious cases perpetuates the problem. We believe that HCFA’s actions must echo this sentiment. The agency must refrain from judging all physicians as “guilty until proven innocent.” HCFA must ensure that it uses its resources to effectively target those prone to committing fraud. Anti-fraud initiatives that impose a regulatory burden on all physicians to catch the “few” unscrupulous providers are unacceptable. We share HCFA’s hope that identifying fraud and preventing improper billing will remove the cloud of suspicion that hangs over honest physicians.
In conclusion, ASIM recognizes that Congress has made a commitment to program integrity by including a separate and stable, long-term funding mechanism for program integrity activities in HIPAA of 1996. ASIM understands that HCFA is enthusiastic that its increased funding will enable it to more effectively protect the integrity of the Medicare program. ASIM does not question HCFA’s commitment to rid Medicare of fraud and abuse, and ASIM supports adequate funding for reasonable and effective program integrity activities. However, ASIM questions whether HCFA is committed to ensuring that Medicare’s contractors are equipped to perform the less newsworthy, but equally essential function of claims processing.

HCFA’s January 9, 1998 memo to its intermediaries and carriers advising them of specific reductions in the fiscal year (FY) 1998 Budget and Performance Requirements (BPR) heightens our concern. The memorandum instructs contractors to take actions that will “eliminate services that both the beneficiary and provider communities have come to expect from Medicare” to enable HCFA to operate within its approved FY 1998 Medicare Contractor Program Management budget. It is totally inappropriate for HCFA to direct carriers to stop mailing acknowledgments of voluntary refunds, suppress explanation of Medicare benefits (EOMB) forms for claims with no beneficiary liability, use automated response units as the sole means for handling provider claim inquiries, and reduce the frequency in which they pay providers. HCFA cannot move forward by stepping back. Program operations, claims processing, and program integrity are complimentary—it is inappropriate to promote one at the detriment of the other.

The January 9 memorandum indicates that HCFA wants carriers to slowdown payments of claims even though they may have to pay interest on such claims. This is especially troubling considering that the interest HCFA generates by holding on to the money longer could offset the interest it is liable to make on late payments. Under this scenario, HCFA has no incentive to ensure that its contractors make timely payments to providers. Beneficiaries and physicians rely on Medicare to honor its debts in a timely manner. Physicians are not afforded the same opportunity to delay repaying Medicare once they have been notified that they received an overpayment—the carrier will simply withhold the overpayment amount from a physician’s future payments. Additionally, the public’s confidence in Medicare will be undermined if HCFA fails to meet its payment obligations for the purpose of saving money. In fact, it sets a dangerous precedent that could be followed by other government agencies when facing budgetary problems or simply looking to save money.

The January 9 memorandum also threatens HCFA’s ability to adequately evaluate the performance of its carriers. Instructing carriers to withhold services that their contracts specifically require them to provide is illogical. Will a carrier’s performance be judged as deficient by HCFA because it failed to meet the established standard for paying on clean claims at the agency’s request? Do HCFA’s instructions exempt carriers from meeting other established performance standards? Are HCFA’s current standards for evaluating carrier performance still relevant?

The January 9 memorandum indicates to us that HCFA places greater emphasis on program integrity than program operations. HCFA is eager to use competitive forces to maximize its investment in program integrity functions. Unfortunately, it appears even more eager to
The American College of Physicians—American Society of Internal Medicine (ACP–ASIM), representing the nation’s largest medical specialty, is pleased to provide the following comments to the Practicing Physicians Advisory Council (PPAC) on Medicare Integrity Program Contracting Initiatives and Proposed Regulations to Implement the Medicaid Managed Care Provisions of the Balanced Budget Act of 1997.

Medicare Integrity Program Contracting Initiatives

ACP–ASIM has concerns regarding the Health Care Financing Administration’s (HCFA) Medicare Integrity Program (MIP) contracting initiatives. Our comments on HCFA’s “Medicare Program; Medicare Integrity Program (MIP), Intermediary and Carrier Functions, and Conflict of Interest Requirements” notice of proposed rulemaking (NPRM) that appeared in the March 20, 1998 Federal Register spell out many of our concerns and recommended solutions. A copy of our comments on this NPRM are included under “Attachment A.”

ACP–ASIM objects to the use of proprietary commercial off the shelf editing software by Program Safeguard Contractors (PSC) under the MIP (or by existing contractors). While we understand that HCFA is under pressure to use proprietary, or “black box,” edits to save money, we point out that the appropriateness of these edits cannot be judged solely on their ability to generate savings by denying payments to providers. The Department of Health and Human Services Office of Inspector General (OIG) report, “Using Software to Detect Upcoding of Hospital Bills,” released August 12, 1998, questions the ability of commercial software to accurately detect over-billing. The report, which analyzed two off the shelf software products currently on the market to identify hospital upcoding, found that only about 20 percent of the Medicare billing cases that commercially available software identified as being upcoded were in fact upcoded.

HCFA’s PSC draft Statement of Work (SOW), discussed at its April 17, 1998 pre-solicitation conference, that outlines how PSCs will coordinate with other entities raises serious continuity concerns for physicians. The draft SOW states that a PSC will work with its “affiliated contractor,” the contractor responsible for claims processing, when hearing appeals on denied claims, identifying and determining overpayments, and providing customer service. The draft SOW stipulates that the affiliated contractor will serve as the initial point of contact to carry out these functions, while referring matters relating to program safeguard within each area to the PSC. ACP–ASIM questions the ability of the PSC and affiliated contractor to coordinate with each other in a seamless way that will not disrupt services that are essential to physicians. The