DECEMBER 2001

REPORT TO THE CONGRESS

Reducing Medicare Complexity and Regulatory Burden

MEDPAC Medicare Payment Advisory Commission

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Many providers claim that the Medicare program is over-regulated and burdensome. Medicare started in 1966 without any regulations because there was not enough time between the passage of the act in 1965 and its implementation to write and approve them. Instead, the program used only conditions of participation for providers. Now, by one widely used estimate, over 125,000 pages of regulations—more than the Internal Revenue Service regulations for the entire tax system—control the program.[1] Providers can point out that the first section in the Social Security Act governing Medicare is a prohibition against federal interference in the practice of medicine or the manner in which it is provided, yet the program now directs how notes should be documented in a patient's medical record.

However, in addition to paying providers, the program also must protect beneficiaries and ensure that over $200 billion is spent appropriately each year. Given this tension, is Medicare over-regulated? Is the program too complex? Must complexity lead to burden on providers and beneficiaries? Does the current situation impose an unfair or unreasonable burden on providers and possibly beneficiaries? To what extent can the program be simplified and the burden reduced?

In the Balanced Budget Refinement Act of 1999, the Congress required that MedPAC study these questions. In this report, we do not attempt to catalog all the regulations in the Medicare program or the burdens and costs they impose on providers. Rather, we strive to understand some of the sources of complexity in the program and determine whether Medicare can be simplified. By getting to the source of complexity, we might be able to trim not only regulations that might be particularly nettlesome today, but also eliminate entire branches of complication and all the regulations associated with them. This larger-scale pruning of regulations can be thought of as a long-term strategy that can be pursued along with the targeted efforts already under way in the Centers for Medicare & Medicaid Services (CMS) and the Congress.

In Chapter 1, we describe the complexity of the Medicare program and investigate the sources of that complexity such as the program's size, scope and original design.

In Chapter 2, we analyze what can and cannot be simplified in the program and make seven recommendations which are outlined below.

Recommendation 1: CMS should move to a standard nationwide system of claims processing and eliminate local descriptions of policy and regulation. The Congress should allow CMS to contract as necessary to implement a standard system efficiently.

The original legislation for Medicare envisioned a very different world than now exists. It was designed for a program with local administrators paying locally determined rates for health care services. Today, the program uses nationally determined prospective payment systems but still retains multiple contractors and local policies for administration and claims payment; this adds unnecessary complexity and confusion to the program.

[1] Estimates of the number of pages of regulations for Medicare vary widely. The widely quoted 125,000 pages number included Medicaid as well as Medicare regulations when it was computed. CMS reportedly has suggested 30,000 pages is a more accurate estimate (Statement of Douglas L.Wood, M.D. Mayo Clinic to MedPAC, September 2001). As we show in Appendix A there are many levels of regulation and instruction and to some extent any number is suspect. In this report, we use the term "regulation" to encompass the broad range of requirements that govern the Medicare program and that providers, suppliers, and beneficiaries must follow. There is general agreement that the sheer mass of regulation is considerable by any measure.

Carrying out this recommendation would eliminate much of the complexity, inconsistency, and uncertainty in the current program and make possible one accepted statement of Medicare policy, consistent descriptions and understanding of regulations, and standard instructional materials. The change also would lessen the regulatory burden on providers and beneficiaries, help them get more consistent and correct answers, and set the stage for implementing Recommendation 2.

Recommendation 2: The Medicare program should provide timely, binding written guidance to plans and providers. Plans and providers that rely on such guidance should not be subject to civil or criminal penalties or be required to refund related payments if that guidance is later found to be in error.

Providers cannot now rely on answers from Medicare to protect them against future prosecution. If some of the layers of the present system were cut out, the probability of correct, timely information being communicated would be increased. It might then be possible to assure providers who make a good faith effort to follow guidance that they will not be held liable for additional penalties or be required to refund related payments if that guidance were incorrect.

Recommendation 3: CMS should explore ways to reduce routine administrative requirements for plans and providers that demonstrate sustained good performance.

Fear of unfounded prosecution and the formidable array of enforcement tools available to the Medicare program have created fear among providers. Well-intentioned providers are cowed from appropriate behavior or even from participating in the program because rules are written for the few "bad apples" rather than for the vast majority of honest providers. Rewarding good behavior has the advantage of encouraging compliance and simplifying administration of the program; for example, data can be collected less frequently from plans and providers that demonstrate sustained good performance. Private-sector models should be investigated as CMS evaluates pursuing such a strategy in the Medicare program.

Recommendation 4: The Secretary of Health and Human Services should work with the Department of Justice to improve consistency and eliminate redundancy in enforcement roles and activities.

Another problem in enforcement is that many entities that may be poorly coordinated are involved in setting, interpreting, and enforcing rules. Because the enforcement agencies have grown with their increased activity in fraud and abuse, their roles may no longer be optimal for the current environment. Rationalizing resources to emphasize provider education and improve communication to avoid government waste can be accomplished administratively, but statutory changes would be required to transfer or consolidate which executive branch agency could levy penalties, exclude providers, and prosecute civil or criminal penalties.

Recommendation 5: The Congress should provide reasonable time lines and resources for CMS to develop and test regulations thoroughly before implementation.

Constant change will complicate any system because new regulations must be developed and will interact with previous regulations in possibly unanticipated ways. Congress could be less prescriptive in its legislation and leave CMS more leeway to implement policies according to a schedule that allows the agency time to test regulations before putting them in effect. Poorly conceived regulations create a demand for Congress to change policies, which in turn results in more prescriptive laws and further changes in regulation. When appropriate, CMS should test regulations before putting them into effect for an entire industry. Time should be allowed for proper development and consultation with industry so that the likely impact of regulations can be understood as soon as possible.

Recommendation 6: CMS should eliminate regulations and other issuances that become obsolete as a result of program changes.

The continuing move to prospective payment creates complexity and a challenge for the program to make accurate payments. However, the data collection burden might be lessened because some of the data is no longer needed, and some of the instruments are too complex. Outdated data collection requirements illustrate the larger point that as the program changes, regulations, manuals, instructions, and other issuances become obsolete. CMS should develop a sunset mechanism to eliminate obsolete regulations.

For example, as new prospective payment systems are implemented, regulations and other issuances that supported the previous payment mechanism and are now obsolete should be removed. Congress may have to take legislative action to eliminate obsolete requirements if they are specifically called for in law.

Recommendation 7: The Congress should appropriate the necessary resources for CMS to acquire new technology that would simplify administrative processes and improve information exchange with program participants.

Some of today's burden could be eliminated by using new technology to modernize program administration. Examples include increasing use of the Internet for communication, taking advantage of the Health Insurance Portability and Accountability Act of 1996 billing standardization, and using electronic medical records.

Medicare will remain a complex program because much of the complexity is irreducible. However, complexity stemming from difficulties in information sharing and from complex payment rules may be made less of a burden on providers and plans through more modern information systems. Developing better systems is a long-term opportunity that CMS should be given the resources to pursue. ■

CHAPTER 1

Medicare program complexity

Certain aspects of Medicare would make it surprising if the program were not complex. The most basic are the program's size and scope, the fiduciary responsibility of running a public program, the need to protect beneficiaries, and the need to ensure high-quality care. We also examine two other sources of complexity: the program's origin, and the difficulty of coping with rapid changes. Finally, to provide some context, we briefly examine the burden of regulation from the Medicare program, compared with that associated with other payers.

Complexity resulting from the size and scope of the Medicare program

The large size and broad scope of the Medicare program make it complicated to administer and amplify the effects of its rules and regulations on plans, providers and beneficiaries. Purchasing health care for a large number of beneficiaries with different health care needs, in different geographic areas, and from a broad array of providers will inevitably be complicated. At the same time, because the program is so important to many providers and beneficiaries, any burden caused by complicated processes will be noticed.

Size of the program

One of the most salient features of the Medicare program is its sheer size. Measured in terms of the money it spends, the number of beneficiaries it serves, or the number and type of people and facilities that provide health care services to program beneficiaries, Medicare is the biggest health care program in the country.

Spending

Medicare spent about $238 billion in 2001 (CBO 2001), accounting for about 13 percent of the federal budget and about 19 percent of total national spending for personal health services. The program spends an average of about $5,950 per beneficiary annually, but the distribution of spending is skewed. For example, 15 percent of beneficiaries accounted for more than 75 percent of Medicare spending in 1997. To manage the program, CMS spends less than 2 percent of benefit outlays, compared with administrative spending of 12 percent and more by private insurers (HCFA 2000).

Beneficiaries

Medicare serves nearly 40 million beneficiaries across the nation, more than twice the number covered by the largest private health insurance company.[1] Of the 40 million, 35 million are aged and the others are disabled or have end-stage renal disease (ESRD). The average age of beneficiaries has increased since the beginning of the program; about 11 percent of aged beneficiaries are now over 85.

Medicare beneficiaries live and seek health care in all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, and other U.S. territories. In addition, compared to the general population a higher percentage of aged beneficiaries live in the most rural areas.

[1] Aetna had 17.5 million health care members as of September 30, 2001.

TABLE 1-1

Entities recognized for payment in Medicare

Hospital inpatient settings
- short-term acute care hospitals
- psychiatric hospitals
- cancer hospitals
- children's hospitals
- rural referral hospitals
- Medicare dependent hospitals
- sole community hospitals
- critical access hospitals

Ambulatory settings
- hospital outpatient departments
- rural health clinics
- federally qualified health clinics
- community mental health centers
- ambulatory surgical centers
- physician offices
- community health centers
- Indian health service facilities

Post-acute settings
- skilled nursing facilities
- home health agencies
- long-term care hospitals
- rehabilitation hospitals

Other fee-for-service settings
- durable medical equipment suppliers
- ambulance service suppliers
- diagnostic testing facilities
- end-stage renal disease facilities
- clinical laboratories
- mammography screening centers

Non-fee-for-service settings
- Medicare+Choice organizations
- cost health maintenance organizations
- Program of All-inclusive Care for the Elderly (PACE)
- hospices

Source: Centers for Medicare & Medicaid Services website (www.hcfa.gov), October 2001.

In addition to the complexity created by the number and geographic diversity of beneficiaries, other characteristics of the population magnify the challenge of administering the program. Medicare beneficiaries are more likely than others to have greater health care needs, be in frail condition, have cognitive impairments, and reside in nursing homes. Many, particularly women, live alone and may be either socially or geographically isolated. In addition, aged and disabled beneficiaries tend to have lower incomes; about 17 percent of beneficiaries are dually eligible for Medicare and Medicaid (HCFA 2000). Assuring that beneficiaries understand the rules and limits of the program, their supplemental insurance options, and their health care needs is challenging.

Providers, suppliers, and plans

To provide health care for beneficiaries, Medicare contracts with about 650,000 physicians, 6,000 hospitals, and thousands more providers and suppliers of other types nationwide (GAO 2001a, Berenson 2000). In addition, it contracts with some 180 health plans to provide care through Medicare+Choice (M+C).[2] The Congress has defined a broad array of entities recognized for payment in the Medicare program (some of which are defined as distinct only in the Medicare program), many of which are shown in Table 1-1.

[2] Number of health plan contracts as of September 1, 2001.

The number and myriad types of providers and suppliers, their geographic dispersion, and the dynamic nature of technology and the practice of medicine make administering the Medicare program complex and vulnerable to fraud and abuse. Medicare must enroll each provider and process the 900 million claims submitted by providers each year (GAO 2001b). Each type of provider is paid through a complex payment system that is subject to various adjustments and updated annually through a process that attempts to take into account the dynamic nature of the health care field.

Managing the M+C program, in which Medicare contracts with health care plans to provide all covered health care services to beneficiaries, presents a somewhat different set of administrative challenges. Medicare must set comprehensive payment rates by county and modify them to account for the demographic and health status of the individuals that enroll in plans. In addition, under M+C, the Centers for Medicare & Medicaid Services (CMS) must collect information (including data on premiums and quality) from plans each year and monitor how the plans market themselves to beneficiaries.

Regulators and administrators

A vast array of regulators and administrators interacts with health plans, providers, suppliers, and beneficiaries to develop and carry out Medicare regulations. Their roles range from educator to enforcer. To complicate matters, some actors are government agencies and others are contractors to the government; some have nationwide and some have regional responsibilities; some are within the Department of Health and Human Services and some are not. Table 1-2 displays these regulatory and administrative entities and their regulatory functions. Excluded from the chart is the Congress, whose statutory language is the cause of much of Medicare's complexity. Entities in the chart must interpret the Congress's legislative intent and then develop, implement, refine, administer or enforce the resulting regulations. The complexity of this system contributes to burden by making it difficult for providers and beneficiaries to know whom to call or where to get information, guidance, or answers.

Scope of the program

The broad scope of the Medicare program contributes to its complexity and would be difficult to diminish. The Medicare program must regulate:

- who is eligible to enroll,
- which services are covered,
- who can provide services,
- the conditions under which providers, suppliers, and health plans can participate, and
- how payment should be made.

The result is Medicare statute that takes up more than 600 pages of the U.S code, and regulations that comprise two volumes of the Code of Federal Regulations. In addition, myriad other issuances of CMS and its contractors (discussed in Appendix A), accompanied by the commentary provided by newsletters and professional organizations, create a flood of paper for providers to sort through. For example, a home care agency we visited reported that there have been 8,000 pages of regulations and other issuances since July 1999 (Abt Associates 2001).

TABLE 1-2

Regulatory and administrative entities

Entity	Function					
	Promulgate	Implement	Interpret	Refer or enforce	Educate	Evaluate or investigate
CMS (central office)	✔	✔	✔	✔	✔	✔
CMS (10 regional offices)		✔	✔	✔	✔	✔
CMS software venders						
Claims processing contractors carriers, fiscal intermediaries, regional home health intermediaries, durable medical equipment regional carriers		✔	✔	✔	✔	✔
Carrier advisory/fiscal intermediary advisory committees			✔			
Program safeguard contractors 11 task order contracts issued to various entities for pre-/post-payment reviews and data analysis/ data mining			✔	✔	✔	✔
Peer review organizations				✔	✔	✔
State health insurance programs			✔	✔	✔	✔
Department of Justice, regional U.S. attorney's offices			✔	✔	✔	✔
Department of Health and Human Services, Office of the Inspector General			✔	✔		✔
Federal Bureau of Investigation			✔	✔		✔
Courts and boards			✔	✔		
Social Security Administration		✔	✔			

Note: CMS (Centers for Medicare & Medicaid Services), Courts and boards (includes administrative law judges; Provider Reimbursement Review Board; Medicare Geographic Classification Review Board; Department of Health and Human Services, Departmental Appeals Board, Appellate Division; Courts: state, U.S. District, U.S. Appeals, U.S. Supreme).

Source: MedPAC.

Genesis of current provider-based criteria

Since Medicare's inception, some facilities (primarily hospitals) have owned and operated other facilities such as home health agencies and rural health clinics. Before implementation of prospective payment systems, such affiliations did not increase payments because payments were cost based. Medicare law did not use or define the term "provider-based" and there was no statutory requirement to establish explicit criteria for determining provider-based status. With the advent of prospective payment systems and increased payment for provider-based facilities, the Centers for Medicare & Medicaid Services (CMS), then the Health Care Financing Administration (HCFA), had to establish criteria. The delicate balance between CMS' administrative authority and the Congressional intervention that followed, as illustrated below, highlights the complexity of rulemaking in a dynamic and political environment.

- **August 7, 1996:** HCFA issued Program Memorandum A-96-7, which compiled general instructions for the designation of provider-based status for all facilities or organizations from previously published documents.
- **October 1999:** HCFA "manualized" the instructions in program manuals.
- **April 7, 2000:** HCFA published a final rule governing provider-based status, slated for implementation October 10, 2000. Providers voiced opposition to and concern about many aspects of the final rule.
- **October 3, 2000:** In response to provider concerns, HCFA published a notice delaying the effective dates of the provider-based rule to January 10, 2001 and allowed one year from that date to phase in the implementation.
- **December 21, 2000:** Congress responded to facilities' concerns with narrowly crafted statutory provisions in the Benefits Improvement and Protection Act of 2000 (BIPA).
- **August 24, 2001:** CMS published a significantly altered proposed rule that implemented BIPA provisions to grandfather certain facilities, delayed the implementation date, and modified other criteria of the proposed rule.
- **November 2001:** CMS is expected to publish a final rule implementing the revised criteria for provider-based facilities. ■

Developing policies to answer eligibility, coverage, and payment questions and devising regulations to implement the policies has produced much debate and a dense web of regulation. Policies are interrelated and must adapt to a dynamic marketplace and rapid changes in health care technology and delivery. In addition, as shortcomings of Medicare regulations have become apparent, policymakers have tended to adopt more detailed and prescriptive regulations. For example, when policymakers suspected that some providers were opening "hospital-based" clinics far from hospitals to maximize reimbursement (because "hospital-based" clinics receive increased Medicare payments), they responded by delineating a complicated set of definitions of "provider-based." Because so many variations in the marketplace need to be addressed by regulators, CMS has published more than 100 pages in 3 separate Federal Register notices to explain 3 pages of proposed rules governing provider-based facilities.

Who is eligible for coverage?

Eligibility criteria for Medicare are based upon age, disability, and work history. Much of this is specified in statute, but regulations must define "work history" and "disability". Regulations also govern other enrollment issues, such as how to assess penalties for delayed enrollment in Part B and how to conduct enrollment in M+C plans. The mechanics of enrollment in Medicare, as well as determinations about disability status, are carried out by the Social Security Administration.

What services and supplies are covered?

Although the Congress specifies that all medically necessary care furnished by contracting providers should be covered within the general scope of the benefit package outlined in statute, program administrators must make countless coverage decisions every day. For example, some procedures (such as organ transplants) are only covered for beneficiaries who meet certain health status criteria, lung volume reduction surgery is only covered for beneficiaries participating in clinical trials. CMS coverage regulations, determinations made by the Medicare Coverage Advisory Committee, local medical review policies, and appeals rulings guide administrators in making these decisions.

Efforts to define covered services are complicated by the dynamic nature of health care services and technology, the decentralized system of claims processing, limited resources to evaluate new technologies, and the political environment surrounding these decisions.

Who is qualified to provide care and supplies to Medicare beneficiaries?

Medicare, like any other health care insurer, must determine whom it will contract to provide care and supplies to its beneficiaries. Defining participation qualifications (known as conditions of participation), collecting reliable and timely information on providers, and enforcing compliance are critical to promote high-quality care. For example, Medicare must ensure that its providers are licensed.

The provider enrollment process helps to ensure that only qualified individuals and entities receive reimbursement for services furnished to beneficiaries. In addition, a provider's geographic location and facility type may have direct bearing on its payment amount.

Physicians have complained that the enrollment process takes too long and that it must be repeated each time doctors change employers or make other practice changes. Enrollment is a decentralized process in which providers must complete separate copies of HCFA Form 855 to enroll in each federal program they intend to bill (for example, the civilian health and medical program of the uniformed services, the Public Health Service, the Indian Health Service, and Medicaid), including separate applications for billing Medicare Parts A and B. The form itself (HCFA 855) is considered overly complex. In contrast to durable medical equipment suppliers, whose enrollment is administered under one contractor nationwide, each local contractor administers its own physician enrollment processes.[3]

[3] CMS recently announced steps to simplify the enrollment form and intends to process 90 percent of enrollments within 60 days.

How should payment be made?

Policymakers must determine which methods the Medicare program will use to pay providers, suppliers, and health plans. At the inception of the program, Medicare paid providers based upon costs and their usual, customary, and reasonable (UCR) charges. However, this payment method provided no incentive for efficiency, and costs and payments rose as a result. The Congress reacted by changing the basis for payment and the program moved toward prospective payment systems (PPSs), which pay a set price for a bundle of services, and are intended to reward efficient providers. The PPS for inpatient care, for example—introduced in 1984—pays hospitals a set amount according to the principal diagnoses for a hospital stay, regardless of the actual costs for individual cases. Now, nearly all sectors are under some form of PPS or a fee schedule, including skilled nursing facilities, hospital outpatient departments, ambulatory surgical centers, home health agencies, and physicians. However, each payment system requires its own regulations, rules, and data gathering.

Setting prices administratively through prospective payment systems is inherently complex because it is difficult to know providers' true costs of efficiently caring for Medicare beneficiaries. To arrive at payment rates that approximate market prices and cover providers' long-run costs, payment methods must account for the individual circumstances confronting providers, such as local market conditions and the mix of complicated and simple cases. Adding to the complexity is that Medicare payment regulations have attempted to achieve multiple objectives that private payers do not share, including supporting physician education and improving access to care in rural areas.

The result is separate regulations specifying payment methods for each type of provider. While payment systems share many of the same fundamental components, each is tailored to the specific resources needed to provide the service. For example, Medicare pays physicians based upon a fee schedule that takes into account their practice costs, professional liability expenses, and work content.

Although the entire rationale and method of payment has changed, the mechanism for paying claims—relying on local contractors—has not. The original rationale for using local contractors was that they could determine local UCR charges and audit the costs of local providers. Neither of those determinations is used under national PPSs, yet the claims payment mechanism has been preserved. A basic contradiction now exists between the payment mechanism and the payment system.[4]

To a great extent, the complexity of Medicare's payment system is linked to the fact that the program directly contracts with providers to provide fee-for-service care and must set prices for thousands of services in every part of the country. If, like the Federal Employee Health Benefits (FEHB) Program, Medicare instead contracted with private insurance plans to provide coverage, CMS regulatory requirements for providers would be reduced.[5] However, when policy experts have explored adopting the FEHB model for the Medicare population, most, including the Bipartisan Commission on the Future of Medicare, have concluded that fee-for-service Medicare is needed to guarantee beneficiaries the option of retaining their current plan. Even under this vision for a reformed program, many of the existing regulatory requirements would remain.

[4] Even where there has been consolidation of contractors (for example one carrier now covers 11 states) separate medical directors and carrier advisory committees for each state have been retained and separate claims payment and coverage policies still persist.

[5] Presumably, as in the M+C program, a private health plan would perform many of the regulatory functions that CMS currently performs and the providers would still have some regulatory burden.

Complexity resulting from the responsibilities of the Medicare program

Beyond the size and scope of the program, the responsibilities of the Medicare program lead to complexity: the fiduciary responsibility of a public program, the responsibility to protect beneficiaries, and the responsibility to ensure quality.

Medicare's fiduciary responsibility as a public program

Running a public program adds requirements for public decision making and due process to the already difficult fiduciary task of any health insurer. Every insurer needs to establish billing rules to pay contracting providers agreed-upon rates and to prevent paying fraudulent claims. These rules begin with provider enrollment and also cover rules for claims submissions and efforts to stem fraud and abuse. Compared with private insurers, Medicare claims processing is dramatically complicated by the sheer volume of claims and by the structure of claims processing, which relies on multiple contractors such as fiscal intermediaries and carriers. These characteristics directly contribute to a high risk of Medicare fraud and abuse and to the complexity and regulatory burden of the program.

Recent efforts to improve the detection and prosecution of fraud and abuse have raised concern among providers, but of the 650,000 physicians in the program, less than 2,000 physicians are subject to complex medical review each year and the Department of Health and Human Services, Office of the Inspector General (HHS OIG) investigated only a few hundred physicians (GAO 2001a). Nevertheless, the fear of unwarranted fraud accusations is real, and influences providers' perceptions of the burden of the program. Many feel that they cannot win; the program is so complex that they are bound to miss some requirements no matter how hard they try to comply, and the penalty for non-compliance is perceived to be harsh.

In addition to the fiduciary responsibility any insurer has to prevent payment of fraudulent claims, Medicare's identity as a public program leads to additional administrative complexity because the program must maintain a degree of accountability, openness, transparency, and commitment to due process not required of private insurers. Medicare's administrators must conform with laws such as the Administrative Procedure Act (APA), Federal Advisory Committee Act (FACA), Federal Civil Service laws, the Freedom of Information Act, the Government Performance and Results Act, and the Paperwork Reduction Act, among others. Most of these laws have no analogs in the private sector.

For example, the Administrative Procedure Act specifies, among other things, how agencies must conduct rulemaking. The Act generally requires public notice and the opportunity for participation by interested persons. FACA governs how Medicare administrators can seek advice or recommendations from outside entities, and requires that committees be established only after public notice, that they have a clearly defined purpose, that membership be balanced in its point of view, and that meetings be open to the public.[6] Furthermore, civil service laws dictate hiring and firing practices as well as salary structure for federal employees. While serving an important purpose, these laws restrict CMS's ability to nimbly respond to new resource or expertise requirements. Indeed, other federal agencies have more flexibility to offer competitive salaries to attract top advisors (DeParle 2001).

[6] According to a former administrator, if CMS wanted to confer with industry groups to resolve issues in developing a regulation, it would need to charter a federal advisory committee, an action that requires financial disclosure forms and notices in the Federal Register, among other requirements.

Coverage appeals and other decisions are also subject to a higher level of due process than are those of private entities. For example, if an employee appeals to her self-insured employer for coverage of a needed medical service, the employer can consider the request with less public scrutiny and under a more liberal time frame than Medicare can.

Finally, Medicare is ultimately governed by Congress in a political environment. The legislative process is subject to political pressures that do not often apply to decisions made by a private insurance company. This process allows the public, through its representatives, to participate in shaping a vast and important program. Sometimes, however, Congress is so prescriptive that even when administrators realize there are problems in implementing the law, they cannot fix them.

A current example concerns the sustainable growth rate (SGR) mechanism for physician payment. CMS has recognized that the mechanism will result in wide swings in the update factor for physician services and that the result for 2002 will be a 5.4 percent negative adjustment. However, because the formula for the SGR is set in statute, the agency has little latitude to make changes.

Medicare's responsibility to protect beneficiaries

Medicare regulations require various provisions for beneficiary education and protection. These range from requiring that CMS distribute a handbook explaining the program to beneficiaries to setting procedures for appeals and grievances. Through the enrollment process, providers attest to the basic educational and licensure qualifications required to bill the program for furnishing services to Medicare beneficiaries. In addition, Medicare statute and regulations require that participating providers and plans adhere to other federal health laws, including privacy and confidentiality requirements in the Health Insurance Portability and Accountability Act, Emergency Medical Treatment and Active Labor Act requirements governing anti-dumping, and laws encouraging the use of advance directives.

Medicare's responsibility for ensuring quality

Policymakers have become increasingly interested in promoting high-quality care for beneficiaries. In addition to establishing and enforcing conditions of participation, Medicare uses peer review organizations to help providers improve the quality of care. However, measuring quality in health care is difficult. Few outcome measures exist, and using them requires adjusting for the health status of patients before treatment. Using process measures is difficult when care is delivered in a fee-for-service environment by unrelated providers and no one entity has ownership for the whole process. In the M+C program, plans have expressed concern about the extensive set of requirements for quality assurance and quality improvement currently in place. Attempts to measure quality, let alone improve it, add complexity to the program.

Complexity resulting from the way the Medicare program began

The childhood shows the man
As morning shows the day.—*Milton, Paradise Lost*

Some of the complexity of the Medicare program can be traced to the way in which the program was established. Part A of Medicare grew out of a series of legislative proposals to cover hospitalization for the aged that had been under discussion by policymakers and the American Hospital Association in the early 1960s. Part B emerged from a proposal by Congressman Byrnes (R-Wisc.) for a voluntary coverage plan. (The actual legislation for Part B was written over one weekend and was based on Aetna's federal employees plan [Gluck and Reno 2001].) The combination of the two parts, although in some sense a compromise to generate support, was a giant step forward in health care coverage for the elderly and was much more comprehensive than the hospital-only coverage that had been proposed earlier.

Meanwhile, the American Medical Association, which was opposed to the proposal for hospital coverage, offered a state-run, means-tested program as an alternative. Instead of being adopted as a substitute, that proposal was included as well and became the basis for Medicaid.

No overarching vision or coherent undergirding principles linked the two parts of Medicare or Medicare with Medicaid, nor did the Congress make any attempt to rationalize cost sharing or incentives resulting from the two parts of Medicare. Any resulting discordances remained in the programs and some of today's complexities are reverberations of those original discords.

Complexity from the Part A-Part B split

The Part A-Part B split results in a series of complexities in the program starting with eligibility for enrollment. Part A was conceived of as a compulsory program accepting anyone eligible for Social Security retirement benefits and financed by payroll taxes (much like Social Security). Part B, on the other hand, was conceived of as a voluntary program; enrollees would make a one-time election into the program which would be financed partly by beneficiaries and partly by general revenues.[7] (When the program began the premium was split 50-50; now it is 25 percent from beneficiaries and 75 percent from general revenue.) The vast majority of beneficiaries are enrolled in both Part A and Part B, although some are enrolled only in one part. This means that every provider and plan must establish not only that patients are eligible for Medicare, but in which part or parts they are enrolled.

As an example of the complexity that results, consider enrollees in the M+C program (Part C of the Medicare program) who have only Part B Medicare coverage and have been "grandfathered" into the program. Because of those few enrollees—about 1,100 out of 5.5 million—some M+C organizations must calculate and submit a Part B-only Adjusted Community Rate Proposal (ACRP) filing in addition to their usual ACRP filings.

[7] Beneficiaries who did not contribute to the Social Security system, such as some state and local government employees, some federal employees, and railroad workers, must pay an additional premium to enroll in Part A.

The two-part split also adds complexity for beneficiaries because they must choose when to start Part B coverage and must be aware of the perils of delaying that election, whereas Part A coverage starts automatically. Each part also has completely independent coinsurance and deductibles. For example, paying the $100 Part B deductible has no effect on the size of the Part A deductible for inpatient hospital services, and the 20 percent coinsurance for most services under Part B has no analog in Part A. Furthermore, some services, such as home health, are split between Parts A and B. Physicians' services are under Part B even if the beneficiary is in a facility under Part A. All of this compounds the difficulties for beneficiaries trying to interpret an explanation of Medicare benefits (EOMB) form or Medicare summary notice (MSN) form and attempting to figure out how much they owe and whether claims have been properly paid. It also makes it difficult for beneficiaries to assess choices for supplemental coverage and to choose whether to enroll in a M+C plan rather than remain in the traditional fee-for-service program.

Claims payment was also complicated by the original design of the program because Medicare established contracts with two sets of contractors. Fiscal Intermediaries to pay Part A and Part B institutional bills, and carriers to pay only Part B claims.

Complexity from the contracting arrangements

Those who designed the program originally intended that Medicare's primary interface with providers and—to some extent, beneficiaries—would be insurance companies, rather than the federal government. This may have been a way to placate those worried about socialized medicine, a worry that also probably resulted in the provision in Medicare law that prohibits any federal interference in the practice of medicine. At least one fiscal intermediary and one carrier were chosen for each state and each contractor was free to use whatever system it wanted to pay claims.

Policymakers considered reliance on local contractors to be a strength of the original program design. After all, most providers were to be paid based on their costs and UCR charges in the local area. In addition, policymakers thought that "acceptable practice" differed across the country and that procedures might be standard practice in one area but not in others. Using local contractors familiar with local practice standards was a way to recognize this variation and allow for it in payment.

The legislation also placed some unusual contracting limitations on the program. The Part A fiscal intermediaries are nominated by providers, even though they are in charge of paying those providers for services rendered to Medicare beneficiaries. Carriers for Part B were designed to be local organizations. Their contracts are normally automatically renewable and exempt from any provision of law requiring competitive bidding.

Early in the program, administrators recognized that using insurance companies to pay claims was not working as well as anticipated. In some cases, the companies lacked both capacity and experience (NASI 2001). As claims processing has become more automated, payment systems less cost based, and multi-state providers more common, the basic contradiction of a national program and local claims processing has become even more evident. Because the reality of what is policy for providers is what the automated claims processing systems pay, the logic embedded in the code for processing claims is all important. Recognizing that, CMS has attempted to standardize claims processing systems and has now migrated fiscal intermediaries to two standard systems and carriers to four standard systems. However, contractors still have latitude to establish local medical review policies and their attendant automated system edits, with the result that the same claim may sail through one carrier and be rejected by another. Also, because some system edits may be intermittently turned off due to workload considerations, the same claim may meet different fates even with the same carrier.

Complexity resulting from coping with change

The Medicare program has become more complex with changes in the goals of the program, laws and regulations, the health care world, and the beneficiary population it serves. Because Medicare regulations are continually rewritten, reinterpreted, and augmented, providers have difficulty keeping up—both small providers that lack extensive administrative resources as well as large, diverse facilities affected by many simultaneous changes. Health plans in M+C face a similar challenge.

Changing goals

The original Medicare legislation aimed to save elderly beneficiaries from ruinous hospital and physician bills. However, the legislation limited covered hospital days and did not impose out-of-pocket limits to beneficiary liability: the goal was not total protection from catastrophic expenses. At the same time, Medicare was an insurance program for acute medical expenses, not a pre-paid health care program, with sizable coinsurance and deductibles and no coverage for preventive services such as annual physicals. Some coverage has since been instituted for preventive measures (for example, screening tests for breast and colon cancer) further complicating rules about the number and frequency of covered services.

Other goals incorporated into the program have brought about more regulation, including encouraging medical education; preserving access to care by protecting providers with certain characteristics, such as rural location or service to indigent patients; and providing private sector choices.

Changing laws and regulations

Although the Medicare program has undergone many changes during its more than 35 years of existence, the most dramatic changes have occurred over the past several years. The Balanced Budget Act of 1997 included more than 700 specific directives to HCFA (Abernathy 2001), including creation of the M+C program and new PPSs for skilled nursing facilities, home health agencies, and services in hospital outpatient departments. Following quickly on the heels of this massive legislation were the Balanced Budget Refinement Act of 1999 and the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000. Each of these laws amended the BBA and added new regulatory requirements. In addition, other laws, such as the Health Insurance Portability and Accountability Act of 1996 (HIPAA), imposed administrative and privacy standards that many in the industry find burdensome.

TABLE 1-3

Medicare contractors

Contractor (number)	Responsibilities
Claims administration contractors (56) • carriers (Part B claims) (20) • fiscal intermediaries (Part A claims) (28) • regional home health intermediaries (4) • durable medical equipment regional carriers (4)	➔ make coverage decisions and establish local medical review policies ➔ generate notices to beneficiaries explaining benefits ➔ identify claims mistakenly billed to Medicare ➔ operate fraud units and develop and refer cases to law enforcement agencies ➔ identify instances or patterns of inappropriate billing
Program safeguard contractors (11) • CMS issues task orders to contractors on a functional basis	➔ on-site reviews to determine compliance with corporate integrity agreements ➔ postpayment data analysis, statistical analyses and trending activities on claims ➔ perform all program integrity functions, including prepayment and postpayment review, for a DMERC ➔ develop national paid claim error rates by contractor, benefit category, and provider type through independent review of a random sample of claims ➔ maintain automated system edits (correct coding initiative) used by all claims administration contractors ➔ created in BBA
Peer review organizations (37)	➔ determine whether services are reasonable and medically necessary ➔ check validity of diagnostic and procedural information supplied for payment purposes ➔ evaluate completeness and adequacy of hospital care provided ➔ evaluate quality of services
Qualified independent contractors • minimum of 12 contractors required by BIPA, effective October 2002	➔ review redetermination decisions for Part A and B claims ➔ external to claims administration contractors

Note: CMS (Centers for Medicare & Medicaid Services), BIPA (Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000), DMERC (durable medical equipment regional carrier), BBA (Balanced Budget Act of 1997). Fiscal intermediaries also pay some institutional bills under Part B.

Source: CMS.

The new laws have also required new contractors to help implement them. As Table 1-3 shows, the types of contractors have now expanded well beyond the original Part A fiscal intermediaries and Part B carriers. Attempts to specialize by function, while alleviating some variation, create new boundaries and barriers to communication. The program now has multiple contractors divided by geography, entities covered, and function.

Changing health care world

Many factors—including changing technology, demographics, reimbursement policy (such as capitated payments), and market dynamics—have led to changes in the organization and structure of the health services industry. The advent of national chains of hospitals, nursing homes, dialysis facilities, and others and consolidation among health plans has altered the dynamic of health care and the loyalty and trust of patients and regulators, increasing the desire for more extensive regulations and enforcement.

When Medicare began, payments for inpatient hospital stays and physician services accounted for most expenditures. Now other settings, such as hospital outpatient departments, ambulatory surgical centers, skilled nursing facilities, and home health agencies, have increased in importance.[8] In addition, health care technology has grown and changed rapidly. Imaging technologies, arthroscopic surgery, coronary artery bypass grafts, and angioplasties are all examples of technologies that did not exist or were of very limited availability at the beginning of the Medicare program. All had to be brought into the program and their appropriate use and payments determined.

[8] In some cases, technology has allowed procedures formerly limited to inpatient stays to be performed in an ambulatory setting. In addition, Medicare reimbursement policy may have made some settings more lucrative than others.

The massive movement toward managed care by insurers and the consolidation and increased predominance of national firms in that industry has also had an enormous impact on the organization of health care. Not long ago, it was widely anticipated that managed care organizations would continue to grow while holding down health care costs. But largely due to the consolidation of providers, such as mergers among hospitals, providers have regained leverage in the marketplace and are either demanding better terms or refusing to join managed care networks (Strunk et al 2001). At the same time, consumers are demanding more flexibility in the choice of providers. The result is slower growth in more highly integrated managed care options, increasing demand for less tightly structured options, and escalating premiums. As the entire marketplace has grown more unsettled, policymakers have increased regulation and exceptions to help ensure access. The fast changing nature of the marketplace has resulted in increased anxiety and may have contributed to a concomitant increase in the pace of regulation.

Changing beneficiary population

The changing beneficiary population also has increased the complexity of the program. The most obvious change was the inclusion in 1972 of those eligible for Social Security disability benefits and people with ESRD. In addition, changes in the aged population (such as the increasing proportion of beneficiaries over age 85) and the services they use (such as procedures formerly limited to relatively young beneficiaries) require the program to deal with an ever broader range of issues.

Another change for beneficiaries has been the availability of supplemental insurance through their former employers or the Medigap market. In 1997, 86 percent of beneficiaries had supplemental coverage (including those with Medicaid). If the original program was predicated on the inclusion of deductibles and coinsurance to influence beneficiaries' behavior, the advent of supplementary policies negated that premise by providing first-dollar coverage for most services. The interaction between Medicare and supplemental insurance introduces other forms of complexity. It makes it more difficult to forecast the likely effects of changes in incentive structures, because different segments of the beneficiary population have different levels of supplemental coverage. It also creates an additional step in the claims administration process and uncertainty among beneficiaries over who to ask for reimbursement.

Complexity and burden

If the complexity in Medicare only made the program difficult to administer, it would not be the subject of such concern in the Congress; the concern stems from how the complexity affects providers and beneficiaries. When assessing the burdens of Medicare requirements, it is worth considering whether there is a better alternative. Can any large, national system provide health care coverage in a way that is not burdensome to providers and beneficiaries? We examine this question by briefly comparing how requirements imposed on providers and beneficiaries by the Medicare program compare with those of other payers, such as private insurance companies and other government programs. We also look at how Medicare and other payors balance different means for accomplishing specific program functions.

We note that comparisons between Medicare and other payors may be somewhat misleading, because other payors can often assume that providers are meeting requirements imposed by Medicare. Thus, the unique requirements of other payors may not replace Medicare's requirements but rather add to them. Furthermore, to encourage provider participation, other payors may be forced to moderate their requirements in some markets.

Comparison with requirements imposed by other payers

Medicare is considered to be particularly burdensome in its requirements for documenting evaluation and management visits, applying diagnosis codes to all laboratory tests, filling out Medicare secondary payor forms, and providing advance beneficiary notice of coverage forms. As an example, Medicare providers and beneficiaries express frustration with Medicare's requirement that providers furnish advance beneficiary notice forms to inform beneficiaries that services they receive may not be paid for by Medicare. The frustration is that beneficiaries cannot receive advance determinations from Medicare carriers about covered services and therefore cannot know if they may be liable for payment. Private insurers or health plans usually have clear mechanisms for an advance determination about what is covered under a patient's policy or plan.

Interestingly, despite these complaints, in a 1999 MedPAC survey physicians reported that the paperwork and administrative billing hassles of health maintenance organizations (HMOs) or other capitated plans were worse than those under traditional Medicare. More than half of physicians called the paperwork burden of HMOs and other capitated plans a very serious problem; 30 percent of doctors placed Medicare's administrative burden in the same category (Project HOPE 1999). This finding is consistent with results from a similar study by the Physician Payment Review Commission in 1994. We also heard consistently from providers in site visits that Medicare is considered one of the better payors in terms of timeliness in paying clean claims.

Compared with some other payors, Medicare's administrative burden may appear less worrisome to physicians. However, another aspect of the program raises the stakes for providers and may make the program appear much more burdensome. If providers make a mistake in complying with Medicare's administrative requirements, in addition to not being reimbursed they also can face the risk of other sanctions if investigators interpret their actions as fraudulent rather than simply mistaken. Where a private plan may have an investigative arm to ferret out fraudulent claims, Medicare has well-funded investigators from the HHS OIG, the Department of Justice, and U.S. Attorney's offices in every state. Providers are constantly reminded by a burgeoning compliance industry and urban legend that the jeopardy to which they are exposed by Medicare billing mistakes may result in extrapolated overpayment demands, criminal prosecution, or the imposition of civil monetary penalties and corporate integrity agreements.[9]

[9] Extrapolation refers to the practice whereby contractors review a small set of claims for a particular provider and if errors are noted in some percentage of the sample, extrapolate that percentage to the entire set of claims the provider has submitted within some time period and calculate overpayment amounts accordingly. Modern statistical methods might improve the accuracy of extrapolation. Currently, a provider can ask that a statistically significant sample of claims be taken but most are loathe to do so. Legislation is pending that changes specific extrapolation procedures.

In fact, the OIG investigates a small fraction of the more than 700,000 providers and suppliers that annually submit more than 900 million Medicare claims.[10] Although only a nominal number of providers are investigated each year, the savings to the program are substantial and the behavioral response and fear elicited in the provider community undeniable. The perception of burden stemming from liability under the Medicare statute has no analog in the private market, where insurers lack the authority or resources to impose such sanctions and few, if any, hold a market share comparable to Medicare.

Comparison with requirements in other government programs

Although similar in size and broader in scope than Medicare, Medicaid (which provides a full range of services, including long-term care and prescription drugs) is a smaller part of many providers' revenues than Medicare. States have substantial flexibility to run their Medicaid programs under broad federal guidelines and use this prerogative to establish eligibility standards, set payment rates, and determine the type, amount, duration, and scope of services. In 1999, more than 42 million people were enrolled in state Medicaid programs, but more than half were enrolled in an HMO or other partially capitated managed care arrangement, compared with a participation rate of less than 14 percent in the M+C program. Accordingly, discontent with Medicaid tends to focus on inadequate payment rather than regulatory burden.

Balance

To achieve their goals, all regulatory systems must achieve a balance among various means for accomplishing specific program functions. Where that balance is struck can affect the burden of the regulatory system on the regulated entities. Below, we examine how Medicare and other payors strike balances in three program functions.

Claims payment: balancing customer service and enforcement

Any regulatory system must balance providing acceptable customer service and enforcing the rules of the program. For example, the Customs Service seeks to minimize inconvenience to freight shippers and at the same time prevent contraband from being smuggled into the United States. It could stop every truck entering the country, unload the cargo, and go through it piece by piece—an enforcement-heavy approach. However, if it took such an approach, lines of trucks would accumulate at the border, leading to massive delays. This would be very poor customer service. Instead, the Customs Service uses automated tools to decide which trucks to pre-approve and which to search. Most trucks are not searched; those that are searched have been deemed high risk. The Customs Service also searches some trucks at random.

[10] In FY 2000, the OIG conducted or participated in 2,597 health care cases, of which fewer than 600 led to either criminal conviction or successful civil recoveries (OIG 2001).

The Medicare program must balance paying claims in a timely way (customer service) and preventing fraud and abuse (enforcement). Most claims are considered "clean" and processed rapidly. Some are denied and some are reviewed before payment: when these things happen, the system can seem arbitrary and burdensome to the providers. Even if a claim is initially paid rapidly, the claims administrator may retroactively determine there has been an error, assess the provider for an overpayment and in some cases request prosecution for fraud. This latter pattern (a process sometimes referred to as "pay and chase") can come about as a result of post-payment audits or analyses of patterns of use, or as a result of a fraud complaint. This multidimensional approach adds complexity and can appear particularly onerous to providers. In recent years, as reports of fraud against the program multiplied, the Congress thought the balance had shifted away from enforcement. As a result, provisions in the Health Insurance Portability and Accountability Act of 1996 gave more financing and broader authorities to the Department of Justice and the HHS OIG for fraud and abuse enforcement efforts. Providers now think the balance has shifted too much toward enforcement.

Provider participation: balancing up-front requirements and back-end rigor

To ensure program integrity, Medicare also must balance up-front requirements for provider network inclusion with back-end rigor of claims processing and enforcement. The program could have strict conditions for participation and then lessen the intensity of claims review as providers build up track records of good behavior. Instead, the Medicare program relies heavily on claims processing and the medical review process to identify problems and tends to treat all providers the same, regardless of past performance. Some private-sector plans take the opposite approach: they rely more heavily on provider selection and will not retain providers in the network if utilization goals are not achieved. The current balance in the Medicare program is less reliance on strict participation requirements and more reliance on claims and medical review, placing more burden on current providers.

Coverage of services: balancing pre-certification and retrospective adjudication

Medicare must balance retrospective adjudication of claims with pre-determination (a determination of coverage before a service is performed). Unlike many private plans, which provide for or even require pre-determination, Medicare will not give a binding determination before a service is provided and instead solely uses retrospective adjudication of claims. At the same time, regulations require that beneficiaries be informed of the possibility of non-coverage through advance beneficiary notices (ABNs). Having no pre-determination adds to the complexity of decision making for beneficiaries and makes it difficult for providers to explain to beneficiaries which services are covered. ■

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CHAPTER 2

Simplifying the program: recommendations

RECOMMENDATIONS

1 CMS should move to a standard nationwide system of claims processing and eliminate local descriptions of policy and regulation. The Congress should allow CMS to contract as necessary to implement a standard system efficiently.

*** YES: 13 • NO: 1 • NOT VOTING: 1 • ABSENT: 2**

2 The Medicare program should provide timely, binding written guidance to plans and providers. Plans and providers that rely on such guidance should not be subject to civil or criminal penalties or be required to refund related payments if that guidance is later found to be in error.

*** YES: 14 • NO: 0 • NOT VOTING: 0 • ABSENT: 3**

3 CMS should explore ways to reduce routine administrative requirements for plans and providers that demonstrate sustained good performance.

*** YES: 15 • NO: 0 • NOT VOTING: 0 • ABSENT: 2**

4 The Secretary of Health and Human Services should work with the Department of Justice to improve consistency and eliminate redundancy in enforcement roles and activities.

*** YES: 12 • NO: 0 • NOT VOTING: 0 • ABSENT: 5**

5 The Congress should provide reasonable time lines and resources for CMS to develop and test regulations thoroughly before implementation.

*** YES: 13 • NO: 0 • NOT VOTING: 0• ABSENT: 4**

6 CMS should eliminate regulations and other issuances that become obsolete as a result of program changes.

*** YES: 15 • NO: 0 • NOT VOTING: 0 • ABSENT: 2**

7 The Congress should appropriate the necessary resources for CMS to acquire new technology that would simplify administrative processes and improve information exchange with program participants.

*** YES: 15 • NO: 0 • NOT VOTING: 0 • ABSENT: 2**

***COMMISSIONERS' VOTING RESULTS**

Understanding the sources of complexity in the Medicare program is only a first step. In this chapter, we examine the different aspects of the program, determine whether elements in each can be simplified, and identify promising targets for simplification that will lift burden from beneficiaries and providers. We make recommendations where warranted for legislative or administrative actions.

Simplifying fundamental aspects of the program

Some aspects of the Medicare program are fundamental to its very nature. These include the scope of the program, its fiduciary responsibility to taxpayers and beneficiaries, its role in beneficiary protection and education, and its responsibility to ensure the quality of care provided. Because they are fundamental, these aspects would at first appear to be less amenable to simplification than others. Nevertheless, some simplification may be possible.

Size and scope of the program

The size and scope of the program—the large number of beneficiaries, the wide range of covered services, and the variety and number of participating providers and plans—is enormous by any measure. Complexity that arises directly from this scope is to a large extent irreducible. For example, because the program has beneficiaries all over the country, the program must be able to pay providers appropriately in all areas so that beneficiaries can have access to health care. The program also must be able to enroll beneficiaries wherever they live and send them information about the program.

In contrast, private plans can choose where they want to do business and who their customers are. For example, they may choose to cover only large employee groups in urban areas, because marketing to groups is more efficient than marketing to individuals and forming networks is easier in urban areas than in rural areas. The Medicare program cannot make such a choice; instead, it must accept the complexity associated with providing nationwide coverage for all qualifying beneficiaries.

The scope of the program is also influenced by the goals of the program. Currently, Medicare is more than an insurance plan for acute care of the elderly. The program serves not only the elderly, but also individuals with ESRD and the disabled. It covers not only acute care, but also some preventive services. It also provides funds for educating physicians and other providers and for facilities that provide care for the indigent. These additional goals make the program more complex in several ways. For example, the graduate medical education (GME) program requires Medicare to collect data on resident physicians and makes the payment system more complex for hospitals in fee-for-service and M+C plans. GME payments also complicate the political climate because they are concentrated in particular states and hospitals. If mechanisms could be found outside the Medicare program for fulfilling these other policy goals, the program could be simplified, although the regulatory burden associated with those goals might simply be shifted elsewhere.

Alternatively, a more comprehensive goal for the program could be envisioned in which Medicare covered all medical services—including preventive and acute—and provided a catastrophic cap on beneficiary cost sharing. Such a goal could lessen burden on beneficiaries by lessening the need for supplementary coverage. The current benefit design is essentially unchanged from the original legislation and reflects the split between Part A and Part B in its cost-sharing provisions.[1] The complication of the current cost-sharing rules along with the lack of a out-of-pocket cap on beneficiary liability drives many beneficiaries to seek supplemental insurance (86 percent of beneficiaries had supplemental coverage in 1997). Such coverage increases complexity for beneficiaries, who must choose between various policies, and for the program, which must link to the automated systems of supplementary carriers so they can cover the appropriate cost-sharing amounts for Medicare claims. MedPAC's June 2002 report will discuss the benefit package design in more detail and present recommendations for its simplification and improvement.

Fiduciary responsibility

The program's fiduciary responsibility to taxpayers and beneficiaries leads to complexity. This responsibility entails ensuring that payments made by the program are legitimate; that is, that they are for medically necessary covered services, provided to eligible beneficiaries by enrolled providers, and for the correct amounts.

Many of providers' concerns about regulatory burden stem from this aspect of the program. Providers view documentation requirements and claims processing issues—including medical review of claims, appeal processes, and potential prosecutions under the False Claims Act—as burdensome or worse.

Is simplification possible? The basic requirement for safeguarding the program's resources must be separated from the mechanisms and regulations used to do it. The basic requirement is intrinsic to the program; the various mechanisms are not, and are ripe for simplification. The goal of being responsible custodians of the trust fund should be examined, however. Should the program aim for zero tolerance of payment errors or for something less? The rhetoric calls for zero tolerance, yet businesses, such as credit card companies, assume some level of loss, enforce what they can but accept that zero is not an efficient outcome, and go about their business. By acting as though zero tolerance is the goal, the Medicare program may limit its options and unnecessarily increase burden on providers and beneficiaries. In fact, although political considerations might make it difficult to enunciate as policy, the program could be simplified by determining a tolerable level of loss.

[1] One possible simplification of the program would be removing the distinction between Part A and Part B services. As discussed, this distinction arose from the legislative history of the program and is in no way intrinsic to providing health care. The distinction complicates administration of the program by having separate contractors and claims processing for Part A and Part B. For example, rural health clinics (RHCs) bill fiscal intermediaries for defined RHC services and carriers for some physician services not included in RHC services. Because there is little coordination between the two, the program may pay twice for the same service if duplicate claims are made (OIG 2001). In carrying out this simplification, issues of financing and eligibility, as well as how to treat beneficiaries who are enrolled in only Part A or Part B, would have to be resolved.

For example, in some situations (such as working beneficiaries with employee heath insurance, or injuries resulting from auto accidents), Medicare is the secondary payer for health care expenses. To ensure that primary insurers are held responsible, Medicare requires that beneficiaries fill out Medicare Secondary Payer (MSP) forms when they seek health care. The problem is that regulations require the form to be filled out each time a beneficiary receives services—even several times in one day. It is unlikely that an 85-year-old who has been retired for 20 years will resume employment suddenly during the course of treatment. There appears to be latitude in cases such as this for Medicare to accept some risk by limiting how often and under what circumstances the MSP form must be completed.[2] Such a policy change might save Medicare money as well as decrease burden on beneficiaries and providers.

Beneficiary protection

Because of the vulnerabilities of some Medicare beneficiaries, one of the program's goals is to protect beneficiaries from unscrupulous and incompetent providers, vendors, and plans. Efforts to protect beneficiaries include provider conditions of participation, controls on marketing materials from M+C plans, actions to standardize the types of Medigap policies that can be sold, and quality initiatives. Some simplification may be possible in this area. For example, marketing materials for M+C plans are currently reviewed by CMS regional offices, which require that all beneficiaries enrolled in a plan receive the same information. However, some beneficiaries are also members of employee retiree group plans that have additional benefits. If those members receive the same information as others do, they may become confused because they are actually eligible for different benefits. The burden on the beneficiaries could be lessened by sending them the correct information and not the same information that other M+C members receive.

Quality

The quality of care can always be improved and quality problems abound, so it is often tempting for policymakers and regulators to use the Medicare program to force providers and plans to improve quality. The tools to measure and improve quality are new, however, and the federal government has only recently shifted its role from one of a guarantor of a minimal level of quality to one in which it increasingly expects plans and providers to continually improve quality.

In this new world, compliance takes on new meaning as regulators begin to use and apply such terminology as process and outcomes measures, demonstrable improvement, statistical relevance, and others that are not easily or neatly defined. One could characterize the world of quality standards compliance as increasingly complex, but there may be ways to create simplicity.

One of the ways that Medicare has made it possible to simplify regulation in the fee-for-service program is through deemed status authority. Deemed status allows organizations accredited by a body with standards and a process deemed to be as stringent as the Medicare requirements to become certified for participation in the program without an additional evaluation from the federal program. Extending this approach to M+C plans could help ease the burden of Medicare-specific requirements for M+C quality improvement.

[2] CMS is addressing the more egregious aspects of this regulation through administrative action. As with other examples throughout the text, regulations that are well known to be burdens are in many cases being addressed by CMS through administrative actions or by the Congress through legislation, with varying degrees of success.

In the fee-for-service program, processes may be simplified by developing performance measures for providers that are useful for organizations and coordinated with private-sector requirements. Many purchasers ask for a higher level of accountability from providers and their efforts need to be aligned with Medicare's. CMS could take the lead in coordinating such efforts.

Simplifying the structure of the program

The structure of the Medicare program—how it is organized to accomplish its varied functions such as enrolling beneficiaries and providers, paying claims, and providing information—is the most promising target for simplification. After reviewing the problems with the current structure, we make four recommendations. The first two relate to removing complexity by instituting a standard nationwide system for claims processing. The last two simplify the enforcement structure.

Problems with the current structure

Providers often ask: "To whom do I go for answers?" "Why do I get audited by three different groups?" The administration of the Medicare program is oddly divided among many different actors. Just knowing the rules is a challenge for some providers. They can look at written rules in the law; in regulation; in Medicare pronouncements, such as program manuals and operational policy letters; in carrier or intermediary instructions; or on CMS or contractor web pages. They can ask their contractor or CMS questions, but they cannot rely on the answers to protect them if they later become involved in a dispute with the enforcers from the Department of Justice or the HHS OIG.

Providers suffer from incomplete and incorrect information from contractors. In one study, the General Accounting Office (GAO) found that carrier bulletins, which are a principal form of communication between contractors and providers, were often unclear and difficult to use, and in some cases were out of date. Even worse, GAO found that correct and complete answers to questions were received only 15 percent of the time from their sample of carrier telephone call centers. About half the time, answers were incomplete and a third of the time answers were entirely incorrect. Being unable to receive correct information or answers to questions represents a serious burden on providers (GAO 2001).

Providers operating in areas controlled by several contractors also experience inconsistent interpretation of regulation. For example, claims denials for lab tests vary widely among carriers. Claims for a common lab test were denied 68 percent of the time in one state, but only 7 percent of the time in another, apparently because of differing interpretations of coverage and medical necessity (IOM 2000). For laboratories that provide services to beneficiaries in several states, this variation greatly increases uncertainty and burden.

Some providers have turned to consultants to help them with compliance. But should it be necessary for a provider who wants to follow the rules to have to ask for help in doing it? Must the rules be so complex? Cutting out some layers of rules and some regulators would reduce complexity. Medicare does not inherently demand multiple levels of regulators or enforcers, or multiple versions of regulations. For example, carriers are required to write bulletins to providers apprising them of changes in regulations from CMS, but as described above, they do not always provide the correct information in an understandable way, target it to the provider, or produce the bulletins in a timely fashion. Why not eliminate that layer of interpretation and have Medicare speak directly to providers? Other similar steps could be taken to eliminate unnecessary layers that have accumulated over the years.

Beneficiaries have a more basic problem: knowing whom to call. The *Medicare and You 2002* pamphlet has 100 pages of information on the Medicare program; 28 of these are filled with telephone numbers. The office a beneficiary needs to call depends on the beneficiary's location and whether she needs information on Part A, Part B, or from her DMERC or regional home health intermediary (CMS 2001). Woe to beneficiaries who do not know to which part of Medicare their question refers. It may not be apparent to someone receiving care in a RHC to call the fiscal intermediary concerning an office visit. Beneficiaries who go to a different state for care than the one in which they live may also be confused about whom to call for information.

The confusion extends to M+C plans when they must pay Medicare fee-for-service rates to out-of-network providers. This can occur, for example, when plan members seek emergency care away from their usual place of residence. The inconsistent policies of the various contractors make the appropriate rates difficult to determine.

Moving to a nationwide standard system for claims processing

To providers, Medicare is represented by the contractors that process Medicare claims. These contractors deny payment, send checks to providers, and communicate with them on CMS letterhead. They send out bulletins updating Medicare regulations, and what they say is in large measure what providers know of the program. However good or bad CMS is at translating statute to policy and regulation, the ultimate expression of that policy and regulation to the ears and pocketbooks of providers is the contractor's action.

The original legislation for Medicare envisioned a different world than now exists. The program was designed for local administrators to pay locally determined rates for health care services, but because it has evolved to using nationally determined prospective payment systems, Medicare is currently at odds with itself. Local administration and claims payment policies no longer make sense and add unnecessary complexity to the program. They are therefore a prime opportunity for simplification efforts. For a national program that wants to provide equitable treatment to all beneficiaries, moving toward a standard, national claims processing system would be an important step toward simplification.

Currently, claims payment decisions are made by individual contractors that are required to have a local medical review policy (LMRP) when their claims systems make automated denials. LMRPs help contractors identify claims for services that are, for example, inappropriate for a specific diagnosis. These policies frequently differ between contractors; this arbitrary variation would be eliminated under a standard system for claims payment.[3]

[3] LMRPs could be considered essential for the program to take into account variations in local medical practice. However, health insurers that operate nationwide do not have local policies and many of their clients with employees in different locations would probably object if they did. In addition, some argue that local practice standards are giving way to national standards. It is also not clear that a state is a small enough area to reflect local medical practices.

Local coverage decisions also may give rise to LMRPs. Some argue that local coverage determinations are needed to allow more rapid introduction of innovations than the national coverage determination process allows.[4] A different approach to coverage determination is exemplified by the DMERCs. DMERC LMRPs are jointly developed by the medical directors, but do not have to go through the national coverage determination process and so can be implemented more rapidly. The four DMERCs share one set of LMRPs and therefore claims are treated the same regardless of what DMERC processes the claim. A similar process could be followed under a standard nationwide claims payment system if there are multiple contractors. Yet another approach would simply be to make the national coverage determination process more responsive using resources formerly used by local contractors.

Others argue that some innovations will not be effective, and demonstrating this locally rather than nationally is good for the program. More broadly, some means of demonstrating the effectiveness of innovations when no national coverage determination has been made may be appropriate. If Medicare were to implement a standard system—using multiple contractors or not—the geographic basis for claims processing might be eliminated. However, the current arrangement of geographically based advisory committees and medical directors could be retained or advisory committees could be established on some other basis, such as type of provider or facility, or tied to the existing national Medicare Coverage Advisory Committee. In any case, medical directors would still need to have authority to make provisional coverage decisions in the absence of national determinations. Doing so in the context of a standard national system however, might allow more deliberate decision making, more explicit consideration of health outcomes, and provide better evidence for national coverage decisions than the current fragmented system.

If the goal is a nationwide Medicare program in which all beneficiaries and providers are treated consistently, then having 100 or more private sector contractors interpreting and implementing the program is not a good idea. At the same time, the mechanism for paying and selecting contractors is not aimed at efficiency or performance. Because contractors are paid their costs, they have no incentive for increasing their efficiency. Because many of them operate under no-competition clauses, they have no great incentive for customer-pleasing performance. The fact that some contractors do their work efficiently and please their customers speaks highly of those contractors and their public spirit, but should not be the basis for perpetuating the current system.

Current efforts to change the rules under which CMS selects and pays contractors are a step in the right direction, but why continue the system at all? We have shown that its existence is a result of how Medicare began and that the conditions that may have justified it at the time (such as payment based on costs and use of local UCR rates) no longer exist. In addition, even under the current system, it is clear that contractors do not have to be local. Noridian Government Services is the Part B carrier for Alaska, Arizona, Colorado, Hawaii, Iowa, Nevada, North Dakota, Oregon, South Dakota, Washington, and Wyoming. The carrier for Washington D.C. is in Texas and is owned by a firm in South Carolina. One contractor in South Carolina handles DME supplier enrollment for the entire nation, a function that includes conducting site visits nationwide. Why continue having multiple "locally based" contractors if they contribute to complexity and burden?

[4] For a local coverage determination, the contractor medical director must decide whether the device or procedure is a covered benefit under Medicare, assure that it is not statutorily excluded, and determine that it is safe and effective. The medical director must then give guidance to providers on reasonable and necessary use and explain how to submit claims (either by assigning a temporary code or directing that it be billed under an existing code). The national coverage determination process is considered to require a higher level of evidence, take more time, and be more cumbersome.

RECOMMENDATION 1

CMS should move to a standard nationwide system of claims processing and eliminate local descriptions of policy and regulation. The Congress should allow CMS to contract as necessary to implement a standard system efficiently.

Moving to a standard nationwide system of claims processing and eliminating local descriptions of policy and regulation would make it possible to have one accepted statement of Medicare policy, help ensure consistent descriptions and understanding of regulations, and allow the development of standard instructional materials. The current complexity, inconsistency, and uncertainty in the program would be reduced, along with the associated burden on providers and beneficiaries.

The Congress would have to eliminate current contracting limitations and CMS would have to determine the most efficient division of labor between government and contractors, as well as the optimum number of contractors for claims processing (including the common working file operation), provider education, and program safeguard activities. The current division of labor and contractor operations should be rethought and simplified to give providers and beneficiaries a consistent source of information and consistent results of claims adjudication. This recommendation represents a significant change of direction for the program and will be difficult to accomplish. Providers should be consulted on Medicare operations and coverage policies and their suggestions used to improve the system. The existing carrier advisory committees could be reconfigured for this role, or another mechanism could be used.

Moving to a standard nationwide system may require more resources for CMS, particularly for fielding more up-to-date automated systems. Consolidating multiple automated systems has proven to be a difficult task in the past for Medicare and private sector organizations and carries significant risk. It will undoubtedly prove challenging in this case as well and, therefore, sufficient time and resources, human and other will have to be made available for planning and execution. Increased resources for CMS, as endorsed in the past by MedPAC, may pay large dividends in better information for providers and in more responsive and capable information handling (MedPAC 1999). These investments, in turn, could pay off not only with more responsive claims processing but also with an enhanced capability to identify discrepant behavior for enforcement actions. CMS should have the authority to redirect resources made available through eliminating inefficient, duplicative policy development in the current contractor system.

The above recommendation would be an important step to help providers and beneficiaries get more consistent and correct answers to their questions. The commission also recommends the following as a next step.

RECOMMENDATION 2

The Medicare program should provide timely, binding written guidance to plans and providers. Plans and providers that rely on such guidance should not be subject to civil or criminal penalties or be required to refund related payments if that guidance is later found to be in error.

A serious complaint of providers is that they can get answers from contractors, file claims accordingly, receive payment and then retrospectively be told that their actions were incorrect and sometimes actionable. If some layers of the present system were cut out, the likelihood of correct, timely information being communicated would increase. It might then be possible to assure providers who make a good faith effort to do the right thing and receive affirmative official guidance that they will not be held liable for penalties or required to refund related payments if the guidance is later found to be incorrect.[5] In order for guidance to be timely, the possibility of considering e-mail as a form of written guidance should be examined.

Incorrect guidance under the present system can be caused by differences between information in the contractors' automated systems and that in regulation. To meet tight deadlines, programming changes are often made before regulations are finalized. Such changes made to the automated systems are reality for contractors and providers. If providers do what the contractors' systems tell them to do, then the OIG can later say that providers were wrong, even if contractors encouraged them to behave as they did. Having a single standard automated system would help simplify the process of moving from regulation to implementation.

As contractor roles are rationalized and some of the layers removed, the role of the CMS regional offices and the consortium structure in contractor management might be reconsidered.[6] If the contractor structure were rationalized and did not retain a local or regional basis, the current regionally oriented management structure should change as well.

Other functions of the regional offices might also change. For example, their role in supervising M+C plans may need to be revisited if the review of marketing materials is revised. The role of CMS regional offices with respect to beneficiaries may also be reexamined. Regional offices have limited contact with beneficiaries, as evidenced by the fact that they do not have toll-free telephone numbers for beneficiaries and are not included in the list of offices under *Where do I call for help with my Medicare questions?* in the *Medicare and You* pamphlet. Some observers have recommended that a local CMS presence be created within local Social Security offices so that beneficiaries can have someone in their immediate area to answer their questions (Vladeck and Cooper 2001). How those local representatives would coordinate with regional offices, or if they would report directly to the central office, must be determined.

Simplifying enforcement

A highly visible face of Medicare to providers—one they do not want to see—consists of the enforcers: the OIG in HHS and the various arms of the Department of Justice (DOJ), the Federal Bureau of Investigation (FBI) and the U.S. Attorney's offices. Fear of unfounded prosecution and the formidable array of enforcement tools available has reportedly created a pall over the program among providers. It is clear from the explosive growth in the compliance industry that this fear is palpable and real.

[5] We use the term "official guidance" to mean written rather than oral direction from the program. The courts have never held verbal guidance to be binding on the government. Moreover, if guidance were not written, there would be no reasonable way to track such exchanges. This recommendation would require CMS to create a process for providers, suppliers and beneficiaries to request and receive sanctioned written guidance on program questions.

[6] The 10 CMS regions are divided into 4 consortia for contract management purposes. Regional offices also play a major role in Medicaid and State Children's Health Insurance Program administration, oversee state survey agencies and the peer review organizations, and perform other functions.

It is good if providers and suppliers contemplating fraudulent activity fear detection and prosecution. The problem is when providers trying to do the right thing are discouraged from appropriate behavior or even from participating in the program. Writing rules and enforcement policies for the "bad apples" may cause a serious misallocation of resources and unnecessarily complicate things for the vast majority of honest providers.

RECOMMENDATION 3

CMS should explore ways to reduce routine administrative requirements for plans and providers that demonstrate sustained good performance.

One approach to solving the problem of burden is to scrutinize providers and plans less as they prove themselves reliable. Doing so would create incentives for good behavior, lessen burden on compliant providers, and free resources to pursue less-than-compliant providers. For example, examination of M+C plan networks could occur less frequently for plans that repeatedly demonstrated the requisite network availability and quality, and physicians with sustained good performance could be excused from resubmitting management data every time office personnel change. Private-sector models should be investigated as CMS evaluates strategies to reward good performance.

Another problem in enforcement is that many poorly coordinated entities are involved in setting, interpreting, and enforcing rules. Rationalization of the contractor structure may help to some extent. Also, legislation already has been proposed to address some of the most burdensome regulations identified by providers. However, beyond changing individual regulations, the agencies involved might attempt to rationalize the enforcement process itself, for example, by ensuring that audits are non-duplicative. Because the enforcement agencies have grown rapidly with the increased funding for their fraud and abuse activities, their roles may not be optimal for the current environment.[7]

RECOMMENDATION 4

The Secretary of Health and Human Services should work with the Department of Justice to improve consistency and eliminate redundancy in enforcement roles and activities.

The Health Insurance Portability and Accountability Act of 1996 expanded the duties of the OIG to include coordination of federal, state and local enforcement efforts targeting health care fraud. Under HIPAA's health care fraud and abuse program, the DOJ also received new investigative powers and additional funding to support its responsibilities through the FBI and U.S. Attorneys' offices. Although the Secretary of HHS and DOJ issued joint guidelines to carry out fraud and abuse activities following passage of HIPAA, reviewing how those guidelines are implemented among the OIG, FBI and U.S. Attorneys' field offices may yield opportunities for better leadership and coordination, particularly to reduce the incidence of providers being audited by multiple entities during an investigation. Rationalizing resources to emphasize provider education and improve communication to avoid government waste can be accomplished administratively, but statutory changes would be required to transfer or consolidate which executive branch agency could levy penalties, exclude providers, and prosecute civil or criminal penalties.

[7] In fiscal year 2000, HHS OIG had more than 1,000 full-time equivalent (FTE) staff devoted to Medicare and Medicaid investigations. Department of Justice had more than 1,200 FTE staff involved in health care fraud control activities (GAO 2001b). In comparison, CMS has approximately 4,200 FTE staff.

Moderating the pace of change

A significant source of complexity is the pace of change in Medicare regulations. Constant change will complicate any system because each new regulation must be developed and will interact in possibly unanticipated ways with previous requirements. New regulations also must be promulgated to the affected community, which entails an educational effort. According to many providers, keeping up with changes in regulation is one of the most difficult and burdensome aspects of participating in the Medicare program. It also creates a burden on the regulators and policymakers themselves, as was perhaps best illustrated by the BBA of 1997, which required that HCFA develop four new prospective payment systems[8] and numerous other changes at a time when it was already overloaded with trying to cope with a major reorganization and planning for Y2K.

Plans and providers are concerned that the rules of the game keep changing, making Medicare an unpredictable, and thus undesirable, business partner. M+C plans, for example, have seen major changes in the payment mechanism almost every year since 1997, making it very difficult to make long-range business plans and possibly discouraging market entry.

Ironically, one aspect of the problem stems from the Congress being so responsive to provider concerns about Medicare. If the Congress were less prescriptive in its legislation and gave CMS more leeway in implementation and timing, it might protect plans, providers and beneficiaries better. For example, the implementation date for Medicare legislation could be left open in statute, but be coupled with a requirement that CMS produce a regulatory calendar showing planned implementation dates. This would create an opportunity for some planning and public discussion about the interaction among various items on the agenda. If the Congress had severe objections, it could override CMS.

Another way to moderate change would be to have CMS test regulations before putting them in effect. The recent development and implementation of several PPSs called for in the BBA shows why this might be desirable. A poorly conceived system inflicted on an entire industry can have many negative effects, including incentives for behavior that increases Medicare's cost. In addition, poorly conceived systems will create demand for Congressional action, which can result in more prescriptive law and further changes in regulation.

RECOMMENDATION 5

The Congress should provide reasonable time lines and resources for CMS to develop and test regulations thoroughly before implementation.

When appropriate, CMS should test regulations that increase complexity and burden before putting them into effect for an entire industry. For the testing to be credible, the testers should be independent of those proposing the manner of regulation and sufficient sites should be chosen to illustrate any differential impacts of the proposed regulation. Time should be allowed for proper development and consultation with industry so that the likely impact of regulations can be understood as soon as possible. CMS should investigate whether this consultation can be accomplished within the strictures of the APA and the FACA, or whether some aspects of developing Medicare regulations could be exempt from those laws.

[8] For home health services and care in skilled nursing facilities, rehabilitation hospitals, and hospital outpatient departments.

Simplifying program operations

The continuing move to prospective payment in Medicare creates complexity and challenges for the program to make accurate payments. However, this evolution should not necessarily burden providers. The data collection burden might also be lessened.

Data collection

Some of the data collected by CMS may no longer be needed because the program has changed. For example, hospital cost reports were designed to permit cost-based payment to hospitals; as a result, they contain a great deal of data. Some simplification may be possible now that hospitals are paid primarily through PPS. As another example, adjusted community rate proposals (ACRPs) are detailed submissions required of all M+C plans. The ACRP formula adjusts the costs of caring for commercial plan members to estimate the higher costs of caring for Medicare members. Before the BBA, at least 50 percent of the enrollment in M+C plans had to be commercial members; now, Medicare no longer requires plans to have commercial members, and therefore basing estimates on the cost of commercial members is no longer logical.[9]

In some cases, data collection requirements may have been excessive from the start. For example, when HCFA designed the prospective payment system for skilled nursing facilities (SNFs), the agency adopted an existing care-planning tool—the Minimum Data Set (MDS)—as its patient assessment instrument. However, increases in assessment frequency and the decision not to trim the original instrument led to excessive data requirements. Originally, SNF staff were required to fill out the MDS at 90-day intervals. Under PPS, the frequency increased; patients are now assessed on days 5, 14, 30, 60, 90, and when a significant change in condition occurs. While the original MDS was administered chiefly to long-term patients, under PPS it also applied to patients who stay for much shorter periods and to all types of patients, including Medicare, Medicaid and private sector.[10] Out of the 350+ items, only 109 are used to adjust per diem rates under the SNF PPS. Twenty-four items are used as quality indicators. Many items do not have an explicit rationale. Limiting the data requirement would remove a significant burden from SNF operators.

Regulation "sunset"

Outdated data collection requirements illustrate a larger point. As the program changes, some regulations, manuals, instructions, and other issuances become outdated and should be eliminated or simplified. CMS should expand its efforts to eliminate obsolete regulations and develop a sunset mechanism triggered by program changes that would allow for the identification and elimination of all regulations, manuals, instructions and other issuances that were made obsolete by the change.

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[9] Some argue that ACRPs are not needed anyway because their primary function is to ensure that plans return payments above their revenue requirements to beneficiaries in the form of additional benefits and that function is performed by the market. In areas with multiple plans, additional benefits will be offered by efficient plans as a marketing tool. If they do not offer reasonable additional benefits, members will leave and enroll in plans that do. Even if only one plan operates in an area, beneficiaries will not join unless value is added.

[10] The Medicare program can dictate data collection for non-Medicare patients if Medicare participation implies Medicare's approval of the provider. The rationale appears to be that if Medicare agrees to use a facility for Medicare beneficiaries it is giving it a quality seal of approval, on which other patients might rely.

RECOMMENDATION 6

CMS should eliminate regulations and other issuances that become obsolete as a result of program changes.

For example, as new PPSs are implemented, an effort should be made to eliminate regulations that supported previous payment mechanisms and are now obsolete. The ACRP process, which was predicated on commercial enrollment in plans that provide services to Medicare enrollees, should have been eliminated when the BBA eliminated the requirement for commercial enrollment. After CMS identifies obsolete requirements, Congress may have to take legislative action to eliminate them if the requirements are specifically called for in law.

Payment

As the Medicare Payment Advisory Commission, we are particularly sensitive to the complexity of Medicare payment systems, both within individual payment systems and between different payment systems.

Within individual PPSs, payment accuracy depends on the unit of payment, the product classification system, relative values, adjustments to payment rates, and base payments. As the quest for accuracy of payment continues, more refinements are added to the system. For example, the PPS for hospital inpatient care is based on diagnosis related groups (DRGs). Because some providers began to transfer patients to post-acute settings earlier to decrease their inpatient costs, certain DRGs were designated as transfer DRGs and payments for those DRGs were lowered when patients were transferred to other settings earlier than usual. Such refinements increase the complexity of the payment system.

At the same time, the Congress often legislates exceptions to a system to protect certain providers. Within the inpatient hospital category, for example, rural hospitals receive special payments if they are designated as rural referral hospitals, Medicare-dependent hospitals, sole community hospitals, or critical access hospitals. Each of these designations has specific criteria and may fulfill certain goals for the program. Nonetheless, the designations make the program more complex. Medicare must regulate for every exception (not just those relating to payment) and the program would be simpler with fewer exceptions.

The differences in payment systems among settings increases overall complexity and may lead to conflicting incentives and unforseen outcomes. To some extent, Medicare payments depend on the name over the door as well as on the activities inside. For example, a physician may perform the same procedure in a hospital outpatient department, an ambulatory surgical center, and a doctor's office, but payment will differ by setting. This particular source of complexity—the definition of many types of settings, each with its own payment system—may be peculiar to Medicare, and private-sector approaches may guide simplification.

More generally, the boundaries—geographic, definitional, or professional—may make payments more accurate, but they also introduce complexity to the payment system and raise the possibility of providers shifting over boundaries to increase payment. For example, a physician in a rural area might choose to have an office or to be redefined as an RHC because payment differs between these two settings. This creates an opportunity for the physician, but it is also a burden. The physician must determine what definition would be preferable, taking into account any additional requirements for an RHC, how payments will differ, and any effect on his or her patients, such as changes in cost sharing.

The ideal simplification for payment would be to remove some of the boundaries or improve accuracy in ways that do not complicate the program. Failing that, improved technology may help relieve the burden of the payment system, if not its complexity. It might be possible to make much of the payment system's intricacy transparent to providers.

Using technology to simplify the program

Efforts to simplify the Medicare program and relieve the burden of Medicare regulations must take advantage of new technology that could modernize program administration.

Internet for communication

Having the Internet commonly available could improve communication between the Medicare program and both beneficiaries and providers. Building on earlier recommendations to remove layering, the Internet makes possible direct communication between CMS and both beneficiaries and providers. In addition to easier and more accurate dissemination of information, it should be possible for providers to determine whether claims will be acceptable before actual submittal. (All the automated edits for single claims could be made available to providers so that only clean claims are submitted.) For example, if information such as a beneficiary number were missing or incorrect, the provider could find out immediately and correct the claim. If two procedures were submitted on the same claim that were not allowed together, the provider would know immediately. Given one standard claims processing system, CMS could make such a pre-submission service available over the Internet or even on CD-ROM. Just as tax preparation software creates a simple interface with the extremely complex tax system, a better interface could remove some of the burden of the complex Medicare system.

Health Insurance Portability and Accountability Act of 1996 standardization

Although the advent of HIPAA regulations is enormously complicated, the standardization of billing forms may lead to simplification and lessen burden. Once a standard form is defined, promulgated, and put into practice, the burden of billing Medicare should decrease. Legislation delaying the implementation of the HIPAA transaction standards is in process.

Electronic medical records

The eventual ready availability and use of electronic medical records could relieve some of the burden of Medicare audits and medical record review, and possibly of documentation for evaluation and management visits. Care for beneficiaries might also improve: Medicare's efforts to monitor quality through an episode of care when beneficiaries are treated by multiple providers in a variety of settings could be greatly enhanced by access to a comprehensive electronic medical record.

RECOMMENDATION 7

The Congress should appropriate the necessary resources for CMS to acquire new technology that would simplify administrative processes and improve information exchange with program participants.

In many ways, Medicare will remain an extremely complex program because much of its complexity is irreducible. However, the complexity that stems from difficulties in information sharing and from complicated payment rules may be made less of a burden on providers through judicious application of more modern information systems. Developing better systems is a long-term opportunity that CMS should be given the appropriate resources to take. ■

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APPENDIX A

Layers of regulatory issuances

APPENDIX A

Layers of regulatory issuances

Table A-1 attempts to capture the complexity added to the Medicare program by the large volume of guidance documents issued. The chart merely documents those issuances made during calendar year (CY) 2000. It does not list the documents in existence or issuances made prior to that time period. For example, the two relevant volumes of the Code of Federal Regulations are not listed, though CY 00 Federal Register (FR) issuances of regulations are listed. Providers and suppliers are, thus, required to be in compliance with all existing guidance materials and to keep abreast of the many changes imposed by new issuances.

In addition, Table A-1 lists most of the standard documents issued by the relevant government entities. It does not, however, capture every document issued that contained relevant policy guidance. For example, the Centers for Medicare & Medicaid Services (CMS) issues "Q & A" documents, posing and responding to questions on various topics. These are not, however, issued with any regularity, nor are they easily accessible as a distinct group of documents; thus, they have not been included.

TABLE A-1

Medicare-relevant issuances during calendar year 2000

Regulator	Issuance/publication	Number	Sample documents
Congress	Laws	1	Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (P.L. 106–554)
Department of Health and Human Services (DHHS)	Regulations	9	Organ Procurement and Transplantation Network, final rule (65 FR 15252
	Information collection requests	5	Office for Civil Rights standardized automated review format for the conduct of civil rights compliance investigations of health care providers who have requested certification to participate in the Medicare Program (65 FR 25925)
	Notices	12	Notice of interest rate on overdue debts (65 FR 25730)
	Other	46	Notice of meeting of the Advisory Committee on Blood Safety and Availability (65 FR 14283)
DHHS/Centers for Medicare & Medicaid Services	Regulations (published in FR)	41issuances	• Prospective payment system for home health agencies, final rule (65 FR 41127–41214) • Requirements for the recredentialing of Medicare+Choice organization providers, proposed rule (65 FR 81813–81815)
	Proposed Information Collection Requests[1] (published in FR)	165	Follow-up of Medicare+Choice disenrollees receiving fee-for-service inpatient hospital care; Form No.: HCFA-10017 (65 FR 65860)
	Notices (published in FR)	30	Hospice wage index (65 FR 600071–600820)
	Other (published in FR)	46	Notice of meeting of the Negotiated Rulemaking Committee on the Ambulance Fee Schedule (65 FR 4545)
	23 manuals	133 revisions	• Intermediary Manual Transmittal No. 1811, 10/00, adding new section providing coverage, billing, and payment instructions for extracorporeal immunoadsorption using Protein A columns • Skilled Nusing Facility Manual Transmittal No. 364, 5/00, manualizing policies in May 1996 regional office memorandum on the prohibition of two or more distinct part skilled nursing facilities in a single institution
	Program memoranda	102	Program Memorandum PMI A-00-94 new end-stage renal disease (ESRD) composite payment rates effective January 1, 2001
	Operational policy letters (OPLs)	16	OPL #114, 1/17/00, reporting appeal and quality of care grievance aggregate data to beneficiaries upon request
	Administator decisions	58	Tri-State Memorial Hospital v. Blue Cross and Blue Shield Association, HCFA administrator decision, (May 8, 2000) ESRD exception request
	Provider Reimbursement Review Board (PRRB) decisions	81	Lloyd Noland Hospital (Fairfield, Ala.) v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Alabama, PRRB Hearing (April 5, 2000) PRRB Hearing Dec. No. 2000-D43, reasonable compensation equivalent limits
DHHS/Center for Medicare and Medicaid Services	Medicare Geographic Classification Review Board (MGCRB) decisions	10	MGCRB 10/6/00 00C0586 Bruce A. Tedesco & Co., Inc.
	Departmental Appeals Board decisions	56	Garden City Medical Clinic v. Health Care Financing Adminitration, HHS Deparmtnetal Appeals Board, Civil Remedies Division (September 11, 2000), Doc. No. C-99-766, Dec. No. CR 698, conditions of participation
DHHS/Office of the Inspector General (OIG)	Regulations (published in FR)	4	Fraud and abuse; revised OIG civil money penalties resulting from Public Law 104–191, final rule (65 FR 24400)
	Compliance guidance	7	OIG compliance program for individual and small group physician practices (65 FR 59434)
	Program exclusions	12	Notice of program exclusions: August 2000 (65 FR 57358)

Note: [1] Filed with the Office of Information and Regulatory Affairs of the Office of Management and Budget pursuant to the Paperwork Reduction Act, 44 §33501-3520.

FR (Federal Register).

Source: MedPAC review of Congressional and DHHS issuances.

APPENDIX B

Commissioners' voting on recommendations

Commissioners' voting on recommendations

In the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), the Congress required MedPAC to call for individual Commissioner votes on each recommendation, and to document the voting record in its report. The information below satisfies that mandate.

Recommendation 1

CMS should move to a standard nationwide system of claims processing and eliminate local descriptions of policy and regulation. The Congress should allow CMS to contract as necessary to implement a standard system efficiently.

Yes:	*Braun, Burke, Feezor, Hackbarth, Loop, Muller, Nelson, Newhouse, Newport, Raphael, Reischauer, Rowe, Stowers*
No:	*DeBusk*
Not Voting:	*Rosenblatt*
Absent:	*Smith, Wakefield*

Recommendation 2

The Medicare program should provide timely, binding written guidance to plans and providers. Plans and providers that rely on such guidance should not be subject to civil or criminal penalties or be required to refund related payments if that guidance is later found to be in error.

Yes:	*Braun, Burke, Feezor, Hackbarth, Muller, Nelson, Newhouse, Newport, Raphael, Reischauer, Rosenblatt, Rowe, Stowers, Wakefield*
Absent:	*DeBusk, Loop, Smith*

Recommendation 3

CMS should explore ways to reduce routine administrative requirements for plans and providers that demonstrate sustained good performance.

Yes:	*Braun, Burke, Feezor, Hackbarth, Loop, Muller, Nelson, Newhouse, Newport, Raphael, Reischauer, Rosenblatt, Smith, Stowers, Wakefield*
Absent:	*DeBusk, Rowe*

Recommendation 4

The Secretary of Health and Human Services should work with the Department of Justice to improve consistency and eliminate redundancy in enforcement roles and activities.

Yes:	*Braun, Burke, Feezor, Hackbarth, Loop, Muller, Newhouse, Newport, Reischauer, Rosenblatt, Rowe, Stowers*
Absent:	*DeBusk, Nelson, Raphael, Smith, Wakefield*

continued on next page

Commissioners' voting on recommendations (continued)

Recommendation 5

The Congress should provide reasonable time lines and resources for CMS to develop and test regulations thoroughly before implementation.

Yes: *Braun, Burke, Feezor, Hackbarth, Loop, Muller, Nelson, Newhouse, Newport, Reischauer, Rosenblatt, Rowe, Stowers*
Absent: *DeBusk, Raphael, Smith, Wakefield*

Recommendation 6

CMS should eliminate regulations and other issuances that become obsolete as a result of program changes.

Yes: *Braun, Burke, DeBusk, Feezor, Hackbarth, Loop, Muller, Nelson, Newhouse, Newport, Raphael, Reischauer, Rosenblatt, Rowe, Stowers*
Absent: *Smith, Wakefield*

Recommendation 7

The Congress should appropriate the necessary resources for CMS to acquire new technology that would simplify administrative processes and improve information exchange with program participants.

Yes: *Braun, Burke, DeBusk, Feezor, Hackbarth, Loop, Muller, Nelson, Newhouse, Newport, Raphael, Reischauer, Rosenblatt, Rowe, Stowers*
Absent: *Smith, Wakefield*

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