TESTIMONY OF
ALEXANDER TRUJILLO
REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
ON
REACHING OUT TO HEALTH CARE PROVIDERS
BEFORE THE
SENATE FINANCE COMMITTEE

May 28, 2002

Chairman Baucus, thank you for inviting me to join you here in Bozeman to discuss the Centers for Medicare & Medicaid Services' (CMS) continuing efforts to reach out to the physicians and providers that care for some of the nation's most vulnerable citizens -- the elderly, poor, and disabled. Many physicians, health plans, providers, and Members of Congress have raised concerns about Medicare, particularly Medicare's regulatory and paperwork burden and the cost of doing business with the Medicare program. We share these concerns, and are making every effort to identify and address areas where improvements can be made. Physicians and other health care providers play a critical role in ensuring that Medicare beneficiaries continue to receive quality health care. To do that we must streamline Medicare's requirements, bring openness and responsiveness into the regulatory process, and make certain that regulatory and paperwork changes are sensible and predictable.

I also am aware that these issues are extremely important to you, Chairman Baucus. I know that you and the Committee have spent a great deal of time working with CMS, especially Administrator Scully, as well as your colleagues in Congress, to help make Medicare a better business partner for providers. We appreciate all of your work in this important effort, and we look forward to our continued partnership with you, Congress, and the physician and provider community to improve Medicare.

BACKGROUND

This year, Medicare will pay approximately $240 billion for the health care of nearly 40 million beneficiaries, involving nearly one billion Medicare claims from more than one million physicians, hospitals, and other health care providers. CMS strives to ensure that

Medicare pays only for the services allowed by law, while making it as easy as possible for qualified health care providers to treat Medicare beneficiaries. We have to carefully balance the impact of Medicare's laws and regulations on physicians and other providers with our accountability for billions of dollars in Medicare payments.

Medicare's requirements, as outlined in the law, generate many of the concerns that your constituents bring to your attention and to mine. Of course, there is a genuine need for clear rules in a program this large and complex. But rules should exist to help, not hinder, our efforts to assist seniors and the disabled, help control costs, and ensure quality, while remaining consistent with our obligation and commitment to prevent fraud and error. When regulations, mandates, and paperwork unnecessarily hinder the services providers are trying to give, those rules should be changed. And so CMS is working to reform the way Medicare works, making it simpler and easier for everyone involved. We are listening closely to Americans' concerns and learning how we can do a better job of meeting patients' and providers' needs to serve beneficiaries in the best way we can. In many areas, we can be less intrusive to the providers who participate in Medicare and more responsive to the beneficiaries who depend on Medicare.

IMPROVING AGENCY RESPONSIVENESS

Since Secretary Thompson and Administrator Scully began their work last summer, one of their major goals has been to reform the way Medicare does business while ensuring accurate and timely payments to providers and preserving our ability to collect overpayments and pursue fraud. We already have taken aggressive steps to raise the service level of the Medicare program and bring a culture of responsiveness to the Agency. These are not hollow words: creating a "culture of responsiveness" means ensuring high-quality medical care for beneficiaries, improving communication with providers, beneficiaries and Congress, and redoubling our education efforts. To promote improved responsiveness, the Agency is:

- ***Sponsoring Open Door Policy Forums*** to interact directly with beneficiary groups, plans, physicians, providers, and suppliers, to strengthen communication and information sharing between stakeholders and the Agency. Currently, we have 11

forums, and they are open to all providers – rural, urban, small, large, for-profit, and nonprofit – and to the public. They allow outside groups to meet with senior CMS staff on a regular basis, most of them monthly, to bring to our attention those nagging problems that they encounter when dealing with the Medicare and Medicaid programs. We have had overwhelming success with well over 4,100 attendees participating in person or calling in to more than 50 of these meetings since late last year. In fact, just this month we have had 11 meetings involving more than 700 public participants.

- ***Enhancing Outreach and Education*** to beneficiaries, providers, plans, and practitioners, by building on the current educational system with a renewed spirit of openness, mutual information sharing, and partnership. Last fall, we started by educating seniors through a $30 million advertising campaign to engage seniors in the program, combined with a massive enhancement of the 1-800-MEDICARE number. We have expanded the toll-free lines to 24 hours a day, seven days a week, and the information available by phone also has been enhanced so that beneficiaries can obtain specific information about the health plan choices and costs. The Agency also is developing and improving training for physicians and providers on new program requirements and payment system changes, increasing the number of satellite broadcasts available to health care industry groups, and making greater use of web-based information and learning systems across the country. We have also installed toll-free provider inquiry lines at all Medicare contractors.
- ***Establishing Key Contacts for the States*** at the regional and central office level. Paralleling the senior staff contacts for industry and beneficiary groups, these staff members are assigned to work directly with the Governors and top State officials to help eliminate Agency obstacles in obtaining answers, feedback, and guidance. Each State now has one Medicaid staff member assigned to their region, and another in Baltimore, both of whom are accountable for each State's specific issues. For Montana, the key contact is in my office, and has been working closely with all of the States in this region, including Montana.
- ***Responding More Rapidly and Appropriately to Congress and External Partners*** by promptly responding to their inquiries. We have developed an intra-Agency

correspondence routing system, and timeliness standards, to respond more efficiently and promptly to congressional inquiries. We also are exploring ways to make data and trend analyses more readily available to our partners and the public in a timely manner. In addition, CMS will make explicit, and widely publicize, the requirements for obtaining data and analyses from us, including protecting the confidentiality of the data.

EASING THE REGULATORY & PAPERWORK BURDEN

A culture of responsiveness alone will not alleviate the regulatory and related paperwork burdens that for too long have been associated with the Medicare program. Last summer the Secretary created an Advisory Committee on Regulatory Reform, which includes patient advocates, providers, and other health care professionals from across the nation. This Committee is helping guide the Secretary's efforts to streamline unnecessarily burdensome regulations and to eliminate inefficient regulations that interfere with the quality of health care for Americans. Providers should focus on patients, not on paperwork. And we recognize that these requirements can have a disproportionate impact on small providers who often do not have the resources that larger providers use to mitigate the effects of such burdens. Earlier this month, the Advisory Committee on Regulatory Reform held a field hearing in Denver, Colorado, where our regional office is located, to gather insights from consumers, doctors, health care providers, and businesses. Similar hearings have been held in Miami, Pittsburgh, and Phoenix. This is one way the Secretary is reaching outside of Washington, D.C. to hear from patients and the providers who care for them. The input gathered at these hearings is helping the Committee develop recommendations both to change specific regulatory requirements and to develop broader reforms. This group is determining what rules need to be better explained, what rules need to be streamlined, and what rules need to be dropped altogether, without increasing costs or compromising the quality of health care services.

To support this initiative, we have developed a program at CMS, focusing on listening and learning, to get us on the right track. For example, Administrator Scully personally travels around the country, meeting with and listening to literally thousands of providers,

suppliers, physicians, beneficiaries, and others who live and work with the regulations we create, so he can hear their concerns and better understand the changes we need to make. I know he met with you, Mr. Chairman, last August, and enjoyed talking with providers at the Billings Deaconess Clinic about the needs of Montana rural health care. So far he has had 22 of these town hall meetings with CMS constituents, most of them with their Members of Congress, and he is conducting three more as we speak today. Additionally, health care providers have been working with members of CMS headquarters staff to provide a more thorough awareness of Medicare's impact. The CMS staff spend several days with providers in their offices, learning about their practices, understanding their daily challenges, and seeing how Medicare's rules and regulations affect their ability to serve patients.

We are listening and we are learning. But we are also taking action. We are committed to making common-sense changes and ensuring that the regulations governing our program not only make sense, but also are plain and understandable. Let me give you a specific example. Recently, a physician assistant here in rural Montana raised a concern with our implementation of the statutory prohibition on paying physician assistants directly. Some of our contractors found our guidance on this issue confusing and were denying payment to any physician practice or practice management group that had a physician assistant as an owner. Because of that confusion, this physician assistant was unable to have an ownership interest in the physician group in which he practiced. We understood and agreed with his concern, and we agreed to look into it. As a result of this review, we issued a program memorandum to our Medicare carriers, effective April 1, 2002, clarifying our policy. Now, if State law permits a physician assistant to have an ownership interest in a medical practice or practice group, our policy is to reimburse the practice notwithstanding the physician assistant’s ownership.

In another example, at one of our open door meetings, a group of durable medical equipment (DME) suppliers aired their concerns about paperwork burden. After reviewing their concerns, we put together a high-level group of DME suppliers, CMS policy staff, and the private contractor DME carrier medical directors, to work through

their concerns. We are in the process of doing the same thing for small home health agencies and orthotic and prosthetic suppliers. We have a meeting scheduled for June 27 with DME suppliers, suppliers of prosthetics and orthotics, DME Regional Carrier medical directors, and CMS staff to hammer out a solution to their concerns. Our goal is to solve problems quickly. We have taken a number of other positive steps, including:

- Sending a letter to our state surveyors and regional offices clarifying once and for all the requirements that a home health "branch office" has to meet to be designated a branch office under the Medicare program. Specifically, we have clarified that mileage alone will no longer be the sole criterion for determining a branch office's status. This guidance will end misinterpretation of this policy by state survey agencies, and is especially important in large, rural states such as Montana where it is quite common for a home health agency to have a branch office.
- Writing articles for several clinical journals clarifying the scope of Medicare's hospice benefit. We want to ensure that physicians and hospitals understand that we will not sanction them if they appropriately use their best clinical judgment to determine whether a patient will qualify for hospice care.
- Announcing that critical access hospitals will no longer be required to complete the MDS for "swing bed" patients: since we don't need the data for quality or financial purposes, and it makes no sense to make our critical access providers continue to collect it.
- Reducing the paperwork burden on hospitals by shrinking the size and scope of the Medicare cost report. There is a statutory requirement that, for payment, hospitals report their overhead for old capital costs and new capital costs. These forms are long and burdensome, and we are eliminating some reporting requirements and doing away with unnecessary questions. By 2004, the cost report will be even shorter than it is now.
- Working with our hospital contractors to immediately implement key payment provisions of the BBA for critical access hospitals.
- Changing the rules so that the Medicare Secondary Payer form only has to be completed every 90 days. Hospitals have repeatedly complained about the Medicare

Secondary Payer form and the requirement that it be completed for patients with secondary insurance coverage time and time again.

- Reforming EMTALA is one of the things we have heard loud and clear in our open door meetings and in the Secretary's regulatory reform task force. This is an especially important concern for rural hospitals that may have difficulty staffing a traditional emergency department 24 hours per day, 7 days a week. Some of the changes that we've proposed are a clarification of where EMTALA applies; we've proposed to clarify that it generally does not apply at off-campus entities such as a physical therapy clinic on the hospital's license. We also clarified that, in general, EMTALA does not apply to stabilized inpatients. We also proposed to modify the rules dealing with hospital-owned ambulances to permit a hospital-owned ambulance to comply with local or regional EMS protocols.

We believe that our outreach efforts, which led to changes like these, will go a long way in alleviating providers' fears and reducing the amount of confusion and paperwork that, in the past, has all too often been an unnecessary burden on providers.

In addition to these efforts, we are taking concrete steps to streamline Medicare's regulatory processes. We have developed a Quarterly Provider Update of all changes to Medicare that affect physicians, and other providers, to make it easier for them to understand and comply with Medicare regulations and instructions. The Quarterly Provider Update contains a list of all regulations we expect to publish in the coming quarter, as well as the actual publication dates and page references to all regulations published in the previous quarter. The Quarterly Provider Update also generally includes all program memoranda, manual changes, and any other instructions that could affect providers in any way. Additionally, we are publishing all of our regulations monthly, usually on the fourth Friday of each month, barring any extenuating circumstances, such as meeting statutory deadlines. That way, physicians and providers do not have to sift through pages and pages of the Federal Register – or pay someone to do it for them – for proposed rules, regulations, and other changes that may affect them. Furthermore, in an effort to make updated regulations more readily accessible, we routinely post them on our

website, www.cms.gov. These postings coincide with the display of these documents in the Federal Register and have been well received by providers and other interested parties.

These changes provide predictability and ensure that physicians and other providers are fully aware of Medicare's changes so they have time to react before new requirements are placed on them. Secretary Thompson and Administrator Scully have been clear: we need to be more responsive to the people who participate in our programs, and our efforts to reduce paperwork burdens on health care providers are just one way that we are trying to do that. In the months ahead, the Secretary's regulatory reform task force, the Open Door initiative, and our other, similar administrative initiatives that we have ongoing will accomplish much, much more. Through these efforts, we are taking administrative action where we are able, and we want to work closely with this Committee and your constituents in the provider community to better understand their needs and to improve our working relationship with them.

IMPROVING PHYSICIAN AND PROVIDER EDUCATION

As part of our efforts to reinvigorate the Agency and bring a new sense of responsiveness to CMS, we are enhancing our provider education activities and improving our contractors' communications with physicians and providers. The Medicare program primarily relies on private sector contractors, who process and pay Medicare claims, to educate physicians and providers and to communicate policy changes and other helpful information to them. We have taken a number of steps to ensure the educational information our contractors share with physicians and providers is consistent, unambiguous, timely, and accurate.

We recognize that the decentralized nature of our educational efforts has, in the past, led to inconsistency in the contractors' communications with physicians and providers, and we have taken a number of steps to improve the process. We have centralized responsibility for CMS's educational efforts in our Division of Provider Education and

Training in Baltimore, whose primary purpose is to oversee and coordinate contractor education efforts with national educational activities regarding Medicare policies. We have also implemented several "train-the-trainer" programs for our Medicare contractors on new Medicare policies such as a revised payment methodology for swing beds. These programs include in-person instruction and a standardized training manual for the contractors to use in educating physicians and other providers, thereby ensuring consistency so that our contractors speak with one voice on national issues. We are continuing to refine our educational programs on an on-going basis by monitoring the training sessions conducted by our contractors.

On a national basis, we are providing free information, educational courses, and other services, to physicians and providers through a variety of advanced technologies. We are:

- ***Expanding our Medicare provider education website***, www.cms.gov/medlearn. The Medicare Learning Network homepage, MedLearn, provides timely, accurate, and relevant information about Medicare coverage and payment policies, and serves as an efficient, convenient provider education tool. The MedLearn website averages over 125,000 hits per month, with the Reference Guides, Frequently Asked Questions and Computer-Based Training pages having the greatest activity. I encourage you and your physician and provider constituents in the audience today to take a look at the website -- it really is a wonderful tool. We also want to hear feedback from you and from your constituents on its usefulness so we can continue to strengthen its value. In fact, physicians and providers can email their feedback directly to the MedLearn mailbox on the site.
- ***Providing free computer and web-based training courses*** to doctors, providers, practice staff, and other interested individuals can access a growing number of web-based training courses designed to improve their understanding of Medicare. We also have them available on CD-ROM for those who may have computers but not Internet access. Some courses focus on important administrative and coding issues, such as how to check-in new Medicare patients or correctly complete

Medicare claims forms, while others explain Medicare's coverage for home health care, women's health services, and other benefits.

- ***Establishing electronic newsletters*** on priority initiatives. These listservs have enabled us to keep thousands of subscribers informed about the latest Medicare changes, we expect to continue this practice for future initiatives. We also are investigating the feasibility of developing a new system to capture, compile, and index frequently asked questions, so we can make these available to more clearly communicate our regulations to physicians and providers.

We also recognize that, often, rural providers face unique challenges in caring for Medicare beneficiaries. That's why we recently began a concerted effort to target the Medicare educational needs of rural providers. We plan to develop a provider survey to identify specific rural educational and informational needs. We also are looking into installing satellite dishes at all Indian Health Service facilities to increase access to distance learning programs. We plan to develop a rural health website on our MedLearn webpage, and we are working to enhance our outreach to rural health provider associations, as well as individual rural facilities, to establish a grassroots education and information network.

We also are working to improve the quality of our contractors' customer service to physicians and providers. Last year, our Medicare contractors received 24 million telephone calls from physicians and providers, and it is imperative that the contractors provide correct and consistent answers. Now that we have toll-free call centers at all Medicare contractors, the need is even more pressing. In the past, we have had problems with our contractor call centers and we are taking significant steps to correct them. We have performance standards, quality call monitoring procedures, and contractor guidelines in place to ensure that contractors know what is expected and so that we can be satisfied that the contractors are reaching our expectations. Last year, for the first time, Medicare contractors' physician and provider telephone customer service operations were reviewed against these standards and procedures separately from our review of their beneficiary customer service. During these weeklong contractor

performance evaluation reviews, we identified areas that needed improvement and best practices that could be shared among our other Medicare physician and provider call centers.

We want to know about the issues and misunderstandings that most affect provider satisfaction with our call centers so that we can provide our customer service representatives with the information and guidance to make a difference. So we have reviewed and made significant changes in the wording of monitoring criteria and in the weighting of segments of our contractor performance scorecard to increase its relevance for monitoring provider calls. The scorecard was tested late last year, and implemented nationally in December 2001. It helps us to measure skills that are common to all customer service operations, as well as accuracy and completeness of information specific to CMS. This allows is to more appropriately direct our coaching sessions so providers get the best customer service we can provide. Additionally, via our Satellite Learning Channel, which we launched in November 2001, we provide Medicare contractors with the latest information on contemporary topics of interest. We have installed a network of satellite dishes at all contractor call centers to improve our training efforts with contractor customer service representatives. In addition, we are holding regular meetings and monthly conference calls with call center managers to ensure customer service practices are uniform in their look, feel, and quality.

In addition to monitoring call centers, we have established requirements for the features and content of contractor websites that give providers and suppliers timely and understandable Medicare program information. We now require all Medicare contractor provider/supplier websites to contain:

- all bulletins/newsletters;
- a schedule of upcoming events (seminars, workshops, fairs, and the like);
- on-line registration for contractor-sponsored events via the website;
- features which permit providers to order and receive copies of bulletins;
- a quarterly listing of provider frequently asked questions;
- search engine functionality;
- e-mail based support/help/customer service;
- a "What's New" or similarly titled section;

- an ability to link to other provider interest sites, and
- an area designated as the Medicare Learning Network, which will contain promotional material, supplied by CMS, as well as link to CMS' MedLearn and Best Practices websites.

In fact, most reports indicate that the provider websites were generally clearly presented, user-friendly, and contained an abundant amount of easily retrievable Medicare provider information.

This year, we have instructed our Medicare contractors to establish and maintain electronic mailing lists, listservs, for providers and suppliers. These listservs notify providers via e-mail of important and time sensitive Medicare program information, upcoming provider education and training events, and other announcements or messages necessitating immediate attention. Contractors also will use their listservs to notify providers about new contractor bulletins on their websites.

Just as we are using new technologies for our national provider education efforts, and are working with our contractors to improve their provider education efforts, we also are working directly with physicians and other health care providers to improve our own communications and ensure that we are responsive to their needs. For example, our Physicians Regulatory Issues Team (PRIT) continues to work closely with physicians to clarify our rules and find ways to reduce Medicare's burden on doctors. The team is led by a practicing physician, Dr. Bill Rogers, who experiences first hand the types of concerns that physicians have, and he is doing a great job of helping to address them and to more effectively educate doctors about Medicare's rules and regulations.

We also are taking other steps to communicate more effectively with providers. For example, we are reaching out to physicians and providers at their professional conferences. We recently established a National Physician and Provider Organization Exhibit Program designed to make CMS information available to physicians and providers all over the country at these conferences. And we are establishing plans for a customer satisfaction survey and focus group program. This will help us to do an even better job of obtaining physician and provider feedback on how we can be a better

business partner for them. We will continue to work collaboratively with you and the provider community to improve our communications so that, together, we can ensure that Medicare beneficiaries are able to receive the high quality care they need and deserve.

CONCLUSION

Physicians and other providers play a crucial role in caring for Medicare beneficiaries. We share their concerns regarding the program's regulatory and paperwork burden, and we are working hard to address them and bring openness and responsiveness into the process. We also must ensure that regulatory changes and requirements are sensible and predictable. The Secretary and Administrator are committed to this effort, and so are the rest of us at CMS. We want to be better business partners, and we appreciate your help in our improvement process. We look forward to continuing to work with Congress and we will continue to seek input from the health care community, our beneficiaries, and partners in reaching our goals. Thank you for the opportunity to come to Bozeman to discuss these issues with you today, and I am happy to answer your questions.