SCREENING MEDICARE CLAIMS FOR MEDICAL NECESSITY

HEARING

BEFORE THE

SUBCOMMITTEE ON HUMAN RESOURCES AND INTERGOVERNMENTAL RELATIONS

OF THE

COMMITTEE ON GOVERNMENT REFORM AND OVERSIGHT
HOUSE OF REPRESENTATIVES

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SCREENING MEDICARE CLAIMS FOR MEDICAL NECESSITY

THURSDAY, FEBRUARY 8, 1996

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HUMAN RESOURCES AND
INTERGOVERNMENTAL RELATIONS,
COMMITTEE ON GOVERNMENT REFORM AND OVERSIGHT,
Washington, DC.

The subcommittee met, pursuant to notice, at 9:12 a.m., in room 2247, Rayburn House Office Building, Hon. Christopher Shays (chairman of the subcommittee) presiding.

Members present: Representatives Shays and Davis.

Staff present: Lawrence J. Halloran, staff director and counsel; Kate Hickey, Robert Newman, professional staff; Thomas M. Costa, clerk; and Cheryl Phelps, minority professional staff.

Mr. SHAYS. I'd like to call this hearing to order. I apologize for being late.

This subcommittee's oversight of Federal health programs has focused on fraud, waste and abuse that undermine the integrity and threaten the solvency of both Medicaid and Medicare.

In our four previous hearings on the management of health care programs, we heard testimony from regulators and law enforcement officials expressing their frustration with a system that requires them to pay and chase scam artists and repeat offenders. All too often, Medicare pays a claim only to engage in an expensive and very frustrating chase to recoup improper payments.

We have also learned that while Medicare may process more claims electronically than the private sector, its 73 contractors do so using nine different, incompatible computer systems without the benefit of commercially available software to detect waste and abuse. As a result, Medicare too often pays claims that do not meet the required test of medical necessity. The technology capable of screening out claims for overused or inappropriate medical services is simply not used.

The purpose of this hearing is to determine why all Medicare contractors are not using this specific program safeguard more aggressively to check the accuracy and medical necessity of claims.

In response to the subcommittee's request, the General Accounting Office has analyzed the results of their survey of seven Medicare contractors to determine the extent to which automated claim screening could be used more widely. The results of their work indicate hundreds of millions of dollars could be saved if the Health Care Finance Administration, HCFA, focused more of its Medicare program integrity efforts on the use of this technology.

Incredibly, HCFA seems to be moving in the opposite direction. While more and more claims are flowing through the system, fewer and fewer claims are being screened.

Despite a 32.5-percent increase in claims and a $54 billion increase in outlays between fiscal years 1991 and 1995, medical review as a percentage of Medicare outlays declined from .15 percent to .08 percent. Program safeguard activities as a percent of Medicare contractor budgets also decreased.

The need for greater safeguards was dramatically underscored by this week's revelations about the performance of the Medicare Trust Funds in 1995. The hospital insurance, or Part A, trust fund unexpectedly ran a $35.7 million deficit, beginning its slide toward bankruptcy 2 years earlier than previous forecasted. And while the Supplementary Medical Insurance, or Part B, trust fund ended 1995 with $1.7 billion more than anticipated, the Medicare trustees in 1995 noted "with great concern" the explosive growth of Part B expenditures. They urged Congress to take additional actions designed to control SMI costs more effectively.

That is precisely what we are talking about today, controlling Medicare costs more effectively.

As a senior member of the Committee on the Budget and chairman of that committee's Medicare and Medicaid task force, I have worked throughout this prolonged budget process to restrain uncontrolled spending growth and save the Medicare program from insolvency and ultimate bankruptcy. When I say I, I mean this entire majority in Congress. Sadly, the administration has been virtually no help in that effort.

This week's ominous revelations should have given HCFA the sense of urgency it lacks, but that apparently is not the case. Two days ago we invited HCFA's chief actuary, Richard Foster, to testify today on the implications of the Medicare deficit. He declined to do so.

Let me assure the subcommittee that we will continue to investigate the impact of these alarming revelations, particularly as they affect the ability of HCFA and Medicare contractors to implement necessary program safeguards. We will invite Mr. Foster and other HCFA witnesses at a later date, and we obviously expect their full cooperation.

Some law enforcement authorities estimate that 10 percent, or $26 billion, in Federal health funds will be wasted or stolen this year. Others put the figure much higher. Our goal is to see that every available tool is employed to reduce these unconscionable and unsustainable losses. We appreciate the assistance of all our witnesses in that effort and we obviously look forward to their testimony.

At this time I would recognize Mr. Davis.

Mr. DAVIS. Thank you. I want to be very brief, Mr. Chairman, but I appreciate your holding these hearings. I don't think anything could be more timely in light of the announcement earlier this week that in fact the Medicare trust fund for Part A is running deficits higher than initially projected. Clearly the Medicare system is undergoing serious scrutiny. Dollars are running short. As we take a look at the baby boomers over the next decade becom-

ing of age to enter into the system, we need to be as wise as we can in spending every penny of tax dollars on this system.

In the town meetings I go to in my district before senior citizen groups and others, the first thing I hear is before you start touching our system, let's make sure that we've ferreted out waste, fraud, and abuse and let's start there. I think we're not credible in some of these other areas until we show that we're doing everything we can to make sure that a dollar spent is spent for the right reasons and spent for something that is justified under the law.

I think that an increasing Government investment in this program for safeguards can help control the Medicare costs, and I think whatever the outcome of the Medicare debate, however you end up slicing the banana, people want their Medicare dollars spent wisely. From all appearances it appears that HCFA and the Federal Government can do a better job, and maybe Congress can help in that regard. So today's hearings are to focus on the problems of wasteful overpayments and to help us recommend safeguards. I appreciate the opportunity to be here today and our witnesses for being here.

Mr. SHAYS. I'm very grateful you're here. I just want to say, since it should be obvious that there are two Republican members here and not the minority representation, that I will welcome some questions from the staff of the minority, Cheryl Phelps, if she wants to ask a question or two, because candidly the whole point of this is to learn. It's not to embarrass anyone; it's not to try to prove a point that shouldn't be made. I obviously think that we've got some serious problems, and I want to look at this and I want both sides of the aisle to be looking at this.

With that statement, I'm just going to get rid of some housekeeping and ask unanimous consent that the full testimony of anyone be put into the record and that any members as well as—any testimony they have can be submitted. So a statement—unanimous consent to have the full statement put into the record as well as obviously the transcript, and I would ask unanimous consent to keep the record open for 3 days.

With that, I would invite our Panel 1, Sarah Jaggar, Director of Health Financing and Policy Issues at the General Accounting Office, which is GAO, you're going to stay standing if you would because I'm going to swear you in. I welcome you here. Also you're accompanied by William Reis. Mr. Reis, I'll also swear you in as well because you may be giving testimony. Everyone in this committee is sworn in. If you both would raise your right hand.

[Witnesses sworn.]

Mr. SHAYS. For the record, note that both witnesses have answered in the affirmative. We welcome your testimony. Basically the GAO's testimony is what is launching this part of our hearing, this hearing and this part of our look at Medicare. You should feel free to make sure that everything is on the record.

STATEMENT OF SARAH F. JAGGAR, DIRECTOR, HEALTH FINANCING AND PUBLIC HEALTH ISSUES, HEALTH, EDUCATION, AND HUMAN SERVICES DIVISION, ACCOMPANIED BY WILLIAM REIS

Ms. JAGGAR. Mr. Chairman, Mr. Davis, Ms. Phelps, we're pleased to be here today to discuss how Medicare can avoid paying millions of dollars in claims for unnecessary services. My testimony is based on our report entitled "Medicare: Millions Can Be Saved by Screening Claims for Overused Services," which we are releasing today and which you requested.

Mr. SHAYS. If you could pull the mike just a little closer. Can you hear in the back of the room?

Ms. JAGGAR. With me to discuss our findings is Bill Reis from our Boston office who is in charge of this work.

In brief, in looking at six groups of medical procedures that accounted for almost $3 billion in Medicare payments in 1994, we found that many Medicare claims processing contractors routinely pay claims without using their computer to evaluate the patient diagnosis included on the claim to determine if that claim makes sense. For example, in one instance we found that Medicare paid a claim for an echocardiogram, which is an ultrasound image of the heart, when the diagnosis described only an inflammation of the patient's eyelid. If the seven claims processing contractors in our study had used autoadjudicated screens for all six groups of procedures we looked at, they would have ultimately denied payment for as much as $150 million in claims. This approach is easy to use and very low cost.

Let me use some charts, please, to explain how this works.

As chart 1 shows, and it's the chart most to the left, the 29 contractors who processed Medicare Part B claims may pay claims without question unless a computer screens the claims to determine if the claim is reasonable. In other words, if you follow the left-hand part of the chart, the claim can be submitted and can be immediately paid without any question or review of its reasonableness.

Claims are screened either manually or automatically when you follow the right-hand part of the chart. Obviously I would mention that manual review is time consuming and expensive. But autoadjudicated screening automatically approves or denies a claim on the spot without requiring manual intervention, comparing the diagnosis on the claim with the acceptable diagnostic conditions specified in a corresponding Medicare medical policy.

An example of that would be shown in the middle chart, which is chart 2. As shown in that chart, an autoadjudicated screen for echocardiograms would approve such a claim for a patient who has heart disease but would deny this claim for a patient whose only diagnosis was, for example, depression. Because this type of screen is entirely automated, contractors can review all the claims for a specific procedure inexpensively. As long as the contractor has developed policies setting out the medical necessity criteria, they can use such screens.

We surveyed 17 Medicare claims processing contractors and found that less than half were using computerized screens to check claims for the 6 groups of high volume procedures subject to over-

use in our study. For example, even though echocardiography is the most costly diagnostic test in terms of total Medicare payments, only seven of the contractors we surveyed used screens to review echocardiography claims.

Lack of this basic control had very expensive consequences. Had the contractors used autoadjudicated screens for all six of the procedures we studied, the contractors would have denied between $38 million and $200 million in claims, as shown in chart 3.

So you can see—I hope you can see over the edge of the podium—for five of the top six major procedures, the shaded part illustrates payments that would have been denied for five major procedures: Echocardiography, colonoscopy, chest x rays, YAG laser surgery and a duplex scan.

It's important to note that autoadjudicated denial of claims does not preclude ultimate payment of the claim if the service is appropriate. For example, if there is a miscoding on the claim as it is submitted, the billing physician can later resubmit the claim with additional or corrected information or else appeal the denial.

We should also remember that all 29 contractors can apply medical necessity screens for some of these procedures, not just the ones we looked at. Hence, if the use of autoadjudicated screens were expanded to all of Medicare's contractors, the savings we identified would likely be hundreds of millions of dollars greater for claims payments for services that should have been denied.

We believe that by using its national claims data base to examine national trends and develop a strategy for controlling payments for widely overused services, HCFA can save hundreds of millions of dollars. While HCFA has made some limited progress in this area by establishing contractor work groups to develop model medical policies for local use, HCFA had approved only one model medical policy at the time of our review.

Further, HCFA does not currently know which contractors use diagnostic screens and for which medical procedures. They do not know what medical necessity criteria are used in the screens or how effective the screens are in denying claims for unnecessary services.

In summary, we believe that HCFA should systematically analyze its national medical claims data base to identify medical procedures that are widely overused. HCFA should work with its contractors to evaluate existing medical policies and prepayment screens for widely overused procedures and to disseminate model policies and screens to all of its contractors.

Further, we believe HCFA should hold contractors accountable for implementing local policies and prepayment screens or for taking other corrective action to control payments for widely overused procedures.

Mr. Chairman, this concludes our prepared statement. We'll be plead to answer any questions you may have.

Mr. SHAYS. Thank you very much.

[The prepared statement of Ms. Jaggar follows:]

PREPARED STATEMENT OF SARAH F. JAGGAR, DIRECTOR, HEALTH FINANCING AND PUBLIC HEALTH ISSUES, HEALTH, EDUCATION, AND HUMAN SERVICES DIVISION, GAO

Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today to discuss how Medicare can avoid paying millions of dollars in claims for unnecessary services. The Congressional Budget Office estimates that Medicare costs of $162 billion in 1994 will spiral to $336 billion by the year 2002 unless costs are controlled. We believe that preventing payments for unnecessary services is an important way to help control costs, prevent the waste of program dollars, and help restore public confidence in the integrity of the Medicare program.

In the past year we have come before the Congress many times, describing how increasing the government's investment in program safeguards can help control Medicare costs. Some of the approaches could require substantial investments, but today we will focus on a program safeguard that is relatively inexpensive and easy to use with existing claims processing systems and that can be quickly implemented. This very basic safeguard, called an autoadjudicated (or fully automated) prepayment screen, can help control payments for some of the services most frequently billed to Medicare. More specifically, we will discuss why Medicare payments for unnecessary services are a problem, how autoadjudicated screens can save millions—even hundreds of millions—of dollars being wasted on unnecessary services, and what the Health Care Financing Administration (HCFA) can do to help prevent these payments.

Our comments today are based on our report, *Medicare: Millions Can Be Saved by Screening Claims for Overused Services* (GAO/HEHS–96–49, Jan. 30, 1996), which we are releasing today. Our work focused on Medicare spending for six groups of medical procedures that are susceptible to widespread overuse and should, therefore, be of concern nationwide to the contractors that pay the claims billed to Medicare. Four of these procedures—echocardiograms, eye examinations, chest X-rays, and duplex scans of extracranial arteries—are noninvasive diagnostic tests. The other two procedures are colonoscopy, which can be either diagnostic or therapeutic, and YAG (yttrium aluminum garnet) laser surgery, sometimes used to correct cloudy vision following cataract surgery. As shown in table 1, these six procedures accounted for almost $3 billion in Medicare payments in 1994.

TABLE 1.—MEDICARE SERVICES AND PAYMENTS FOR SIX MEDICAL PROCEDURES (1994)

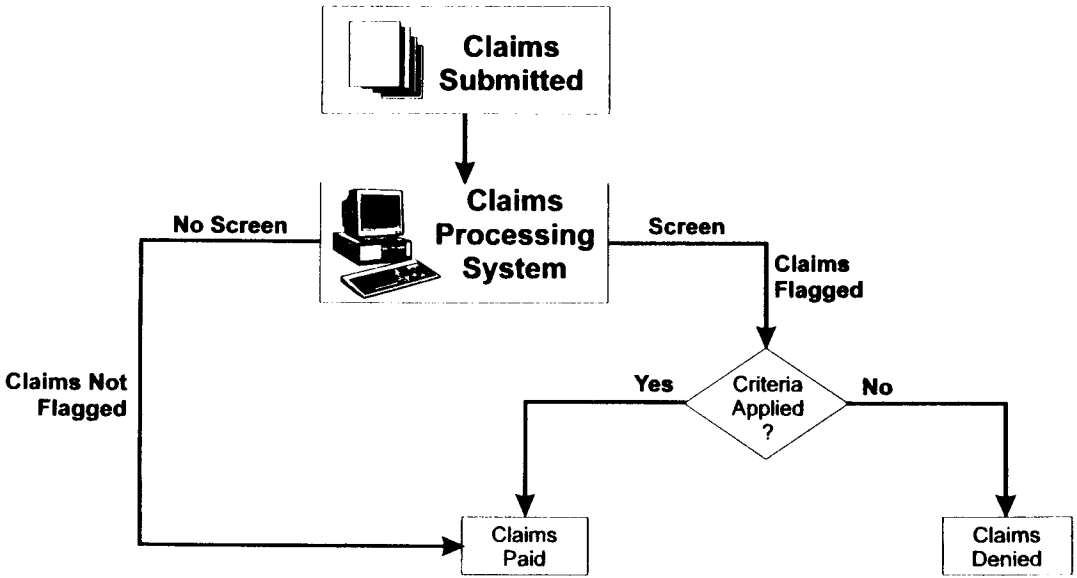
Procedure (procedure codes)	Medicare services (in thousands)	Medicare payments (in millions)
Echocardiography (93307, 93320, 93325, 93350)	8,976	$851
Eye exams (92002, 92004, 92012, 92014)	14,400	686
Chest X rays (71010, 71020)	34,597	507
Colonoscopy (45378, 45380, 45385)	1,416	478
YAG laser surgery (66821)	895	325
Duplex scan of extracranial arteries (93880)	1,513	143
Total	61,797	2,990

We selected those procedures because evidence from various studies shows that they are commonly used even when not warranted by medical symptoms. To determine the Medicare savings possible by greater use of autoadjudicated screens, we reviewed the Medicare claims paid by seven of the largest claims processing contractors. We estimated the claims they paid for services in 1993 that would have been denied if the contractors had used autoadjudicated screens.

In brief, we found that many Medicare claims processing contractors routinely pay claims without using their computers to evaluate the patient diagnosis included on the claim to determine if the claim makes sense. For example, in one instance we found that Medicare paid a claim for an echocardiogram—an ultrasound image of the heart—when the diagnosis on the claim was conjunctivitis (an inflammation of the eyelid). If the seven claims processing contractors in our study had used autoadjudicated screens for all six groups of procedures we looked at, they would have ultimately denied payment for as much as $150 million in claims. HCFA can and should work with its contractors to make greater use of prepayment screens to deny payments for unnecessary services and reduce the widespread overuse of certain medical procedures.

Chart 1

GAO Impact of Prepayment Screens



BACKGROUND

HCFA contracts with 29 firms to process Medicare part B claims.[1] As chart 1 shows, these contractors pay claims without question unless a computer screens the claims to determine if they are reasonable. Claims are screened in one of two ways: screening for manual review and autoadjudicated screening. Manual review by claims examiners is time-consuming and expensive, and funding for claims review has declined in relation to claims processed. HCFA required contractors to review only about 4.6 percent of all claims before payment in 1995—down from 15 percent in 1991. However, autoadjudicated screening automatically and immediately approves or denies a claim instead of flagging the claim for manual review. This sort of screen usually compares the diagnosis included on the claim with the acceptable diagnostic conditions specified by corresponding Medicare medical policy. As shown in chart 2, for example, an autoadjudicated screen for echocardiograms would approve such a claim for a patient with heart disease, but would deny this claim for a patient whose diagnosis was, for instance, depression. Because this type of screen is entirely automated, contractors can review all the claims for a specific procedure, and at far less cost than manually reviewing claims.

Chart 2.—Autoadjudicated screen

Patient: John Doe
Procedure: Echocardiogram
Patient Diagnosis:
    Depression (311)
Acceptable Diagnoses:
    Heart Disease (394.0)
    Valve Disorder (424.0)
    Heart Murmur (785.2)
    High Blood Pressure (416.0)
Action Taken: DENY CLAIM

Autoadjudicated screens are most effective for denying claims that do not meet very basic medical necessity criteria. Claims denied by these screens can be resubmitted by providers or appealed. Also, claims that pass these basic criteria may be further screened against more complex medical criteria to identify claims that warrant manual review. To screen claims for medical reasonableness, HCFA or the claims processing contractor need only develop specific screening criteria, a process referred to as setting medical policy. For example, some contractors have medical policies that specify the patient diagnoses that warrant an echocardiogram. Most medical policies are developed by contractors, then finalized after consultation with local physician advisory groups and publication of draft policies for comment.

WHY PAYMENTS FOR UNNECESSARY SERVICES ARE A PROBLEM

Controlling the alarming growth in Medicare spending has proven difficult, in part because the fee-for-service payment system that Medicare uses provides little financial incentive for physicians or patients to resist unnecessary diagnostic tests and routine services.[2] In addition, patients often lack the information and expertise needed to question the medical necessity of services ordered by physicians. Preventing such payments therefore calls for program safeguards that check the medical necessity of the services billed.

Some Procedures Are Vulnerable to Widespread Overuse

Evidence from studies by the Inspector General of the Department of Health and Human Services (HHS) and analyses by some claims processing contractors strongly suggest that certain high-volume procedures billed to Medicare are especially vulnerable to overuse. These procedures are frequently performed on patients who show few or none of the symptoms requiring such treatment. The six groups of procedures in our study are typical of such widely overused procedures. But despite the evidence that these procedures are widely overused, many claims processing contractors do not use the computerized screens that could prevent payment for these procedures when they are used unnecessarily.

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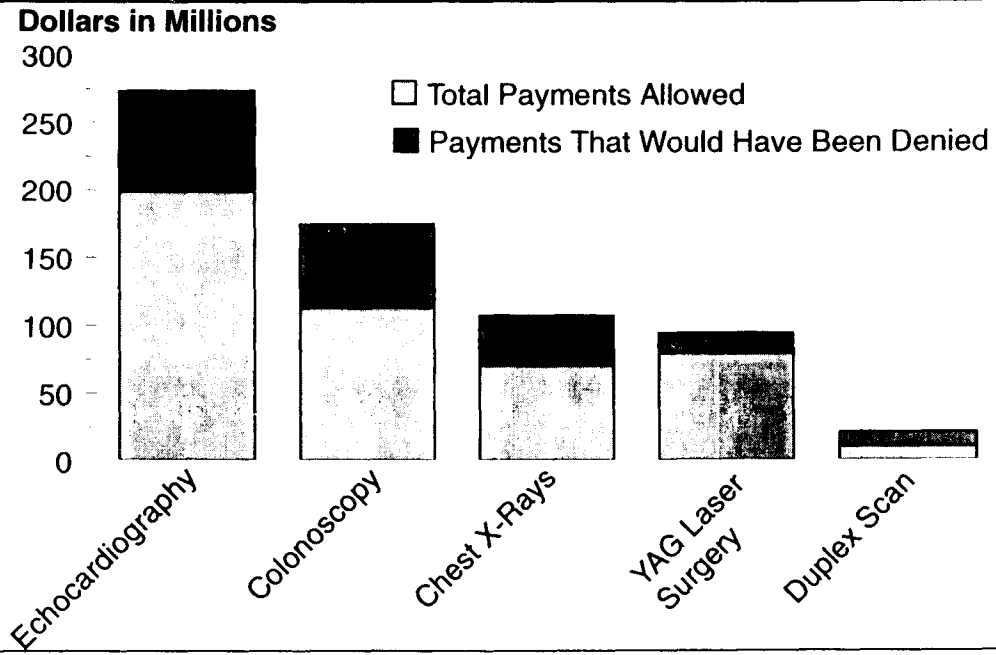
[1] Four additional contractors process Medicare part B claims for durable medical equipment.

[2] The Medicare fee-for-service payment system, which currently covers more than 90 percent of all Medicare enrollees, pays physicians a fee for each service they perform. In contrast, capitated managed care plans receive an annual fee for each Medicare enrollee, regardless of the number of services they perform.

Chart 3

GAO

Medicare Payments That Would Have Been Denied by Seven Contractors



Contractors Focus Primarily on Local Problems

HCFA requires contractors to use a process called focused medical review to help decide what claims to review. This process focuses on local overuse of medical procedures and is largely ineffective in controlling overuse that is national in scope. Contractors analyze the claims they have paid and identify procedures where local frequency of use differs from the national average.[3] Contractors then decide whether to develop a medical policy covering payment for that procedure and, if a policy is created, whether to enforce the policy with a computerized prepayment screen or to educate physicians to get them to conform to the policy.

Based on our survey of 17 Medicare claims processing contractors, we found that fewer than half were using computerized screens to check claims for each of the six groups of procedures in our study. The lack of this basic control had very expensive consequences. For example, even though echocardiography is the most costly diagnostic test in terms of total Medicare payments, only seven of the contractors we surveyed used screens to review echocardiography claims. Some contractors had developed screens for echocardiography because local use exceeded the national average, but others allowed unconstrained use of the procedure. At the same time, national use of echocardiograms increased from 101 per 1,000 Medicare beneficiaries in 1992 to 113 per 1,000 in 1994. This increased by 12 percent the national benchmark against which contractors compare their local utilization rates.

USE OF AUTOADJUDICATED SCREENS COULD SAVE MILLIONS

We tested claims that seven contractors paid for six groups of procedures to identify any payments that would have been denied had contractors used autoadjudicated screens.[4] In each case, we found that contractors used no medical criterion to screen claims for one or more of the six groups of procedures. Had they used autoadjudicated screens for these procedures, the seven contractors would have denied between $38 million and $200 million in claims. (Our estimate of the range of payments that would have been denied reflects the different diagnostic criteria used by those contractors who did have autoadjudicated screens for these procedures.) As shown in chart 3, most of the denied claims would have been for five of the six groups of procedures. For the sixth—eye examinations, not shown on the chart—less than $1 million in claims would have denied.

It is important to note that autoadjudicated denial of claims does not preclude ultimate payment of the claim if the service is appropriate. When claims are denied by an autoadjudicated screen, the billing physician can later resubmit the claim with additional or corrected information or else appeal the denial. Based on a limited analysis of claims denied by autoadjudicated screens, about 25 percent of the claims denied were ultimately paid. Assuming that our 25-percent rate is typical and that, as we have said, between $38 million and $200 million would have been denied by autoadjudication of claims in our review, then between $29 million and $150 million in savings would have been realized for the six groups of procedures we tested. However, all the claims in our review were paid by the seven contractors.

While these estimates involve only six groups of procedures and cannot be statistically generalized beyond the seven contractors included in our analysis, we should also remember that all 29 contractors—and not just the seven—focus their efforts on local rather than national overutilization problems. The 22 contractors not included in our tests may also lack medical necessity screens for some of these procedures and have likely paid millions of dollars in claims for services that should have been denied. Moreover, because autoadjudicated screens do not suspend claims for manual review, their use would not increase the workload of claims examiners.

WHAT HCFA CAN DO TO PREVENT PAYMENTS FOR UNNECESSARY SERVICES

By using its national claims database to examine national trends and develop a strategy for controlling payments for widely overused services, HCFA can save hundreds of millions of dollars. And while HCFA has made some limited progress in this area, by establishing contractor workgroups to develop model medical policies for local use, HCFA had approved only one model medical policy at the time of our review. Feedback from HCFA and the contractors' medical director steering committee on a draft of our report indicates support for more model medical policies.

HCFA also has a responsibility to monitor and evaluate its contractors' prepayment screens and other safeguarding efforts. Yet HCFA does not know which contractors have diagnostic screens for which medical procedures; what medical neces-

[3] Some contractors receive permission from HCFA to identify aberrant procedures using alternative methods, such as trend analysis.

[4] The claims we tested were for services provided in 1993.

sity criteria are used in the screens; or how effective the screens are in denying claims for unnecessary services. Without this information, HCFA cannot identify best practices and promote such approaches as autoadjudicated screens that can be cost-effective alternatives and complements to manual review.

HCFA officials told us that they are considering greater use of autoadjudicated screens in a new national claims processing system. However, full implementation of that system is scheduled for late in 1999. Meanwhile, HCFA continues to allow contractors to pay millions of dollars for services that may be unnecessary.

CONCLUSIONS AND RECOMMENDATIONS

Our report, which is being released today, identifies several strategies that HCFA should implement now to help prevent Medicare spending for unnecessary services. We believe that the following strategies can help the agency target and address Medicare's most significant payment problems.

First, HCFA should systematically analyze its national Medicare claims database to identify medical procedures that are widely overused. This would allow it to focus on screens that would identify unnecessary claims for these procedures. Second, HCFA should work with its contractors to evaluate existing medical policies and prepayment screens for widely overused procedures and disseminate model policies and screens to all of its contractors. Third, the agency should hold contractors accountable for implementing local policies and prepayment screens or for taking other corrective action to control payments for widely overused procedures.

Mr. Chairman this concludes my prepared statement. I will be happy to answer any questions you or other members of the committee might have.

Mr. SHAYS. This is kind of pretty straightforward stuff. It doesn't appear to be real complicated, but let me just be clear on some basic facts.

There are 29 contractors for Part B?

Ms. JAGGAR. Yes.

Mr. SHAYS. You looked at seven of them?

Ms. JAGGAR. We looked at 17.

Mr. SHAYS. Excuse me. You looked at—I'm sorry, what?

Ms. JAGGAR. Seventeen.

Mr. SHAYS. Of the 29.

Ms. JAGGAR. Right.

Mr. REIS. We tested claims from seven of the carriers, the contractors.

Mr. SHAYS. Just define the difference. You surveyed—I'm sorry.

Mr. REIS. We surveyed 17 to find out what prepayment screens they were using for the 6 procedures, specifically medical necessity prepayment screens. From our survey, we found that less than half of those 17 were using prepayment screens to look at these procedures for medical necessity.

Mr. SHAYS. Then there are basically 44 contractors who do Medicare Part A.

Can I draw any analogies in terms of Part A in terms of there is basically hospital cost and so on?

Let me just tell you where I'm interested in seeing. I'm interested to get a sense of the significance of the seven that you actually tested, and you said the amount could be a number up to $150 million. I'm just trying to extrapolate, and you haven't done that, and I'm first trying to understand why you haven't. So let the me just ask this. Of the 7 of the 29 that you really looked into after you had done your survey on the 17, were they the ones that appeared to be the most egregious?

Mr. REIS. We focused on the seven contractors that accounted for most of the claims filed for these six procedures, about 36 percent, I believe.

Mr. SHAYS. So of these 7 contractors of the 29, they did 36 percent of these types of claims.

Mr. REIS. That's correct.

Ms. JAGGAR. Yes, sir.

VOICE. They process——

Mr. SHAYS. Unfortunately you're not going to be able to unless I swear you in, so if you want to share your information with someone else, feel free to move a little closer if you want to whisper in someone's ear.

Ms. JAGGAR. In other words, of the total claims that were submitted, these seven contractors were responsible for the largest percentage, 36 percent. We took the seven largest.

Mr. SHAYS. Of the 17 or of the 29?

Ms. JAGGAR. Of the 17.

Mr. SHAYS. Fair enough. So we don't know about the other 12 in terms of——

Ms. JAGGAR. What we know about the other 12 is we know whether or not they had in place these screens, and that was the purpose of looking at the 17. I'm sorry that these numbers are confusing.

Mr. SHAYS. I'm looking at the gap between the 17 and the 29. You didn't survey those?

Mr. REIS. No, we did not.

Mr. SHAYS. So we don't know anything about them?

Ms. JAGGAR. No, we don't know whether or not they have these screens in use.

Mr. SHAYS. When the claim is submitted and the claim is processed, under this system someone would have to put into the computer the information for the application, or can you just stick the application through the system and it would automatically pick the data?

Ms. JAGGAR. When the carrier develops a medical policy, which is a process that involves local involvement from the physician community, and that's a very important part of making sure that it is something that is going to be effective in that local community, thereafter they can—after it's approved and established, they can program into the computer what the screens are.

Mr. SHAYS. That's not what I'm asking. I'm asking, the claim is submitted. Does the claim physically have to be put into the computer, in that data, or is the application such that you can just—like a car card, just stick the card through and it automatically appears on the screen? Does it have a scanner to it?

Mr. REIS. About 70 percent of the claims are filed electronically. They come in on tape. So there's no paper involved at all.

Mr. SHAYS. So from that standpoint, there's no inputting that the contractor basically has to do. So it's just basically having this system.

Ms. JAGGAR. Right.

Mr. SHAYS. What would be the logic—why wouldn't every claim have to go through this process?

Ms. JAGGAR. The guidance that the contractors are given gives them discretion, which we think is not always inappropriate, to determine whether the performance in its local area is consistent with or in keeping with national averages. So, for example, perhaps

the number of beneficiaries who receive a particular kind of procedure on national average is 100 beneficiaries per 100,000, and so they might decide not to screen for that; in other words, in order to focus on something else.

Mr. SHAYS. I guess what I'm trying to understand is that if it's already done electronically, fed into the claim as submitted, and the contractor—why wouldn't that just be a gate which everybody has to go through?

Ms. JAGGAR. We're suggesting that HCFA take a much stronger role in regard to doing that.

Mr. SHAYS. I just need to understand, is there an extraordinary cost involved? It seems to me that it would just be established. Your claim doesn't get into the system before it goes through and automatically sorts out through this screening process.

Mr. REIS. For these types of procedures, the six we're talking about, I think you're exactly right. We cannot see any justification for not using an autoadjudicated screen.

Mr. SHAYS. Literally 100 percent?

Mr. REIS. Right. For other types of procedures, that type of screen may not be appropriate, a screen that, for example, requires a claims examiner to look at some additional documentation to determine whether it's appropriate or not. But for this type of screen, to these six procedures we can't see any reason for not having them.

Mr. SHAYS. We're not talking about the bureaucracy of it, screening out and automatically sending it back to the physician. It would then have to be manually checked or checked through another process. You've got a pretty simple system here. One goes that way and one goes this way.

Mr. REIS. This is about as basic as you could get.

Mr. SHAYS. I wish you could make it more complicated so we could feel we are more justified in doing this.

So that's the bottom line there.

In terms of your determination of the up to $150 million, how did you arrive at that number with the seven that you looked at?

Ms. JAGGAR. What we did was we selected the seven and then we ran the screens on the cases that the seven had processed. In so doing, we identified claims that had been paid that we think would have been screened out should the screens have been used. Because contractors have slightly varying screens, we used the screens of different contractors on each other, and that's why we have a range of costs that we identified up to $150 million.

Mr. SHAYS. Is the 150 everyone that the computer caught? Yes. And that's not feasible. It wouldn't be 150, because obviously some that the computer caught there could be justification.

Did you try to get into greater depth as to how many of those could be justified?

Ms. JAGGAR. The actual number that we came up with, the 150 reflects the estimate that we made after we adjusted for those that we think might have been——

Mr. SHAYS. So the computer basically screened——

Ms. JAGGAR. It would screen up to 200 million. We did an analysis to determine what the——

Mr. SHAYS. You screened out a total of 200 and your estimate was as high as 150 of those 200 could have been inappropriate?

Ms. JAGGAR. That's the upper range.

Mr. SHAYS. The upper range, right, but it's only 7 of 29.

Ms. JAGGAR. Right.

Mr. SHAYS. The problem that we have is that we are seeing—if we think 10 percent of Medicare and Medicaid—and we use this 10-percent number, and I think most people think it's pretty low—that's $26 billion, and I think there's an insensitivity to the fact that just with seven you can have $150 million, and because in Medicare and Medicaid we think in such large numbers $150 million is so tiny.

Ms. JAGGAR. Of course this is only six procedures. There are many, many other procedures which would be susceptible, as it were, to this kind of autoadjudication.

Mr. SHAYS. Let me go now if I could to Mr. Davis, and then I'm going to come back and then we're going to go to Cheryl.

Mr. DAVIS. I'm going to ask a couple of questions.

When we talk about savings, the paperwork, everything that is worked up didn't fit the criteria. Realistically—maybe we could describe some of the individual cases if you have them, but is this the fault of the doctors or hospitals in some cases not doing the appropriate paperwork, that if it were kicked back this could have been justified and we have just not asked for enough paperwork from some of the medical providers?

Ms. JAGGAR. There are instances where it could be a situation where people are—it's just simply a mistake. It can be a situation where the person who was filling out the claims documents was not recording things properly, perhaps needed additional training. However, we think that the result of our analysis showing that of the claims that are resubmitted after initially being denied, only about 25 percent of those are approved indicates that there are some problems here that need further looking into.

For example, we found an instance where a chest x ray was paid for a patient with a diagnosis of injuries to the hand and the wrist. You can't quite understand why. Or an echocardiogram was paid for a patient with a diagnosis of chronic conjunctivitis, a disease of the eye. Another, a therapeutic colonoscopic examination was paid for a patient with a mental health diagnosis of hysteria. So there are disconnects like that which don't seem logical and do indeed make you wonder what the basis is for it.

Mr. DAVIS. Your kind of off the cuff estimate is that maybe ¾ of these claims that are kicked back couldn't be rejustified?

Ms. JAGGAR. Yes. Hopefully our estimate is more scientifically based than off the cuff, as we did run an analysis and look to see what the experience was with the resubmission of claims. It resulted in our estimate of about 25 percent of those that are resubmitted, of those originally denied, are approved upon being resubmitted.

Mr. DAVIS. This doesn't even get at the fact if somebody wanted to commit real fraud, they could of course put down other justifications that may not be justified. That of course is much more complex, but you're saying without a lot of work you can ferret out ¾ of those claims that are not justified.

Ms. JAGGAR. You could put down something that makes sense and would pass the screens. The screens are known. They are not meant to be a secret. It's important to recognize that physicians—this is an important part of the process of developing the medical policies, that they be known to the physician community, because of course the best thing would be to not have claims that would be denied because they didn't meet the criteria, that they were coherent, I guess, medically speaking.

Mr. DAVIS. Can you put a dollar figure on what we could save annually by the program we're talking about?

Ms. JAGGAR. We've not tried to do that.

Mr. DAVIS. I noticed that. I was wondering. We like to throw that around.

Mr. REIS. We did some very rough projections or extrapolations, not statistically projectable from these seven. But just looking at these six procedures and the volume of claims nationally, our rough guess would be about a half a billion dollars a year for these six procedures. And that is a very rough estimate.

Mr. SHAYS. Just the six.

Ms. JAGGAR. And these six account for about $3 billion a year total billings now.

Mr. DAVIS. You think these six. Are you more likely to have a higher incidence of mismatches here than you'd get in some of the other procedures?

Mr. REIS. Yes. The reason we selected these is that most of them are essentially noninvasive diagnostic tests. A couple of them are not. But they are very high volume, they are high on the list of procedures that are most commonly billed to Medicare, particularly echocardiography, chest x rays, duplex scans. They are noninvasive diagnostic tests that physicians frequently order.

Mr. DAVIS. Is another problem maybe that we just haven't set a high enough standard in policing, and the other things we do for physicians, that the people who are filling these out—it's not physicians in many cases but the staff member—that we've become so lax and they in turn become lax in terms of their paperwork and backup on this?

Mr. REIS. I think—if there's no screen in place, there's little incentive to get them to prepare the claims properly. If essentially the claims just sail through the system and a check comes out the other end, there's no feedback to somebody who may have made a mistake in filling out a claim form.

Mr. DAVIS. Let me ask one other question. How much incentive is there—because the reimbursement levels are low for Medicare in some areas. I will tell you in northern Virginia, there are some doctors who won't take Medicare patients because the reimbursements are much lower than they are for some of the HMO's and some of the managed care and fee-for-service plans.

Are you finding doctors trying to pad the bills, trying to find other justifications to do procedures so they can pay for what needs to be done that they're not getting properly reimbursed for?

Ms. JAGGAR. As you can tell, we didn't look specifically at that, but there are many reports of that tendency, of upcoding, I believe, frequently. It's certainly something that's worried about widely.

Mr. DAVIS. That's all of my questions, Mr. Chairman. Thank you.

Mr. SHAYS. The Medicare Transaction System that is not being used that often, when it is being used you determined that 25 percent of the time they then allow that claim to go through?

Mr. REIS. That's autoadjudicated screens. You said Medicare transactions? The MTS system is not yet in place.

Ms. JAGGAR. Not in place yet.

Mr. SHAYS. That's what I meant. And 25 percent is in fact.

The bottom line is when they screen out—when they screen out the system, how many of them are ultimately approved?

Ms. JAGGAR. When they have denied the claims for these six claims——

Mr. SHAYS. It hasn't been denied yet. When it goes in this direction instead of that direction, how many of them ultimately, when they manually review, are approved?

Mr. REIS. Autoadjudicated screens do not result in a claims examiner manually reviewing the screen.

Ms. JAGGAR. Unless it's appealed back, resubmitted.

Mr. SHAYS. I'm missing something pretty basic here. Out of my ignorance I'll learn something. When the claim is processed automatically, so when it is screened, it is then reviewed, correct?

Mr. REIS. For some types of screens. For an autoadjudicated screen, it is not reviewed, at least at the contractor.

Mr. SHAYS. I'm misunderstanding, then. I thought what it did is it flagged the claim and then you would go through the process. So walk me through that. I misunderstood.

Ms. JAGGAR. The process is that when it goes down the right-hand side and this screen is applied, where it says "criteria are applied"—if you use the words "criteria met," that would perhaps be better—the criteria are met, no, it's denied, and it's sent back as a rejection.

Mr. SHAYS. I made the assumption from your testimony that 75 percent were rejected; in other words, claims denied, and that 25 percent of the claims were paid.

Ms. JAGGAR. Actually I don't know that number. What I meant by the 75 percent is that of the claims that were denied when or if they were resubmitted, when someone said, hey, this wasn't right, then 75 percent of those were again still denied, 25 percent were paid. In other words, it might be an indication of the fact that there was simply an error, a coding error, and the person who was doing the coding did not——

Mr. SHAYS. I'm sorry I'm misunderstanding; obviously something hasn't connected with me on this. I made the assumption that in the screening process that all it did is it took a different route and then it was reviewed by the contractor. What you're saying is if it—in that initial screening, if it takes—is screened out, it goes back to the contractor automatically.

Ms. JAGGAR. It goes back to the provider.

Mr. SHAYS. Back to the provider.

Ms. JAGGAR. In fact, that's one of the great advantages of autoadjudication. I think hence the word "auto," which means that it's automatic. It does not require manual intervention on the part of the contractor, so it is a very efficient and not very costly way.

Mr. SHAYS. You could say it that way or you could say it's very bureaucratic. You could make the claim that a claim is submitted,

there is justification, and typical HCFA, typical contractor, it's just come right back to us. They didn't bother to look at it and if any idiot had looked at it more closely, they could realize it was this, this and this that justified the claim.

Ms. JAGGAR. You could say that. HCFA receives over 800 million claims a year and computers allow a lot of things to be done less expensively than by manual intervention. As you are well aware, the pressure on the HCFA budget has not relented in the past couple of years and this is a way to try to——

Mr. SHAYS. One thing on the chart that would be helpful to me, it would seem to me—and tell me where I'm just not seeing it clearly here—really you're saying that the claim goes through the processing system and if it's rejected it goes right back to the person submitting the claim. So rather than going to the right and down, it's going right back.

Ms. JAGGAR. The difference is that if you have on the left-hand side of the chart, no one would have screened it at all.

Mr. REIS. The computer wouldn't have.

Ms. JAGGAR. Right, the computer would not have screened it. So automatically the physician or whoever had submitted the claim would be reimbursed regardless of whether it was a chest x ray.

Mr. SHAYS. I understand that. We're not communicating and I'm sorry. All I'm saying to you is that in the screening process, without the screening process, it gets paid.

Ms. JAGGAR. Right.

Mr. SHAYS. We understand that. Walk me through. The claim is submitted, it comes to the processing system. OK. If it is rejected, if they have a system to screen it out, where does it go?

Ms. JAGGAR. If it is rejected, it goes back to the——

Mr. SHAYS. All I'm saying is that in this chart, I would have sent it right back to the claims—it's sent back. And the way I'm looking at this chart, the way I see it here, it implies that it comes back, that it isn't rejected. It's just put in a different area, and then the way it looks like in this chart, it's then reviewed by the contractor. That's why I'm confused.

Ms. JAGGAR. Sorry for the chart.

Mr. SHAYS. The bottom line is in this system, it goes back to the person submitting the claim and then they resubmit the claim.

Ms. JAGGAR. Right. Or they choose not to in a number of instances. But yes, that's what happens.

Mr. SHAYS. In this last part, it is fair to say, whether it's a half a billion a year, which you're then saying basically the high end could be ⅙ of all of those types of claims, is that correct? You're saying about $3 billion are submitted?

Mr. REIS. Again, that's a very rough approximation. Maybe we could switch to the chart on the far right for a second. For echocardiography there—again it relates only to the seven contractors—there are $273 million in echocardiography claims submitted. The percent that would have been denied by an autoadjudicated screen up there, the dark shaded area, that's 27 percent. That's about $75 million. On the next one, colonoscopy, it's about 35 percent been denied. That's a range.

Mr. SHAYS. I feel pretty comfortable assuming we are talking about hundreds of millions of dollars. What is the incentive for a contractor to adopt a system like this?

Ms. JAGGAR. HCFA has put in place a variety of requirements for the contractors. They provide guidance. Financially there's not an incentive that I'm aware of, but certainly the guidance and the direction that HCFA provides calls for this. In the end, I think contractors also are concerned about fraud, waste and abuse. The other aspect of it is by using an autoadjudicated screen, they can in many instances reduce the manual labor that's involved. We think HCFA should provide more incentives for the contractors.

Mr. SHAYS. The good part of management care, is that the managed care provider has an incentive to save money. I mean, if they pay out false claims, it's their loss. Does the contractor lose anything by paying out false claims?

Ms. JAGGAR. No.

Mr. SHAYS. There's no penalty for paying out false claims; there's none.

Is there obviously an incentive to reduce their cost—it strikes me I'm asking a question that's so obvious. I'll just tell you my reaction. My reaction is no incentive to save cost—excuse me, no incentive to catch fraudulent claims except wanting to get the bad guy, but no financial incentive. Are there some rewards? Do they get a certain percentage of whatever they reject?

Ms. JAGGAR. No.

Mr. SHAYS. When they have to submit—to your knowledge, when they have to submit, I'm assuming they bid for this?

Ms. JAGGAR. Yes. The contracts are bid.

Mr. SHAYS. And they bid based on price and service, too?

Ms. JAGGAR. There are of course many factors to consider.

Mr. SHAYS. I won't ask you for that. But I'm struck by the fact that any system that does not provide some kind of incentive to catch the people that are putting through fraudulent or just inappropriate claims, that any system that doesn't provide that is just a wasteful system. It's a no-brainer for me.

Ms. Phelps.

Ms. PHELPS. Thank you, Mr. Chairman, for the opportunity to ask a few questions on behalf of the Democratic members. I want to follow up on a point that Chairman Shays was making.

HCFA's primary responsibilities are prevention and detection, is that correct? For example, the prepayment screens would be used to detect and possibly prevent overpayment?

Ms. JAGGAR. Perhaps I would phrase it slightly differently, that HCFA's primary responsibility is to pay for medically necessary treatment in accordance with policies and good medical practice.

Ms. PHELPS. But in using the prepayment screens, their goal is to detect opportunities for fraud or unnecessary medical procedures?

Ms. JAGGAR. Yes. What their objective is, is to efficiently identify instances where the diagnosis and the procedure don't match and they don't make sense and thereby avoid paying for things that seem unreasonable.

Ms. PHELPS. However, if a contractor were going to deliberately upcode or, for example, for reasons of just making an error or put-

ting the wrong thing on the paper, those are two different types of actions. One is a deliberate fraud and the other is, oops, we made a mistake, and I guess a prepayment screen would be effective in catching that. But in terms of a fraudulent type of activity, would a prepayment screen catch fraud?

Mr. REIS. It's not likely that a prepayment screen would catch fraud if—let's say a physician knew that the patient's diagnosis was not heart disease but coded it as heart disease and heart disease was an appropriate diagnosis for use of an echocardiogram, then the claim would go through on an autoadjudicated screen.

There are other things that contractors can do to try and detect fraud and abuse. One is look at billing patterns, how often is this procedure billed, what is the growth and so forth.

Ms. PHELPS. So what's the role that enforcement is supposed to play in all of this? I understand that enforcement's responsibilities are shared across several agencies, including the HHS IG. So what role should enforcement play in catching some of this overutilization and inappropriate payments?

Ms. JAGGAR. We think that fraud and abuse detection needs to occur and does occur at different points throughout the system. We call some things upstream and others downstream. What you want to do is and what this is important for is to make sure that payments aren't made inappropriately at the outset as opposed to what the chairman referred to as the pay and chase approach, which is to say make the payments without consideration and then find out there's a problem, whether it be fraud or just a simple mistake, and going back and trying to recapture the money that's already been paid out. That's very expensive and not often very successful. In fact, the safeguard activities that are used in the Medicare program have been shown again and again to have about a 10-to-1 or an 11-to-1 return on investment, so that you save that much money throughout the system by having the prevention of the bad payments and then the pursuit of them after the fact.

Ms. PHELPS. How do you respond to HCFA's concern that autoadjudication is not appropriate in all cases?

Mr. REIS. I think we would agree with that. There are some procedures that simply looking at the diagnosis is not an indicator of whether or not that claim was medically necessary. A complicated procedure—for example, a justification for some procedures like eyelid surgery, the question arises, was this done for cosmetic reasons or was it for medical reasons. There may be additional documentation that a physician has to submit when he files that type of claim. The only way to know if that claim was appropriate is for someone to review that documentation. It would not be inappropriate to, if you will, program computerized criteria to approve or deny that claim.

Ms. PHELPS. Does HCFA have a policy for what the effective mix should be, of what should be manual, what should be electronic?

Mr. REIS. I think that's one of the things that should be on their agenda, and that is looking at procedures that can make greater use of autoadjudicated screens. I think it tends to be an underutilized type of tool.

Ms. PHELPS. I've got one last question, Mr. Chairman.

When did you—series of questions, I guess. What's the time period in which you conducted this study of their activities in this area?

Mr. REIS. Our overall review ended about November of last year. We looked at——

Ms. PHELPS. Ended in November 1995?

Mr. REIS. Yes, that's correct.

The claims that we tested had been paid in 1993, for services in 1993. Our survey of the 17 contractors was the last quarter of 1994.

Ms. PHELPS. So you surveyed the results of activities that took place in 1993 and the results came out in November 1995.

Did you have an opportunity to review any of the proposed initiatives that HCFA is undertaking to become more efficient in this area?

Mr. REIS. Yes, we have had. We've met with many of the contractor medical directors, we've met with HCFA staff and discussed some of their plans for the future. Those plans apparently do include greater use of autoadjudicated screens. We don't think it's necessary to wait for the MTS system to be fully implemented in 1999 to implement more of those screens now.

Ms. PHELPS. Do some of their initiatives jibe with your recommendations?

Mr. REIS. Yes, they do. As a matter of fact, I think the contracted medical director steering committee, after looking at our results and commenting on a draft of our report, agreed that they should develop model medical policies for these six types of procedures and encourage the contractors to use autoadjudicated screens for them.

Ms. PHELPS. So the recommendations that you made were based on the study—a snapshot in 1993, but were in fact—correct me, you can stop me if I'm wrong because I don't want to go down the wrong path.

Mr. REIS. We tested claims that were paid in 1993. Our survey of the contractors, what screens they were using and what screens they were not using was much more recent. There I think is still plenty of opportunity for the contractors to use autoadjudicated screens for at least the six procedures and perhaps many more.

Ms. PHELPS. In terms of your three recommendations, what is the gap between what HCFA is doing now?

Mr. REIS. It is a gap between what they say they are going to do and what has been done to date. For example, in model medical policies, at the time of our review they had approved one, I think.

Ms. PHELPS. How many now?

Mr. REIS. I don't know. The last I heard it was one. They may have approved some additional ones. We know the contractor medical directors are working on additional model medical policies. I don't know whether HCFA has approved them or not.

Ms. PHELPS. Thank you.

Mr. SHAYS. I am happy you asked the question. It has just triggered something. What I am wrestling with is the following: It was a snapshot in 1993. In other words, you looked at those claims. But your testimony is that today this adjudicated system is being used to process how many of the claims?

Mr. REIS. I do not know how many of the claims.

Mr. SHAYS. After you go through the system?

Mr. REIS. Again, we surveyed 17 contractors.

Mr. SHAYS. Just within the contractor. Did the contractor use it in every instance?

Mr. REIS. They were not using it—at least half of the contractors we surveyed were not using adjudicated screens at all for these six procedures.

Mr. SHAYS. OK. So it could even be worse?

Mr. REIS. Yes.

Mr. SHAYS. In other words, we could have more claims. The snapshot was 1993, but in 1996 we could have more of these claims going through, not less?

Mr. REIS. I expect that is the case.

Mr. SHAYS. It would probably be more?

Mr. REIS. I expect that is the case. I think there is an interest in——

Mr. SHAYS. This is what I want to ask you, but I am really going to be asking HCFA, or if they could be thinking about it for their answer. What I need to understand—in my simple mind it is saying to me, "You do not get the contract unless you have a system. You do not get to apply unless you have a system." If HCFA comes back and tells me, "Yes, but that increases costs umpteen amount," then that is interesting, and then you weigh the cost-benefit of that.

In other words, it seems to me a no-brainer. You cannot be a contractor unless you have a system that screens out these kinds of claims and forces the claimant to resubmit it or to justify it. That is the bottom line to what I am hearing of your testimony. That is what I will want ultimately—I need to know why that is not happening. When I was talking about the MTS system—this is the other whole issue of nine separate systems—and getting to one, we have had one hearing on it with Mr. Horn's subcommittee and concern that that system is not moving along the way we want. So this is—because maybe it is computers and we do not want to think about it, it does not get that kind of attention, but we are talking about hundreds of millions of dollars just in this area alone and not to mention all the other challenges that we've got. So I appreciate your report. You didn't make any wild claims. If anything, you probably understated them, but you have alerted us to something that this committee is going to definitely be working on in conjunction with other committees in Congress. Thank you very much.

Panel two, I would request if they would come up, and if they could remain standing while they are sworn in: Dr. John Kelly, chief medical officer of GMIS; and Nancy Boyer, president and chief operating officer, Equifax Analytical Services.

[Witnesses sworn.]

Mr. SHAYS. Dr. Kelly, we will start with you. Your full testimony will be in the record, and you are more than welcome to summarize or whatever.

STATEMENT OF JOHN KELLY, M.D., CHIEF MEDICAL OFFICER, GMIS; AND NANCY BOYER, PRESIDENT AND CHIEF OPERATING OFFICER, EQUIFAX ANALYTICAL SERVICES

Dr. KELLY. Mr. Chairman, it is a real pleasure to be here. You have my full testimony. I would like to make several major comments.

First, the kinds of problems which the GAO has identified in the Medicare program are also widespread in the non-Medicare program, which is part of the reason why, in every other aspect of the delivery of health care in this country, that whether it is the Medicaid program, CHAMPUS, private indemnity, HMO, managed care and the rest, why many of those different systems have put into place commercial software to review and analyze claims prior to payment to try to prevent unnecessary or incorrect payment.

There are a wide variety of different kinds of screens which those contractors use to evaluate claims. One of the activities which they look at is medical necessity, but that is but one of the whole array of kinds of review that they conduct. So the first message that I would like to just share with the committee is this kind of technology is currently available, widely used, and being effectively used to review claims prior to payment.

Second, although HCFA and the Medicare program has made progress in this area, it is our view that HCFA had lagged behind in taking advantage of the kinds of technology which is currently available and could be used to advantage in the Medicare program in exactly the same way as is occurring in every other aspect of health care outside of the Medicare program.

With that, we think that the kinds of findings that have been identified here really should identify a direction HCFA should look at and should put into place as a way to help to address payment of unnecessary services.

Mr. SHAYS. Thank you.

[The prepared statement of Dr. Kelly follows:]

PREPARED STATEMENT OF JOHN KELLY, M.D., CHIEF MEDICAL OFFICER, GMIS

I am John T. Kelly, M.D., Ph.D., Chief Medical Officer of GMIS Inc., headquartered in Malvern, Pennsylvania. GMIS develops medical decision support systems which enable health care organizations to manage quality, utilization, and outcomes, and control costs. GMIS' products include ClaimCheck, a comprehensive computerized auditing software system that automatically audits and corrects provider coding and billing errors.

ClaimCheck is currently used by over 150 organizations, including many of the largest commercial carriers, Blue Cross and Blue Shield plans, and HMO's. The majority of the Medicare Part B carriers use ClaimCheck in their commercial business operations. Several government entities, including OCHAMPUS, CHAMPVA, and eight Medicaid programs have licensed ClaimCheck. The General Accounting Office used ClaimCheck in a previous study of Medicare Claims: "Commercial Technology Could Save Billions Lost to Billing Abuse" (GAO/AIMD–95–135). The HHS Office of Inspector General used ClaimCheck in two studies of Medicaid claims.

The GAO report "Millions Can Be Saved by Screening Claims for Overused Services" (GAO/HEHS–96–49) makes various recommendations to help prevent Medicare payments for unnecessary services. The recommendations include proposals to analyze Medicare claims data to identify medical procedures that are subject to overuse, gather information on medical policies and prepayment screens for overused procedures, and hold contractors accountable for implementing policies, prepayment screens (including autoadjudicated screens), or other corrective actions to control payments for procedures that are highly overused.

As the Committee considers the above recommendations, I would like to note that many GMIS customers have implemented, or are in the process of implementing, activities consistent with these recommendations to prevent payment for, unnecessary services in their non-Medicare accounts. GMIS has developed various products which allow our customers to identify services that may be unnecessary and to prevent payment for unnecessary services.

More specifically, GMIS has developed computer software that enable GMIS and our customers to analyze claims data to identify the frequency and the cost of services. These data are used to identify services that may be overused or unnecessary. For example, substantial variations in the use of specific services (e.g., chest x-rays) may indicate that these services are overused. Overuse of specific services may be widespread among many providers, or overuse may be limited to a small subset of providers.

GMIS has also developed a product which identifies services that are unexpected for a given diagnosis and prevents payment for unnecessary services. For every diagnosis, a large number of different services may occur. Many of these services are expected (e.g., chest x-ray for a patient with pneumonia). However, for every diagnosis, many other services are unexpected (e.g., chest x-ray for a patient with a sprained ankle). The unexpected services for one diagnosis differ from the unexpected services for another diagnosis. As there are thousands of different diagnoses and thousands of different services, the number of potential combinations of diagnoses and services is large. GMIS has developed rules to identify services that are unexpected for a given diagnosis and incorporated these rules into computer software that enable customers to review claims prior to payment and identify claims for potentially unnecessary services.

The rules to identify potentially unnecessary services are one of the many categories of edits that GMIS includes in the ClaimCheck product to detect errors prior to payment. Other edits include:

1. Procedure unbundling
2. Mutually exclusive procedures
3. Fragmentation of an incidental procedure
4. Pre- and post-operative care
5. Split billing
6. Duplicate claim
7. Multi-channel laboratory
8. Cosmetic procedure
9. Age and sex conflict
10. Unlisted procedure
11. Assistant surgeon
12. Experimental/investigational procedure
13. Multiple visit
14. Outdated/obsolete procedure
15. Procedure modifier
16. Duplicate procedure
17. Multiple procedure reduction.

All of these edits may be used in the review of claims prior to payment, As the payment policies of health care organizations often differ, ClaimCheck customers may decide which edits to use, modify, or delete.

In a typical claim processing operation, data from claims are passed through the ClaimCheck software, which analyzes the claims according to the various rules in the ClaimCheck database. After identification of the claims which may need to be modified, ClaimCheck software returns instructions to the claim processing system that indicate how the claim should be modified. In instances in which a coding error is identified, the codes may be modified prior to payment. In instances in which a potentially unnecessary service is identified, the claim processing system may:

1 Deny payment of the procedure;
2. Suspend the claim for further review; or
3. Monitor claims for further action.

Through the use of ClaimCheck, GMIS customers are able to review and process claims in an accurate and efficient manner. ClaimCheck customers typically achieve savings of approximately 1 to 2% of total claims payments.

The use of commercial computer software to facilitate prepayment screening is widespread in the non-Medicare arena. The above GAO studies have shown that the unnecessary services, coding issues, and billing issues found in the non-Medicare arena also occur in Medicare. Although GMIS believes that the Medicare program has made progress in the use of computer technology to facilitate unproved claims review and claims processing, GMIS believes that the Medicare program lags behind the non-Medicare arena in the use of proven technology that assures accurate, ap-

propriate, and efficient claims payment. The prepayment screening performed in the non-Medicare arena is much more extensive than the prepayment screening currently conducted by Medicare carriers.

GMIS recognizes that the use of commercial pre-payment review software in the Medicare program may require modification to assure that the edits are consistent with Medicare coverage and payment policies. Existing commercial software can be readily modified to achieve this goal.

GMIS believes that the Medicare program would benefit from the use of commercial prepayment screening software that has been successfully developed and implemented in non-Medicare claims systems.

Mr. SHAYS. Ms. Boyer. It was so short. You were waiting to just kind of relax. You do not have to be as short.

Ms. BOYER. Thank you, Mr. Chairman, Mr. Davis, and staff. We appreciate the opportunity to testify today.

Mr. SHAYS. We appreciate having you here.

Ms. BOYER. In May 1995, I testified before the Senate Appropriations Committee on work that was performed at that time for the GAO. At that time, we identified and the GAO confirmed that, minimally, $2 million a day was being paid at that point for creative coding for Medicare Part B. That was $540 million ago, just to put it into perspective.

In the GAO study, only 8 of our system's 40 edits were used. Had the 40 edits been used, which represent over 6.4 million different code combinations that are embodied into a software program, including medical necessity, the potential savings would be well over $1 billion per year. To paraphrase the words of Senator Everett Dirksen, "$1 billion here, $1 billion there, pretty soon it starts to add up."

Mr. SHAYS. Is this $1 billion a year?

Ms. BOYER. Yes, sir, in Medicare Part B.

Just to give you just a bit of a background, I am president of Equifax Analytical Services. Prior to that, I was a nurse practitioner that specialized in gerontology, a hospital vice-president, and an HMO chief operating officer. In 1988, we started our company called HealthChex and were acquired in 1994 by Equifax. The whole purpose for the company was, very honestly, to get at system-intensive approaches to truly managed care. We really believe, and so do the 150 organizations that are currently our clients, that the majority of physicians are doing things correctly and, in fact, have documented evidence that at least 90 percent of them are doing things correctly. But, clearly, there is a lot of money that can be saved——

Mr. SHAYS. I hope so.

Ms. BOYER. They are. They are. We also believe that the patients and physicians are partners in the care process, and they must be supported with very strong information systems.

In the 1930's, when the Social Security Act was developed, no one could have probably possibly predicted the number of cases that would have been handled on an outpatient or physician office basis. It was assumed most care was going to come from the hospital side.

The Johnson era did have the foresight to recommend—and clearly these recommendations should be put into place today—that only services that are reasonable and necessary for diagnosis and treatment of a medical condition be paid for. Unfortunately, no

one could have estimated the number of human hours that until recently are required to comply with that recommendation.

I say that we are required, because very honestly, as Dr. Kelly has noted, what we find is that the private payers have recognized that expert systems and artificial intelligence on a prepayment basis can be used for all claims and still comply with Medicare rules and regulations. Unfortunately, the public sector has not kept up. The public sector continues to pay for human intervention, and obviously only the most egregious of claims are stopped prior to payment.

In developing our prepayment edits for medical protocol, we used protocols that are already existing, and they came from the American colleges, including the American College of Cardiology, among others, the Agency for Health Care Policy Review, and from our panel of 15 physicians that are considered to be "thought leaders".

Our experience echoes that of the GAO. We have concluded that for every Medicare recipient, an average of $62 is misspent just on overused and unnecessary medical services. This is outside of the upcoding and bundling, whereby we had identified $2 million a day. So, above and beyond that, $62 times 37 million recipients is what we are talking about for medical policy and medical protocol.

To equate the health arena with the general business world, physicians write over 1 million purchase orders a day. We call them the diary of health care, because there is no other way to look at how your dollars are being spent. Physicians submitted claims to not only give us the ability to determine the health of the individual but also find the 95 percent of the docs who are doing things correctly.

Of the 40 edits, as I mentioned, or the 6.4 million code combinations that are embedded in the software, the one that has been described earlier, the sonar EKG or the echocardiogram—I will not go into the details as far as our findings are concerned, but clearly $175 a pop is what the average cost is.

In our experience, medical protocol represents about 20 percent of all the claims that we deny. Of all of the claims that are submitted to our customers, our clients, on average, 7 percent of them are denied; and of the 7 percent, 20 percent are denied for medical protocol or medical policy.

To put it in an equation, to answer your question earlier with real-life experience, that is what we see. Of the 20 percent denied for medical protocol, what we are finding from our clients is that approximately 4 percent are overturned. In other words, the physicians then come in and submit some type of documentation that states that "I didn't have something in the patient claim that would have indicated the need for that particular service," so it is not a big turnabout. That is looking at submitting all claims through the software system.

I would like to conclude, and that is that we recommend HCFA obviously use—we recommend the use of commercially available review technology, but probably the most important thing is strengthening the payment policy and not changing the benefits. If, in fact, the private payers have already begun to do this with their medical communities and put standard payment policies in place, we strongly believe the same standardization should occur within

the Medicare side of the business. Good systems will give the payers and providers an opportunity to reduce the unit price of the diagnosis by giving comparisons of community and national costs.

HCFA has, and with the AdminaStar program now put into place at the beginning of the year, 84,000 possible code combinations. My grave concern to you today is the fact that if the commercial carriers—and Dr. Kelly as well—if we have over 6 million code combinations in place and the AdminaStar now is looking at approximately 84,000, the standard for the country is going to be dictated by HCFA; and, consequently, the tightness of the payment policies that have been put into place for the private sector are going to be diluted.

Again, I ask that we start looking at this, instead of decreasing benefits.

In conclusion, before mopping up the water, let's take time to fix the leak. Thank you.

[The prepared statement of Ms. Boyer follows:]

PREPARED STATEMENT OF NANCY BOYER, PRESIDENT AND CHIEF OPERATING OFFICER, EQUIFAX ANALYTICAL SERVICES

Mr. Chairman and Members of the Subcommittee on Human Resources and Intergovernmental Relations. My colleague, Catherine McCabe, our principal clinical liaison to the GAO, and I, thank you for the opportunity to testify today.

In May of 1995 I testified before the Senate Appropriations Committee on work that was performed for the GAO. At that time, we identified and the GAO confirmed that $2 million dollars per day is paid inappropriately for Medicare Part B claims. That was $540,000,000 ago. In the GAO study only eight of our system's 40 edits were used. Had the 40 edits been used, the potential savings would be over $1 billion per year. To paraphrase the words of Senator Everett Dirksen, "a billion here a billion there, pretty soon it adds up."

My name is Nancy Boyer. I am currently President of Equifax Analytical Services, a division of the Equifax Healthcare Information Company. Previously I was a nurse practitioner with a specialty in geriatric medicine, a Vice President for Patient Care Services and chief operating officer for a HMO in Rochester. My partner, Nancy Perkins, M.D., M.P.H., Ph.D., and I founded HealthChex, Inc. in 1988 and became a part of the Equifax Company in May of 1994. The focus of our company is to provide clinically intensive software and analytic services to the health insurance and managed care markets to control costs, track outcomes and improve quality. These systems and services are now in use by over 150 organizations nationwide. We founded our company on the premise that the majority of physicians are doing things right—billing and ordering services that result in appropriate care. We also believe that the physician and patient are partners in the care process, and must be supported with strong information systems.

In the 1930's when the Social Security Act was developed no one could have possibly predicted the numbers of procedures that would be performed outside the hospital—in physician offices. The Johnson era had the foresight to require that Medicare pay for "only services that are reasonable and necessary for the diagnosis and treatment of a medical condition." No one could have ever estimated the number of human hours that would be required to comply with Section 1842 requiring Medicare contractors to apply "safeguards against unnecessary utilization of services provided by providers."

Today private payors have discovered that expert systems and artificial intelligence can be used on a pre-payment basis to comply with the rules governing Medicare payments.

Unfortunately, the public sector has not kept up with the private sector. The public sector continues to pay for human intervention and thus, only the most egregious of Medicare claims are stopped prior to payment. In developing our pre-payment edits for medical protocols, we used protocols and guidelines from physician organizations such as the American College of Cardiology, who long ago recognized the need to monitor usage of certain procedures. We have also used the expert advice from the Agency for Health Care Review as well as our panel of 15 physicians considered to be "thought leaders" in their specialties.

Our experience in the application of medical protocols supports the recent GAO study. We have concluded that for every Medicare recipient, an average of $62 is misspent just on overused and unnecessary medical services. That is $62 times 37 million recipients.

To equate the health arena with the general business world, physicians write over one million purchase orders . . . per day. They are called insurance claims. We call them the diary of health care. Physician submitted claims not only give us the ability to determine the health of the individual patient, but also allow us to find the 95% of practicing physicians who are doing things right. These physicians do not stoop to creative billing or ordering practices—better known as waste—at the expense of the government and their patients. This creative billing is practiced by only 5% of the physicians and yet it represents millions of dollars that could have been saved. Identification of this type of fraud and abuse using only very basic payment denials is only one way that the GAO studied the problem. If we were to look at the other ways that dollars could be saved without cutting benefits we would be talking billions—or by our calculations, enough to cover the cost of system implementation in less than four months. This plus the administrative savings from paying the claims correctly the first time.

AUTO-AUDIT® is our software system designed to review physician claims for inappropriate billing behavior. It was used in the GAO analysis of Medicare claims processing. This fully automated expert system allows customers to identify and correct improper physician billing before the claim is paid. The system's forty edits, which cover over 6.4 million billing code combinations, can be easily and completely customized according to the specifications of the plan administrators. AUTO-AUDIT is fully automatic, and is installed as a sub-component of standard claims processing systems, eliminating the need to have claims processing personnel make complex medical decisions. The system supports complex diagnosis and context-dependent payments (common in Medicare). For all of these reasons, our physician claims review system is like having a Medical Director personally review and consistently decide how a physician claim should be managed before the claim is paid. Savings result both from the thoroughness and accuracy of the automated review as well as from the administrative savings achieved through automation.

The private sector has begun to put systems in place to track the physicians and other providers who are abusing the privilege of writing a purchase order to the government. The GAO has proven that these tools exist and Equifax, along with other vendors, can identify inappropriate billing behavior and to correct it before the claims are paid.

Of the forty editing rules imbedded in our system, only eight were selected for the demonstration analysis (performed on sample Medicare claims data). These eight areas were considered by the GAO to be the most clear cut demonstration of how these types of commercially available systems can be an asset in management of Medicare's physician claims. These edits and associated findings include:

Medical Protocol: One of the most powerful and clinically sophisticated edits incorporates the ability to identify medically unnecessary or clinically inappropriate services. This is accomplished by AUTO-AUDIT through its unique ability to compile a "patient record" made up of all claims much like a patient chart. This empowers the system to come to accurate conclusions about the medical necessity of a given service for that patient. For example, a common finding by AUTO-AUDIT was the inappropriate use of echocardiography. Diagnoses used to justify this service included: chest pain, fatigue, gall bladder disease, shortness of breath. None of these medical conditions is considered an acceptable reason for performing echocardiography by the American College of Cardiology.*

Echocardiography: 93307=$175 approximately 28% of all medical protocol findings were for this service at $175 per procedure.

In addition to savings from inappropriate services, we also identified savings from inappropriate compliance with payment policies.

Unbundling: According to the AMA, physicians are not allowed to bill for procedures which are incidental to the "major" procedure being done. For example, within the sample data reviewed by AUTO-AUDIT, a common problem was the billing of (and payment for) abdominal radiological procedure (CT scan) with pelvic radiological procedures; "glancing" at the pelvic area while performing the abdominal exam requires little more than moving the device down a few inches. A true pelvic study is only indicated when the need to thoroughly visualize the pelvic area is required, such as in the evaluation of widespread cancer. However, review of this data found that approximately 60% of the time, the diagnosis for such things was non-specific;

*"ACC/AHA Guidelines for the Clinical Application of Echocardiography", JACC Vol 16, No 7, 12/90: 1505–28. reaffirm. 1995.

for example, "abdominal pain," even when reviewing the patient's historical claims information for a qualifying condition.

72192 CT pelvis = $525
74159 CT abdomen = $650
Savings of $525, on average for each incident.

Fragmentation: Equally inappropriate is the billing for a procedure not by using the one procedure code which most accurately describes the service rendered, but by using several procedure codes individually, which when combined equate to the actual service rendered; this is often referred to as "a la carte" billing. For example, a common finding in this review was the individual billing for all the parts of a complete EKG instead of the one procedure code:

93225 EKG recording
93226 EKG analysis
93227 EKG interpretation
$70 total, on average.
93224 EKG complete should have been billed which pays $45, a $25 savings, on average.

Global Fee Period Violations: According to the Medicare Part B Answer Book and the Federal Register, payment for a surgical procedure includes all pre- and post-operative visits associated with that procedure. Our physician claims review system prevents paying for any of these services that are billed in addition to the surgical procedure. 20.7% of the potential savings were associated with this particular violation. For example, billing of (and payment for) post-operative visits after cataract surgery was frequently identified.

New Patient Code: Because new patients require more time to evaluate than a patient a physician has previously seen, visits for new patients to a physician are reimbursed at a higher rate than established patients. However, according to the Medicare Part B Answer Book, a patient is new to a physician only once every three years for a given patient seeing a given physician. Our system prevents multiple payments for new patient codes within the specified time frame.

Assistant Surgery: Many surgical procedures are not complicated enough to warrant an assistant surgeon's help. For example, removal of an ingrown toenail is a fairly routine procedure, and assistant surgeon services are not warranted. HCFA has clearly identified those procedures for which it will pay an assistant surgeon. Generally, the carriers did very well in this particular area and this is indicative of some of the successes HCFA has experienced with uniform payment policies.

Our company's AUTO-AUDIT system is used by 150 clients nationwide. These clients include third party administrators, insurance companies, managed care plans, and physician/hospital groups who use the software to manage their physician payments. These organizations include CIGNA HealthCare, The Travelers Plan Administrators, HMO Oregon, Lifeguard HMO, California Health Partners, Pacificare of Washington, the American Postal Workers Union, Harris Methodist Health Plan, and Managed Care Management of Honolulu.

Physician involvement in the creation of this software has been extensive. Not only does the company currently employ 4 nurses and 2 physicians full time, but a fifteen member Physician Advisory Panel has been extensively consulted in the development of the system. In addition, the payment guidelines published by the AMA in the annual Current Procedural Terminology Manual, the Medicare payment guidelines as published in the Federal Register, as well as the medical community's various payment guidelines and recommendations (e.g. American College of Cardiology), are incorporated into the system. All sources for the logic used in the AUTO-AUDIT system have been incorporated and referenced. The system's decisions are fully documented for its users.

Physicians also appreciate the documentation and consistency of decision making achieved with this software. Explanations of payment decisions can be automatically generated and sent with the physician's payment, thus ensuring full explanation of all decisions. Equifax Healthcare Analytic Services also provides a secondary review process, where claims in dispute may be reviewed by Physician Advisory Panel members. The system is so complete and accurate that this service is used only occasionally; current clients of the AUTO-AUDIT system report only a 0.07% appeal rate. Our system is routinely updated twice a year. These updates include incorporating changes made by the AMA and HCFA to the coding structure for physicians, and, separately, new reporting and clinical logic additions are made as warranted.

As stated earlier, in the GAO study, only eight of the system's forty edits were used. Had all forty edits been applied, the potential savings defined by the GAO would more than double. Typical savings in a commercial insurance plan where all edits are used range from five to eight percent of all physician billings. HCFA could

realize $350 million in savings (conservatively, based on only those eight rules used), and up to $1.5 billion per year using all forty edits at a conservative commercial rate of experience. Additional savings can be captured through effective case management, adherence to physician specialty protocols and case mix adjusted utilization management . . . all dependent on integrated systems.

There are three obstacles for contractors incorporating this software into the Medicare system: technical, financial and political. The solution to overcoming technical obstacles is relatively straightforward in that the data transfer to the AUTO-AUDIT software from the claims processing engine and back again would need to be programmed. This information transfer would include programming messages that would inform the physician of system decisions on his or her Explanation of Payments form. In addition, in cooperation with Equifax Healthcare Electronic Data Interchange (EDI) Services, the AUTO-AUDIT system will soon be available on the information superhighway as part of the claims clearinghouse business, while maintaining full patient confidentiality. In this application, claims screening would occur prior to the carrier receiving the claim. Claims that fail the editing system would be returned to physicians faster, information about these submitted claims would be forwarded to the responsible carrier, and a single system integration would be maintained and serviced. This application would result in significant administrative savings by reducing the volume of claims which are not accurate and currently are returned to the physician for correction. This eliminates the current requirement that the claim be handled at least twice, often more if the claim needs to be returned repeatedly for different reasons.

The financial obstacles should also be relatively straightforward to resolve since the return on investment to Medicare would occur within (approximately) the first four months after full implementation of the system. This investment would include both the integration programming and license fees for the first year. Alternatively, Equifax Healthcare Analytic Systems is willing to share in the risk of the installation, by accepting reimbursement on a percentage of savings basis. Under this scenario, the carriers would have to follow Medicare guidelines in order to avoid financial risk, and would be evaluated for performance.

The political obstacles to implementation relate to carrier autonomy. In the past, HCFA has allowed the contractors to establish their own payment guidelines for certain procedures, resulting in non-standard policies which are confusing to physicians and patients alike. Implementation of a sophisticated, computerized review system could allow payment policy standardization in this national plan, at the expense of carrier "control" and autonomy.

CONCLUSION

We recommend that HCFA mandate the use of commercially available physician review technology for the processing of Medicare Part B claims. The technology should be automated, and should free claims personnel from making complex medical decisions while trying to process claims "quickly." This requires that the system be fully and completely customizable, not only to meet current context-sensitive processing requirements which are Medicare specific, but also to ensure that the system operate according to pre-defined specifications which can and will be used as a national standard for payment policies. The funding for the software integration process should be recouped from savings resulting from the use of the system. Finally, and most significantly, this technology has a major impact on HCFA's current initiative to shift claims submissions and management into a fully electronic medium. Therefore, software like AUTO-AUDIT should be available in an EDI (information superhighway) environment within one year if the savings targets for the next seven years are to be realized.

The GAO believes, and we, as clinicians concur, that efficient and consistent medical review of physician claims represents an opportunity for HCFA and the government to achieve real savings in excess of not millions, but billions per year. Moreover, taking advantage of the EDI environment, spearheaded by HCFA, will result in an additional multi-billion dollar decrease in administrative costs. Accuracy in claims payment and speed of payment are not mutually exclusive. Right now there are inadequate incentives for contractors to scrutinize claims.

In addition to billing practices, ordering and other utilization behavior must be analyzed by case mix to determine genuine issues within physician activity. This profiling cannot be done without additional pieces being assembled in the Medicare puzzle.

Strengthening the payment policies rather than changing the benefits should be a mandatory requirement of the carriers especially given the fact that the same car-

riers, in concert with their respective medical communities, have already performed this task for their private insurance business.

HCFA was the leader of health care administration innovation, from electronic claims submission to the early recognition for the need for focused medical review. However, the private sector has continued the progress well beyond these initial innovations. The private sector is already using available systems to stop the labor intensive reviews. The private sector began the process of decreasing costs by using systems, not people, to prevent payment of the fraud and abuse plus other improper billing approaches that are used by some physicians. We believe that the current HCFA leadership, given the dollars involved and its resources and power, should lead the effort to streamline the cost escalation and realistically manage the necessary cost reductions over the next five years.

Good systems will give the payors and providers an opportunity to reduce the unit price of the diagnosis by giving comparisons of community and national costs. This instead of decreasing benefits.

Before mopping up the water, let us take the time to fix the leak. I thank you.

Mr. SHAYS. I wish you could think of another analogy, because I don't think it is just a leak.

The private sector has an adjudicated screen system for the most part. Would most HMO's?

Dr. KELLY. Many, in fact, have. Most parts of the private sector, in fact, use tools of this sort, Mr. Chairman.

Mr. SHAYS. You are both in the business. You both provide software to provide this. Are there hundreds of people in this business, thousands, tens?

Ms. BOYER. No.

Dr. KELLY. I think, to characterize what has happened here, Mr. Chairman, is that, years ago, every single organization that paid for services had a way of reviewing claims. What emerged over time in the development of Nancy's business as well as ours is the recognition that this is a highly sophisticated, complicated area in which keeping up with the rules, developing software to try to help implement the rules, was advantageous. What happened then over time is most of the major insurers, most of the major delivery systems, have outsourced this activity to specialized organizations who focus on this activity.

Mr. SHAYS. Like yourselves.

Dr. KELLY. Like ours. There are only a handful of companies like ours that develop these kinds of tools.

Our view is that even though Medicare has made progress and plans ultimately to implement certain kinds of evaluations of the way that the dance is described, our view is that they are moving too slowly and that they are also moving in a way which is not sufficiently comprehensive to take advantage of the kinds of technology which is available and also to do a much more in-depth look at claims prior to payment.

Mr. SHAYS. I am going to try to get through some basic things, though. We sometimes have hearings where it is kind of complicated—I mean, it seems like it is kind of complicated, and there are lots of explanations. This, to me, seems like a no-brainer. Therefore, I am wondering what I'm missing. I am going to ask you some questions that you may think don't make any sense but will help me.

So what you have told me is there are a few of you in this business and that you all know each other, pretty much?

Dr. KELLY. That's correct.

Mr. SHAYS. And, among yourselves, you can speak pretty aggressively with each other?

Dr. KELLY. That's correct.

Mr. SHAYS. If I was an HMO and I had to pay claims and if I paid the claims and I was paying bad claims and I was losing money, I would be very interested in making sure that I had a system that would weed out these bad claims. I would go to any one of the 6 or 10 or whatever number there are. If I went to you, how are you going to charge me?

Dr. KELLY. There are two things. First of all, Congressman, in the process of evaluating us, what we typically will do is run data for our organization and show them what kinds of payments they are currently making that are faulty and the savings they could achieve if they were to implement software such as ours. Those savings typically are in the range of 1 percent to 2 percent of their total claims payments.

Mr. SHAYS. The bottom line, whatever their total claims payments, you would take a percent of the total claim or the total that you rejected?

Dr. KELLY. No. What we would do, that is the level of savings. In terms of the business arrangement, what we—and there are different kinds of arrangements. The most typical one that we have is we license the use of the software to them, so they pay us a fee.

Mr. SHAYS. A fixed fee?

Dr. KELLY. A fixed fee, typically based on the size of their operation. Then they implement the software, and they achieve the savings.

Mr. SHAYS. Anything to add, Ms. Boyer?

Ms. BOYER. That is very similar to what we do for the GAO, to identify exactly where the potential savings are. But I think——

Mr. SHAYS. Very similar to what the GAO did, you say?

Ms. BOYER. Yes. But I think, in going back to the comment that you made earlier, having been on the other side of the business with paying claims——

Mr. SHAYS. You were a nurse.

Ms. BOYER. Yes, and I also ran an HMO. And, honestly, we were going for speed, not efficiency; speed, not efficiency; how fast the claims could be paid. Because then, if you go back to the Social Security Act——

Mr. SHAYS. Who is concerned about speed? I need to be clear.

Ms. BOYER. Our requirements for being able to participate in contractual arrangements are based upon how fast the claims are paid.

Mr. SHAYS. OK. That is how you are evaluated by your customers?

Ms. BOYER. Precisely. What is happening on the managed care side now is the recognition that it is not only speed but it has to be efficiency, which is why these systems have popped into place.

Mr. SHAYS. OK.

Ms. BOYER. Again, when you recognize and look at Medicare, it was primarily hospital claims. Now all of a sudden we have started to get heavier and heavier into more things done on the physician side, which makes it more difficult.

Mr. SHAYS. I think you get a sense, though, of where I'm going. So I'm a contractor. I'm not an HMO that is going to consider your services. I am a contractor working for HCFA. What incentive do I have to use your service?

Dr. KELLY. I think one comment first, Mr. Chairman, is that most of the contractors that are currently providing services for HCFA in the Medicare side in fact are already using these tools in their non-Medicare business. That is the first part. They are being used every day, all day, by the very same contractors under the same roof in their non-Medicare business. So, in fact, they have the systems in place; and they have the ability to implement them. That is the first thing.

Mr. SHAYS. That is a pretty outrageous thing you are saying. What you are saying is that, ultimately—what you are saying is that they ultimately have a system available, but they choose to use it where it is financially beneficial for them to use it—for them?

Ms. BOYER. It is not required that we are aware of.

Dr. KELLY. That is correct. In fact, what we are finding now is that many——

Mr. SHAYS. There has to be a reason, like you charge too much or something. Obviously, in the private sector, people have said, "You charge this but we get this benefit, so you are worth it." But under this incentive system or lack of incentive system that we have under the contractors working for HCFA, there is no incentive for them to do this. That is what it appears. I am going to learn from HCFA, but that is what it appears.

I will just ask you, what am I missing?

Dr. KELLY. I think, at least in our view, HCFA is moving forward with the process that you have evaluated previously in which there are plans to implement programs down the road in the future, when in fact our view is that those kinds of products are already available, could be used, are being used elsewhere, and so it is really because of a lack of will.

Mr. SHAYS. You say there are plans. The problem is that—and I am going to yield to Mr. Davis. The problem I have is that I think of the song in My Fair Lady. Instead of "words," I would say "plans, plans, plans, all I hear are plans," instead of "words, words, words."

Tell me what I am missing here. I'm trying to understand. I'm told that contractors don't want our Government to waste money, but there is a disincentive for you to use your services for HCFA. Is the disincentive the cost of your programs?

Ms. BOYER. Our average client has totally recovered every penny they have spent in less than 4 months.

Mr. SHAYS. But they don't give a damn.

Ms. BOYER. Well——

Mr. SHAYS. No, they don't. There is no incentive. Maybe there should be. Maybe there should be an incentive or maybe there should be a requirement that they use the service; and if HCFA does not like what you do, maybe HCFA should develop their own. I didn't recommend it. I just said maybe.

Mr. DAVIS. I think Mr. Shays is right. If you are a private contractor dealing with HCFA, it is an added cost to add this to your

Medicare side of it, and there is no commensurate gain for you, and there is no incentive on the part of HCFA to date that would make you do that because HCFA is not driven by the bottom line. Is that the answer——

Dr. KELLY. I think that is correct, which is that—you are absolutely correct. This would add—the licensing fees are a very small portion of it. There is implementation of the software, so there are some system requirements.

Mr. DAVIS. There is maintenance of the system.

Dr. KELLY. Beyond that, there is the processing of the claims and handling the denials and reviews and the rest. It is our view that the cost of that to the program is a very small portion of the overall savings, at least a 10 to 11 to 1 return; but it is our view also that the contractors have not been incentivized to use this kind of technology.

Mr. DAVIS. Do any contractors use this on the Medicare side?

Dr. KELLY. A number use it in their Medicare at-risk programs, so when they are at risk themselves, they are using it. A number, as I have mentioned, use it in the Medicaid program, because the States are demanding and wanting to make sure that payments are done appropriately, so a number of the Medicaid programs currently have this.

As I mention in my document, the CHAMPUS program does it, as well as almost all of the rest of the private sector. The only part of the delivery system substantially that does not use this is the Medicare program.

Mr. DAVIS. It seems to me programs are driven by the bottom line. That would be your HMO's and groups like that cannot afford not to use it.

Ms. BOYER. You are absolutely correct.

Mr. DAVIS. But in the Government sometimes we have not appropriately incentivized Government to look at some of these same things.

What about the issue of upcoding that doctors use? Is there any software that can address that or identify instances of upcoding?

Ms. BOYER. The same software that is used to look at medical policy looks at everything. That is why I alluded to the fact that we have 40 edits that are in place. We look at it every possible way in fact that a physician can inappropriately bill.

Mr. DAVIS. It just looks to me like we have to get with HCFA and try to appropriately incentivize them to use it. It is a no-brainer, I think, as the Chairman mentioned it before. We can't afford not to do it, with all the cost to programs and professional people who are going to see either their benefits cut or their premiums raised to pay for this kind of fraud and abuse and, sometimes, just neglect.

This could also make for better medical practices, at least on the recordkeeping side of this, by trying to set a standard for physicians when they are justifying this so they are not wasting effort and time with some of these procedures that may not be called for. Right now, they can get away with it, so there is no incentive not to try to fit it in. Now I think once you set that aside, they will become more efficient as well. Has that happened on the private sector side?

Ms. BOYER. Absolutely correct. When we look at the 7 percent of the claims that are submitted and denied, very few of them are overturned.

Mr. DAVIS. Thank you very much.

Mr. SHAYS. Ms. Phelps?

Ms. PHELPS. Thank you, Mr. Chairman.

I'm the one, I guess, who is still unclear. It seems to me, Dr. Kelly, that you stated that the contractors are already using auto-adjudication in their private sector side, in the private sector side, is that correct?

Dr. KELLY. That is absolutely correct.

Ms. PHELPS. But you are both saying that that's not being used in the public sector side because of the lack of incentives. But I think that you are also saying that there is a cost-effectiveness overall in using these screens, so I don't understand why that is not translating into use on the Federal side.

Mr. SHAYS. Good question.

Dr. KELLY. I think I have two comments. Most of the contractors do have in place some limited screens that look at certain issues. It is my view and our company's view that the scale of the review which is going on in the Medicare program is just not as comprehensive as it should be, that they are not looking at the whole variety of potential issues and taking advantage of computer technology to do that in as effective and efficient a way as they can.

So even though the carriers are, in fact, doing some level of review, it is just not on the scale that they can and should do to help prevent unnecessary or incorrect payments.

Ms. PHELPS. And you agree with that, Ms. Boyer?

Ms. BOYER. Yes, I do.

Ms. PHELPS. So what you are saying is if it was incentivized to use it in the Medicaid-Medicare program, you would also see more use of it, then, in the private sector as well?

Dr. KELLY. I think that the private sector is already very extensively using this. The Medicaid program in a number of the States is using it as well. It is only Medicare which at this point has chosen not to use it on the scale that it could potentially be used.

Ms. PHELPS. But it is the private contractors who decide how much they are going to use it, isn't that correct?

Ms. BOYER. Yes, and they may decide on factors that include how easy is it to customize. Because, again, if you are going to have different benefit structures in different parts of the country, and until they become uniform, you really do have to be able to customize and how quickly can you get the claim through the system prior to it being paid, so there are some obstacles. But, in truth, with the level of software sophistication that is out there right now, neither should be an obstacle any longer.

Ms. PHELPS. So are there obstacles in the Medicare program? Is that why they are not using it? I understand your point about the scale, but it is not making sense to me. If the licensing has already been paid and they've already got the software there, why isn't it just as easy to use it in the private sector side?

Ms. BOYER. Again, because of, I think, the multitude of payment policies—they vary by region, which is why I mentioned how im-

portant it is to have them uniform across the country, and that can be done.

Ms. PHELPS. So HCFA does not have uniform procedures across the country?

Ms. BOYER. No.

Ms. PHELPS. And if they did, private contractors could then use the software they are already using on the private side?

Ms. BOYER. They can now, because the current—if you will, the current generation of software sophistication allows individual customization. So even though the payment policies are not uniform, you can still use the software and customize it down until payment policies become uniform, so that is no longer an obstacle.

Dr. KELLY. I think, just to elaborate on that, most of the private payers in fact have very different medical policies and payment policies. So the kinds of software that are available in fact allow taking into account differences in payment policies. So one service might be paid under a particular payment plan, not paid under another.

So the same is true or potentially true in the use of the software in the Medicare program. If it is chosen in a particular area to pay for certain services in a certain way and not in another way, that kind of customization is, in fact, available.

I think really it is a case of lack of will and also an interest in doing this through a procurement process which may not be as effective as taking advantage of certain of the technology which is already available and does not need to be developed. That, I believe, is part of the reason why the Medicare carriers are not using this kind of technology; and I think it has to do, in part, with the strategies which have been currently put into place by HCFA.

Ms. PHELPS. So you are saying HCFA is building its own rocket ship, rather than sourcing out and using the resources that are out there?

Ms. BOYER. That's correct.

Ms. PHELPS. I've got one last question. What would you say, both of you, and it may be something too broad for you to respond to now, but just your immediate thoughts on what would be an effective Federal-State-private sector partnership in addressing this prepayment screening process?

Dr. KELLY. I think there are a number of consistent issues here. First of all, as I think this as well as previous GAO reports have indicated, there is an awful lot which has gone on in the private sector which in fact points the way for some successes that can occur in the Medicare program. I think they range from analyzing data that are currently available, identifying where some of the variations in practice are—and there are huge variations—and then putting into place policies as to what is covered and what shouldn't be covered and then putting into place more effective review mechanisms so that on a case-by-case basis, as services are provided and claims submitted, those claims are reviewed in a fair and efficient way.

I think the second part is that, obviously, medical practice keeps evolving. There is new practice; there are new services. All of this has to be done in an updated way. It has to be kept current, and there has to be very broad involvement of the medical community

as well as those who pay for the care. So I think there are tremendous opportunities on that front as well in order to help make sure that we have a more effective and efficient coverage as well as payment policy.

Ms. BOYER. I think part of the partnership should include what would be determined to be three obstacles right now. They are financial, political, and technical.

The technical one, as we just described, is relatively easy to overcome now with the fourth generation language, so that is not an issue anymore. But incorporated into the contract, a contract, should be the fact that, if a carrier is to respond, they have to have with their source, be it EDS or whomever, the ability to incorporate prepayment screens, so technical, no longer.

Financial, I honestly believe there has to be some type of incentive system put into place and included in the contract whereby a percentage of the savings would be kept by the carrier to allow them to upgrade their own information systems.

Third would be political. Right now, probably the biggest political obstacle that we have found is the fact that there is distinct carrier autonomy.

Mr. SHAYS. Distinct what?

Ms. BOYER. Carrier autonomy. Each carrier is allowed to decide what particular guidelines for their particular region they are going to endorse. When you start looking at studies such as done by the GAO, all of us had to take into consideration the fact that, for a given region, the payment might be different. I think in this day and age that level of autonomy is outdated; and so, in addition, standard payment policies and no longer the carrier autonomy we have seen for the past 20 years and all of them incorporated into a contract.

Mr. SHAYS. I just need to be clear that I'm hearing you correctly. You are saying a contractor can decide what standards they use?

Ms. BOYER. That's correct, what payment they are going to make for what benefits they are going to offer for certain procedures. So, for example, the comment that was made earlier by Mr. Davis about his particular district, physicians were saying that the payments for Medicare in his area precluded their physicians from maybe doing extra things to make up for it, that that might not be the case in Illinois, because what they pay for and what they are charging may very well be different.

Mr. SHAYS. But it is decided by the contractor?

Ms. BOYER. That is correct. That is absolutely correct.

Mr. SHAYS. Do you have another question?

Ms. PHELPS. One more followup. You opened up my thinking in another area.

HCFA has a medical review process called focused medical review. It seems to me that some of what you are saying there also touches on this particular process, is that correct?

Ms. BOYER. Yes.

Ms. PHELPS. Can you elaborate for me?

Dr. KELLY. I think that the focused medical review, in which there is a review of data and an identification of potential problem areas and then looking or developing a way of looking at those data or those areas in much greater detail, clearly that is advantageous;

and our company and a number of other companies have developed techniques to analyze data, to identify variations, areas in which there may be unnecessary services, in which there may be overpayment and the rest. So the focused medical review is an important strategy.

At the same time, though, part of what was talked about in the GAO report is that focused medical review only looks at a portion of the overall picture. Obviously, there is value in having in place screening programs and screening processes that look at all services, all care, all claims; and then, depending upon what comes from that, in certain instances there can be ways to deny payment for unnecessary or inappropriate services, to change the payment.

In other cases, a more focused strategy may be an additional approach which is also beneficial. So focused medical review can be advantageous but in the context of a much more comprehensive strategy to assure that payment is fair, accurate and appropriate.

Ms. BOYER. Just a touch of a comment. I think HCFA was, without question, the leader in innovation as far as claims payment was concerned; and clearly one of the most innovative strategies was focused medical review. Where it fell apart was, first of all, it has to be incredibly difficult to get clinicians to agree on what should have and should not be paid. For that reason, I'm sure the process has been very slow.

We have opted to use procedures that are already out there, as I mentioned, the American College of Cardiology, and not bother going through that particular review. As Dr. Kelly has stated, why only target certain claims or the egregious claims, as you mentioned earlier? Why not be able to put it through all systems? Unfortunately, at this point in time, HCFA has not kept up; and, instead, now focused medical review systems, as far as I am concerned, really is passe.

Ms. PHELPS. Does focused medical review kind of also reinforce your concerns about this carrier autonomy because it focuses on local levels?

Ms. BOYER. Absolutely.

Mr. SHAYS. Thank you. I am really happy you have asked your questions and have been participating.

When I say something is a no-brainer, I'm trying to find out what the answer is. I think there is an assumption that most people act rationally and most businesses act rationally, based on what is before them in terms of making that decision. When you watch 60 Minutes or 20/20 and they show some outrageous thing that happens in Government and I have constituents call me and say, "How dumb, how stupid, how could this happen," 60 Minutes does not give you the full story, and they want to develop a theme and make it as outrageous as possible.

To me, on the surface this is pretty outrageous. You all have been suggesting that it is just not a muddy issue. I bring to the table not enough knowledge, unfortunately; but what I'm hearing you get into is the whole issue of—and I will ask you, Dr. Kelly, this question: How do you address the basic claim that when you have a national prescreening kind of system, that it is going to interfere with the proper conduct of medicine, and is this really what is in play here? In other words, that this concept of "if we

centralize, we have one national kind of system," is that in play in this discussion?

Dr. KELLY. I think, Mr. Chairman, two things.

First of all, on the issue of why is this occurring or the no-brainer notion, in the private sector all of these organizations have implemented these tools voluntarily. Nobody forced them. They voluntarily choose to use it because they see benefit in it. The one place where they don't have that opportunity or that opportunity is not available is in the Medicare program.

Second is that there are issues, complicated issues—and Nancy touched upon them, and I will elaborate upon them a little further—which include the issue of what kinds of services should be provided to a particular patient with a particular condition, how those services should be coded for, how those code combinations should be analyzed and paid. Then are there certain kinds of situations in which, such as the GAO described, in which services shouldn't be provided. Those are complicated, complex medical issues here. In order to address those, just as Nancy's firm has a number of physicians, we have several hundred physicians who work with us, who provide guidance to us over what is proper practice, how to analyze that practice and what the rules should be.

I think that is one area in which a number of organizations—the American Medical Association, for which I used to work, as you know, has developed rules and guidance about coding. They keep updating that every year. I think there are a number of issues surrounding this that are, in fact, complicated and complex, and at times, controversial.

But having said all of that, I think also we are saying that most physicians in this country who practice not just in the Medicare program but elsewhere in fact are evaluated by this kind of software, they are used to dealing with it, and in fact the level of understanding and complaint is relative. Understanding is high and the level of problem is low, so we see no reason why the same kind of tools can't be transferred to the Medicare program.

Mr. SHAYS. Ms. Boyer talked about having—again, Ms. Boyer, how many different variations? You said 1.6 million?

Ms. BOYER. 6.4 million different code combinations.

Mr. SHAYS. Million?

Ms. BOYER. Million.

Mr. SHAYS. Is that consistent? Is that a trade number?

Dr. Kelly, is that a high number?

Dr. KELLY. I think it is on the right order of magnitude. The important thing is, I don't want to get into the issue of whether we have more code combinations than Nancy's company.

Mr. SHAYS. I just want to say I do not want to get into it, either. I want to know if in the many millions—and Ms. Boyer had made reference to the fact that HCFA was looking at 87,000, or 84,000?

Ms. BOYER. Yes, approximately.

Mr. SHAYS. Just explain to me what the significance is and what is motivating that 84,000 versus the multimillion.

Ms. BOYER. I think that—and, again, I'm sure that our colleagues from HCFA will address it better than I; but I think that if you were to look at the issues and map out two different problems, clearly the two big problems are in upcoding and unbundling.

That is where those particular code edits are centered. But that is the tip of the iceberg. You cannot end there. You have to get into the other problems that are associated with the way claims are submitted.

The real concern that I have to put on the table is, and now I am speaking as a clinician, is the fact that if HCFA comes forward with the AdminaStar and that is considered to be the state-of-the-art, then the implications to the private sector are very great. Because if they are talking about 80,000 to 100,000 claim edits, the private sector is going to have a very hard time convincing physicians that the remaining edits are valid.

Mr. SHAYS. To make sure I am putting things in perspective, I am making an assumption that Medicaid and Medicare are basically about 25 percent of the health care costs. Am I way off?

Ms. BOYER. I don't know.

Mr. SHAYS. In the industry? In other words, basically, we are looking at $260 billion in terms of health care costs for those two programs. I'm just taking a round number of $1 trillion. I'm using that number for the entire medical economy.

Ms. BOYER. It sounds like a good guess.

Mr. SHAYS. OK. But it is a real guess.

I want to get to this last question. That is, is the concern, though, on the part of some—do you suspect that this idea that we end up with a national system—basically, whether it is 25 percent or not, it is an extraordinary critical mass, so they become—what they end up doing becomes very influential on the rest of the medical community?

Ms. BOYER. That is absolutely correct.

Mr. SHAYS. So is the concern, though, is that as we—you told me something I was not aware of, that individual carriers basically can decide their coding systems and so on.

Ms. BOYER. Their payment policies.

Mr. SHAYS. Not coding, their payment policies.

Ms. BOYER. Yes.

Mr. SHAYS. Their payment policies. I'm trying to get a sense, if HCFA has had a disincentive because of politicians—and we can rail on HCFA because they exist and they have lots of problems, but they respond to the public and the pressure they get from politicians, and there are many who are concerned with a national health care policy and this one-size-fits-all kind of concept. Is that a factor in this process here?

Dr. KELLY. I am going to take just a little different approach to that, Congressman, which is that, clearly, HCFA has made progress in developing the edits which they have done and the 80,000 or 90,000 which are in the process of coming out. That is progress; but, in fact, it is just too little, too late. It is not moving quickly enough. And, at the same time, those particular edits were developed at a particular point in time, and the level of commitment to expand them, update them, is not as strong as it needs to be.

Second, the kinds of issues the GAO identified in the six procedures they looked at, obviously a similar kind of review can and should be and is occurring in the private sector for literally thou-

sands of procedures. So, again, even though HCFA is moving in the right direction, they are just not moving as rapidly.

Mr. SHAYS. You gave me the answer she wanted to give. I want to have an answer to the question I asked, though. Is this a factor—if you don't know, you don't know.

Dr. KELLY. In terms of the issue of requirements of standardization, at least the approach which my organization has taken is that we do not require or expect that organizations have a standardized approach. In fact, there can be flexibility. So whether or not there is—what level of standardization occurs in the Medicare program and what level of flexibility is an issue that, at least in my view, will be decided by you and others. From our point of view, this kind of technology can support either approach.

Mr. SHAYS. Either approach?

Dr. KELLY. So whether it is standardized or customized, national or local, the technology is available to do whatever the Congress chooses in terms of the right way to have health care coverage in this country.

Mr. SHAYS. Just because we are using technology does not mean we ultimately have to go into a standardized system? If anything, it could provide flexibility?

Dr. KELLY. If we find——

Mr. SHAYS. Is the answer yes?

Dr. KELLY. The answer is yes. What we find is that in the 150 to 200 customers, every one of them has a different approach. They use the technology and tailor the technology to their own particular needs, so that the technology is not the barrier. The opportunity is to use the technology as a way of helping to make a more effective and efficient payment policy, regardless of whether we have a local or a national standard or some combination of the two.

Mr. SHAYS. Now, I appreciate both of you being here. Is there any question you wish I had asked or felt I should have asked?

Ms. BOYER. No. I think you were very well rehearsed.

Mr. SHAYS. No, it is just that it is a fascinating issue. I didn't know what we would expect when we got into this issue.

You are raising some other questions. One thing that you are answering that I think is important is if there is a fear that we have this kind of—let me just say that I did realize that I still do not have an answer to this one question. I got kind of sidetracked to this national health care policy. Does anything in this technology preclude good health care? In other words, is there a concern that—do you have a lot of confrontation with the medical community over doing what you are doing?

Ms. BOYER. If there had been a concern, I honestly believe that the appropriate physician agencies would never have put policies and practices guidelines in place. Instead, their concern is to make sure that—in fact, they recognize there are certainly physicians that may have scruples that don't match their own and that, in fact, they are identified and stopped. But in fact, in terms of as clinicians, we could not sit here and promote the products.

Mr. SHAYS. I think this is helpful for HCFA to be here, because I think there are a lot of answers to some of the questions. They will see where my confusion is, and they can kind of give me a sense of how they see this issue. So it is important for you all to

have preceded them and for me now to be able to interact with HCFA and be able to kind of get answers to some of our questions.

The bottom line for me here is that whether HCFA just simply requires all contractors to have a screening system or whether we provide financial incentives for the contractors, we have to do one or the other, but the bottom line is they have to get into the system.

Ms. BOYER. That's correct.

Mr. SHAYS. Is there anything either of you want to add?

Dr. KELLY. I just would like to thank you for focusing on the issue and providing us with the opportunity to come here today. If there is anything further we can provide, we certainly would be happy to do so.

Mr. SHAYS. I'm sure we will be back in touch. You have been very helpful. Thank you.

Our final panel is Gary Kavanagh, Deputy Director of the Bureau of Program Operations Programs of the Health Care Financing Administration.

Mr. Kavanagh, I want to say, it is really a pleasure to have you here, and if you would remain standing. You are joined by?

Mr. KAVANAGH. Linda Ruiz, our Director of the Office of Benefits Integrity.

Mr. SHAYS. Have you appeared before us before?

Ms. RUIZ. No, I haven't.

[Witnesses sworn.]

Mr. SHAYS. Do one of you or both of you have testimony?

Mr. KAVANAGH. I do.

Mr. SHAYS. Mr. Kavanagh, I just want to preface my comments to you by saying just a few things, hopefully to put your mind at rest.

We could have had you come and testify first and make your case and then kind of walk away, but it is far more helpful for the committee to hear the claims that are being made.

Also, I hope to hear answers to my confusion as well. I think there are answers to a lot of these questions.

I also want to say to you that it is not the style of this committee to just kind of go after—there are a lot of players involved in this process and a lot of people responsible for both the problems and the solutions, and that is the way I approach this.

So I welcome you and am happy to have your testimony.

STATEMENT OF GARY KAVANAGH, DEPUTY DIRECTOR OF THE BUREAU OF PROGRAM OPERATIONS, HEALTH CARE FINANCING ADMINISTRATION (HCFA); ACCOMPANIED BY LINDA RUIZ, DIRECTOR, OFFICE OF BENEFITS INTEGRITY

Mr. KAVANAGH. Thank you for the invitation to testify on the Health Care Financing Administration's strategy to prevent payment for inappropriate claims. Accompanying me is Linda Ruiz, Director of the Office of Benefits Integrity.

HCFA is committed to protecting beneficiaries and the integrity of Medicare Trust Funds by ensuring that claims are processed quickly, accurately and in a manner that minimizes vulnerability to inappropriate payments or abuse.

HCFA's strategy to achieve this goal relies on our contractors, who have the experience and expertise needed to identify potential abuse in their areas and to act quickly to stop them. HCFA expects contractors to identify items and services that are vulnerable to abuse, develop appropriate local medical review policies, educate providers and implement prepayment screens.

Beginning in 1993, HCFA adopted the focused medical review strategy, which requires contractors to target services that are vulnerable toward use in their area and take appropriate steps to address them through prepayment screening and development of local medical review policies. Previously, we had required contractors to use uniform national screens for a variety of items and services, diverting attention from pressing local problems. HCFA holds contractors accountable for the priorities they set as part of our contractor performance evaluation. When contractors identify potential problems, they work in partnership with the local medical community to develop local medical review policies which serve as the basis for paying or denying claims. This consultative process produces better policies and helps ensure acceptance of the policies by providers. It means, however, that we cannot simply import prepayment review screens without first ensuring that they are in accord with local medical review policy. Once contractors have implemented a local medical review policy, they educate providers about that policy, a highly effective means of avoiding inappropriate claims.

Contractors also use prepayment screens to identify claims that conflict with established medical policies. Finally, post-payment medical review is used to identify cases of consistent abuse.

I would like to talk in a little bit more detail about prepayment screens. Prepayment review can occur electronically, also called auto-adjudication, or through examination by trained personnel. Adjudicated screens generally use fewer resources, as long as they are used carefully so that any resulting denial of claims is appropriate. Inappropriate denial of claims is not only wrong, but it leads to appeals that require substantial resources to resolve. We are expanding our use of adjudicated screens wherever it makes sense. All prepayment screens must, of course, accord with Medicare coverage and payment policy.

While focused medical review is designed to allow contractors flexibility to use their resources efficiently to target local problems, HCFA and our contractors use a variety of means to identify more widespread problems. These include analyses of utilization trends and patterns, contractor knowledge of actual and potential abuses and help from the law enforcement community, including the Office of the Inspector General. We agree that better methods need to be developed to identify and stop true overutilization at the national level, and we are exploring ways this can be done.

We will continue to develop better methods to analyze our health care utilization data bases to identify national variations in practice and utilization patterns. This analysis will enable us to direct the focus of local contractors to areas of potential overutilization.

When HCFA or our contractors identify the possibility of a widespread problem, the carrier medical directors, through 1 of over 20 regional and national work groups convened by HCFA, develop

model policies that can be adopted by local contractors. The carrier medical directors have established 7 model medical policies to date and are actively working on 33 more, including policies for the 6 services discussed in the GAO report.

HCFA is creating a data base of all local and model medical policies which will be accessible to all contractors by April 1996. Contractors will be able to review other contractors' local policies and use them to help create their own local policies. We will continually update the data base as new policies are developed.

HCFA has already undertaken a variety of activities to develop better claims processing edits. For example, in January, 1992, HCFA developed an initial set of edits to help contractors pay claims appropriately when implementing the new physician fee schedule. We have continued to refine these edits over the last several years.

In 1994, HCFA contracted with AdminaStar Federal through a competitive procurement process to develop a list of comprehensive and associated component codes that are commonly billed together. This project developed methods to prevent overpayment of Part B claims whenever manipulation of coding would lead to inappropriately increased payments.

On January 1, 1996, Medicare contractors implemented 84,000 additional correct coding combinations recommended by AdminaStar in communication with the medical community.

HCFA is continuing to refine new methods for adaptation in the complex environment of Medicare claims processing. For example, we are piloting new anti-fraud and abuse technology and experimenting with new concepts, such as pattern recognition software using neural net technology.

In September, 1995, HCFA entered into an interagency agreement with the Los Alamos National Laboratory to analyze Medicare data bases and, among other things, to develop pattern recognition software for identification of fraud and abuse. Our ultimate goal is to improve prepayment software and other analytical methods to detect and deter fraudulent and improper claims.

In addition, as you know, the Medicare Transaction System, which will be phased in from 1997 to 1999, will incorporate state-of-the-art detection and analysis technology. The Medicare Transaction System will provide contractors with quick access to national and local claims data and improve their ability to identify utilization patterns and problems more efficiently.

The agency's ongoing effort to develop efficient and effective prepayment screens and to facilitate information sharing between contractors is an important part of our comprehensive anti-fraud and abuse initiative. HCFA and the Office of Inspector General, in partnership with law enforcement agencies, are implementing a variety of strategies to deter fraud and abuse and to promote the use of the best practices in combatting them.

Ensuring the effectiveness of payment integrity activities in the future requires stable and reliable funding. Congress has addressed this in recent legislation and included a provision to provide stable funding for payment integrity activities, and we urge you and your colleagues to retain such a provision in any further Medicare legislation.

In closing, let me reiterate HCFA's commitment to protecting our beneficiaries and the integrity of the Medicare Trust Funds by preventing inappropriate payments. As I have described, we have a multi-pronged strategy for addressing issues of overutilization and payment of inappropriate claims.

We center our strategy on the Medicare contractors and provide coordination and support to address widespread problems. We continue to search for improved solutions to these problems, including expanding Medicare's use of auto-adjudicated prepayment screens, where appropriate, and developing cutting edge technologies to detect and prevent abuse.

We appreciate your subcommittee's interest in the problems we confront in this area and look forward to continuing to work with you to improve the Medicare program.

Mr. SHAYS. Thank you, Mr. Kavanagh.

[The prepared statement of Mr. Kavanagh follows:]

PREPARED STATMENT OF GARY KAVANAGH, DEPUTY DIRECTOR OF THE BUREAU OF PROGRAM OPERATIONS, HEALTH CARE FINANCING ADMINISTRATION (HCFA)

Mr. Chairman and Members of the Subcommittee: Thank you for the invitation to testify on the Health Care Financing Administration's (HCFA) management of contractors' prepayment screens to prevent payment for inappropriate claims. HCFA is committed to protecting beneficiaries and the integrity of the Medicare Trust Funds by ensuring that claims processing is done in a timely, equitable manner that minimizes the program's vulnerability to losses due to inappropriate payments or abuse.

Medicare contractors are our front line of defense against inappropriate and fraudulent claims. We are actively working to improve our contractors' ability to detect and prevent payment of inappropriate claims before they are paid. HCFA and its contractors share the goal of paying claims right the first time. We want to avoid paying inappropriately and then "chasing" after overpayments.

HCFA's national strategy to prevent overutilization and payment of improper claims is centered around our local contractors and their medical directors, operating in a decentralized but coordinated fashion. Contractors are expected to identify areas of abuse, develop appropriate medical review policies, educate providers, and implement prepayment screens. We support and coordinate the contractors' efforts through regional and national forums to share information about possible abuses and local medical review policies designed to address these abuses, and to develop model policies that may be adopted by many contractors. HCFA then holds each contractor accountable for its medical review activities and evaluates them regularly on their performance.

HCFA's strategy involves an array of methods, including using focused medical review, which employs prepayment screens and local and model medical review policy, experimenting with new anti-fraud and abuse technology, and developing the Medicare Transaction System. We are continuously improving our array of tools as we learn more about the nature of abuse and overutilization. For example, we have recently contracted with the Los Alamos National Laboratory to analyze our Medicare data bases and, among other things, to develop state-of-the-art pattern recognition software designed to identify fraud and abuse on a pre-pay basis. We appreciate the help of the General Accounting Office in identifying not only sources of abuse, but also suggestions of methods with which to combat the abusive practices. The balance of this statement discusses in more detail our current methods and the steps we are taking to improve them

HCFA'S STRATEGY FOR FOCUSED MEDICAL REVIEW

Beginning in 1993, HCFA adopted the focused medical review strategy, which requires each contractor to develop criteria for selecting claims for prepayment review. Focused medical review is a process through which contractors target services that are vulnerable to abuse in their area and take appropriate steps to address them through prepayment screening and development of local and model medical review policies. Focused medical review is one of our most effective and most promising tools for helping to ensure that claims are paid properly. Since a major element of our program integrity strategy is to ensure that claims are paid correctly in the first

place, we have been placing increasing emphasis on these techniques, and we expect to develop them much further in the future. HCFA's strategy in this area has evolved over time as we have gained experience with prepayment review.

Previously, we had required contractors to use uniform, national screens for a variety of items and services. We concluded that this approach was not cost effective, because patterns of inappropriate claims vary substantially from one part of the country to another and the provider community was well aware of what was being screened. Indiscriminate use of the same screens everywhere meant that many contractors were screening for things that did not present particular problems in their areas and that they could not shift their limited resources to deal with more pressing local problems.

The development of medical review policy on a local basis is key to our strategy. The Medicare contractors are closest to the source of the problems and have the most intimate knowledge of abuses and their perpetrators. Thus, we believe that Medicare contractors should have some discretion, with appropriate oversight, to take actions quickly within the realm of their knowledge and resources. What the problems are and how they can be resolved may vary from locality to locality, and our focused medical review methodology takes this variability into account and permits effective action by the contractors.

One tool for selecting items and services to target has been analysis of local utilization patterns that differ substantially from national utilization patterns. Contractors are expected to rely on other sources of information, including the local medical community, HCFA, other contractors, the Inspector General, or the General Accounting Office in deciding which items and services are most subject to overutilization or abuse. In addition, HCFA uses its historical utilization databases to provide contractors with analysis of variations in practice and utilization patterns across the country.

Once contractors have implemented a local medical review policy, the contractors use a combination of steps to combat problems in their locality. One of their most important functions is to educate Medicare providers about their policies, since most providers operate in good faith and adjust their billing practices to conform to what they know and understand about Medicare policy. In addition, contractors institute prepayment screens to identify providers who continue, in the face of established policy, to bill incorrectly. Postpayment medical review is also instituted where providers are identified as being consistently abusive.

As part of the annual contractor performance evaluation, HCFA holds contractors accountable for their focused medical review activities by requiring them to report on and evaluate their choices for items and services to target and to defend the process they have used to set priorities.

PREPAYMENT REVIEW TECHNIQUES

A prepayment screen operates by pulling selected claims from the routine claims processing flow and evaluating them before they are approved for payment. This review can occur in two ways: electronically, also called auto-adjudication, or through examination by trained personnel. Auto-adjudication screens can be expected to use fewer contractor resources, as long as they are used carefully so that any resulting denials of claims are appropriate. Inappropriate denial of claims is not only wrong, but it leads to appeals that require substantial resources to resolve. We agree that, particularly given our resource constraints, we should expand our use of appropriate auto-adjudication screens where this makes sense and in accord with medical review policy, and we are actively doing so.

Of course, auto-adjudication is not appropriate for all claims. Decisions regarding medical necessity are not always simple, and further information, which may not be on the claim, may be required to make an accurate payment decision on a claim evaluated against medical necessity criteria. For these claims, prepayment screens may simply suspend processing of the claim for manual review by trained staff. Although manual review is more resource-intensive than auto-adjudication, it is also an essential component of contractors' efforts to avoid making inappropriate payments.

Medicare prepayment review screens must, of course, accord with Medicare coverage and payment policy. Where screens involve decisions about medical necessity, they must accord with medical review policy developed in consultation with the medical community. Contractors, through their carrier medical directors, establish local medical review policies in consultation with the provider community and other local medical experts. This consultative procedure for establishing medical review policies produces better policies by giving us the advantage of significant medical advice, and it helps insure acceptance of the resulting policies by providers. It

means, however, that we cannot simply import prepayment review screens without first ensuring they are in accord with medical review policy.

ADDRESSING WIDESPREAD PROBLEMS

We recognize that some problems may extend beyond local contractor areas and may even be national in scope. These problems can be identified by a variety of means, including data analysis of trends and patterns, contractor medical professional knowledge of actual and potential abuses, and help from the law enforcement community, including the Office of Inspector General. Our understanding is that these are the same sources that were used by the GAO to identify potential national problems.

GAO has criticized our focused medical review procedure, arguing that the process does not address nationwide overutilization of medical procedures. However, GAO does not address the issue of how HCFA might determine the level of utilization that is appropriate. An increase in nationwide utilization of a particular service does not by itself indicate an inappropriate level of utilization.

We agree that better methods need to be developed to identify and stop true over-utilization at the national level, and we are exploring ways this can be done. As part of our strategic plan, we have made becoming a leader in health care information resources management a goal for HCFA. As part of achieving this goal, we plan on continuing to develop better methods by which we can analyze our historical health care utilization databases to identify national variations in practice and utilization patterns. This analysis will enable us to better direct the focus of local contractors to areas of Potential over-utilization.

When HCFA or our contractors recognize the possibility of a widespread problem from whatever source, the issue is presented to the contractor medical directors at large, through one of over 20 regional and national workgroups convened by HCFA. The primary goal of these workgroups is to develop model policies that can be adopted by local contractors.

The use of model policy enhances uniformity and consistency in local policy, and permits more policies to be developed efficiently. Prepayment screens and edits can follow, where possible. Without the necessary policy to support them, it is not effective to develop pre-payment screens for denial of claims, since the denials will not be upheld through the appeal process. This model policy process combines the best of both worlds, taking advantage of the knowledge and expertise at the local level, while it offers the efficiency and consistency of a more centralized process.

The carrier medical directors are currently developing model medical review policies for each of the six services discussed by the GAO report. They have established seven model medical policies to date and are actively working on 33 more.

HCFA is in the process of creating a centralized data base of all local and model medical policies. Contractors will be able to review other contractors' local policies and use them to help create their own policies. The database has been a pilot project and is undergoing final modifications. It will be accessible to contractors, in a user-friendly form, by April 1996. The database will be updated as new policies are developed to maximize its usefulness to Medicare contractors.

CORRECT-CODING INITIATIVE AND THE MEDICARE FEE SCHEDULE

HCFA has already undertaken a variety of activities to promote the development of more effective and efficient claims processing edits to prevent inappropriate payments. For example, in January 1992, HCFA implemented a fee schedule for payment of Medicare physicians' services, which involved specification of payment policies applicable to many services. In preparation for the implementation of the fee schedule, we developed an initial set of bundling and payment edits for contractors to use. Refining these edits has been an ongoing process, involving iterations in each of several years. These edits, for example, preclude duplicate payment when a claim includes both a comprehensive procedure code and codes for component parts of the procedure.

In 1994, HCFA contracted with AdminaStar to develop a list of comprehensive and associated component codes that are commonly billed together. The purpose of the contract is to develop methodologies to prevent overpayment of Part B claims whenever manipulation of coding could lead to inappropriately increased payments. AdminaStar identified problematic coding situations after soliciting comment from the medical community. On January 1, 1996, Medicare contractors implemented 84,000 correct coding combinations based on AdminaStar's recommendations. We will have a preliminary evaluation of the results of the AdminaStar edits by July of this year.

IMPROVEMENTS FOR THE FUTURE

HCFA is looking to the future and experimenting with technology to take advantage of methodologies that are just being developed and have not yet been refined for use in the complex environment of Medicare claims. For example, we are piloting new anti-fraud and abuse technology at several contractors and experimenting with some concepts that have not yet been adapted for widespread use, such as pattern recognition software using neural net technology.

In September 1995, HCFA entered into an interagency agreement with the Los Alamos National Laboratory to analyze our Medicare databases and, among other things, to develop pattern recognition software for identification of fraudulent or abusive patterns. Our ultimate goal is the development of prepayment software and other analytical methods to detect and deter fraudulent and improper claims.

The Medicare Transaction System (MTS), which will be phased in from 1997 to 1999, will incorporate state-of-the-art detection and analysis technology that will further enhance our efforts to detect abuse and avoid making inappropriate payments. Beginning with its initial implementation in 1997, the MTS will usher in the next generation of Medicare claims processing and data analysis. Through MTS, contractors will have quick access to national and local claims data to improve their ability to identify unusual utilization patterns and other potential concerns more quickly and efficiently than the current claims processing systems. One of the most significant improvements will be the ability to easily access information on all services delivered to beneficiaries. In addition, contractors will be better able to share best practices, such as efficient local prepayment auto-adjudication edits.

OTHER ANTI-FRAUD ACTIVITIES

The Agency's ongoing efforts to develop efficient, effective prepayment screens and to facilitate sharing of information on screening criteria and local medical policies between contractors is an important part of the Agency's comprehensive anti-fraud and abuse initiative. We want to eliminate any opportunity for unprincipled groups or individuals to "game" the Medicare program. The public rightfully becomes enraged when they read about yet another scheme to steal from or abuse a government program. Minimizing fraud and abuse is one of our top priorities. HCFA and the Office of the Inspector General, in partnership with law enforcement agencies, are implementing a variety of strategies that fully exploit available information to improve detection of fraud and abuse and promote the use of best practices in combating it. Prevention, early detection and management, and coordination and cooperation in enforcement make up the core of our approach.

Through Operation Restore Trust, HCFA has developed partnership agreements to work with national, state and local law enforcement agencies to deter and detect fraudulent and abusive activity in the Medicare program. This initiative includes a major, multi-state demonstration of improved enforcement techniques. The President has proposed expanding and extending the Operation Restore Trust initiative.

While Medicare's payment integrity activities are improving, they need further improvement, and we look forward to working together on this subject with this Subcommittee and others in Congress. To ensure effectiveness of our payment integrity activities, they need stable and reliable funding. The President and Congress have addressed this need by including in various balanced budget plans a provision that would provide stable funding for payment integrity activities, and we urge you and your colleagues to retain such a provision in any further Medicare legislation.

CONCLUSION

In closing, let me reiterate HCFA's commitment to protecting our beneficiaries and the integrity of the Medicare trust funds by preventing inappropriate payments. As I have described, we have a multi-pronged strategy for addressing issues of overutilization and payment of inappropriate claims. We center our strategy on the local contractors, who know best where the problems are and can deal with them most directly, and we provide coordination and support to help ensure that widespread problems are addressed effectively.

We are continuously attempting to improve our approaches to these problems. Our contractors are developing more effective local medical review policies, and we are working together on model policies that can be adopted widely. We expect to expand Medicare's use of prepayment edits, including auto-adjudication screens where appropriate. In partnership with leading public and private organizations, we are developing "cutting edge" technologies to detect and prevent abuse.

Our efforts to prevent inappropriate payments are part of HCFA's comprehensive strategy to combat fraud and abuse in the Medicare program. We appreciate the

Subcommittee's interest in the problems we confront in this area, and we look forward to working with you to improve the Medicare program.

Process to ensure correct payments	Planned improvements
System Edits (both Standard Systems and Common Working File).	Medicare Transaction System (MTS)
Coding	AdminaStar/Improved Correct Coding Initiative (CCI) and MTS
Prepayment Medical Review	Improved Prepayment Screening From Los Alamos National Laboratories and MTS, and Use of Autoadjudicated Screens When Possible
Postpayment Medical Review	Improved Review Techniques Developed with Los Alamos National Laboratories and MTS, and Improved Anti-Fraud Technology
Payment	More Accurate through Improved System Edits, Prepayment and Postpayment Reviews, and MTS
Enforcement	Continue Operation Restore Trust, Access Fraud Investigation Database (FID), and MTS

Mr. SHAYS. Did you have any statement you want to make?

Ms. RUIZ. No.

Mr. SHAYS. Mr. Kavanagh, when would it be inappropriate to—when is it inappropriate not to use an auto-adjudication system?

Mr. KAVANAGH. It is inappropriate in two instances. One instance for certain is when we have not developed a medical policy in that area to sustain that screen. The other instance is when we need additional documentation that is not on the claim to justify whether that claim should be paid or not. Because, in the first instance, you must have a policy to back up what you are going to deny in the Medicare program. We don't want to just go around and deny claims for no reason whatsoever.

Mr. SHAYS. What that is suggesting to me is that you will never do it, because there will always be new systems, new programs, and new procedures that will always have to be evaluated. We are just taking five areas here—or I mean GAO did. I cannot think of 1 region of the country—I cannot think of why you would not have all 29 who are involved in the Medicare Part B not at least screening these five areas.

Mr. KAVANAGH. We pay our contractors to analyze and make an assessment of the services in their area that are being billed inappropriately. We rely to some extent on their expertise, certainly looking at the data. I think our greatest statistics show that probably more than half of the contractors do have prepayment screens in for these procedures.

We are developing model policy. We intend to look behind the reasons why or why not carriers either have these screens in place or do not have these screens and hold them accountable for it.

Mr. SHAYS. I don't know what you mean by "hold them accountable." I realize you summarized your testimony, and therefore you may have left out some of the details. I heard "hold accountable" more than once in your statement. I didn't hear an explanation of how you hold them accountable. I'm not really satisfied with your answer. The reason is that you didn't really answer it.

Why wouldn't you require every one of your contractors to screen, particularly in these five areas?

Mr. KAVANAGH. Because they only have limited dollars available for medical review activities and program safeguard activities. They have to make a determination whether they're using those dollars appropriately. It's our responsibility to look behind them to see if they're using those dollars appropriately. In some local areas

you may be able to use autoadjudicated screen, in others you may not.

Mr. SHAYS. I don't understand that. Why not?

Mr. KAVANAGH. Because medical practice in different areas of the country varies. Actually the policies that are behind these local prepayment screens differ somewhat in each area of the country.

Ms. RUIZ. Perhaps I could add a little bit. The GAO described some of the problems they saw at particular contractors in terms of a diagnosis code that did not seem to make sense in connection with the service. But every contractor finds that local practice and the billing practices that they see vary. What we know is that these services—and we agree with the GAO—that these are services that are very extensively used, and even before we ever saw the GAO report, we had also identified these services as being highly utilized services that needed attention. That's why the carrier medical directors have been working on a model policy in those areas.

In the process of working on a model policy, they examined what the problems are that local carriers have experienced to see how much similarity or differences there are in the problems and in the practice and then come up with some kind of consensus about the most commonly identified problems and what is the policy that is appropriate to solve those problems. Autoadjudication may work in some places, but it may not solve all the problems associated with these services.

Mr. SHAYS. Solve all the problems. Hell, I would be happy to solve some of the problems. There is a culture, I think, at HCFA that I find very disturbing. How long have you worked at HCFA?

Ms. RUIZ. Three years.

Mr. SHAYS. How long?

Mr. KAVANAGH. Eighteen years.

Mr. SHAYS. It is like I feel there's a real world out there and then I feel there's HCFA. I don't mean that with any disrespect. I mean that you had an opportunity to hear GAO say that it's up to $150 million in 7 of the 29 that they looked at. Even if it was half that, I can't believe that this system would cost anything like $150 million to implement. So in my simple mind, I'm thinking a no-brainer, get on it. What I am hearing—and I am trying to understand what the culture is at HCFA and what the culture is out there. Maybe we're all talking code and nobody's just leveling with me. But I feel like if you said to me we don't have the courage to take on the medical community or we have just decided that we just don't want to deal with that, because, and you gave me a reason. But bottom line is we have testimony that it could be half a billion dollars a year. What I don't understand, and, Mr. Kavanagh, you basically said to me that, well, each area has got to work out its own—you have a localized concept in decisionmaking and different procedures we have got to check into. It's like, just do the ones you can agree on.

Those there, it seem to me, are pretty straightforward, and I think every literature I have ever read has said there's overutilization in these areas, significant overutilization.

So why don't you use an autoadjudicated screen, a system, to just go after these? Forget all the others that are more complex.

Ms. RUIZ. In part because the overutilization is of several different types, and you don't solve all overutilization by putting in autoadjudication screens.

Mr. SHAYS. But what bothers me about that is I didn't say all. I have long decided that "all" will never happen. I've decided that if you get a 20 percent, you're talking hundreds of millions of dollars. So I'm willing to get a 20 percent. I have an MBA and an MPA, and I have some sense of this, maybe not in the field you have, but I have an economic sense of cost-benefit and I am going to say again it is a no-brainer. Why isn't it a no-brainer that you don't do this?

Mr. KAVANAGH. I think again we agree with the approach, what the GAO is saying. We are in the process of developing model medical policies that we intend to hold contractors accountable for in making a determination. Again it's an issue on their part and our part when they make this decision. They have limited dollars to spend on premium safeguards.

Mr. SHAYS. Who is "they" is this?

Mr. KAVANAGH. The Medicare carriers.

Mr. SHAYS. Why do they have limited dollars?

Mr. KAVANAGH. Because the way the carriers are currently paid for under law, they get an annual appropriation from Congress.

Mr. SHAYS. Let me just say as problem solver, you're basically saying to me, all of us being problem solvers, you say they get limited dollars. That reminds me, in my mind, say, OK, what are you doing about it or what is the solution. You remind me of what we did in the Secretary of State's office in Connecticut when there was a new Secretary of State came in after having a Secretary of State there for years and they used to have to process applications from the business community. There was a desk here and a desk here and a desk here. One of the desks was empty and they were all in a line. You saw all this pile of paper on one empty desk, then there were five desks beyond and they were all sitting doing nothing.

And he came around and said, why aren't you doing anything and they said, because Sarah isn't here today. And they said, well, so what?

Well, Sarah is the one that has to stamp in before we have the ability to do our part.

And he said, well, get out of this seat and get into that seat and stamp the damn things.

I mean, it was literally like if there was one weak link in the chain, then they're all shook up. There were five people in the secretary's office who didn't do anything that day because she wasn't in.

Your answer isn't that we aren't wasting the money. You are aware that there is a problem and your explanation to me is that the carrier doesn't have enough money to do it.

So what is the solution?

Mr. KAVANAGH. What I'm trying to make you aware of is the fact that carriers have a difficult job and we have a difficult job. You can't say from a national perspective that we're going to impose all these screens on the carriers. What can potentially happen there are two things. One is that the screen might not work in that area.

It may cause a lot of appeals and a lot of unnecessary denials. There were questions asked earlier about was the diagnosis coded improperly, or did that system pick up on the wrong diagnosis because it could only accept one or two diagnoses and the third diagnosis was the one that was appropriate.

There's also the issue of developing medical policy in that area. We have to have medical policy to be able to justify those screens.

Mr. SHAYS. Let's get beyond this point. I think there is medical policy dealing with these areas. There may not be on a whole lot of areas but I think there are in these areas. So that to me is not the issue. Where I hear you saying—I have met with a number of doctors who demonize HCFA because they talk about all the times they're denied. So I can understand, and I mean this sincerely, I can understand that you keep getting burned because people keep criticizing you for not making payments and doctors contact Congressmen and they contact everyone else and say, look here, I have a request and it's 6 months old. So you have a culture that's developed at HCFA that says, we have got to get these claims paid for because we're going to be evaluated on how we get these claimed paid. So there is a disincentive for even you—I used to think it was just the contractors—even you to say, hey, wait a second, some claims are being paid that are inappropriate. What I want to get beyond, though—so you have added to your story about a whole lot of money. I understand the appeals and the denials and all these things that HCFA has been critical of, you want to speed up the process and this works in the opposite direction. I admit it. Let's just go back to the issue of a whole lot of money, because that's your quote. They don't have a whole lot of money. They don't.

So what do we do about it? Because there is no doubt in my mind there is a cost-benefit here that is so obvious to even an elementary school kid that they would be able to say, well, why aren't they doing this.

Let's talk about that. What is the solution to that? How do you deal with that?

Mr. KAVANAGH. I think there are a number of solutions. The one that the administration has recommended is a proposal that we call the Medicare Benefit Integrity System, which provides additional money from the Medicare Trust Fund for our contractors to do payment safeguard activities, such as medical review and prepayment screening. That, as I said in my testimony, is something that I think would be extremely beneficial and make some of these difficult choices easier for us and for the contractors to make.

The other thing is that it's a point that you brought up earlier, was the fact about incentives for contractors themselves. We don't have a system today where contractors are incentivized. They're pretty much paid their costs for processing and paying Medicare claims and finding inappropriate claims. We have sent forward a proposal to reform the Medicare contractor process that we think creates a much more competitive environment and that people would actually bid for this business, because for the most part all of our contractors that are in the program today in 1996 were in the program in 1966 and have pretty much had a—what's the word I would use? I guess others would disagree with—but a monopoly

in this business and that we would like to create more competition among the other contractors for this.

Mr. SHAYS. That gets me to the next question. Let's not be reluctant to talk about the issues. Is one of the restraints that you only have one player, one contractor, and that's it? Let me ask you this: How are contractors determined? Is this a buyer's market or a seller's market? If you are selling a product to a contractor, do you have a lot of people—you're selling the opportunity to provide this service. Actually you're purchasing this service in one sense.

Mr. KAVANAGH. Right.

Mr. SHAYS. What kind of market is it out there? Do you have a lot of choices in contractors?

Mr. KAVANAGH. No, we don't. We have a very limited choice in contractors. In fact we're limited to the current health insurers. You have to be a health insurer to be a Medicare contractor. Not only that, but you have to provide all the—I guess we have broken it down into 21 different functional areas. A contractor has to do all of those things. Some people, certainly we know in the private sector, are much better at doing certain things than others. Finding fraud and abuse is not necessarily a competency that someone who is good at paying a claim should be doing. We're trying to get legislation to allow us to be able to restructure the Medicare contractor environment.

Mr. SHAYS. There are basically 29—excuse me, there are basically 9 different systems out in the United States, correct?

Mr. KAVANAGH. Right.

Mr. SHAYS. Of which there are now 29 contractors. Are those 29 contractors going from one area to another or did they cover a bigger territory than the 9 separate systems that we have out there right now?

Mr. KAVANAGH. The systems don't really relate to regions of the country.

Mr. SHAYS. OK. But you have 29 contractors. Do they have—are they given a certain region?

Mr. KAVANAGH. Yes.

Mr. SHAYS. And they're the only person—only contractor in that particular area.

Mr. KAVANAGH. Yes, that's correct.

Mr. SHAYS. Do these contractors compete, go after each other's—the only knowledge I can think of is bus companies. They come into a school system and they almost just simply don't try to get the contract in another system and the other bus companies don't try to get their school system. Once in a while that's not obviously the case. But you have one or two people bidding. Do you bid these out?

Mr. KAVANAGH. Usually only when someone leaves the program, voluntarily.

Mr. SHAYS. So they're basically locked in, they've got a lock in the system. You have worked there 18 years and maybe for 18 years you have seen the same contractor in some of these areas.

Mr. KAVANAGH. Oh, absolutely. As I said, most of the contractors, in fact almost all the contractors that we have today are doing business in the same area that they were in 1966.

Mr. SHAYS. This is just something that I'm not fully aware. That in itself boggles my mind. I guess the disincentive is that if you're a new person here, the incredible disruption that would come by getting rid of one contractor and getting another contractor in, I guess. I don't understand why this isn't a more competitive business, why you would not have one contractor who is doing great in one area, say, hey, I'm going to bid to get the contract in another.

Mr. KAVANAGH. Certainly we believe that it should be a more competitive business. I think the argument has been that there would be an incredible disruption and I think we have shown through—just recently in the last several years, we have had maybe four or five transitions from one contractor to another that have gone very smoothly, and we think that we have shown that we have the ability and the contractors have the ability to move this business.

Mr. SHAYS. Basically new information for me is that there really is no competition, that it is in a sense a seller's market to you. You're the purchaser of this service and you're saying there's one or two people out there. But have we ever really tried to just say, OK, we're going to bid out each region? Have we ever done that?

Mr. KAVANAGH. No, we haven't. We don't have the legislative authority to do that.

Mr. SHAYS. What, they're locked in? These contractors are locked in?

Mr. KAVANAGH. Actually on the Part A side. Providers, it's a process called nomination, they get to pick who processes and pays their claims.

Mr. SHAYS. Who gets to pick?

Mr. KAVANAGH. The providers do.

Mr. SHAYS. Do you have any questions?

Ms. PHELPS. Yes, thank you, Mr. Chairman.

Mr. Kavanagh, as sort of a two-parter, how do you respond to GAO's assertion that HCFA lacks an effective national strategy? The second part is, are there any impediments to making your strategy, if you have one, more effective?

Mr. KAVANAGH. I think we do have a national strategy. As I said earlier, I think it keys on the focused medical review program and our relationship with the contractors and the carrier medical directors. We try to have a decentralized process, a process that does recognize individual medical practice in local areas. But we try to do it in a coordinated way where we're in the process of developing model policies for carrier medical directors to use to identify problems in their local area. We do use prepayment screening. We are using autoadjudicated screens; we're trying to increase the use of autoadjudicated screens. We have the correct coding initiative that's trying to identify coding problems when claims are submitted through the system and inappropriately coded, that they're undenied.

We are also working, as I said in the testimony, to develop the Medicare Transaction System, a system that will give us a much richer data base in terms of both Part A and Part B claims for us to analyze in terms of utilization problems, utilization concerns. We're working with Los Alamos National Labs to help us look at

our data bases today and help us hopefully to develop more and better prepayment screening.

Ms. PHELPS. Are there impediments right now to your implementation of any of these initiatives?

Mr. KAVANAGH. I think we have discussed to some extent the major impediments we have. There are impediments in terms of incentives for local contractors to do the best job that they possibly can. I don't want to sit here and denigrate our contractors because I think they do a tremendous job with the resources that they have, but we don't have a competitive environment. I think there are also impediments—you cannot go and just adopt those screens tomorrow. You have to go through a process of local policy development, working with the local medical community, looking to see if those screens are appropriate in that area and will be effective in that area and cost beneficial in that area.

Ms. PHELPS. Do you know which of your 29 Medicare contractors perform diagnostic screens?

Ms. RUIZ. All of them have some diagnostic screens and other kinds of unbundling or rebundling screens. But because we have 70 contractors, 29 of which process SMI claims, and 9 different systems, we have not to the present time kept a detailed catalog of all the edits that exist out there. Edits change very quickly, also, at the contractors. They're constantly putting new edits in, taking edits out and changing them. For us to monitor all those at the current time would be difficult to say the least. We do have—through the Medicare transaction process underway a committee is surveying all of the contractors to get a comprehensive list of all edits that exist. We hope to handle edits in the Medicare Transaction System in a very different way, where we do have a central process for knowing what the edits are and making some approval or disapproval. It's a little harder to do that with 70 contractors and 9 systems.

I would also like to add that Mr. Kavanagh is absolutely correct, that we believe that lack of true competition is a disadvantage to us as well as having so many contractors to oversee. But I spend a fair amount of time going out and meeting with the contractors either onsite or in different kinds of regional meetings, and I have to say that for the most part the companies that do process the claims for us do have incredible pride in their work and they are very concerned about payment safeguards. I believe that while there could be further incentives for them, obviously, and a lot of discussion has gone on about what are the appropriate incentives, they are not poor quality contractors. They are doing a very good job. They have pride in their work.

We do have a contractor evaluation system that goes out every year. Two years ago, we changed the system for fraud and abuse and medical review to be very outcome oriented, to say what are the problems you found in your area, what did you do about them, what was the result. I think we're learning how to do that.

Payment safeguards is like a living document. What is going on out there in the medical community, and the nature of the health care system changes very rapidly. What we know about doing effective payment safeguards is a constant learning process for us, and

I think our strategy is constantly being added to and changed as we learn new things, and we have learned things from the GAO.

Ms. PHELPS. Excuse me. I would like you to respond to some testimony given by the previous panel that you're developing your own infrastructure to provide these program safeguards where the resources and the technology already exists outside and perhaps you could be procuring that technology.

Mr. KAVANAGH. We are very interested in the technology that was discussed by the previous panel. We have committed to, in the Medicare Transaction System, utilizing that technology, either developing it ourselves or utilizing the technology in the private sector. You may say, why would you want to develop it yourself.

Ms. PHELPS. Yes, I will say that. Why would you want to develop it yourself?

Mr. KAVANAGH. I think the answer to that is we just did a review at our local carriers of the claims that were run through the GAO study last spring. What we found is that many of the edits that are in the proprietary systems, the commercial office shelf systems, we like to call them, are in conflict with Medicare policies. So we have to make a determination: if we purchase those systems, whether it's more cost beneficial for us to develop that software ourselves, or whether we should go out and procure those systems and then modify those systems or modify our policies to conform with those systems. It's something that we have to make a decision on here with the Medicare Transaction System. We don't think it would be cost effective to put them into our current systems. We have made that determination.

Ms. RUIZ. Our current systems are capable of autoadjudication. The real challenge for us is developing the underlying policy and deciding that autoadjudication is the appropriate resolution of the problem.

Ms. PHELPS. Before we ask a question on that, I still want to follow up on what we were just discussing. The example given is the fact that the AdminaStar system that HCFA is incorporating can perform 84,000 code combinations. Yet previous testimony was that there were 6.7 million—6.4 million possible code combinations that could be used. How do you reconcile the difference there in terms of what you have developed and what's commercially available? I think that puts you behind the curve. And if I remember, the implication there is that you're setting the standard that the industry may follow when in fact it's inferior to what is out there. Is that correct?

Mr. KAVANAGH. No, I don't believe that is correct. What the 84,000 number represents is in addition to what we currently have in our system, additional edits that we have put into our system. We're going to have to do more investigation of the number of 6.4 million or 4.7 million or 84,000 with the proprietary software as we move into making this assessment with MTS. But certainly we have thousands and thousands, if not millions, of edits in our systems. When you add up all the various combinations and algebraic algorithms that probably is a number more like in the millions. So I would say that assertion, in a simplistic way, it looks like we have a much more antiquated system, I would not agree with that.

Ms. PHELPS. So millions and millions, what does that mean?

Ms. RUIZ. The 87,000 is edits, not code combinations. Each edit can include several code combinations. I couldn't tell you the exact number associated with the 87,000 edits, but the actual number of code combinations is much larger than 87,000.

Ms. PHELPS. Is it larger than 6.4 million?

Mr. KAVANAGH. I——

Ms. RUIZ. I couldn't tell you that. Equifax testified that they had 40 edits. We are putting in 87,000 edits in addition to those that we already have in the system. The 87,000 edits are primarily coding edits, but we already have rebundling, unbundling edits, all different kinds of payment edits. I think what Mr. Kavanagh is trying to say is that if you added up all the edits that we have in the system and looked at that from a code combination standpoint that it would probably be in the millions.

Ms. PHELPS. So we were comparing apples and oranges before?

Ms. RUIZ. Yes.

Ms. PHELPS. Are any of the GAO recommendations underway at this time, the GAO recommendations in their report?

Mr. KAVANAGH. Yes, I think most of them are. I don't remember, there were three recommendations in that report and I don't have those in front of me. But certainly we are moving to develop more model medical review policies. We're actually developing a model medical policy for these six services that are being provided plus a number of other ones. We're doing more in terms of holding our carriers accountable for what they do in terms of medical review to make certain that if they do either install the model policy or tell us why they didn't install it and justify that to us.

We are using more effective means to try to utilize our national claims data base to try to identify a barren season and utilization problems.

I guess difficulties, you asked about difficulties earlier, we know that these services are widely utilized. One of the things we don't really know is are they overutilized, are these services overutilized or are other services overutilized. That is one of the responsibilities we place on the local carriers working with us to try to make that determination. They have to look at data; we look at data; we work with the IG; we work with the GAO.

Mr. SHAYS. I'm going to interrupt you there for a second. Whatever you think of GAO, they did a report. The report is one in which they have their experts do. They didn't have me do this report. They had experts do this report. There was no agency response. Did they not show you this report? I mean, have you just been made aware of this report now?

Mr. KAVANAGH. No, they showed us the report. My understanding—I didn't quite know what happened in the process. We did develop a response to their report. I think it came out at the beginning of the Federal shutdown and what happened was it didn't get through the process to get to the GAO.

[The information referred to follows:]

We have reviewed the GAO report which discusses payments to physicians for six groups of high-volume medical procedures. The report suggests a number of actions that the Health Care Financing Administration (HCFA) should take, focusing on overused services identified nationwide, to prevent Medicare payments for unnecessary services.

HCFA agrees with the goals identified by GAO. Overutilized services need to be identified and such abuse needs to stop. Our strategy to achieve these goals differs from that of the GAO. We have a multi-pronged strategy for dealing with abuse in the Medicare program. Our strategy to prevent overutilization and payment of improper claims is centered around our local contractors and their medical directors, operating in a decentralized but coordinated fashion. The strategy includes using focused medical review, which employs prepayment screens and local and model policy; experimenting with new anti-fraud and abuse technology; and implementing the Medicare Transaction System (MTS). With more comprehensive, up-to-date data, MTS will provide Medicare contractors with the tools necessary to uncover and thwart local and nationwide fraud and abuse schemes, and, effectively reveal providers performing fraudulent activities in more than one area of the country.

In this report, the GAO first recommends that HCFA systematically analyze national Medicare claims data and use analysis conducted by HHS OIG and Medicare contractors to identify medical procedures subject to overuse throughout the country. HCFA agrees that it is important to identify and stop such abuse.

In response to this recommendation, we are exploring ways to develop data-driven methodologies that utilize national data to identify widespread overutilization (e.g. trends or national patterns). It is important to note that high volume does not always indicate overutilization. As acknowledged by the GAO, the six groups of procedures addressed in this report "may" be overused. The GAO does not offer any concrete data supporting their assertion that these services are overused. We are unaware of any existing, reliable statistical method to make such determinations. While our current approach targets local variations, it does not preclude carriers from addressing more widespread variation.

Additionally, the two sources used by the GAO to select the potentially overused services cited in this report—Office of the Inspector General reports and Medicare "contractor analyses and views that providers commonly bill for these procedures when they are not warranted by medical symptoms"—are good initial sources. HCFA also uses these sources. We asked the OIG to distribute their report to all carriers and then instructed carriers to evaluate the need for corrective action. Carrier experience with providers' billing patterns and practice parameters makes them astute at identifying where abuse may be occurring or where the potential for abuse is great.

Second, the GAO recommends that HCFA: (1) gather information on all contractors' local medical policies and prepayment screens for widely overused procedures, (2) evaluate their cost and effectiveness, and (3) disseminate information on model policies and effective prepayment screens to all contractors.

HCFA already gathers information on contractors' local medical policies and prepayment screens. We have been pilot testing a database and policy development system, the Medical Policy Retrieval System (MPRS), which stores national coverage policy and all contractor local medical review policies. Carriers can access the data base, review other carrier policy on similar issues, and create policy. The database will be fully operational by April 1996; and will be updated as new policies are developed.

Currently, carriers are required to evaluate the cost effectiveness of their prepayment screens on a quarterly basis. HCFA collects certain information regarding contractors' prepayment screens. With the implementation of MTS, we will have the capability to develop a fully comprehensive database of screens that can be analyzed and shared with all carriers.

HCFA disseminates information on model policies to all contractors through its model policy process developed by HCFA and the Carrier Medical Directors (CMDs). The CMDs have formed clinical workgroups to pool CMD resources and avoid duplication in work efforts in developing local medical review policies. Model policy developed through the clinical workgroups is offered to all carriers for consideration. The use of model policy enhances uniformity and consistency in local policy, and permits more policies to be developed in an efficient fashion. Each state has a Carrier Advisory Committee (CAC) which advises the carrier on local medical policy. This committee includes broad representation from the medical community in the carrier's jurisdiction. The use of the CAC increases the likelihood of clear and consistent policy, supported by the local physician community.

For the six potentially overused services cited by the GAO in their report, we plan to have model policies for all six services completed by March 1996. In fact, model policies for three of these services were already being developed prior to this GAO report. The model policies will be distributed to the CMDs and local medical review policies will be developed by summer. This allows for the local review of policy, including a 45 day comment period. Policies will be adopted and, where appropriate, further specified into prepayment screens. The policy step is key because policy de-

velopment educates the provider community and without supporting policy, denials are more likely to be reversed on appeal. Contractors will be held accountable for addressing these overused services in their area through our contractor performance evaluation.

As a final suggestion, the GAO recommends that HCFA hold Medicare contractors accountable for implementing local policies, prepayment screens (including autoadjudicated screens), or other corrective action. Medicare contractors are already held accountable for ensuring that abusive practices are properly controlled through mechanisms, such as those mentioned above. HCFA holds its contractors accountable by monitoring the contractors' actions through contractor performance evaluation, regional office oversight, and required management reports. Contractors are expected to address the abusive practices in the most efficient manner, including implementation of autoadjudicated screens, when appropriate.

As a way to increase efficiency and consistency in determinations, HCFA has emphasized to its contractors the need to use autoadjudicated screens whenever a policy supports automatic denial. Although autoadjudication is not appropriate in all instances. if a service is only necessary for certain diagnoses, a policy that supports autoadjudication can be developed. The policy is needed to inform the physician community about what criteria must be met for a claim to be considered medically necessary and to support denials upon appeal.

Finally, the report discusses decreasing carrier budgets. The Administration has submitted a legislative initiative, "The Medicare Benefit Integrity System," that would provide a more stable and reliable funding for program safeguard activities.

Mr. SHAYS. I would like to see that response. But your answer just doesn't wash with me, because the bottom line is the estimates could be anywhere from 100 million to $500 million. Maybe the $500 million is way off. But if it was $100 million, there's more than enough in that $100 million to deal with the problem. We're probably not talking about a gigantic sum of money to do this autoadjudication screen system, at least for some of these types of procedures.

Ms. RUIZ. We don't disagree with the recommendation from the GAO that autoadjudication may be appropriate for these areas. I think that the issue here is that we needed the underlying policy to be put in place nationally in order to have any kind of screens thereafter. We have now—out of the six services, we have three policies finished and the other three are near completion. We will thereafter be able to put in autoadjudication screens in any place where the carrier believes that that's the appropriate solution.

Mr. SHAYS. This is my problem. It's becoming quite clear to me that you have HCFA, you have the carrier, you have the providers, and the bottom line is the providers and the carriers are deciding what to do. Now you really have made it clear to me something you have known for a long time and I just should have known it, that basically the carriers, they've got a monopoly. My basic economic sense is they have not any incentive whatsoever to try to go after this. Your saying you hold them accountable is a meaningless statement because, big deal. I'm going to say HCFA's going to hold me accountable, I'm a monopoly. You can make life a little difficult for me, but you really don't hold them accountable. It's a meaningless statement to me. Because you can't say you are doing a terrible job, we're just going to go to *A, B, C,* and *D.* You don't have that option, so you don't really hold them accountable. For you to say there's not a whole lot of money, how do you base that, there's not a whole lot of money, Mr. Kavanagh?

Mr. KAVANAGH. I wasn't really saying there wasn't a whole lot of money.

Mr. SHAYS. You know what, I wrote it down and I won't go back to it. I want to be fair. You said the carriers don't have a whole lot of money necessarily to go into this system. How do you know they don't have a whole lot of money?

Mr. KAVANAGH. What we do know is that we have an appropriated amount of dollars each year for program safeguard activities. That is the full range of activities from auditing of hospital cost reports to doing Medicare secondary payer reviews, to doing fraud and abuse reviews.

Mr. SHAYS. So you're saying you have it in your contract, you only tell them to go after—you allocate a certain sum for getting at waste and fraud and so on, the so-called policing of the system.

Mr. KAVANAGH. What we do is say, we try to give some flexibility here because there is still a responsibility to perform all these other functions that they have to perform: process and pay claims, work with beneficiary and provider groups.

Mr. SHAYS. See, the problem is that, I think you will agree—I'm sorry, I didn't want to interrupt you. Did you finish?

Mr. KAVANAGH. That's OK.

Mr. SHAYS. The problem is that the one value in a competitive system is that you are forced to really get your costs down. You have provided them a certain sum of income and as long as they can live with what you have given them, they're doing fine. They don't have someone else coming in, saying I'm going to take away your business and I can bid it at half the price because I'm much more efficient. So we have no way of knowing whether they potentially have a whole lot of money.

Mr. KAVANAGH. You're looking at an economic analysis, whether they have an incentive to do a good job or not. In looking at it from a purely economic analysis, I would have to agree with you. However, I do believe that the contractors have a lot of pride in what they do, are held accountable for us because we can nonrenew their contract, although it's somewhat difficult to do that.

Mr. SHAYS. And almost meaningless, so—I mean, how often has it happened since you have been there?

Mr. KAVANAGH. It's happened. It's probably happened 10 or 15 times.

Mr. SHAYS. In 18 years.

Mr. KAVANAGH. But we do look at what they do, we do evaluate what they do, we do go back to them and say——

Mr. SHAYS. In all due respect, it's hard to evaluate—I know I'm interrupting you, but it's hard to evaluate them because you can't compare them to something else. You really can't. When you compare carrier to carrier, do you see a big difference in terms of we want to know carrier by carrier, is there a way to evaluate whether they're more efficient because they're not in the same district? Do you have any analysis like that?

Ms. RUIZ. I'm not sure efficiency is really the question that we're dealing with here today. The carriers generally have brought their unit costs for an entire claim from start to finish down by probably about half in the last 5 years. You could say that's a measure of efficiency in and of itself. The real question is what are they doing with the dollars that they get. In the end we can set up all kinds of numerical or objective standards for them to meet, but what we

have found is that that really can be sort of a perverse incentive. We needed to come up with new incentives, which is why in payment safeguards we focused on outcomes, what are they really finding, what are they doing about it. Is that a simple process to do? No. Oversight of them has not been an easy process, and we agree with you that competition would help, more competition would help.

Mr. SHAYS. I want to come back to you in a second. The bottom line for me is I can't get beyond the fact that there are certain types of health care services that can be screened out pretty quickly that are inappropriate, that aren't happening. The response is, first, that there's not a whole lot of money to deal with that on the part of the carrier. That's where I'm asking us to be problem solvers here, and that got us into the fact that there isn't a lot of competition, which basically got us into the fact that basically HCFA is at the mercy of providers and carriers and is letting them work it out.

That begs an analogy which I won't give, but it's not a good analogy. I came into Government life in 1987, thinking the Government could do it better, but now I have a feeling that's impossible just because of the mind-set and the culture. You all have been in a system where there isn't competition. So I wonder why we just don't say, and tell me why if there is a reason, why we just don't require every carrier to have an autoadjudicated screening system and then say you keep expanding it once we can be comfortable, that for these particular services this screening system will work. I mean, we can knock out those as being inappropriate. Why don't we do that?

Mr. KAVANAGH. I wish it was that simple. What we would like to do—what we are doing and I may have left you with the impression that the dollars were the overriding issue. It is certainly a part of the issue, but that's not the overriding issue. What it is, is that each individual carrier has to develop medical policy in that area to justify those screens. We are developing model policy on these six services and I said a number of others, to be able to autoadjudicate those screens. We allow the contractors to make a determination of whether they're going to implement those screens or not. We will then go look behind and make them justify whether they made a cost effective decision about implementing those screens or not.

Mr. SHAYS. So what I hear you saying is that for some of these, HCFA is coming in and is in a sense overriding the carriers and saying we want you to do it in these areas, is that what I hear you saying?

Ms. RUIZ. I think what we have found is that there is a combination or a cooperation and coordination that's necessary. We need the help of the provider community. If we do not have the help of the provider community, we're not getting adequate input about what the medical practices and standards are out there. But we also need the carriers because they have the day-to-day expertise about what they see as the abuses and the problems in their area, and where the dollars are flowing out the door.

What we have through our model policy development is a combination of central office, the carrier medical directors from the car-

riers and the local provider community inputting into that process to come out with something that's fairly uniform across the country.

Mr. SHAYS. But, see, I'm just at these six. You're back into the "all" kind of frame of mind.

Ms. RUIZ. Those six are being addressed through that process. Three have already been addressed. The other three will be finished soon.

Mr. SHAYS. What do you mean addressed?

Ms. RUIZ. That we have policy developed for them.

Mr. SHAYS. It's great that you have policy. It's mot being addressed. You have policy. So is it being implemented?

Ms. RUIZ. As soon as they have policy, they can put screens in place.

Mr. SHAYS. Let me back up. Are you going to require all your carriers to have this kind of system?

Mr. KAVANAGH. What we're going to do is we're going to put out the model policy, tell the contractors, through their process of making a determination of what are the most effective screening techniques in their local area, to make a determination to install these or not, and then look behind whether they did that or not. Because we don't want to get into a process where we're forcing them to spend money on screens that aren't effective because we in Washington think that they're the right screens for them.

Mr. SHAYS. I think that's something that a Republican would say, and so it's interesting, but it doesn't really answer the question.

On these six issues, do you have any doubt that if you had a screening system that you would be able to knock out a lot of inappropriate claims?

Mr. KAVANAGH. Yes.

Mr. SHAYS. You do have doubt?

Mr. KAVANAGH. Yes.

Mr. SHAYS. Where is your doubt?

Mr. KAVANAGH. My doubt is that what the GAO did was look at claims after the fact that were paid. They don't know what process the carriers went through in terms of looking at those claims in the actual process because they didn't look at that. They looked at after the fact. And we don't know what other screens the contractors have in place that may effect these services. The one problem you have, this looks like a simple process, but you could end up screening out these services and it balloons out in another area. That's one of the real difficulties we have here. That's one of the reasons why you want to develop medical policy on these areas, to be able to address those issues, also.

Mr. SHAYS. That begs another question, but before I ask that question, you have for three policies and you're going to look at a few more, and those are policies. When will you be done?

Ms. RUIZ. We'll never be done. This is a constant process.

Mr. SHAYS. On those items.

Mr. KAVANAGH. You're talking about these six?

Mr. SHAYS. Yes.

Mr. KAVANAGH. We should be done sometime this summer.

Mr. SHAYS. Why would it take you until the summer?

Mr. KAVANAGH. I'm talking about actually getting the policy out to the carriers, having them put it through their local comment process, getting back the policy and actually implementing that.

Mr. SHAYS. So we have to go through a policy where the contractors have the right to look at this, there are certain schedules by regulation?

Mr. KAVANAGH. No, it's our schedule, that we believe that it's important to get input from the local medical community. Again our greatest screen, it's not an automated screen, our greatest screen is education of physicians. We don't want physicians to inappropriately bill this program. We want to educate physicians about what is appropriate billing and inappropriate billing. That happens in that consultation process, in that education process.

Mr. SHAYS. These models are being developed by physicians outside or are you doing it in-house?

Ms. RUIZ. It's being done by the carrier medical directors. The Bureau of Policy Development reviews the policy.

Mr. SHAYS. So the carriers are doing it?

Ms. RUIZ. Yes.

Mr. SHAYS. Then you're going to ask them to review what they've done?

Ms. RUIZ. No, what happens is they submit those policies to their carrier advisory committees, which are made up of local physicians from all the specialty societies in the States. They have a 45-day notice and comment period, which includes comment from that carrier advisory committee, so that they're sure to get input from the local physician community.

Mr. SHAYS. I'm going to ask Ms. Phelps to go. I'm just going to say, this is on the table. I would like to hear your response to it. This committee is going to devote a lot of time and effort to this. We're not necessarily talking about any change in law, but we're looking, in my judgment, at hundreds of millions of dollars. You have told us a lot of things, told me a lot of things that I have to digest to enter into this about the lack of competition and so on. But to me it's still a no-brainer.

Ms. PHELPS. No more questions.

Mr. SHAYS. I thank you both for being here. Is there anything you wanted to say in conclusion before we close up here?

Mr. KAVANAGH. I just thank you for the invitation to testify, and I'm sure we'll be working closely with your committee on this.

Mr. SHAYS. Mr. Kavanagh, I thank you for being here. I want you to know that we will be working closely together. I do want to say for the record, I am kind of disappointed, however, that there would not have been a more in-depth response to this report explaining to us why you don't think it's valid, because we haven't even gotten into that one. So I need to see that, and I think really what we'll do is we'll revisit this.

I hope when we do revisit it in the next few months that you could give us some concrete steps on how you're addressing what you think is valid, and then how you're simply not going to address the other things you don't think are valid and that would be helpful to the committee and I thank you.

This hearing is adjourned.

[Whereupon, at 11:40 a.m., the subcommittee was adjourned.]

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