

Review & Commentary on Health Policy Issues from a Rural Perspective - March 1st, 2001

Medicare Accountability—"First Do No Harm"

From "It's Not the Job, It's the OIG and the 99203s" by Leonard Laster in the *Washington Post*, 1/21/01:

"It was one of his 'free' Thursday afternoons, and my friend invited me to come by and visit. His desk was piled high with patient records that he needed to review and sign. Later he was scheduled to work at the clinic where he volunteers to care for patients who can't afford health insurance but aren't poor enough for government help. I'm not using his name here because it wasn't his choice to go public like this. A graduate of a top medical school, my friend is a very caring family practitioner in solo practice... At age 55, he ought to be at the peak of his career."

"After our talk I told a number of people about my friend's discontent. Many reacted with skepticism: 'Oh sure, doctors always threaten to quit, but they never do.' Well, this one did. In mid-November my friend informed his patients that he's through as of early April. For the many people like me who respect and count on him, it's a serious loss."

"To my friend, the familiar problems facing most American doctors today -- HMO clerks second-guessing his clinical decisions, massive paperwork, the pressure to cut back time with patients--are only background noise. What's driving him out is the feeling that the agency that runs Medicare--the Health Care Financing Administration, or HCFA -- treats

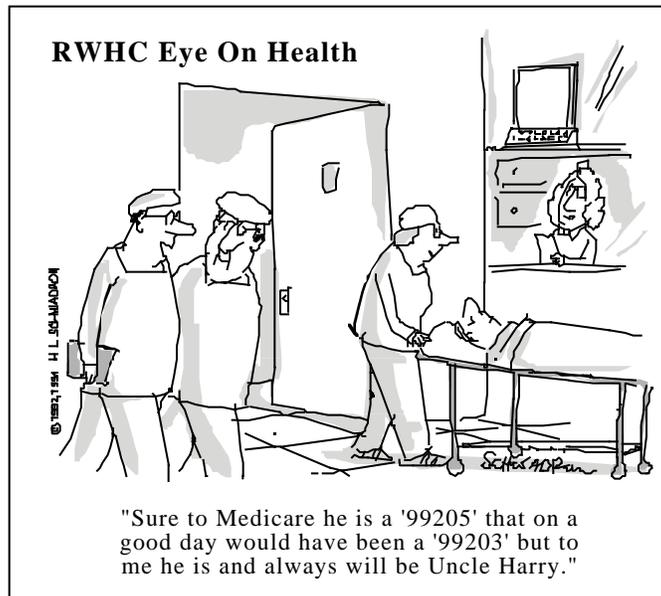
him like a penny-ante chiseler. 'I'm at the mercy of HCFA, the OIG, the HHS and the DOJ, not to mention the HMO administrators outside of government,' he said. (The rest of that alphabet soup refers to the Office of the Inspector General of the Department of Health and Human Services and the Department of Justice.)"

" 'Maybe I'm just a chronic complainer who whines a lot,' he said. But after hearing his story, I don't think he is. He's really being driven away from a profession that needs people like him."

"This is what I've learned. After seeing a Medicare patient, a doctor has to classify and document his services in sufficient detail for HCFA (or its contracted regional agents, called 'carriers') to determine what to pay him. This turns out to be a lot more convoluted than I had suspected. Having first

put the visit into the subcategory 'new patient' or 'established patient,' the doctor must rank a patient's history as problem-focused (PF), expanded problem-focused (EPF), detailed (D) or comprehensive (C). He does the same for the physical examination (PF, EPF, D or C). Then he labels the medical decision-making process as straightforward (S), low complexity (LC), moderate complexity (MC) or high complexity (HC)."

"These aren't casual choices; HCFA and its carriers have specific requirements for each. For instance, a detailed (D) physical examination must cover two or more body systems and areas and include 12 or more specified procedures, such as listening for heart murmurs and examining the retina for evidence of diabetes. Each procedure, whether it revealed anything or not, must be recorded."



“Then the doctor uses these alphabetical classifications to derive a code number, which he submits to his HCFA carrier. A ‘new patient’ visit with a detailed (D) history, a detailed (D) physical exam and low complexity (LC) decision making might qualify for a code number such as 99203 for reimbursement. A high complexity (HC) decision would have rated a different number, say 99205, and a higher payment.”

“If the doctor’s any good, he’s doing this paperwork in a hurry, because he prefers to spend more of his time seeing patients than keeping records. It’s all too easy for some things to slip through the cracks. He feels for the liver, it’s normal; listens to the heart, it’s normal; checks the retinas, they’re okay . . . and he omits one or two of these routine and unrevealing checks from the chart. If a random audit by a carrier finds that fewer than the required 12 tests are noted, that doctor has officially been overpaid. He has overcharged the government of the United States of America.”

“At any time, a carrier can demand ‘documentation of the history, examination and decision making which support the level of the evaluation and management service rendered.’ If the carrier should decide that the doctor ‘upcoded’ his bill, then agents can enter his office without warning and conduct a full-scale audit.”

“As my friend sees it, ‘To stay out of trouble, I must provide proof of my innocence in every patient’s chart -- 25 times a day, more than 6,000 times a year.’ ”

“To be fair, in dealing with individual doctors like my friend, HCFA usually leans toward ‘errors’ rather

than ‘intent to defraud.’ But the subliminal threat of being swept into a fraud case is intimidating.”

“At this point, you’re probably thinking, these are doctors, after all. Presumably they’re smart enough to keep complete records. But the HCFA and OIG regulations are fuzzy and changeable. There is no single guidebook about billing and coding questions; every month physicians receive pages of notices, guidances and issuances from their Medicare carriers describing ever-changing policies and regulations. Different carriers can implement HCFA policies differently. Ignorance of a new regulation could result in an unintentional violation—and the possibility of it being declared fraudulent.”

“What difference does all this make to the rest of us? A lot. It takes years of effort and resources to train a doctor, and the good ones grow better with time and experience. The combination of skill in the art and science of medicine and the compassion to treat patients with care and concern is something to treasure. An unnecessary waste of doctors like my friend is bad news for all of us.”

“But I must acknowledge that the problem isn’t easily solved. HCFA isn’t trying to harass doctors; it obviously needs tools and procedures to prevent and detect Medicare waste, fraud and abuse. Last spring, in draft regulations for individual and small group physician practices printed in the Federal Register, the OIG stated that ‘the great majority of physicians are honest’ and ‘are working ethically to render high quality medical care to our Medicare beneficiaries and to submit proper claims to Medicare’ and that the department is not ‘seeking to punish someone for honest billing mistakes.’ ”

“But that’s not how it feels to the doctors. **To say that HCFA needs to pause, take stock of how it treats doctors and make some meaningful improvements is not to condemn Medicare or plead for special treatment for doctors.**”

“Some possible remedies seem relatively straightforward. Make the audit environment more humane by simplifying and clarifying the rules. See to it that HCFA carriers implement the rules consistently. Help the doctors understand the system and don’t change it every 10 minutes. When a pattern of overcharging is discovered among the doctors in a given area, investigate whether the problem stems from confusing regulations.”

“And I have an even better suggestion. Even though I’m a doctor, I had no real appreciation of the impact of HCFA’s system until I heard the story of my friend’s

The **Rural Wisconsin Health Cooperative**, begun in 1979, intends to be a catalyst for regional collaboration, an aggressive and creative force on behalf of rural communities and rural health. RWHC promotes the preservation and furthers the development of a coordinated system of rural health care, which provides both quality and efficient care in settings that best meet the needs of rural residents in a manner consistent with their community values.

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frustration. My guess is that the top people at HCFA and the Office of the Inspector General don't have such an appreciation either. I recommend that they choose five or 10 doctors who treat the elderly and spend a full working day with each. I'm confident that walking through a day in their lives would be invaluable. Let the generals see what things are like for the troops and make corrections based on common sense."

MD Recruitment From Developing Nations?

From "West Lures Its Doctors; South Africa Fights Back," by Rachel L. Swarns in *The New York Times*, 2/11/01:

"In his travels through the bustling towns and remote villages of North America, South Africa's ambassador to Canada discovered hundreds of South African doctors working in Canada's gleaming hospitals and clinics. And when he learned of Canada's plans to hire even more foreign doctors, he howled."

"This week, in a leading Canadian medical journal, South Africa is going public with its battle to stop the Canadian government from recruiting its desperately needed doctors, who are fleeing South Africa by the hundreds as they tire of high crime rates and chronically understaffed and underfinanced hospitals."

"South Africa's ambassador to Canada, Andre Jaquet, argues that it is unethical for the West to lure doctors from the developing world, particularly from South Africa, which has too few doctors, and struggles to provide medical care for millions of impoverished people and to cope with the AIDS epidemic."

"For decades, doctors here have found that their solid medical training has prepared them to pass tests for foreign physicians in the West."

"'If you take two South African doctors to rural Canada, that's great for those two villages, but that means a whole section of Chris Hani Baragwanath closes,' Mr. Jaquet said in a telephone interview, referring to the hospital that serves Soweto. 'And it leaves us less prepared to deal with the biblical plague of AIDS that has hit us.'"

"But Dr. Peter Barrett, the president of the Canadian Medical Association, says South Africa is pointing the finger of blame in the wrong direction. He says South Africans should ask themselves why they cannot keep their own doctors. He added that he doubts that Canada's recruitment efforts are pushing doctors to leave South Africa."

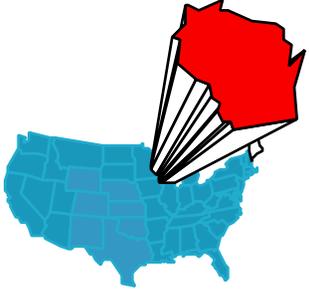
"'We are short of doctors, in every province literally,' Dr. Barrett said. 'But when I talk to South African doctors who have come here, they all give the same reason. They've left because of the violence and the fears for the safety of their families.'"

"Sibani Mngadi, a spokesman for South Africa's Ministry of Health, said foreign governments must consider the damaging impact of their recruitment drives. 'We don't have enough doctors in South Africa; that is a known fact,' said Mr. Mngadi, who said his government has issued similar appeals to Britain."

"But Martin Vogel, a South African doctor who moved to Canada seven years ago, said he doubts the government's efforts will have much impact. He moved his wife and

children to flee the crime, he said, observing that the number of South African doctors in Canada seems to be swelling. There were so many South Africans at the Saskatchewan Medical Association's annual golf tournament last year that Dr. Vogel, who is the president of the association, was able to stand before the group and tell a joke in Afrikaans."

"Dr. Vogel also said, 'It's the duty of any country to try and ensure that you have a high level of trained pro-



Wisconsin's 4th Annual Rural Health Conference
April 26th and 27th in Mosinee
Among other keynotes:
Marcia Brand, Interim Director,
Federal Office of Rural Health Policy
Wisconsin's own national television personality,
Dr. Zorba Paster, author of *The Longevity Code*
For Registration Info: bduerst@facstaff.wisc.edu

professionals to serve the needs of the population. But you cannot do that by closing the door and putting up bars. You have to create an environment where people feel safe, where they can flourish and prosper.’ ”

Excessive Tax Cuts Threaten Medicare

From “A Medicare Shell Game,” an editorial in the *Washington Post*, 2/4/01:

“The Medicare payroll tax has traditionally been reserved for paying hospital bills. The cost of other care has been covered by a combination of premiums and general revenues. Now the Bush administration wants to change that mix. The purpose is to create more room -- or the appearance of room -- for the president’s proposed tax cut.”

“The administration would use the payroll tax—Medicare’s share of ‘FICA’—to cover a larger share of costs, beginning with the cost of the prescription drug benefit that, to different degrees, both parties want to confer. The larger the share assigned to the payroll tax, the smaller the burden left to be borne by general revenues, and the more it will seem that the country can afford the tax cut. But the converse is also true: the larger the burden on the payroll tax, the faster the Medicare program runs out of money. The shift the administration suggests would amount to financing a significant share of the tax cut—as much as a third of a trillion dollars’ worth in just the first 10 years—at Medicare’s expense. And that is wrong.”



“There’s no extra money in Medicare to be tapped for anything—not a drug benefit, not a tax cut. Medicare’s financial condition is in fact the leading argument against an excessive tax cut. In not too many years, when the boomers retire, Medicare will itself be in need of funds, a vast amount, or else benefits will have to be cut more than either party is prepared to countenance. Such cuts would do great harm. There are arguments for and against the kind of reform the President envisions, but at best it would barely moderate the costs that lie ahead. **A large tax cut won’t force a reduction in those costs. It will simply leave the government without the means to pay them.**”

The Rural Interest In Medicare Reform

As Congress again begins to address the fundamental need for a major overhaul of Medicare, it is critical to carefully think through the opportunities and risks for rural beneficiaries. The following is from an excellent analysis published last year by the Rural Policy Research Institute (RUPRI) consequent to earlier discussions and with anticipation of those to come—*A Rural Assessment of Leading Proposals to Redesign the Medicare Program* by RUPRI’s Rural Health Panel, 5/31/00. The full report is available at:

<http://www.rupri.org/pubs/>

“This Policy Paper provides a critique of two proposals to redesign the Medicare program: the ‘Medicare Preservation and Improvement Act of 1999’ (S. 1895, introduced by Senator Breaux and others) and ‘The President’s Plan to Modernize and Strengthen Medicare for the 21st Century.’ Rural implications of the proposals are discussed, specifically how they affect rural Medicare beneficiaries and rural providers of health care services.”

“Both plans redesign the Medicare program in a manner that expands basic benefits and provides increased economic incentives favoring health plans that are able to price their products competitively. Major elements of the two proposals include:

- prescription drug benefits available to all Medicare beneficiaries;
- current Medicare benefits included in a core package that must be offered to all Medicare beneficiaries;
- health plans encouraged to compete based on price and benefits;

- traditional Medicare treated as a competing plan;
- new authority for traditional Medicare to adopt the purchasing strategies used by managed care organizations; and
- special efforts to provide Medicare beneficiaries education about the new structure.”

“The proposals differ in how they would finance the prescription drug benefit: by making it a part of defined benefits in high option plans (S. 1895), or as a new, separately financed, part of Medicare (President’s proposal). The President’s proposal retains current payment systems, S. 1895 does not. Both plans rely on offering beneficiaries choices among competing health plans, to provide greater access to comprehensive benefits (including prescription drugs).”

“The following realities of delivering and financing health care services in rural areas would need to be considered in adopting this approach:

- in remote rural areas there is unlikely to be any competition among health plans;
- in other rural areas the small number of providers and a modest number of beneficiaries will limit the number of competing plans;
- in some rural areas regional providers may be able to support a locally-based competitive health plan;
- in most rural areas the success of new plans, particularly managed care plans, will depend on the active participation of networks of health care providers; and national premiums will be influenced by the ability of insurers to extract savings from health care delivery predicated on a high volume of business, which would disadvantage plans operating in rural areas.”

“In the judgement of the RUPRI Rural Health Panel, the following implications of the two proposals warrant attention during future discussions of Medicare redesign:

- To the extent that competing plans are relied upon as the source of affordable benefits, rural areas are at a disadvantage.
- If traditional Medicare is the only option in rural areas, fiscal difficulties encountered by that plan would pose special problems for rural residents.

- All rural beneficiaries would have access to a plan that includes coverage for prescription drugs, a significant improvement for rural persons. There is no assurance that the difference in current plan offerings between urban and rural Medicare HMOs would be discontinued under these reform proposals. Rural beneficiaries may continue to experience a different, less attractive set of choices.
- Extensions of cost saving provisions in the BBA (President’s proposal), while less onerous than those in effect in 2000, perpetuate the problem of imposing several reductions on the same providers in rural communities.
- Selective contracting could have serious implications for rural providers, especially essential providers.
- The HCFA-Sponsored Medicare plan (S. 1895) could be required to continue special payment considerations for specified rural providers, but with a special subsidy so as not to affect the competitive position of that plan.”

In Quality Matters, Rural Not Small Urban

Congress’s Advisory Committee on Medicare, MedPAC, has been mandated to produce a report in June 2001 on the impact of Medicare in rural areas. They have made a number of site visits and reviewed payment issues. A Rural Quality Of Care Panel was convened on January 24th to discuss how Medicare policy relates to issues of quality of care in rural communities. The following is a brief summary from a participant, Tom Dean, a South Dakota physician specializing in Family Practice. A more detailed report is expected to be produced by MedPAC staff in the near future and be available at:

<http://www.medPAC.gov>

1. “Rural is not a uniform descriptor. Within the category there is wide variability of both geographic and demographic characteristics.
2. The relationship between volume of services and quality is not clear-cut. For a number of high tech services larger volume produces better outcomes but a similar relationship has never been demonstrated for many common procedures. We need better data to sort out what the minimal volume

threshold is for good outcomes for many procedures.

3. Care in rural facilities is better for some conditions than in complex, impersonal urban centers.
4. We need to develop quality assessment techniques which reflect community values -- especially the impact of receiving care close to home. Accreditation standards do not always guarantee good patient experiences and frequently fail to verify personal aspects of care delivered.
5. There is powerful association between access to care and overall quality of care.



6. Out migration of mobile portions of the rural population to urban centers is a threat to the stability and therefore the quality of rural programs.
7. When patients are transferred from one health care facility to another there are often breaks in communication and risks that quality may be compromised.
8. Quality care requires resources -- both financial and personnel. Providing care is not always cheaper in rural settings and is, in fact, often more expensive. One of the participants recommended that the area wage adjustment should be

totally eliminated to make up for the diseconomies of scale in small systems.

9. Focusing on outcome measurement is extremely difficult to assess quality in rural systems because of small numbers and the near impossibility of achieving statistically significant results.
10. Quality measurement is not possible without significant infrastructure in place. In this regard being grouped into larger systems definitely has advantages.
11. There is great potential for assistance from informatics systems to assess quality. Care needs to be taken to be sure that systems that are selected are appropriate for the setting and the tasks. If Medicare is serious about promoting quality they must help with the capital expenditures necessary to put these systems in place.
12. The regulatory burden is proportionally much greater on rural facilities than on urban both because of the inappropriateness of many of the requirements and the shortage of personnel and dollar resources to implement them. (Tom Dean noted that his hospital had been required to install a sprinkler system inside the walk-in freezer -- presumably to protect us from combustion in the ice cream and frozen peas!)
13. The discussion ended with a reminder of the old saw 'rural is NOT small urban.'

Medicare Isn't The Only Federal Program

State profiles describing health status and federal health investments are available on line at:

<http://www.hrsa.gov/stateprofiles/>

from the Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services (Tommy Thompson, Secretary).

"HRSA is the federal agency that assures access to essential health care for low-income, uninsured, and medically underserved populations. HRSA funds support community health centers and other providers of community-based primary care; the National Health Service Corps, which places physicians, nurses, and other health professionals in underserved areas in exchange for scholarships or loan repayment; health care services for people living with

HIV/AIDS, including Wisconsin's AIDS Drug Assistance Program, through the Ryan White Comprehensive AIDS Resources Emergency Act programs."

"HRSA supports systems of care for pregnant women, infants, toddlers, children, and adolescents, especially those children with special health care needs; health professions training programs that increase the diversity and improve the distribution of primary care providers within each state and the Nation; organ, tissue, and marrow donation and transplantation efforts; telehealth and distance learning activities; and a variety of other resources-building programs promoting better health care services in rural and urban America."

"The health indicators featured in HRSA's State Profile illustrate met and unmet health care needs in Wisconsin and describe how the State is using HRSA funds to work in partnership with regional, State, and local programs to improve access to services that will meet those needs. Where appropriate, the State Profile includes objectives from Healthy People 2010, the Nation's disease prevention and health promotion agenda."

Core Rural Health Resources & Contacts

This listing was prepared by ORHP, the Federal Office of Rural Health Policy in HRSA; contact at 301.443.0835 or <<http://www.ruralhealth.hrsa.gov>>.

NOSORH: National Organization of State Offices of Rural Health; <http://www.ruralcenter.org/nosorh>

RICHS: Rural Information Center Health Services
1.800.633.7701
<http://www.nal.usda.gov/ric/richs>

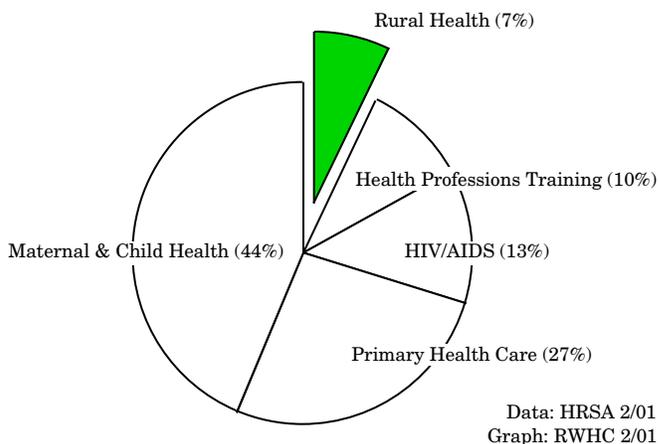
NRHA: National Rural Health Association
816.756.3140
<http://www.NRHArural.org>

NRHRC: National Rural Health Resource Center
218.720.01700
<http://www.ruralresource.org>

3RNET: National Rural Recruitment and Retention Network; 1.800.787.2512
<http://www.3rnet.org>

RUPRI: Rural Policy Research Institute
402.559.5260
<http://www.rupri.org/healthpolicy>

Distribution Of The \$41 Million HRSA Grant Funds Awarded To Wisconsin In FY 1999



Wisconsin's BadgerCare In The Limelight

Wisconsin's BadgerCare has been in the national news quite a bit consequent to our Governor becoming President Bush's Secretary of Health & Human Services. An excellent *States Coverage Initiatives Case Study* of the program (funded by the Robert Wood Johnson Foundation) is available online at:

<http://www.statecoverage.net/publications.htm>

"Wisconsin's BadgerCare program is viewed by many as a model for how other states could pursue comprehensive health insurance coverage for lower income families. The program provides health insurance to working families — both children and their parents — and seeks to eliminate barriers to successful employment by providing a transition for families from welfare to private insurance. BadgerCare's success is founded on its family coverage approach, its single point of entry and administrative seamlessness, and the political commitment to the program from Governor Tommy G. Thompson."

"In 1999 and 2000, New York, New Jersey, and the Clinton administration recognized the importance of a family-based approach to children's coverage by proposing, and in the states' case, implementing some variation of the Wisconsin model. Other states have indicated interest in covering families and look to the flexibility of the Health Care Financing Administration's recent ruling on 1115 demonstration projects to cover parents using the enhanced State Children's Health Insurance Program (SCHIP) match."

“This case study details the BadgerCare program and its impact on the uninsured in Wisconsin, including how the program approaches enrolling families, how family coverage is financed, how the program partners with private insurance, and what cost-sharing obligations exist.”

The State of Wisconsin has its own comprehensive BadgerCare web site at:

<http://www.dhfs.state.wi.us/badgercare>

Rural Teleconferences That Actually Work

The Rural Wisconsin Health Cooperative (RWHC), in partnership with the Southwest Wisconsin Area Health Education Center (SWAHEC), has recently enhanced our teleconferencing capabilities to allow our 29 member hospitals greater access to monthly meetings, professional roundtables, and a wide range of educational programs. Ultimately, this will improve the quality of health care in those rural communities served by RWHC hospitals.

Most of the Rural Wisconsin Health Cooperative membership falls within a hundred-mile radius of the

RWHC office in Sauk City, Wisconsin. But even for a member well within that distance, with rural roads, accessing programs and services in person can prove problematic because of the traveling distance and competing demands on staff time. While face-to-face interaction is preferable, RWHC members now have the option of “attending” meetings and presentations through a state-of-the-art teleconferencing system that includes ceiling microphones, high fidelity speakers and echo-canceling technology built into RWHC’s two conference rooms. No more of those dumb little “flying saucers” that never seem quite to work very well.

This project was made possible through a \$14,000 partnership grant provided by SWAHEC, which was awarded to RWHC last Fall. SWAHEC is one of four regions of the Wisconsin Area Health Education Center, which is a statewide project dedicated to improving access to health care in the state’s rural and urban underserved communities.

Since implementing the new teleconferencing system, RWHC has taken on three new members, experienced a 25% increase in roundtable participation, and documented a significant increase in attendance at monthly board meetings. These enhancements are the first of several planned cooperative telehealth innovations to assist RWHC’s mission of supporting and strengthening rural health care in Wisconsin.

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