



June 23, 2003

Thomas A. Scully, Administrator  
Centers for Medicare & Medicaid Services  
Room 445-G Hubert H. Humphrey Building  
200 Independence Ave, SW  
Washington, DC 20201

**Attention: File Code CMS-6002-P**

Dear Administrator Scully:

The Association of American Medical Colleges (AAMC) welcomes this opportunity to comment on the Centers for Medicare & Medicaid Services (CMS or the Agency) proposed rule entitled "*Medicare Program; Requirements for Establishing and Maintaining Medicare Billing Privileges,*" 68 Fed. Reg. 22064 (April 25, 2003). The AAMC represents approximately 400 major teaching hospitals and health systems; the 126 accredited U.S. medical schools; 96 professional and academic societies; and the nation's medical students and residents and clinical faculty members (academic physicians). Academic physicians represent nearly one-sixth of Medicare providers.

The AAMC recognizes and appreciates the Agency's efforts over the past several years to reduce the regulatory and administrative burdens on the physician community. We especially laud the work of the Physician Regulatory Issues Team (PRIT) and the Health and Human Services (HHS) Regulatory Reform Committee. We are grateful for the monthly open-door forums and other actions taken by CMS to keep the physician community informed about Medicare. Further, recent CMS revisions to Carrier Manual Instructions (CMI) Section 15016, Supervising Physicians in Teaching Settings, have been particularly beneficial to the academic physician community.

We also support the Agency's specific intent in this proposed rule to improve the provider enrollment process for Medicare Part B and prevent fraud and abuse within the Medicare system. However, we are concerned that in attempting to accomplish these goals, the Agency has created a proposed rule that may prove detrimental to both Medicare providers and beneficiaries. We have serious misgivings about the increased regulatory burden that would be established if this proposed rule were enacted. Further, current experiences with the provider enrollment process make it clear that compliance with the proposed rule will greatly increase the administrative and financial burden on academic physicians.

This letter addresses three issues of importance to the academic medical community: elimination of the ability to bill retroactively for services provided to Medicare beneficiaries before a provider number is assigned; the proposed shortening of the length of time for deactivation of Medicare provider numbers; and the reenrollment and triennial enrollment process.

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### **Elimination of Retroactive Billing**

Under current regulations, licensed physicians are allowed to provide services to Medicare beneficiaries while they await carrier assignment of provider numbers. Once the provider number is assigned, physicians are allowed to bill retroactively for these services. Under the proposed rule, physicians would not be able to bill Medicare or the beneficiary for services provided before the carrier issues the provider number.

We believe that enactment of this proposal will have particularly detrimental effects on academic medical centers and the provision of services to Medicare beneficiaries. Academic medicine is more likely than other sectors of the industry to employ physicians from other states, as a result of the nature of academic careers. Each year, on average, our constituent institutions have a new faculty hire rate of approximately 12 percent. For approximately 1/3 of AAMC faculty practice plans, this translates into at least 90 physicians annually. For physicians who are changing state residence along with changing employment, the state licensing process must first be completed to fulfill Medicare enrollment requirements. This step will add to the delay in issuance of physicians' Medicare numbers and the ability of physicians to care for and be paid for treating beneficiaries.

Further, the proposed rule notes that carriers are required to provide 95 percent of requested provider numbers within 60 days. There is some evidence among our members that the average wait time is much higher. Several geographically diverse practice plans reported average wait times of almost three months. One large northeastern faculty practice plan reported a range of three to six months, with an average of four to five months.

As noted above, currently these new clinical faculty provide services to Medicare beneficiaries while they wait the three or more months to receive their Medicare identification numbers and then retroactively bill for services. Data from our constituent institutions indicate that the dollar volume of retroactive billing at a faculty practice plan can be as high as \$5.1 million and the average across several geographically diverse practice plans that we surveyed is about \$2.8 million. Revenue loss of this magnitude, especially in the face of projected declining Medicare reimbursement rates for CY 2004 and beyond, will be a major financial loss to faculty practice plans.

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Under the provisions of the proposed rule, providers would not be able to bill Medicare or the beneficiary directly for care provided before the provider number is assigned. In the event that care is provided during that period, the institution would have to treat the care as charity care and have the administrative systems in place so that neither Medicare nor the beneficiary were billed to avoid sanctions under section 1848(p)(3) of the Social Security Act (the Act) and referenced in section 1848(g)(4) of the Act, which is identified as the source for potential sanctions in the NPRM. Even if an institution were financially able to provide such charity care, the administrative systems that would be necessary to ensure that neither Medicare nor Medicare beneficiaries are billed would be extremely difficult to implement and administer effectively.

Further, if an institution determined that it was unable to provide such charity there could be a detrimental impact on timely access to care for Medicare beneficiaries. Academic medical centers operate highly specialized and critical services, many of which are used by geriatric populations. However, physician staffing of these services are frequently provided by a limited number of physicians. Institutions do not have the luxury of creating "back up" staffing/on-call systems with only Medicare-enrolled faculty. Thus, if institutions are forced to only allow those physicians who have provider numbers to treat Medicare patients, then potentially increased waiting times for Medicare beneficiaries could result.

The AAMC encourages the Agency to eliminate this proposed change and to continue to allow physicians to treat, and retroactively bill, for services provided to Medicare beneficiaries before a provider number is assigned.

### **Reenrollment and the Triennial Enrollment Process**

The proposed rule establishes a requirement that all physicians reenroll with the Medicare program by completing one or two of four new forms: 855A, 855B, 855I, and 855R, depending upon the structure of the practice plan. CMS estimates the completion time for 855A and 855B to be eight hours each. CMS estimates that 855I will take five hours to complete and 855R will take 15 minutes to complete. This would be an onerous task for most of our membership. Approximately 35 percent of all faculty practice plans individually employ more than 750 clinical faculty. In a faculty practice plan with one thousand physicians, all of whom would have to complete forms 855I and 855R, would require 2.4 FTEs working solely on completing these forms for three years! Further, given that approximately 20 percent of enrollment applications need to be filed a second time, there would be a need for an additional 0.5 FTEs working solely

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on the resubmission of these returned forms. If CMS intends to require that the providers return the forms within 90 days, the average practice plan would need to hire approximately 10 FTEs for three months to comply.

Even limiting the reenrollment to physicians who enrolled prior to the introduction of the CMS 855 will be burdensome. Information from several geographically diverse practice plans indicates that more than one-third of their physicians enrolled prior to 1996. Further, plans report that many physicians who have been in practice for many years have difficulty locating original documents required for the process, such as medical school graduation diplomas. This will further lengthen and complicate the process.

The AAMC encourages CMS to reconsider the triennial reenrollment process. While it is understandable that the Agency seeks to keep provider records as current as possible, the undue burden placed on providers in completing 5.25 hours of paperwork per provider and an additional 8 hours of paperwork every three years, would have severe effects on the resources of practice plans and dramatically increase costs. An alternative to this would be a strict requirement that CMS be notified within 60 days of a physician death, transfer, retirement or termination. This would accomplish the same objective without an excessive administrative burden resulting from the regulatory change.

### **Deactivation of Provider Numbers after Two Quarters**

The proposed rule changes the length of time between the date of the last Medicare billing and deactivation of Medicare provider numbers. The rule would change this time period from four consecutive quarters to two consecutive quarters. This is an issue of grave concern for the academic physicians represented by the AAMC. While we understand that CMS could waive this provision for providers who remain in communication with CMS regarding reasons for periods of non-billing in excess of six months, we believe that this requirement will be very difficult to administer effectively and has the potential to cause an increased administrative burden for academic physicians, carriers and CMS.

Academic physicians, like all university faculty, are allowed to take leave from their duties to pursue research and/or for sabbatical. During periods of full time research or sabbatical, faculty physicians may not engage in clinical activity and would therefore not be billing Medicare. Sabbaticals are often granted for an academic year, so there is greater likelihood that faculty physicians will be deactivated while on leave.

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Further, faculty may have other reasons for infrequent billings to Medicare. First, as noted in the NPRM, some specialties, such as Pediatrics and Obstetrics/Gynecology, provide care to Medicare beneficiaries on an infrequent basis. Second, many academic medical centers utilize voluntary clinical faculty who are primarily based in private practice but provide teaching and clinical care on an infrequent basis. These physicians use their own Medicare and employer/tax ID numbers for their private practice and different numbers for their voluntary clinical faculty work. Thus, the shorter deactivation timeframe is likely to result in the deactivation of voluntary clinical faculty under their medical school-based provider numbers.

A final reason for infrequent billing of Medicare beneficiaries is embedded in the infrastructure of academic medical centers. Specifically, at many institutions faculty provide outpatient services in clinics that are hospital-based. Frequently, these outpatient services are billed by hospitals, with their employer/tax ID numbers. Inpatient based services may be billed by the medical school/faculty practice plans. The reverse scenario may also be true. In such cases, the numbers associated with the site of less frequent activity have a high probability of being deactivated.

Our analysis of billings of data from a sample of academic clinical faculty members in 2001 and 2002 showed that approximately 1 in 20 faculty physicians did not bill Medicare for more than 181 days. At one large Western institution, this component was nearly 22%. One institution reported that even under the current twelve-month provision 5 to 6 physicians are deactivated each week. If these physicians are deactivated and barred from treating Medicare patients until numbers are reactivated, access to care will be negatively affected.

As noted above, CMS has proposed that deactivation could be avoided through communication with the carrier and with CMS. Constituent institutions believe that current communication systems are ineffective and increased administrative requirements will necessitate that they be significantly improved if the proposed changes are implemented. For example, institutions reported that when carriers are notified of a physician death or termination, they deny all claims submitted after the date of death/termination, even for services that were provided prior to that dates. This has meant that claims must be resubmitted by the institution, furthering delay in payment.

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The AAMC encourages the Agency to eliminate this provision of the proposed rule and retain the current four-quarter (12 month) deactivation period.

### **Other Issues**

It is noted that the elimination of potential sources of fraud and abuse is a primary Agency objective behind the proposed rule. We would note, however, that a current requirement is not addressed in the proposed rule, and yet, serves as a source of high administrative burden and increases the probability of allegations of fraud and abuse. Specifically, physicians who practice in multiple physical locations are required to have separate enrollment numbers for each location (even when practicing and billing under the same employer). This is particularly onerous for academic faculty who may provide services at a main medical center campus and off-site locations, often in underserved communities.

CMS has said that the objective of this change relates to concerns over a provider's ability to apply for multiple provider numbers, and then use one of those "reserve" numbers to continue to treat Medicare patients if actions/sanctions are taken against the provider under the first-used number. The AAMC supports CMS's attempts to thwart schemes that can lead to fraud, but believes that changes in the rules should not have a negative impact on those who are not attempting to abuse the system. The AAMC suggests the elimination of the requirement that a physician have multiple provider numbers for multiple practice sites when employed by and billing under the same entity, thereby easing the burden on multispecialty groups, while not encouraging fraudulent behavior.

### **Conclusion**

Thank you for this opportunity to present our views. We would be happy to work with CMS on any of the issues discussed above or other topics that involve the academic health care community. If you have questions concerning these comments, please feel free to call Robert Dickler, Senior Vice President of the Association, or Denise Doderio, Assistant Vice President, both of whom may be reached at (202) 828-0568.

Sincerely,

Jordan J. Cohen, M.D.