BE IT RESOLVED, That the American Bar Association supports efforts to improve the administration and judicial process utilized by the Department of Health and Human Services in accordance with the following principles recommended by the Symposium on Medicare Procedures:

I. Establishment and Publication of Medicare Coverage Policy

A. HCFA should identify, compile, keep up to date, and provide reasonable access to all standards, guidelines and procedures used in making coverage determinations under the Medicare program.

B. In promulgating interpretations of Medicare benefits likely to have substantial impact on the public, HCFA should adopt procedures that allow for public comment.

   (1) HCFA by regulation (or Congress by legislation if necessary) should require fiscal intermediaries and carriers to improve access to all guidelines used in making Medicare coverage and payment determinations.

   (2) HCFA and the Office of Health Technology Assessment should promulgate, through notice and comment rulemaking, a description of its procedures and decisional criteria for making national coverage determinations and technology assessments. The process for making individual national coverage determinations concerning medical procedures and technologies should:

      (a) describe how such determinations are to be made, at the national, regional and contractor level;

      (b) allow for the maximum feasible public participation in the development of such determinations;

      (c) provide for timely processing of such determinations; and

      (d) identify, and provide reasonable access to, publications in which such determinations will be published.
C. Congress and HCFA should continue to explore the feasibility of mechanisms to allow prior authorization of benefits for nursing home admission and home health care services.

II. Establishment and Publication of Medicare Payment Policies

Congress, the Office of Management and Budget, HCFA, the Prospective Payment Assessment Commission and the Physician Payment Review Commission should continue to try to develop creative alternative systems and approaches for reimbursing providers for Medicare services which will ensure wide choices for beneficiaries among providers of high quality care. Incentives in the reimbursement system should respond primarily to beneficiaries' needs and should seek to assure quality of care, rather than to budgetary restraints. In establishing such payment systems and policies, Congress and the above-mentioned agencies should, to the extent practicable:

A. Encourage the publication of and public participation in the setting of payment rates for Medicare providers;

B. Consider ways to permit hospitals to appeal decisions under the Prospective Payment System involving rates and the diagnosis related grouping weights; and

III. Review of Necessity and Quality of Care

A. HCFA should continue its efforts to refine the process by which Peer Review Organizations review the necessity and quality of care provided under Medicare. In doing so, HCFA should strive to:

(1) Ensure that issues of medical necessity be reviewed, to the extent feasible, by PRO's (in which practicing physicians participate), rather than by carriers or fiscal intermediaries;

(2) Avoid placing emphasis on numerical standards and objectives in evaluating the performance of Peer Review Organization;

(3) Involve specialists earlier in the PRO process, e.g., prior to the initial denial; and

(4) Encourage PRO's engaged in quality of care review to go beyond review of the paper record in a sampling of certain cases, by attempting to increase patient involvement.

B. Congress and HCFA should ensure that personnel who monitor or review a type of service provided for by Medicare (especially home health care) be sufficiently educated and experienced in that field.

IV. Quality of Care / Sanctions Against Providers

A. Congress and HCFA, in consultation with medical speciality societies, should seek to
develop a system to define "professionally recognized guidelines of care" that is uniformly applicable in coverage determinations and in PRO reviews of individual provider conduct. Such guidelines should be developed, to the extent feasible, by clinicians in the various specialties so that the rough rules of thumb, utilization screens and other policies developed by Medicare contractors and PRO's to identify excess utilization will be less necessary.

B. Congress and HCFA should require PRO's to use, to the extent feasible, providers in the same specialty to review the work of a physician who is being questioned about violations that could lead to exclusion from the program.

C. Congress, HCFA, and the HHS Inspector General should continue to develop legislation and regulations permitting the assessment of flexible sanctions, so that other remedies short of exclusion can be used where warranted. These would include, a sliding scale of civil money penalties, requirements of additional training and temporary suspensions.

D. HCFA and the Inspector General should develop, after public comment, improved methods of notifying the public about PRO actions concerning particular providers. The posting of notices in the legal or classified sections of newspapers should not suffice; individualized mailing to potential beneficiaries should be considered.

V. AGENCY ADJUDICATIONS

A. Initial Determinations

Congress and HCFA should strive to bring more order and rationality to the process of making initial determinations on claims filed under the Medicare program. The current system whereby formal claims determinations are made by carriers, intermediaries and professional review organizations should be simplified and regularized. Specifically:

(1) HCFA should ensure that screening devices are appropriately used as triggering devices for further investigation of individual claims and not as automatic bases for denial.

(2) HCFA should continue to improve the written notices provided to beneficiaries by providing that notices concerning initial coverage and payment (a) be in large print, (b) be written at a reading level understandable by most beneficiaries, (c) clearly explain the medical basis for the decision, (d) advise claimants how to submit additional information and explain what information will be used and (e) explain any appeal rights.

(3) Congress and HCFA should take steps to remedy the lack of awareness by admitting personnel (nurses, doctors, practitioners, suppliers, and other provider personnel) that many "informal" decisions about beneficiary service needs amount to denials of service, which should result in giving beneficiaries written notice and an opportunity to appeal.

(4) HCFA should improve the various notices given to beneficiaries regarding the right
to challenge payment and coverage determinations by taking the following steps:

(a) Provide the notice of appeal rights about hospital discharge to patients of risk basis HMO's.

(b) Notify beneficiaries enrolled in HMOs that they have a right to disenroll from their HMO's 30 days after providing notice of a wish to disenroll.

(c) Study the timing of when notices of the right to appeal a discharge from a hospital are most effective, i.e., at the time of the impending discharge and/or at the time of admission;

(5) HCFA should take steps to ensure that when one of its agents (e.g., carrier, intermediary or PRO), gives advice that is demonstrably relied upon by a provider or beneficiary, the provider or beneficiary normally will not be adversely affected for following that advice.

B. Provider Appeals

(1) Congress should increase the independence of the Provider Reimbursement Review Board by strengthening the status and tenure of Board members. Congress should consider granting Board members the same status and tenure as granted to Administrative Law Judges under the Administrative Procedure Act. At minimum, the current three-year term for Board members should be significantly lengthened.

(2) Congress should consider making the decisions of the PRRB final agency action, (similar to action of agency boards of contract appeals) subject to judicial review by the losing party (whether the provider or HCFA). At minimum, Congress should require that any reversals of Board decisions by the Secretary be based upon the factual record developed at the Board.

(3) When resolving hospital rate appeals under the prospective payment system, the PRRB should be authorized by regulation (or, if necessary, by legislation) to assume jurisdiction of an individual hospital’s appeal in a manner that affords timely relief to successful appellants.

C. Beneficiary Appeals and the New Part B Hearing Process

In developing procedures for implementing the 1986 legislation creating new ALJ hearings in Part B cases, HCFA should ensure that:

(1) The costs and benefits of requiring carrier hearings as a condition precedent to ALJ hearings are carefully examined, including the extra expense and time consumed by such a step, offset by the potential for earlier claims resolution. HCFA should also consider consolidating the carrier reconsideration stage with the carrier hearing, or alternatively, making the carrier hearing optional for the beneficiary.

(2) The ALJ's used in such cases, regardless of their bureaucratic location, are well -
qualified, well-trained, and truly independent. Specifically HCFA should not be "penny-wise and pound-foolish" by attempting to use less qualified and lower paid ALJ's for Medicare cases than are used in social security cases or in any other comparable government program.

(3) Telephone hearings are offered only on a truly optional and voluntary basis. To make sure that this occurs, notices should clearly explain this policy.

(4) Sufficient ALJ's are hired to permit ALJ hearings to be scheduled and held at locations convenient to claimants without undue delay.

D. Appellate Review of ALJ Decisions

In developing procedures for agency review of ALJ decisions in Part A and Part B Medicare appeals, HCFA should consider establishing a discretionary review procedure whereby losing claimants could seek review by an appropriately selected and qualified review board. The board should be giving the discretion to manage its caseload by granting or denying review, but subject to strict deadlines so that expeditious judicial review of denied petitions, or petitions not acted upon, could be sought.

VI. JUDICIAL REVIEW

A. HCFA should continually reevaluate its litigation strategies: (especially the routine raising of jurisdictional defenses) on the ground that they too often force challengers to Medicare policy and practices to engage in lengthy, piecemeal and repetitive litigation.

(1) HCFA's should modify its practice of nonacquiescence in negative judicial decisions by, at minimum, issuing public explanations of when and why it feels constrained not to follow legal interpretations propounded in decisions of federal reviewing courts.

(2) HCFA should cease its practice of settling cases favorable to challengers on the condition that the challenger agree to a court order vacating the opinion.

B. Congress should eliminate the provision that bars judicial review of procedures used in promulgating national coverage determinations and the provision that limits reviewing courts' ability to review the validity of such determinations without first remanding the case to the agency for supplementation of the record (42 U.S.C.A. 1395ff(b)(3)).

C. Congress should amend the provision governing judicial review of PRRB decisions (42 U.S.C. 1395ooo) to provide for review on the administrative record in the court of appeals, rather than review in the district courts.
REPORT

THE ABA SHOULD ENDORSE THE CONSENSUS RECOMMENDATIONS OF THE SYMPOSIUM ON MEDICARE PROCEDURES.

The Symposium on Medicare Procedures, held on October 16-17, 1987 at the Xerox Center in Leesburg, Virginia, was co-sponsored by the American Bar Association Commission on Legal Problems of the Elderly and the Administrative Conference of the United States (ACUS). It was conceived during ad hoc discussions by the Commission, ACUS, administrative law judges and representatives of health care organizations interested in addressing proposed legislative and regulatory changes in the Medicare Procedures. It was modeled after a similar ABA-ACUS-sponsored Symposium on Federal Disability Benefit Programs, held on October 11-12, 1985 at Case Western Reserve School of Law in Cleveland, Ohio. The consensus recommendations generated by that Symposium are now official ABA policy, and many have been adopted by the Social Security Administration.

Because one primary goal of the ABA is to improve the American system of justice, it is particularly important to study and make constructive suggestions for improving the administrative review process available to aggrieved Medicare beneficiaries as well as providers to ensure that the process is both efficient and fair. Therefore, the ABA-sponsored Symposium was of critical importance. It enabled a widely diverse group of experts, many of whom have been adversaries in court, to examine Medicare procedures and suggest changes.

The Medicare Symposium focused on selected procedural issues, divided generally into program administration issues on the first day, and administrative and judicial review issues on the second day. General wrap-ups were presented at the end of each day's sessions. On the first day, Symposium participants heard panel presentations on administrative issues including claims administration by Peer Review Organizations (PROs) and other Medicare contractors; establishment and publication of Medicare coverage policy; and establishment and publication of Medicare payment policies. The second day focused on administrative and judicial review with panels on the potential conflict between procedural rights and quality of care; agency adjudication from initial determination, hearings before ALJs and the Provider Reimbursement Review Board, implementation of the Medicare Part B hearing process; agency appellate review; and judicial review. Panels comprised of experts with often competing or conflicting views discussed current practices and recommendations for change. Each panel was followed by lively discussion between panel members and participants. The Symposium provided a truly unique opportunity to air divergent views and to attempt to reach a consensus about controversial issues.
The process produced a set of recommendations which were circulated to participants for review and comment. These recommendations, modified slightly in response to comments from participants, were reached in large part by consensus by participants. Comments of participants are appended to the Symposium Report and Recommendations. The Symposium fostered the creation of thoughtful, well-reasoned recommendations to form a foundation for ABA policy.

The Commission on Legal Problems of the Elderly and ACUS commends the process used by the Symposium to reach these recommendations. Our review of their substance indicates that they form the basis for solid, needed improvements in the system. We urge their adoption by the ABA.

Respectfully submitted,

May 1988

John H. Pickering
GENERAL INFORMATION FORM

To Be Appended to Reports with Recommendations
(Please refer to instructions for completing this form.)

No._ (Leave Blank)

Submitting Entity: Commission on Legal Problems of the Elderly

Submitted By: John H. Pickering

1. Summary of Recommendation(s).

Recommendations emanating from the Commission on Legal Problems of the Elderly Administrative Conference of the United States (ACUS) Symposium on Medicare Procedures.

2. Approval by Submitting Entity.

May 1988 Commission meeting.

3. Previous submission to the House or relevant Association position.

ACUS has addressed many of these issues in its Recommendation 86-5 ("Medicare Appeals"), 1 C.F.R. §305, 86-5; and Recommendation 87-8 ("National Coverage Determinations Under the Medicare Program"), 1 C.F.R. §305, 87-8.

4. Need for Action at This Meeting.

ABA Board of Governors in August 1987 gave the Commission funds to sponsor the Medicare Procedures Symposium, and to suggest areas for ABA policy.
5. **Status of Legislation.** (If applicable.)

N/A

6. **Financial Information.** (Estimate of funds required, if any.)

None are needed.

7. **Disclosure of Interest.** (If applicable.)

N/A

8. **Referrals.**

Section of Administrative Law
Section of Individual Rights and Responsibilities
Senior Lawyers Division; Young Lawyers Division; Judicial Administration Division
National Conference of Administrative Law Judges
Committee on Federal Judicial Improvements
Forum Committee on Health Law
Commission on the Mentally Disabled

9. **Contact Person.** (Prior to meeting.)

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10. **Contact Person.** (Who will present the report to the House.)

John Pickering