NACDEP
National Coalition for Dually Eligible People
3315 Tulane Avenue
New Orleans, Louisiana 70119

April 27, 2003

Walter Stone
Paralegal Specialist
Division of Privacy Compliance Data Development
Centers for Medicare & Medicaid Services
Room N2-04-27
7500 Security Boulevard
Baltimore, MD 21244-1508
wstone@cms.hhs.gov

Re: The Medicare Part B Privacy Policy decreases access to community health care for our most disabled Medicare beneficiaries. By refusing to verify Medicare eligibility this policy increases medical costs and disparities in health care for these vulnerable people.

Dear Mr. Stone:

Thank you for agreeing to review this issue. Along with all physicians who treat this vulnerable population I ask that Medicare reconsider its new and excessively stringent Part B privacy policy so that all frail, elderly and disabled Medicare beneficiaries can get timely and appropriate access to primary geriatric care in the community.

Statement of the problem

Medicare Part B's "new interpretation" of the 1974 Privacy Act is counter-productive and decreases access to inexpensive community medical care for our oldest, poorest, sickest and most disabled Medicare beneficiaries. This overly-restrictive Medicare Part B Privacy Policy injures the very people the policy is trying to protect by placing a wedge in the doctor-patient relationship even before the relationship has a chance to be established.

This policy has made it difficult — and occasionally impossible — for me to treat frail elderly and disabled Medicare beneficiaries in my geriatric medical practice. Since this policy has gone into effect I have been forced to turn away several severely disabled Medicare beneficiaries because they could not say exactly the required words to the Medicare representative on the telephone, and so the Medicare representative would not release the patients' insurance and billing information to my staff. In this letter I will

describe five Medicare beneficiaries who had significant problems obtaining medical access to my office because of this restrictive Medicare Part B privacy policy.

Background for the problem

In 2000 Louisiana physicians received an "Urgent Message from Louisiana Medicare Part B" stating that because of the 1974 Privacy Act, Medicare

> will no longer be able to provide Medicare eligibility information over the telephone to providers without proper authorizations from the Medicare beneficiary! . . . [HCFA has advised] all Medicare contractors that virtually any information regarding the Medicare beneficiary is classified as 'entitlement information,' and includes the following: Any Medicare eligible information. Any information regarding a patient's secondary and/or primary coverage status. [Any] HMO involvement [and any] Medigap or complimentary crossover information.[1]

I have been practicing internal medicine and geriatrics in New Orleans for 26 years. As described in my monograph, *Dually Eligible People with Medicare and Medicaid,*[2] many of my patients are Medicare beneficiaries who are old, poor, sick and disabled. Some of my patients have had strokes and have difficulty speaking. Some of my patients have Alzheimer's disease or dementia and have difficulty understanding conversation. Some of my patients have psychiatric problems and have difficulty communicating with people in person or on the telephone. Most do not have a formal authorized representative, which Medicare now requires before it will release information the physician needs to begin treating the patient.

Prior to this new Medicare Privacy Policy, it was easy to accept these patients into my geriatric practice. I used to call Medicare and confirm the patient's Medicare eligibility and HMO status. Now, however, each new Medicare patient must hold my office telephone to their ear, speak to the Medicare representative on the telephone, and answer questions about their social security number and date of birth. If a patient's Medicare eligibility cannot be verified because the patient is confused or unable to speak, and does not have an authorized representative, I may not be able to see that patient.

(Patient #1) Last year I received a telephone call from the sister of a bed-bound patient with Alzheimer's disease who had been discharged from a local hospital with "tubes and pipes in her." The sister felt that her previous doctor had "sent her home to die," and asked me to come to their home to evaluate and care for the patient. Before this new Medicare Privacy Policy, I could easily agree to make a home visit to the patient. This time, however, I was stymied because I could not verify this needy patient's Medicare eligibility and HMO status. Medicare would not release the information to me

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[1] United States. Dept. of Health and Human Resources. HCFA. Urgent Message from Louisiana Medicare Part B. Baton Rouge: 2000.

[2] Hersh, Sheldon. Dually Eligible People with Medicare and Medicaid. New Orleans: National Coalition for Dually Eligible People, 2002. 14 Apr. 2003 <http://www.nacdep.org>.

or to the caretaker-sister, despite several rounds of three-way telephone conversations. Because of this Medicare Privacy Policy I could not accept this patient into my practice and could not make a home visit to her.

I am enclosing a copy of this "Urgent Message from Louisiana Medicare Part B," along with pages from Louisiana Medicare Part B Bulletins dated June 2000 and August 2000 which confirm these rigid requirements for releasing information, which physicians need before they can begin treating a patient.

I am also enclosing a copy of a Letter to the Editor by Dr. Michael Ellis, which appeared in The Times-Picayune. This Letter is titled, "New Medica[re] policy should be rescinded," and derides this counter-productive privacy policy as "ludicrous." Dr. Ellis states,

> After 35 years of providing this information, HCFA is now using the Privacy Act of 1974 as an excuse to refuse to give eligibility data about patients. This is akin to a VISA card company refusing to confirm credit to a department store, grocery, etc., which is considering accepting the card as payment.[3]

Other physicians have expressed similar concern and frustration regarding this policy. I am enclosing a fax from the Orleans Parish Medical Society. This fax documents that "the leaders of the Orleans Parish Medical Society met with Congressman William Jefferson and discussed the potential problems that could occur if physicians cannot easily confirm a patient's Medicare eligibility."[4] Obviously this is an issue of concern to a large number of physicians who want to treat Medicare beneficiaries.

Getting information from Medicare Part A is surprisingly easy.

Having resigned myself to living with the frustrations of Medicare Part B's privacy policy, I was surprised to discover that Medicare Part A has no such restrictive policy on beneficiary information.

(Patients #2 and #3) Recently, two mentally disabled Medicare beneficiaries came to my office after having been referred by a psychiatric daycare facility for mentally ill people. In order to be enrolled in this program all Medicare patients must have a physical examination posted on the psychiatric facility's chart. Although the psychiatric facility sent me a handwritten note with the patients' Medicare numbers on it, I was still obligated to contact Medicare to confirm that each number was correct and that the patients were not in a Medicare-HMO. Unfortunately, one patient could not understand the Medicare representative's questions, and the second patient was afraid to

[3] Ellis, Michael. Letter. "New Medica[re] policy should be rescinded." The Times-Picayune [New Orleans] 28 Dec. 2000: B6.

[4] Orleans Parish Medical Society. Fax. Privacy Act Impact Felt in MDs' Offices. 2000.

speak on the telephone. Both patients then got back on the bus and returned to the psychiatric daycare center.

I called the psychiatric daycare facility and explained my problems and frustration with the Medicare Part B privacy policy to the facility supervisor. She listened patiently and then explained to me how easy it is to access the very same information by telephone or fax through Medicare Part A. Apparently all one needs is a Medicare-assigned six-digit "facility number" in order to access a large body of information on Medicare beneficiaries, including sensitive psychiatric data. I dialed the telephone number she suggested and entered her facility's six-digit number. I was greeted with an automatic telephone-tree menu that walked me through the process of verifying a Medicare Part A beneficiary's eligibility and billing information, the number of remaining psychiatric hospital days, the patient's deductible status and more. I noted that I still did not have information on the patient's HMO status, so the psychiatric daycare center supervisor showed me a form to fax to Medicare Part A, which will provide the Medicare-HMO status, enrollment date, and other Medicare benefit data.

The Medicare Part B privacy policy decreases outpatient geriatric access, while increasing access to expensive emergency rooms and hospitals.

(Patient #4) Examine the following frustrating situation, which occurred in 2001. A new patient who had a stroke and dementia was brought to my office. This elderly woman was being cared for by her daughter with whom she lives. The daughter, who works full-time in order to pay for her mother's care, could not be at the first visit. Instead, the daughter sent her patient-mother with her live-in nursing aide, along with two burly men she hired to bring the wheelchair down the steps in front of their home. Although the nurse brought all the Medicare information the patient's daughter gave to her, my staff could still not verify her Medicare eligibility and HMO status because the Medicare representative on the telephone insisted on speaking only to the patient or her legal representative. Because this demented patient — who was strapped into her wheelchair — could not speak to the Medicare representative on the phone, and the patient's legal representative (her daughter) had to go to work to pay for the patient's medical care, the patient along with the nurse and two hired helpers were turned away.

I could not accept this patient into my practice even if I wanted to treat her for free. From previous experience I know that an initial visit for such a complicated, chronically ill patient may generate several hundred dollars of expensive blood tests, x-rays, and medications. These items would be billed directly by the lab, x-ray facility, or pharmacy, and so even if I wanted to offer this patient my office visit for free, it still would not be in my power to offer all of these other services for free. So if the patient is enrolled in a Medicare-HMO, then both Medicare and the HMO may refuse to pay any of these bills (because I am not a member of that HMO) and the patient would be personally responsible for *all* of the lab, x-ray, and medication bills. It is better to turn away such a patient, than to obligate the patient to such a large medical bill by mistake.

I often wondered what happened to people like this patient, because few of them ever return to my office. Do they simply go back home and wait until they became ill, and then go to the local emergency room by ambulance where anyone with a telephone or a fax machine would easily obtain the necessary Medicare billing information? What costs $150 in my office may cost $1,500 in the emergency room, and $15,000 in the hospital. And after lying in a hospital bed will the patient then need thousands of dollars again for a nursing home or rehab center admission? By making it *so difficult* to obtain information for outpatient Medicare Part B treatment in the physician's office, and making it *so easy* for any non-medical person with a phone or fax to obtain sensitive billing and psychiatric information for treatment in a Medicare Part A "facility," Medicare is needlessly pushing beneficiaries into more expensive treatment venues.

(Patient #5) In some cases even people who are not mentally or physically impaired may still have difficulty answering the Medicare questions correctly. For example, last month a Medicare beneficiary who had a 30 pound weight loss came to my office along with her niece, who is her Medicare legal representative. Even though this patient happens to be mentally disabled, she did come with her legal representative who should have been able to speak for her. However, the Medicare representative on the telephone still would not release the required information because the patient did not know her "correct" birth date. I have many elderly patients who were born in rural areas 70, 80, or 90 years ago, a time and place not known for meticulous record-keeping, and so their birth dates were never recorded properly. Basing the release of crucial Medicare data on an incorrect date of birth in the patient's Medicare computer database only harms the most vulnerable Medicare beneficiaries. Fortunately, this time my staff was able to network with the patient's pharmacy and retrieve the "official" date of birth to allow us to treat this patient.

Dually eligible people with Medicare and Medicaid have more difficulty.

Medicare beneficiaries who are healthy, wealthy, and educated will have no difficulty answering Medicare questions on the telephone and will easily find access to a physician's office. But dually eligible people — "the elderly and disabled poor" described by Senator John Breaux — who are disproportionately elderly, minorities, women, and mentally or physically disabled people may have more problems navigating these waters. These people are the oldest, poorest, sickest and most disabled people in the country. For these people, medical access delayed often means medical access denied. The current Medicare Part B privacy policy increases disparities in access to health care for these vulnerable people.

Both Medicare Part B and Medicare Part A Privacy Policies need to be fixed.

Although the Medicare Part B privacy policy and the Medicare Part A privacy policy are both flawed, they are flawed in different directions. The Medicare Part B policy is *too difficult* for physicians to utilize on behalf of their patients and winds up hurting the people it purports to protect. Conversely, the Medicare Part A privacy policy is *too easy* to work with and presents a potential loss of desired privacy, as well as

creating unnecessary opportunities for fraud and abuse. Both policies should be changed and merged into an equitable, secure, workable system with the goals of improving access to health care for all Medicare beneficiaries, the frail as well as the robust, while safeguarding the patient's personal healthcare information from abuse.

Request for information

As we discussed on the telephone, I would appreciate your sending me the following information regarding the Medicare Part B privacy policy.

1. Why are the Medicare Part B Privacy Policy and the Medicare Part A Privacy Policy so different? How does CMS justify such a *strict* privacy interpretation for Part B while allowing such a *lenient* privacy interpretation for Part A?

2. Please tell me which classes of Medicare Part A providers (e.g. hospitals, nursing homes, etc.) have a six-digit "facility number" and are allowed to access Medicare Part A beneficiary information by telephone or by fax.

3. Does the Louisiana Medicare Part B privacy policy apply throughout the United States, or only in the states served by my local Arkansas Medicare carrier?

4. According to Merle Francis, Director of Provider Relations for Arkansas Blue Cross, as noted in the attached Orleans Parish Medical Society fax, any complaints regarding this privacy policy can be directed to the HCFA (now CMS) Beneficiary Services Branch in Dallas. I would like to know how many complaints HCFA/CMS has received regarding the Medicare Part B privacy policy since 2000. I would also like to know how many complaints have been received regarding the Medicare Part A privacy policy, if such a thing exists. If you have received any complaints, may I view them?

5. Has CMS studied the effects of this Medicare Part B privacy rule? What has CMS found?

6. It would be helpful to know the specific battery of questions the Medicare Part B representatives ask the patient on the telephone in order to prove the beneficiary's identity. Are these questions standardized throughout all Medicare regions?

7. If a credit card company refuses to verify a credit card number, the consumer always has the option of paying cash for the desired item or service. Similarly, if a physician is unable to verify a patient's Medicare eligibility (because Medicare would not release the information to him) is he allowed to treat this patient as an uninsured, or "private patient" and charge his standard office fees, as opposed to the generally lower Medicare fees. Can a medical provider require full payment from such an "unverifiable" patient, and not be required to bill Medicare?

8. If a physician cannot verify Medicare eligibility for a *dually eligible* patient with *both* Medicare and Medicaid benefits, then in addition to not being able to use her

Medicare benefits, the dually eligible patient cannot use her Medicaid benefits either. Medicaid will not accept a medical claim for a dually eligible patient unless Medicare has paid its portion of the claim first. Neither Medicare nor Medicaid can be billed if Medicare does not release the billing information. In this case is the physician able to require full payment from an "unverified dually eligible patient" with both Medicare and Medicaid?

Thank you.

Sincerely yours,

Sheldon Hersh, MD

Attachments.

CC: Orleans Parish Medical Society
Louisiana State Medical Society
American Medical Association
And others