TOWN HALL MEETING ON

ECONOMIC IMPACT OF

HEALTHCARE REGULATIONS

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Plaza South
Sheraton Hotel
One North Broadway
Oklahoma City, Oklahoma

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Thursday,
January 12, 2006

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The above-entitled matter came on for public hearing, pursuant to notice, at 10:00 a.m.

MODERATOR:
Carol Simon, Ph.D.

PANEL MEMBERS:

Experts:

Christopher Conover, Ph.D.
Ted Frech, Ph.D.
Robert Helms, Ph.D.
Tim Size
William Vogt, Ph.D.
William D. Rogers, M.D.

Health Care Community Leaders:

William Pierce
Paul David Moore, D.Ph.
Gary W. Mitchell, D.Ph.
Allan Harder
Bohn D. Allen, M.D.

P R O C E E D I N G S

DR. SIMON: May I be -- take the pleasure of being the first to welcome you all to the third town hall meeting on the economic impact of healthcare regulation. My name is Carol Simon. I'm with Abt Associates. And it is my pleasure to be your moderator today for this important meeting.

We have a lot of ground to cover, and we have a lot of folks who are here to tell us their stories and to give us their testimony. Let me give you a brief introduction to essentially what the purpose of today's meeting is and a little bit about the logistics.

My main job here is -- today is to essentially be the traffic cop and to get us in and out efficiently so we can enjoy the beautiful day that's outside.

We have today with us a series of experts from the provider and the stakeholder community who we are going to be introducing shortly who will be providing some testimony on the impact of healthcare regulation for their perspective.

We also have the majority of the day dedicated to be taking public testimony from the floor from providers, from patients, from stakeholders who

are going to help us inform our process.

This study is mandated by Congress. It is part of a large project that is evaluating the economic costs, the burdens of healthcare regulation, and attempting to find ways to maintain the quality of healthcare, to maintain the safety of healthcare, and to use our resources a little bit more effectively. That's our goal here today.

We have also with us a panel of experts who've done considerable research in the area who are going to be assisting us in helping to frame many of the comments that we hear today in a way that will help us generalize, help us write a more effective report to Congress.

They are not the stars of the show. Essentially, the folks who are out in the panel are -- and the folks who are in the audience are the important participants today.

So with no further ado, what I would like to do is introduce a couple of folks who can help explain a little bit more about the context, about why we're here in Oklahoma City, and what we hope to achieve today.

The first person I'd like to call up is Ruth Katz from the Department of Health and Human

Services.

Ruth.

MS. KATZ: A big step here.

MS. SIMON: It's a very big -- well, it's a big step to do this.

MS. KATZ: What a really great thing to see all of you here. This is such a great turnout. One of the problems we have generally working for the federal government is that we work in two dimensions, eight and a half by eleven, and three dimensions, real people, is a wonderful thing to see.

And I don't want to take a lot of time doing this, because I want to hear from real people about real issues. Thank you for taking part in this town hall meeting. The purpose, as Carol said, is to seek your help to quantify the economic impact of federal regulations in the healthcare industry.

This -- in -- at its core, maybe, is about bureaucracy, so I'm going to share with you my title, so you can see that I really understand bureaucracy. I am the deputy to the deputy assistant secretary for disability, aging, and long-term care policy in the Office of the Assistant Secretary for Planning and Evaluation.

DR. SIMON: There is no quiz at the

end --

MS. KATZ: Okay. Yes. I took my time that -- I can do that with one breath, but it's a little intimidating.

When we started work on this project, we realized that many things have changed over the last decade in healthcare. But one of the things that doesn't change is regulation -- it's kind of a given -- and people's comments, complaints, criticisms about why and how the government regulates and whether regulation actually distorts practice and to what degree it's needed for quality.

We previously did a little work -- we started in 2003 -- with something called SACRR, the Secretary's Advisory Committee on Regulatory Reform. And they finished their work a couple years ago. They put forward 255 recommendations about regulatory reform that could still preserve quality but minimize regulation's burden.

I'm really happy to say that 84 percent of those 255 recommendations from the end of the SACRR -- from the SACRR report have been implemented with no decrease in quality.

The majority of those recommendations addressed issues that are regulated by the Centers for

Medicare & Medicaid Services, or CMS. And as a result of those changes, CMS's outreach and information-sharing processes have really streamlined a bit and probably have improved significantly. We are glad that Dr. William Rogers is here with us today from CMS to serve as one of our panelists.

So with these accomplishments completed, we thought, where could we move on? Well, one of the biggest challenges was figuring out the economic burden of regulations, and that is really what we're here to talk about today. And I know Carol will stay focused on that too as our taskmaster.

After we accepted the assignment to examine the economic impact of regulations, we started to plan how to approach the subject, and we made a few decisions. The first was that we thought, well, this could be a fairly academic exercise.

We -- as you can tell from my title, have we got analysts. Analysts are us. We could stay in the office, and we could do it all on paper, look to the literature -- fairly academic, and really get some great data.

But we thought that the real literature is what's in your heads, that we really needed to examine the reports of the people who live these regulations

every minute of every day, basically, you all from the healthcare industry. So we asked for comments from the industry first thing.

But then it -- we thought, well, that might not be quite enough, might not be sufficient. So our second was to ask you to tell us in person just exactly what you're thinking in terms of regulations, quality of regulations, regulatory compliance.

And these two decisions led us to a federal register notice seeking comment and quantification on the issue and to these town hall meetings like the one we're having here today in Oklahoma City. We have also been having numerous conversations with the Washington health care community.

And our third decision was to make what we've called some house calls. We plan to do a series of case studies in the field at a variety of different healthcare settings, hospitals, nursing homes, et cetera, to help us with the analytical work. And Abt, our contractor, will be helping us with that.

So with that said, I'm really chomping at the bit. It's just so great to see all of you here. What I really want to do is hear from you all, and I would love for us to get started. So again, welcome,

and thank you all for giving us your valuable time.

DR. SIMON: Thank you very much, Ruth.

I'd like to ask Mr. Don Perkins, who's the Executive Officer of the HHS Regional Office in Dallas, to come forward and offer his welcoming remarks.

Don.

MR. PERKINS: Thank you, Carol.

I'd like to take this opportunity to welcome everyone to Oklahoma City and to Region 6 of the Department of Health and Human Services. I want to especially thank our hosts from the Assistant Secretary for Planning and Evaluations Office and the Office of Management and Budget for coming to Oklahoma City, for choosing this region for one of these meetings.

What a wise and wonderful decision that was. And I can almost assure you that you'll hear some very candid and forthright comments from everyone here today.

I also want to welcome the -- our panel of distinguished representatives who will be hearing the testimony today, as well as our panel of experts from the healthcare committee who will be providing testimony.

Thanks to each of you who are here today to participate in this meeting, those of you who will be providing comments, as well as those of you who are here just to hear the comments.

I also want to introduce briefly Dr. Randy Farris who's here from our Centers for Medicare & Medicaid services in the Regional Office. Dr. Farris and his staff have been incredibly busy these -- actually, these past several months and certainly these past few weeks trying to bring up the Medicare Part D program.

And we're really pleased that he was able to take a little bit of time away from that effort today to come and participate in this meeting.

As we in the Regional Office perform our duties of program oversight, we often hear comments about the economic burden of some of these healthcare regulations and federal laws that we are trying to implement. We're charged with the enforcement of these rules to assure that healthcare provided to our beneficiaries is of highest possible quality and that patient safety is assured.

But we also must be sensitive to the costs that are borne by providers as they try to comply with these rules. And we also remember that these costs

are ultimately borne, in some portion, by all of us. It's a very delicate and complex balance that we seek to achieve from all of our various perspectives.

And it's an important balance, for if we shift too far in one direction or the other, the consequences obviously can be very significant. I think that the testimony that we will hear today, as well as at the other meetings and the comments that will be provided electronically, are very important and will certainly help us to find that balance.

So I want to thank each of you for your hard work in providing healthcare to our citizens and also for your interest in this particular effort. And I look forward to sharing with everyone else and hearing these comments today. Thank you.

DR. SIMON: Don, thank you very much.

So let's get started. Let me sort of give you an idea of what our game plan is for today. In your packet, you have a lot of very interesting material. And the most important one to go look at right now is our agenda, so we can get a sense of expectations about what we're going to hear and how we're going to hear it.

We're going to start this morning with our healthcare community leaders panel discussion. And we

are very pleased to have here with us a group of individuals who represent varied and considerable interest in the healthcare community who will be providing us with their perspective on healthcare regulations.

And I'm going to introduce them briefly, and we're going to turn to them very quickly.

We have Bohn Allen, who is a general surgeon from Arlington, Texas, and the immediate past president of the Texas Medical Society.

We have Mr. Allan Harder, who's the executive director of the Oklahoma City Area Intertribal Health Board. Mr. Harder.

We have Mr. Gary Mitchell, who is the executive -- chief executive officer from Newman Memorial Hospital in Chaddick, Oklahoma. Mr. Mitchell, thank you very much.

We have Mr. Paul Moore, who is a pharmacy and rural healthcare consultant in the area.

And finally, last and not least, Mr. William Pierce, who is the president of Baptist Village Retirement Communities of Oklahoma.

And we're going to be hearing from them shortly. The panel discussion and presentation is going to be taking place until approximately 11:15, at

which time we're going to be opening up the floor to public comments.

If you intend to present public comments, when you registered, you will have seen a sign-up sheet in the back. And this is a very important vehicle, not only for me, but for me. We have a lot of people here, and no voice is more important than the others.

And so we want to make sure that we have ample opportunity to give everybody a chance to voice their opinion. So we're going to have a few ground rules. I'm going to be calling people as -- in order of which they have signed up.

And when I call you, I'm going to ask you to come to one of the microphones that are placed out in the audience area, repeat your name, because I may have butchered it inadvertently, and tell us who you are from and who are you representing.

They're going to give by -- begin by giving you three minutes to present your testimony. And at the end of two minutes, I'll start waving. At the end of three minutes, I'll start making more appropriate gestures, and we're going to try to cut that off.

We're then going to open this up to

comments from our panel, who are here today to help us ask you some additional questions that will help us put your remarks into context of other remarks we've heard from other town hall meetings so that we can in many ways take your voice and make it broader in the context of our opinions.

We're going to allow them approximately three to five minutes to do this back-and-forth question-and-answer period, and then I'm going to move to the next person.

And so I appreciate your understanding in the fact that we all have much more to say than three minutes, and even if you talk as fast as I do, it's going to be a little bit of a constraint.

For those of you who are presenting commentary, as well as for those of you who may not have come prepared to talk today, there is a second and very important vehicle for entering comment and opinion in evidence -- and I do stress evidence, because this is a very evidence-driven study -- into the public record.

And in your packet -- and we'll talk a little bit more about it later -- are a couple of sheets that show you how you can send us information, even if you don't get up to the microphone today -- or

to embellish on those few words that you were able to speak at this point in time.

We have a website for collecting public commentary. And so if you or your colleagues or your friends or your associates want to present us testimony, we encourage it, and matter of fact, we welcome it. We need it.

And so there are ways that are identified in there for sending public testimony to us, apart from the few moments that you're going to have here publicly.

Okay. So with no further ado, I want to also introduce our expert panel. And I will let them speak for themselves, because they do it quite well.

I'm going to start with Dr. Chris Conover.

DR. CONOVER: I'm Chris Conover. I'm an assistant research professor at the Terry Sanford Institute of Public Policy at Duke University. For -- is it on?

DR. SIMON: There's a switch on the side.

DR. CONOVER: Hello.

DR. SIMON: Good. Thank you.

DR. CONOVER: For those of you who know Duke University, our institute is the one that provides parking spaces for all of Coach Kay and his

staff.

I have actually done this work of going through the literature that Ruth Katz was talking about and trying to come up with some estimates of the cost of health-services regulation. And there's a little monograph in your packets that show our preliminary estimates are that regulation costs $169 billion a year.

So that's all I'm going to say. I'm going to be very interested to hear from you today.

DR. SIMON: Great. Thank you.

Our next panelist is Dr. Ted Frech.

DR. FRECH: Hi. I'm an economics professor at UC-Santa Barbara, and my research and also consulting over the years has been heavily in health economics and particularly in regulatory issues.

DR. SIMON: Thank you, Ted.

DR. HELMS: Okay. I'm --

DR. SIMON: Robert Helms.

DR. HELMS: -- Bob Helms. I -- resident scholar at the American Enterprise Institute, which is one of the Washington-based think tanks. And I've been doing health policy in Washington for about 30 years. I also studied the economics of regulation and

so on in graduate school with Ted and some other people.

But we published things about CON regulation and so on at AEI. And then I went over in the Reagan years to ASPE, served as the ASPE when Doc Bowen was there, and we passed the original catastrophic bill. So you might say I've had a career associated with a lot of lost causes.

I have a -- one other interest in this now. I'm now serving on a -- in a Medicaid commission, which has a little job of -- we are charged with trying to come up this year -- about how to reform Medicaid. So if there are regulatory issues that we can -- recommendations and so on -- I'm particularly interested in looking for those possibilities. Thank you.

DR. SIMON: Thank you.

Dr. William Rogers.

DR. ROGERS: I'm Bill Rogers. I spent my first 20 years of my career managing emergency departments and working full time clinically and was hired by CMS four years ago to really serve as an ombudsman and an advocate for providers.

And to that end, I do a lot of traveling, speaking to speciality societies and meeting with them

also in Washington, D.C. -- I think I did 42 national speeches last year -- and basically make myself and my team available 24 hours a day, seven days a week to providers to try and make their interaction with the Medicare program a little less unpleasant.

DR. SIMON: Thank you. That's a big job.

Mr. Tim Size.

MR. SIZE: Good morning. I'm one of the representatives with those people for whom you're trying to make life pleasant, so I appreciate it. I'm the executive director of the Rural Wisconsin Health Co-op. It's owned and operated by 29 rural hospitals. We work in the area of shared service, education, advocacy, policy development.

Today I'm particularly interested in learning more about the effect of regulation on rural providers, who typically are lower-volume providers. And some of the regulations that make sense for one size don't always make sense for all sizes.

Also -- similarly interested on the impact of regulation on people's ability to access healthcare in rural communities.

DR. SIMON: Great. Thank you.

And finally. Dr. William Vogt.

DR. VOGT: I'm Bill Vogt. I'm an

associate professor of economics and public policy at the Heinz School of Public Policy at Carnegie Mellon. I study the healthcare industries, and specifically I'm interested in competition among healthcare providers.

DR. SIMON: Thank you very much, Bill.

So let's, without delay, turn to the meat of the program. What I'd like to do is begin introducing Dr. Bohn Allen from the Texas Medical Society. We're going to ask Dr. Allen to give us comments for approximately five minutes.

We're then going to move through the panel and go -- and ask Dr. Harder to go next, moving along. At the end of each of the panel presentations, what we would like to do is open the panel -- give us some time to open up the panel to ask each other questions, because we suspect that they will be presenting perhaps complementary and potentially, you know, different perspectives on many of the problems that face us.

We're going to give the panel another five to ten minutes to talk amongst themselves and amongst us. And then we're going to open it up to general questions from the panel sitting here at the front.

Does that sound fine with you gentlemen?

Sounds good.

Dr. Allen.

DR. ALLEN: Yes. I'm Dr. Bohn Allen from Arlington, Texas, immediate past president of the Texas Medical Association. And on behalf of the 40,000 physicians in Texas that are members of the TMA, we want to thank CMS for this opportunity to participate in the town hall meeting.

I basically want to hit three general topics that have a huge economic impact on physicians through the government regulatory process. The first is the calculation of physician reimbursement based on the sustainable growth rate or the SGR.

The second is the fact that we're now beginning our fourteenth year of budget neutrality in the Medicare system -- and finish with the continued moratorium on physician ownership and facility construction.

As -- with regard to the SGR, which is a formula to calculate physician reimbursement in the Medicare system, under the current SGR formula, starting in 2006, this year, physician reimbursement over the next five years will be reduced 26 percent. At the same time, the medical economic index of inflation will increase 15 percent, giving a spread

which is unsustainable for physicians.

The SGR went into effect basically in 2001 in which there was an increase in physician reimbursement. But since then, schedule reductions were to occur, but Congress has put a band-aid on it with only minimal increases in physician reimbursement.

The problem is that this is an overlay to the entire reimbursement system. And the panel will know and understand that physicians, since 1985, have been under wage and price controls through a series of omnibus budget reconciliation acts.

Starting in 1985, physician reimbursement has been frozen. But not only that, in 1988 and 1990, physician reimbursement was reduced as overpriced services. Also in 1988, Congress passed the act which forbid physicians from balance billing, even for patients outside of the Medicare system or physicians that don't participate in the Medicare system.

In 1992, the RBRVS, resource-based relative value system of reimbursement, was established by Medicare, which was based on flawed data and again reduced physician reimbursement.

So over a period of time, physician reimbursement has not only increased or kept up with

inflation, it has actually gone down. And the spread in reimbursement has now reached a point where, in Texas at least -- not all states, but in Texas -- Medicare reimbursement only pays about two-thirds of your cost, which is an unsustainable process.

So the other problem that we face then is in 1992, Congress passed the Balanced Budget Act of 1992, which put Medicare Part B reimbursement in a global reimbursement system, which means we're now in a zero-sum game, so that if there's increased reimbursement in one segment of B, there is a reduction in reimbursement in another segment.

So it pits all the providers -- competing for the same pot of dollars. This is an unsustainable system for physicians. There's not another profession in this country that can sustain wage and price controls and budget neutrality for 20 years. We're going on now our fourteenth year of budget neutrality.

So the SGR, which was established as the new payment mechanism, is based on a formula that physicians have no control over, such as the gross domestic product. We have no control over that. The increased technology and demand -- there are a number of factors that physicians have no control over but

are -- still will be punished if the SGR formula is not changed or we don't get rid of it.

With regard to the continued budget neutrality, starting in 1997 with the continuation of the budget -- Balanced Budget Act, Medicare instituted volume performance standards to try and reduce the escalating cost of physician reimbursement.

And fortunately, specialists and proceduralists were able to reduce somewhat the number of procedures performed, but the primary-care physicians were trapped in a situation where they could not. So as a result, in '99, the SGR formula was -- instituted -- was designed, and like I said, basically went into effect in 2000 and 2001.

The last thing I will -- want to mention is the continued moratorium on physician ownership and construction of new facilities. Only in, I guess, America, the land of free enterprise, are physicians forbidden from investing in their own business.

It will trap our technology in twentieth-century technology unless we're able to expand the technology, to expand the choice of physicians -- of patients and to allow the economics of the free-enterprise system to work.

So those are the three areas that I bring

as having a tremendous economic impact on physician providers.

DR. SIMON: Dr. Allen, thank you very much, and a superb job in being exactly timely.

Mr. Harder.

MR. HARDER: I'm Allan Harder, the executive director of the Oklahoma City Area Intertribal Health Board. I'd like to thank you for the opportunity to present some issues important to the delivery of health services to the Indian people.

First of all, just a little bit about the health board. Its very name is a little misleading. It is not representing the Oklahoma City municipal area. The Oklahoma City area is the designation that the Indian health service uses for the area that encompasses the states of Kansas, Oklahoma and one of the tribes in Texas.

I sit before you as probably the only person who is employed by all of the tribes that I've mentioned for any particular aspect, whether it be health or any other reason. I'm the only person who is actually employed by those people for -- across the board.

The Indian health-delivery system is one that's unique in the nation. There is a series of

federal treaty obligations that have created the obligation for providing federal health care to the Indian people. While it's an obligation through law, through the treaties, the funding of Indian healthcare is through the discretionary-funding appropriations of our government.

So after everything is done that is not discretionary, we start looking at discretionary funds. And in the days that we have where we have a war going on -- and the CMS budget's being non-discretionary, we're left with what's left over as far as what's appropriated.

Virtually every regulation there is that comes down affects the healthcare delivery system for the Indian -- either at IHS, the tribal or the urban delivery systems that exist.

One of the things that's been devastating -- while the IHS received a 3 percent increase last year in its budget, one of the few agencies to receive that -- it's also one of the few who received dual decisions. The IHS is actually appropriated through the Interior rather than HHS, and the money's transferred to HHS.

In the Interior appropriations, there was a rescission that was applied. Once the money was

appropriated in the Omnibus, then there was a second rescission applied. So the 3 percent became nil. There was no increase, even though the 3 percent was shown as the original appropriation increase.

No regulation is free. Some happen to be funded. Some happen to be funded at a lower level than what the funding is required to implement the regulation.

The example of some of the things that might affect the Indian health system that are not from the HHS regulations would be something like the homeland security regulations, where -- that they have mandated that federal facilities provide security measures for the entry and access to the federal building that is there.

That requires the Indian health service, for example, to provide security services for entry and access into the building. But there's no money to do that. So the money that's required to be spent by the Indian health service to provide that security comes directly from the dollars appropriated for healthcare delivery.

Even the positives that exist as far as some things you see down the road can have a negative impact immediately. The example -- the implementation

of the electronic health record is something that, once it's fully implemented, will be a great benefit across the nation and across -- to -- the country to delivery health services and to track those health services and to make sure that we're getting the best bang for our buck.

However, the implementation is something that there is no funding specifically for. Yet we're implementing it and using, once again, those health dollars that are available for delivery of direct healthcare services to our people.

It's important to understand, too, that the Indian people have a severe disparity problem with -- both with health issues and with funding issues. The Indian Health Service for the funding for the Indian health, the tribal operations and the urban operations providing the healthcare, are funded somewhere in the vicinity of 60 percent of the need.

The bulk of the remaining balance is either unmet or is met through a third-party billing system whereby the delivery -- the professionals that are delivering the service or the organizations are billing it back against Medicare and Medicaid.

So every time that we have an obligation to reform CMS and to take $100 million out of

the -- $100 billion out of the CMS ledger over the next few years severely affects the delivery of services, because that's making up, in some cases, 40 percent of the funds that are available for Indian healthcare.

Like I said, there's nothing that is free. And everything that is done affects that delivery, and it more severely impacts -- that the funds that are available to start with are less than adequate for the needs that are present.

DR. SIMON: Mr. Harder, thank you very much.

Dr. Mitchell.

DR. MITCHELL: Good morning. Thank you for the opportunity to be here and make some brief comments. My biography is in the paperwork that was handed out. A minor note is that even though I am a pharmacist, I'd like to note that I'm not here to do consultation for Part D. We'll let other people do that.

And fortunately, even though I chose that as my first career, I'm not a practicing pharmacist normally, so I really haven't had to deal with that. But Mr. Moore probably could answer more than that -- Dr. Moore.

DR. SIMON: But we'd give you more than five minutes.

DR. MITCHELL: Yes. It would take more than that for sure.

Newman Memorial is a small rural hospital in northwest -- far northwest Oklahoma, what is affectionately called by our health department here in Oklahoma as the frontier counties of the state. And indeed, it is quite a frontier.

Our whole population in the county's about 4,200 people. Our community's roughly 1,400. Our service population, however, is about 35,000 because of the outreach that we have and the types of services we've had over the years.

It was established by a pioneering physician many years ago who came from Ohio, had been educated in Minnesota through the Mayo system. And in fact, we've been called the little Mayo of the Plains over the years -- to do that.

As I thought about preparing for the comments, the first thought I thought a little bit about is that in a small town -- and many in the room, I'm sure, are from small towns as well as large communities -- you sometimes get caught in this friction between your sports and your academics at

your schools.

Our community has been fortunate to have some tremendous athletes the last three years in our football program and in fact have won three state championships in a row at an eight-man level. We're very proud of that. We're also quite fortunate to seemingly have balanced those aspects with academics as well. We have a lot of tremendous academics.

But, you know, when you get into conversation with people, it's about, well, you know, it's -- you're against sports or -- my point is that I -- move forward in some comments.

I'm not anti-regulation. I basically believe in regulation or we're going to have chaos and just problems. But sometimes we do have, as our distinguished colleagues here have already commented -- they have consequences that we don't do.

And I certainly agree with Mr. Harder that no regulation has a free cost. It's just as something going to be tied to that. And as he eloquently spoke to, the area of shifting is there, and I think that's the biggest challenge that I probably face.

In that tone, it is a balance of regulations for what we want to do. I mean, we want them to be there, as an earlier speaker spoke about

that, the safety and the quality of what we provide for healthcare. I mean, that's what we're about is trying to provide those things.

And so we need to balance all that. The estimates, as best I recall, from the American Hospital Association show that somewhere around 20, 23 percent of our operating cost is tied to what Dr. Conover said -- is the cost of providing care. And that's 20 percent of funds that are tight and difficult.

We're not going to care -- of patients who come to our facility, either for an outpatient or for an inpatient care. So if you look at that -- and I'm not a statistician or an economist, so I can't tell you whether that's good, bad or otherwise, but it's certainly a good talking point to make that issue.

The other is that clearly -- and I was speaking to a colleague before we started today too -- is the volume regulations are very difficult. I would tell you that we probably -- and I know the -- one of the CMS administrators are here from Dallas.

And I hate to see this, but we all break rules every day, I imagine, largely because we either don't know them or we don't understand them. And

that's it. Indirectly, there's probably, in the federal level at least -- in the federal level, probably 43 or 44 regulatory bodies that visit us periodically.

Recently I had an inspector from the FDA come by. I'd never seen an FDA inspector in my life. But they were there to ask us if we were going to reprocess single-use items. Our answer was no, because we had no way to build upon that regulation to do that, and it would be really --

I think one of the costs that frustrates me the most from a regulatory standpoint is the need for outside people. I went through college. I have a bachelor's degree. I have a master's degree. I think I'm a pretty smart fellow, not the smartest guy in the world, but I think I can understand things.

But, you know, when I have to hire consultants to tell me either how to be a joint-commission hospital or how to meet this or meet that, I have a real problem with that. I ought to be able to read those regulations, do what I need to do, and move forward. So I think that's a -- sort of a hidden cost also.

I was interested in the regulatory process as we move forward in hospital care, move on the

quality indicators and so forth. I think those are real good. But we need to really keep focusing on the issue of whether those are process indicators or outcomes.

You know, what -- I think we're here -- and we're all interested as providers -- is the quality and the outcomes we have. Not necessarily do we do the five steps correctly to do that.

And so far -- example is that -- it's very commonly done, probably almost a hundred percent in the emergency rooms, you know, four chewable aspirins when you show up and you have heart pain. Well, that's good, but what happens after that, and what happened to the patient.

In the long run, I think the other issue of regulations -- we've dealt with regulation, and we've moved forward to adapt to the changes in demand and in technology -- and do that.

I think a lot of times the benefits that we work so hard to gain in terms of improving quality, therefore lowering costs and improving outcomes, don't necessarily -- back to the practitioners that provide those services. And I think we need to do that.

I certainly agree with the other issues there. And as Dr. Allen commented about, there have

been a couple of years that hospitals also had no increase in payments at the federal level, which does impact, ultimately, the availability of providing care. Thank you.

DR. SIMON: Dr. Mitchell, thank you very much.

Dr. Moore.

DR. MOORE: I'm Paul Moore. I am a country pharmacist from southeastern Oklahoma. Unfortunately, like my colleague Dr. Mitchell here, I did spend the last two weeks doing Medicare Part D consults -- with the frustration level on the part of the seniors and the pharmacy and the staff.

And I realize from the USA Today and the national news that it's not just my problem. It's all over the country. And I'll address part D briefly in just a moment. But I just want -- in order for you to hear what I have to say, you have to know where I'm coming from.

I have healthcare in my genetics. My grandmother started the first nursing home in southeastern Oklahoma by taking folks into her home. I tell folks I -- tell my friends I've already had my nursing-home experience, so --

I am also educated as a pharmacist, but

I've also served -- in fact, I was Dr. Farris's first administrator of a critical-access hospital in CMS Region 6. It was at that stage in my life that I learned what it was to curl up with the Federal Register at night.

Because really, in the years I'd had in healthcare, I had never come across how important and how voluminous the regulations that affect just a hospital, just a small country critical-access hospital -- but as I began to relate that to my other lives, I realized that it all affects all of us.

See, it's not just about the hospital and the community, even though in Atoka County, the hospital is the second largest employer in the community. In Atoka County, probably 10 to 15 percent of the employment in Atoka County is healthcare related.

And having used Rural Health Works and learning from economists, I have learned that it's kind of like chopping wood. It can warm you twice. Dollars that are made in your community and stay in your community have an effect even more than their dollar amount, which means the impact on the local community of healthcare dollars is probably somewhere around 20 or 25 percent in a small rural community.

And it's not just about the hospital. It's not just about the community pharmacy. It's about the entire system, how it is over woven and interdependent upon itself in the sense that if you lose one segment of that system, the entire system becomes vulnerable and may fold and may go away.

Not because the healthcare providers can't find work -- they can. They can go somewhere else. It's because they don't have what they need there to provide access to quality healthcare that Medicare has been given the job of making sure exist.

Now, I don't feel that it's Medicare -- I don't feel that it's the government's job to make sure that businesses are successful in rural communities. I do feel that it is their job to make sure that they don't work against that. And that's why when I speak of healthcare, I'm speaking of access to healthcare.

And now to bring it to the rural pharmacy part, which is freshest on my mind, obviously -- is to not do things that will endanger access to services. And in particular, in the case of pharmacy, I'm not talking about access to drugs, because you can get those from Canada and Mexico. You can get them in the mail.

I'm talking about access to pharmaceutical

services, the over-the-counter counseling, the insurance advocacy that has been so much a part of our life lately. Those things that the seniors come to you -- Medicare put out a beautiful website. Medicare made all kinds of efforts to educate our seniors.

But do you know where the number 1 point of entry is into the system now? It is still across my counter with that customer, with them there with a look on their face saying, Tell me what to do. And that -- and I hear some seniors behind me. That is the case.

There has been so much frustration. And I'm not going to harp on the program. We will get through this, and we will work some bugs out of it.

One minute. Okay.

We will get there. What I want to -- the point I need to make today is when it comes to government policy, it should not be one that drives access out of business. You see, when it comes to the rural pharmacy, access -- maintaining that location there for those seniors to come to is what is important.

And policy should not drive them towards mail order. Because in many of the communities, the small communities that have one or maybe two

pharmacies, the reason there's only one pharmacy there is there's not enough business for two.

And if that business migrates out to a mail-order -- PBM mail-order pharmacy, then there won't be enough to keep that one pharmacy there. And once that access is lost, I fear it's lost forever. Thank you for the chance to talk with you about it.

DR. SIMON: Dr. Moore, thank you very much.

Mr. Pierce.

MR. PIERCE: Well, I could say -- just say ditto at this time, because I've heard a lot of good comments up to now. My comments take rather a broad view. And I'd like to say that I have a lot of colleagues in the room.

And I've read the comments that are in front of me here that Scott Pilgrim wrote, which are in the same field that I'm a part of, which is providing retirement-community services and nursing-care services and home healthcare. And I agree with many of them.

But my comments take a broader view and have to do with balance. And all of us in the room would agree that our healthcare resources are precious. And we seem to be involved in a more-

regulation-is-better mind set right now. You know, I think we need to move perhaps away from that and reward quality care.

And a balance is crucial. We seem to have a clock whose pendulum has swung far toward regulations in the areas that we personally provide services. It gives you the ability to say we are doing a good job regulating healthcare providers, but it may be at the expense of healthcare service delivery.

And here's an example, and this is a recent example. I don't have a lot of examples, because my comments are broader and have to do with balance. One recent requirement that nursing facilities have is to, on a daily basis for each shift, post nurse staffing data for the licensed and unlicenced staff directly responsible for resident care in the facility.

Now, some people might say that's a good regulation. I view that as a regulation where the pendulum has swung too far one way. That does not help us use our dollars -- precious dollars in providing healthcare service delivery.

I also would say that my experience over the years has been that the method of rolling out

regulations is extremely expensive. So there's a great dollar expense to the method that regulations are rolled out.

And again, in a broad way, let me say this. We often have the feeling as providers that a healthcare regulation is tossed in our court. The ball is tossed in our court. And providers are left to try to swim, and later a lifeline gets thrown to us with clarification.

And the regulation becomes a hot potato. We'll throw it to providers; we'll see what happens; we'll clarify it later. And that process carries with it a huge cost.

And it's a continual -- it goes on a continual basis. There are always regulations that we're dealing with in that way. So from our point of view, we see that perhaps formulating regulations is easier than thinking through change.

We also are dealing with Medicare Part D right now. And the standard answer is, "If you have any problems, call this hotline number." And I got an e-mail this morning that kind of illustrates this to a certain degree.

We've been in conversation with CMS regarding the Medicare Part D program on a weekly,

daily and even hourly basis in order to resolve the problems our members are experiencing.

So I would submit that the cost of figuring it all out is huge for providers. We're taking precious dollars that we could be spending in healthcare service delivery figuring out the regulations.

One other thing, and that's what I might term -- this is perhaps too harsh a term, but I might call it the piling-on effect. There are continually regulations added without perhaps ever evaluating regulations that are no longer needed.

And that's perhaps my key point. How does the new regulation fit into the whole? Is there duplication? Is there obsolete regulation? If so, it adds to the expense of the healthcare delivery. So there has to be balance.

And regulations should be used to improve outcomes. Quality outcomes should be rewarded in service delivery. And my main point is that we must continually analyze and reanalyze and roll it out right in the beginning to as far a degree as we can and analyze the regulatory process.

In a world of limited resources, additional regulation often comes at the expense of

service delivery. Thank you.

DR. SIMON: Thank you, Mr. Pierce.

We're now going to open back to the panel. Why don't we give the entire panel a round of applause at the close of this? We -- an open -- back to the panel and ask if you have questions for each other or perhaps very brief clarifying remarks.

And then our panel up here, who have been incredibly patient, I know are -- have a number of questions back and clarifying comments to you.

So gentlemen. Excellent. Okay, folks. I'm going to ask you each here to, you know, sort of -- not jump in, but questions from the panel at the front.

Ted. And you can direct them to any of the individual panelists, to the panelists collectively, and then we'll move forward.

DR. FRECH: Okay. I -- right now I have a fairly narrow question -- it's for Dr. Allen -- on the moratorium on physician-owned facilities. Now, I had thought that that moratorium was only for speciality hospitals, and it had ended.

So if you could expand a little bit on what the status of it is and what you see as the pluses and minuses of it, I'd like to hear it.

DR. ALLEN: Yes, sir. As you know, the Stark 1 and Stark 2 laws have exceptions that allow physicians to invest in hospitals or ambulatory surgery centers or imaging centers, provided that they utilize it themselves and they're not a passive investor in that entity.

Now, the moratorium on specialty hospitals again is a -- and I think you're correct. I think the moratorium does involve speciality hospitals. But the impact of that is that today technology is changing so rapidly that we are outstripping our ability under our conventional resources to provide that technology.

And as a result, if we wait for just the hospitals to develop and to utilize that technology, we are trapping ourselves in twentieth-century technology. We can't expand and go forward and give patients the types of services that they demand today. And as this continues to expand, physicians need to be a part of it because they are at the heart of what develops and drives most of that technology.

Now, as far as utilization of -- the big issue is physicians self-referring or capturing patient population. Physicians -- the return on investment in speciality hospitals is so low when you dilute it out to individual procedures and so forth

that profit is not the motive that is driving physicians into specialty hospitals.

What's driving them into speciality hospitals is efficiency and having a say in the technology and how the hospital for their particular services is run. And every study that we've been able, at the Texas Medical Association, to look at -- when you focus -- such as a heart hospital on heart disease -- you by definition are going to be better at it.

So patients get better outcomes, better patient satisfaction, lower cost -- all the things that a free market -- normally drives business happens with a speciality hospital.

The problem that everybody perceives is that physicians are skimming off the cream and leaving all of the difficult cases to the hospitals. Well, there are a number of mechanisms that we already address that with. Hospitals get disproportionate share money. Many of them are not for profit and get tax-free -- have a tax-free status.

They are able to access the bond market at very low rates. So there are a number of things that compensate for that.

The other issue is that physicians

have -- today, time is money for physicians. We're in a fixed-reimbursement system. You cannot pass cost on to patients. So physicians are having to work harder for less. And the only way to do that is to be more efficient.

And part of that is the answer of the speciality hospital where they can become more efficient, turn their cases over faster, have better technology available to them. And everybody in terms of healthcare, particularly the patients, benefit from that.

So that's kind of the issue is that if we continue the moratorium or we prohibit physicians from self-referral and ownership, we will have essentially taken the patient and patient choice out of the mix, which is not what patients want.

DR. SIMON: Thank you. Question.

DR. CONOVER: I had a specific question for Mr. Mitchell and then a general question for all of you.

The specific question is you talked about using outside consultants to interpret things, and I'm curious whether you have some sense of the scale of that, I mean, you know, as a percent of your operating costs. What does that entail? Do you have just even

a rough ballpark on that?

DR. MITCHELL: I'm -- I really don't have a good answer for that, Doctor. I mean, it's variable based on circumstances that we periodically try to review to make sure that we're in compliance and do the things that regulations require.

DR. CONOVER: Right.

DR. MITCHELL: Now, our operating budget at our facility is roughly $7 million of expenses. You know, it's probably -- it's certainly less than 1 percent of that. I think the issue there is much like, if I could give you a quick analogy, is much like when we decided to stay in joint-commission accreditation.

The base fee just to do that, I think in 1999 when we were looking at it, was like $30,000. That wasn't the issue. We could probably find that money somewhere. The issue was the day-in and day-out direction of resources that we've all spoken fairly eloquently about that we took away from the care that we wanted to provide and the dollars that we had to do that.

And so therein lies a very difficult, hard thing for economists and others to make that understanding -- is what are those affiliated dollars

that just move from one place to another and really don't impact care. So that's really hard.

DR. CONOVER: Right. And that's a great segue way to my general question. So for all of you, if you could imagine optimal regulation for your respective sectors, I'm just curious to know whether the impact of that would be to -- would you end up providing better quality care if you could reduce what we'll call excess regulatory cost?

Or would you instead pass the savings from not having to, you know, go through these regulatory processes -- would those get passed along to consumers in the form of lower prices?

DR. MITCHELL: I -- if I could try that first, in a way. I think that some of my comments would be counter to what Dr. Allen spoke to a minute ago on specialty. But that's like asking any businessman, if you find a way to deliver your product or your service better, do you lower your costs or do you make more money?

I don't know the answer to that. I think the answer in our economy is competition because the next guy will probably do that and take that -- in the case. And the reason I mentioned Dr. Allen's comments is that --

And I probably have a jaded view because we have a very small community, and we have a very closely cooperative relationship with our medical staff and work very diligently with them in cooperation to provide the convenience and the access to care that make their jobs well.

I'm a little bit disappointed to hear him say, "Well, physicians are working harder for less." I will tell you every provider is working harder for less. And I think Dr. Allen actually would agree with that. I have not known Dr. Allen before today, and I hope that we continue to be friends after today, as well.

But the -- as he commented about the Stark regulations, from our perspective in hospitals, the regulation is very clear. I can't provide him a return for coming to my facility. That just doesn't work. We're breaking the rules. We can't do that.

It's curious that their facilities can be owned by themselves and then do that service, and they can -- they have an incentive in that sense. So that's -- it's -- about utilization -- it's a lot -- about a lot of things. But, you know, fundamentally for us, it's sort of an ethical question about, you know, do we get that same return.

But I think we all have to believe that, as Mr. Harder mentioned, some of the MRs, electronic records -- a lot of efficiencies are going to build up that are going to help all of us provide the services well and document good outcomes. And that, hopefully, will lower the cost of what we have to do.

DR. SIMON: Mr. Pierce.

MR. PIERCE: The thing that we would do with less regulation which resulted in more dollars being able to -- spent in healthcare is we would create a pathway to the future, which means that -- we know that there is culture change available to us right now in the form of new paradigm shifts in nursing facilities and other services that we provide.

There's new technology available to us today that can improve the lives of our residents, can improve the quality and the outcomes, but we have no way to fund it.

DR. SIMON: Dr. Allen.

DR. ALLEN: Yes. Certainly, physicians want to be partners with their hospitals. I sat on the board of a 13-hospital -- one of the largest not-for-profit hospital systems in Texas, as well as my individual hospital. And part of this whole issue is

how hospitals and physicians can learn to be -- to partnership and to provide the best resources for their community.

And so it's not an either/or. It's a question of how we can come together to do what is in the best interest of our communities and the best interest of our patients.

Now, with regard to what Dr. Conover said, currently, with the amount of Medicare regulations that physicians and hospitals and all providers have to struggle under, if a physician or a group of physicians wants to participate in Medicare, they many times now have to go out and hire two or three people just to keep them in compliance to make sure they're not violating some Medicare rule, which is a cost to them just to comply with the rules for which they're only getting paid two-thirds of their cost to start with.

So the more and more regulations that you have to abide by and have the threat of an audit or fraud and abuse hanging over your head, it makes doctors less and less interested in participating in the program.

In fact, the largest primary-care physician group in my community, over 55 primary-care

docs, refuse to participate in standard Medicare because they were audited one time for not complying with rules that they thought they were perfectly complying with and were fined.

And they said, "It is not worth the risk. With a group of 55 doctors, we will have to hire at least four people just to keep us in compliance, and the reimbursement is not enough that we can afford to do that." So they said, "We're opting out of the standard Medicare program."

So those are the kinds of issues that impact physicians and access to care. Because as we go down the road, if the SGR is not fixed, our latest survey indicates that at least 38 to 40 percent of physicians are -- more physicians are going to opt out of the Medicare program.

In Texas, in the -- in 1990, over 80 percent of physicians participated in Medicare. By the year 2000, that number was down to 78 percent. And in 2004, it's down to 68 percent, and it's dropping because that figure is a jaded figure.

Some doctors that say they take new Medicare patients only see them in the emergency room so they can bill for it. They will not see new Medicare patients in their office. So for the -- for

the patients, the beneficiaries, access to care is becoming more and more a critical problem.

The latest survey at the American Medical Association showed that 40 percent of physicians are going to drop out of the Medicare program if the SGR continues to drop between 2006 and 2011, as it's scheduled to do. So it's a huge issue for Medicare beneficiaries.

And it's not that the doctors don't want to take care of their Medicare patients. In fact, some of them are dropping out of the Medicare program and just seeing the patients outside of Medicare for nothing. The current reimbursement system is so arcane and difficult to understand and so punitive, it's driving physicians out of the Medicare program.

They don't want to get out of the Medicare program, but it's driving them out. So the regulations are now -- I understand in Medicare are more voluminous than the tax codes. So --

DR. SIMON: Thank you.

DR. ALLEN: -- it takes you awhile to understand the rules and the regulations.

DR. SIMON: That's an ominous thought.

Mr. Harder.

MR. HARDER: I'd like to comment that,

once again, the Indian healthcare delivery system is somewhat unique in that profit is not a component of it. So if the healthcare delivery system in the Indian world were unburdened of the financial regulations -- burden currently, certainly the improvement of services and the increase of services would be the net result.

Primarily, the result would be in the implementation of greater speciality care. Speciality care is something that basically does not exist within the Indian health delivery system. In the hospitals and clinics across this area, there is only one speciality medical provider, and that's an orthopaedic surgeon at one of the hospitals.

Outside of that, healthcare delivery in the speciality area is provided through contracts with private physicians, which -- those dollars probably are the dollars that are the first to be depleted. So oftentimes, we're faced with the decisions about whether to treat a broken arm or to continue treating someone who may have cancer or whatever.

So the increase of services definitely would be the result of the financial unburdening of regulations on the Indian healthcare industry.

DR. SIMON: Thank you, Mr. Harder.

Mr. Moore, do you have any comments? Okay. Thank you.

We'll go first to Mr. Size, then to --

MR. SIZE: Okay. Is it okay to make a comment and a question?

DR. SIMON: Yes, as long as the comment --

MR. SIZE: Yes.

DR. SIMON: -- is brief and the question is focused.

MR. SIZE: Both will be undoubtedly true.

Yes. I mean, I just want to say I have sympathy with Dr. Allen's comments. I think part of the complexity is I see a tapestry of regulatory issues and Congressional decisions about funding levels. And to the degree that we focus on regulation, we have some limits in terms of how we could address the issues you raise.

I wanted to get back to -- fellow hospital guy, Mr. Mitchell, because I really liked what you said, only because I agreed with it, I guess. The -- you point out the distinction between process -- regulation accountability around process and around outcomes.

And I totally -- I think that's an

important point for the panels to consider, because I really do think a lot of what we call regulation is derivative from -- most of what we've been able to measure and regulate have been processes.

The issue is as we go forward into this new brave world of -- which I think is a good thing -- of transparency and outcome measures, when do we start to do the tradeoff? I mean, I would argue, particularly from rural perspective, we're still struggling with good metrics for low-volume rural hospitals.

So intellectually, I really support outcome measurements. And I am enough of an anarchist -- I guess I'd do away with all licensure, all regulation if we really can measure outcome. The problem is we can't. So then the issue is how do we manage this transition period.

That was a question. It was relatively focused and possible to answer. I'd like to hear comments from --

DR. SIMON: You'll get lots of gold stars for that.

MR. SIZE: Thank you. I'm interested in people's reactions.

DR. SIMON: Yes.

DR. MITCHELL: In that I've been the lightning rod for two of the questions so far, I'll try to address that. But I agree with your comments as well, sir. And low volume is an issue. As I saw this rolling out and CMS and everybody was participating and the hospital associations, the rural group was back there saying, "You know, there's this thing, and we have a real problem that" --

Our hospital, I believe, does a very good job at what we do. If you look at the website, which I don't think most people can figure out, and really figure out what they're trying to look for, our good hospital will come up insufficient data.

Now, the issue of that -- probably the majority of the population does really understand insufficient data just means that. It doesn't mean that it's bad insufficient data. It just means low. And that is one of the real concerns to do that.

There are groundbreaking measures in all areas of our country -- really trying to take the process that's been instigated and coordinated by a lot of good folks and good groups of doing quality alliance and moving towards those outcomes. What is it we're really going to get? And if we do that, it's going to be a whole lot better for delivery of care in

the long run.

The -- I wanted to go back just real quickly to Dr. Conover's first question. You ask about if we made a better margin, what would happen in -- and much like Mr. Harder in a not-for-profit mode, it's got -- return. Sometimes I think that margin in healthcare seems to be a dirty word, and yet it isn't.

I can't survive if I don't make margin. I have to buy equipment and new things. Our facility just this year has invested over half a million dollars in new technology that's necessary to complement our physicians and our other providers in our community.

And so I think that although we're here talking about regulations and it would impact payment, payment is probably the issue in the long run about whether or not some charges and some of these costs of the individual providers or individual carriers or individual people could actually be lowered because if we continue to have a bad debt problem, we continue to have inadequate payments, as Dr. Allen eloquently spoke about as well, if -- it all shifts. And that's the real problem that we're facing today.

And I think Dr. Allen would agree that, in

his position of working with the hospital -- unfortunately, hospitals don't have the opportunity to say, "I stopped taking Medicare." We don't have that choice. So if the regulations come to us, we're stuck if we're going to stay alive at all. So I hope that I addressed your comments, sir.

DR. SIMON: Thank you very much.

DR. MITCHELL: Thank you.

DR. SIMON: Bob. Same ground rules.

DR. HELMS: Well, I hope -- I want to get back to something that Mr. Pierce said about -- and I hope this is relevant to your study. But you mentioned something about you would like to see more evaluations done of individual regulations in order to -- you know, to avoid this piling-on process.

In other words, before you go issue some new regulation, do some research about sort of what the other one did. I actually tried to promote this when I was in ASPE, and there is a little bit of this kind of research going on at the government, but quite frankly, the government doesn't have a lot of resources to do this kind of thing.

And what I was -- I'd like to ask you and the other panel members, through your either professional organizations or trade associations

or -- do you do anything to promote this kind of research yourself -- or evaluation to be able to come in with some data and say, "You know, this is really a dumb regulation. We can tell you that it costs so much, and if you did it a different way, you would save so much."

Is -- have any of you -- aware of or attempted to do these kinds of studies?

MR. PIERCE: I regret that I cannot point as to a study today that would have that information, although that is discussed regularly in the associations that I'm part of, both in Oklahoma and nationally. And it's needed very much.

I cannot even think of a -- I would not even venture to throw out a specific instance right now. But I do know this. When we look at regulations, we should ask ourselves, "Does this regulation improve the outcomes?"

And if it does not improve the outcomes, because of our limited resources that we have available for healthcare, we should be asking ourselves, "Do we need -- really need that regulation, because it's taking away from service delivery?"

So that goes on all the time. I would also say that providers do know how these regulations

affect them. And I guess that's one of the reasons we're having this forum, this town hall meeting today. They do know, and so they should be consulted.

And I also would say to Dr. Size's comment that we do not believe that we should live in a world any longer where every provider receives the same amount of money per patient, day or for a certain procedure.

We believe that we're in a new world where providers should be reimbursed for quality outcomes and that that will strengthen quality providers, and it will drive providers who are not quality providers out of the marketplace. So we do support a system like that.

DR. SIMON: Dr. Allen.

DR. ALLEN: Yes. Dr. Helms, the Texas Medical Association has a sister organization called the Texas Medical Foundation, which is the Texas quality institute, which is in the process of evaluating a number of the regulations and particularly the quality indicators and other regulations to see what the impact is and to see what the benefits are.

And one of the problems that we have come across is that frequently the regulations will be

promulgated, and they will do demonstration projects to try and determine what the effect is going to be, but because of Congress or budgetary constraints or whatever reason, they go ahead and implement the rules before the demonstration projects are even finished to know what the results of the demonstration projects are going to be.

So that is another problem. So the answer is yes, we are trying to, as organizations, at least physician organizations, to drill down into the benefits of some of the regulations and whether they even work at all.

Like on some of the long-term care projects -- some of them haven't been going on long enough to know if they really are going to produce the savings that we thought they were going to save. Some of them are actually showing we're spending more and getting less results than we thought we would.

So you're absolutely correct. We need to follow and to study the outcomes and find out what really works and what doesn't work before it becomes a cut-and-dried federal regulation that costs not only the provider money -- winds up costing the government money.

DR. SIMON: Thank you.

DR. HELMS: Do you have time for me to make --

DR. SIMON: Yes, I do, as soon as we've had a chance to --

DR. HELMS: Okay.

DR. SIMON: Any other comments to your first question?

MR. HARDER: Certainly in the Indian world, the comment period on regulations that are proposed is taken advantage of. Only this week, I sent a letter to CDC commenting on the impact of the quarantine-proposed rule that is open for comment as we speak.

Those comments don't always impact the economic impact of the regulations. Also the comments address some things as a cultural impact and the impact on implementation that aren't necessarily economic.

But unfortunately, in the Indian health world, too many go without comment because we lack some of the expertise, and we would have to go again, once -- like we said before, in hiring someone with a consultation package to provide those comments for us because we lack some expertise in that area.

DR. SIMON: Thank you.

Dr. Moore.

DR. MOORE: Dr. Helms, If I could give you an example of where I was intimately involved in what you're talking about, and that was the proposed regulation on the sun setting of the necessary-provider status of the critical-access hospitals.

They came out. And during the process, the time for comment on the proposed regulation, we did everything we could do. We pulled out the stops, associations, individuals. I walked around to the doughnut shop and got -- told people the situation, got them to write letters to CMS. And that was an interesting thing to do.

And it made a difference. Now, the point being -- I mean, true, we're given that comment period. But sometimes the way the regulation makes sense where it's regulated and the way it's perceived -- and you know it will -- it is a universe away from making sense out in the field.

I'm not sure that -- this was a successful time. We got the -- it had to do with how far you could move a hospital if you're building a critical-access hospital and it would still be the same entity and it would still be -- have its status as a critical-access hospital.

Fortunately, we were heard on this situation, and they -- the position was changed on that. They're not all that fortunate, though.

DR. SIMON: Thank you.

I'm going to ask if any -- Bob, I know you have a question in waiting.

And the panelists who haven't had a chance to --

MR. SIZE: A brief comment --

DR. SIMON: Yes. Brief comment. Absolutely.

MR. SIZE: I was also heavily involved in that particular advocacy issue. And I think part of the frustration on our part is that the reg is published; you got time to feed back. It's not a conversation. There's one question, one answer.

And so much of what we deal with is so much more complex than that, so I think we need more opportunities to have dialogue rather than just one question, one answer, and it's done.

DR. SIMON: Okay.

DR. HELMS: Well --

DR. SIMON: Bob, I can give you one minute --

DR. HELMS: Okay.

DR. SIMON: -- for question and answer --

DR. HELMS: We'll put this to --

DR. SIMON: -- and then --

DR. HELMS: One of the first things that I was assigned to do when I went to HHS in 1981 was to have a -- to head an internal task force to look at what was called in the hospital conditions of participation. And this was the Reagan administration, so we were going to deregulate.

And so we had the principle that we wanted to try to strip away a lot of the detailed regulations in there and substitute outcomes, in other words, say, "Here's the purpose we're trying to achieve and let it -- leave it more to the hospitals to get there."

Well, just to make a long story short, that's when I learned there were associations of hospital dieticians, and there's also an association of hospital librarians because one of the things we did was -- we were not against the hospital having a library, but we really didn't think the federal government had to require that, you know.

So anyway, you get beat up when you do things like that. But I would really like to hear from Dr. Rogers because he represents CMS, and it seems to me that the discussion back about the

moratorium -- I thought it --

DR. SIMON: Actually, I think that's an excellent idea.

Dr. Rogers --

DR. HELMS: But also, I'd like to ask him --

DR. SIMON: -- you -- can we --

No alsos, Bob. We're over time. We're -- you had your alsos. But I'm going to give Mr. -- Dr. Rogers the floor for about a minute or two to see if he has any comments or questions to wrap that up. And then we do need to move on to the rest of the audience.

DR. ROGERS: Well, I just wanted to agree with Dr. Helms's observation. I can think of a regulation that's near and dear to my heart as a physician. We require that if somebody's going to have restraints put on -- somebody's confused and trying to fall out of bed or something like that -- that they have to be seen by a provider when that's done.

And there are all kinds of regulations about how frequently they have to be seen and things like that, all well-intentioned. Safety is very important, and there have been abuse of practices in

the past, but the second we try to touch those regulations to simplify them a little bit, we are besieged by all sorts of advocacy organizations.

So although you're hearing unanimity in this room that regulations are excessive and too difficult to comply with, we could fill a room ten times this size with people that say we need more regulations having to do with the restraints and seclusions or having to do with physicians prescribing or having to do with speciality hospitals.

I could have a thousand people in here who could tell you that speciality hospitals are going to take the good business and move to the good part of town and leave the general hospitals underpaid and in bad parts of the neighborhood.

So it really is a lot more complex than you can possibly imagine until you're on the receiving end of these comments, but I appreciate you all coming in here, and I think your opinions are very valuable to us.

DR. SIMON: Right. Thank you very much.

At this point, I would like to heartily thank our panelists for their wisdom, and if anybody wants to offer a round of applause -- And end with a couple of housekeeping comments that will make their

comments even more important to us. Gentlemen, if you have brought written copies of your comments today, would you kindly make sure that one of the ladies out at the desk has received your comments so that they go into our official files?

And perhaps equally if not more important is that if you have additional evidence -- and I'm sure you do -- that you would like to bring to the attention of our study that -- please also make sure that we arm you with the appropriate website and vehicles for getting them to us because this is how we make the changes you want to hear. Thank you very much for your time.

And we have reserved some chairs behind there for you so that we can then move on to the next part.

As I indicated previously, we're now going to be taking testimony from the public. I'm going to be operating off of the sign-up sheets that you signed up on for giving public testimony on your way in in an order of first-come first-serve.

Ground rules are approximately three minutes for your time. I will make all sorts of interesting hand gestures as you begin to run out of time. And then we will open to the panel for

clarifying questions.

May I call at this time Sandra Gadson and ask Ms. Gadson if she would introduce herself and briefly indicate who she is representing this morning?

Ms. Gadson. Thank you.

And if somebody could assist to make sure that her microphone is on? Thank you.

DR. GADSON: Good morning. Thank you. I am Dr. Sandra Gadson. I am president of the National Medical Association. And I want to thank you for the opportunity to speak today on a very challenging issue. I have printed a statement so I will go through it very quickly because I cannot get all this done in three minutes.

First and foremost in importance to the National Medical Association -- and let me just say the National Medical Association is the oldest and largest membership organization for physicians of African descent, representing over 35,000 physicians and the patients that they serve.

One of the key elements that we are very interested in is that of quality. The other is actual cost of healthcare regulations and the cost benefit -- regulation. Dr. Conover has already told us -- and this is was actually in my

statements -- with regards to the financial burden of healthcare regulations, which is at about $1 trillion, and that was in 2004.

Perhaps the most compelling rationale for measuring economic burden is that such a measurement can help us to determine how many lives could be saved if we were to identify and trim regulations that pose greater costs than benefits and then redirect the economic savings to the goal of saving lives.

For example, one of the troubling preliminary findings represented by the Duke investigation is that the cost of regulation probably overshadows the benefit by $169 billion a year. Here are two good places to put that money.

One, we have over 44 million medically uninsured citizens in our country. Two, we have a national crisis of severe and persistent racial and ethnic disparities in healthcare across virtually every major disease, and this applies to citizens who do have medical insurance.

Clearly, the question is not should we measure economic impact, but how do we do that. I take a principle approach. And we at the NMA hold a position that such a principle approach should have three elements to it.

One is an independent framework for analysis. The framework must be -- must measure and project both short- and long-term outcomes. Having independent econometric projections available before regulations are crafted is a forward-thinking approach, and it is a recommendation that an independent body such as the Institute of Medicine do that.

The next is having coherent efficient data collection which will represent all of our society.

And thirdly is being very aware of the massive and growing body of evidence to support the increase in health disparities. And it is so important that our regulations don't increase health disparities, but as was federally mandated -- that we can help to eliminate health disparities.

So in conclusion, it is in keeping with the core principles of diversity and cultural competence in that we in the healthcare system be inclusive of minority researchers and also have well-represented at all levels our cost-benefit analysis project and include patients at all levels when we talk about cost-benefit analysis.

In closing, I want to underscore the NMA's commitment to support the advancement of a principled

approach to measuring the cost-benefit analysis and the dynamics of healthcare regulations. Thank you for allowing me to speak.

DR. SIMON: Dr. Gadson, thank you very much. If you could remain for a moment, we could open this up to questions from the panel.

DR. VOGT: Dr. Gadson, thanks for that statement. I thought that was really interesting. Can you think of maybe one or two regulations that you think are -- have a particularly unfavorable cost-benefit ratio or that perhaps exacerbate racial and ethnic disparities?

DR. GADSON: Well, I can think of one. I'm a nephrologist, and I work actually in northwest Indiana, so I've had the opportunity to see both sides of the chasm, especially working in northwest Indiana. When I practice in Gary, which is 95 percent African-American -- and there's a town nearby, Maryville.

So I can see both sides of it. And I can tell you one regulation that does, I think, increase costs at an unnecessary rate. There is the -- not the rehab units where patients go, but the progressive step-down units, which was supposed to be, especially for Medicare patients -- when they left the hospitals, they weren't able to go home. They didn't qualify for

the nursing home, so they would go down -- go to a step-down unit. Well, if they're dialysis patients, instead of them being dialyzed in the hospital, they have to leave the hospital, go out of the hospital to a dialysis unit, which could be 20, 30 miles away -- their unit, and then come back to the hospital. And they do this three times a week.

Well, look at the costs that that serves, I mean, the cost of the transportation, the cost of those who get them ready to go there, to bring them back. And you're doing this three times a week for maybe a month or so. And you'd multiply that times the number of people that do that.

I could never understand why that regulation was there. I know those entities are not considered -- they have a different provider number than the hospitals, but still, they're within the confounds. So that is one example of, I think, a measure that serves no good reason. It doesn't improve quality. It actually, I think, puts the patient at risk.

But we do it all over this country. And it definitely -- it's a regulatory issue which I often question.

DR. SIMON: Thank you.

Chris.

DR. CONOVER: In the current system, regulations -- the OMB has rules for scoring regulations and doing sort of the cost-benefit analysis you're talking about. And there's a comment period, and so people can weigh in on those estimates.

You're recommending -- is it -- are you recommending a system to displace that or to be in parallel to what's already going on?

DR. GADSON: To be in parallel to what's already going on. Not to displace it, but to be in parallel with it and to have more of an involvement of minority populations in that evaluation.

Now, one issue I understand is that in many cases it's difficult to get those populations to become a part of what happens in terms of regulation. But perhaps these town hall meetings can also go to those points to bring those people in to actually discuss. I think it would make a difference.

DR. SIMON: Other questions?

DR. ROGERS: I just -- I'd like to talk to you offline about that issue of transferring patients for dialysis because that isn't actually required by regulation. It's actually driven by the economics of the dialysis and the way those units are paid.

So we haven't written a regulation that said it would be illegal for them to go to the hospital dialysis unit, but because of the way the hospitals are paid, it wouldn't be a profitable thing to do.

DR. SIMON: Thank you.

Any other quick clarifying questions? Bill? Quick followup. Yes.

DR. VOGT: It's often the case that in prospect, before a regulation goes into effect, we don't anticipate exactly how it's going to interact with other regulations and how it's going to interact with economic incentives and so often we can't tell beforehand how costly a regulation would be.

And I'm wondering if you would also favor a mechanism or a better mechanism to comment on or induce studies of already existing regulations which are irrational or which have a larger cost than anticipated.

DR. GADSON: I would favor that.

DR. SIMON: Thank you.

DR. GADSON: And I did say in my recommendations that the Institute of Medicine perhaps could be one of the bodies that would put that together in a very succinct way.

DR. SIMON: Great. Dr. Gadson, thank you very much this morning and for making the trek from Indiana down to Oklahoma to be with us.

Our next commenter is Mr. Kent Abbott.

DR. ABBOTT: I'm Kent Abbott, and -- excuse me -- and I am president of Pharm Care of Oklahoma, a pharmacy company that supplies and takes care of patients in nursing facilities. Principally, I'll drill down to the Medicare D issues that we're faced with, starting with -- well, let me give you just a little further history.

I'm approaching 30 years in pharmacy now, which -- I should have already burned out, but I haven't made that burnout point yet. So having said that, from 1977 to current, we have been reduced in reimbursements, so I'll follow with the physicians and the hospitals that the reimbursements continue to dwindle, but we're requested to do more work.

And so we need to relook at that Medicare D continues that thought process. So from that point, I would say that we need to look at the economic situation that is occurring for Medicare D and for the pharmacies.

The pharmacies are in fact, since January 1, funding this program. There is no money coming in.

Most pharmacies are used to getting -- and require, because of the reimbursement, to get reimbursed weekly. Their wholesale drug sources require weekly payment. They have a simple system: You don't pay; you don't eat. So now we do not expect any payments until February. At the very least, February 15 is my estimate that we will receive our first payment. So pharmacies are funding this operation, if you will, across the nation.

Seventy percent of the long-term care patients in the nation were on a Medicaid system, and, in fact, are being switched over to a Medicare PDP system. Which PDP remains a mystery to many pharmacy providers, so I would ask that you consider that.

The -- some of the problems that pharmacies are facing is the lack of accurate information. They set up several avenues to get the information for the providers, both the facilities and the pharmacies. Most of the time, if that patient made an election to choose a different -- and again, I'm going to narrow this down to most of the dual eligibles.

If they made an election to switch from the one that they were possibly going to be assigned to to a more preferable PDP and formulary, that

information is not available. And I'm already getting close. So that --

DR. SIMON: Close is an understatement.

DR. ABBOTT: -- information's not really available.

Let me quickly move on and point out that in the financing of this transition from a Medicaid system to a Medicare D system, I do believe that it, in the end, will be simpler, and it will be better for pharmacies. But the -- whether or not they survive becomes an issue at this point.

And I would also want to point out that if we -- if a pharmacy fails to get paid for a hundred-dollar cost-item prescription, because they can't get it approved; they go ahead and take care of the patient, it will take 40 prescriptions to get back to even without ever making a profit to cover expenses. Forty prescriptions.

So realizing that -- she'll give me a signal -- formulary --

DR. SIMON: I've already --

DR. ABBOTT: Have you already given that one to me?

DR. SIMON: That was the -- it. So if --

DR. ABBOTT: Okay.

DR. SIMON: -- you could just finish your --

DR. ABBOTT: I thought that --

DR. SIMON: -- current line of thought --

DR. ABBOTT: I thought that was only a half. So formulary considerations --

DR. SIMON: It's always good to get the ground rules established early. So.

DR. ABBOTT: Okay. Yes. I thought that.

DR. SIMON: I thank you, but we have a roomful of folks, so if you could just finish your current question --

DR. ABBOTT: All right. I don't really have a question. I think it's more of a reporting of the Medicare --

DR. SIMON: Sure.

DR. ABBOTT: -- system as it exists. I would reiterate that the pharmacy from southeast Oklahoma was giving accurate information. The patients are not going to surf the web, are not -- the family members are not going to surf the web.

They're coming to their pharmacists and requesting -- tell me what to do.

DR. SIMON: Great. Thank you, Mr. Abbott.

And I'm -- yes. We're going to -- and let

me just -- you know, again, this -- because we have lots of people here with very important things to say -- that -- let me -- this means one minute left. This means finish your current words in your mouth and -- that we will then be able to move forward.

And this means that the folks outside can take your written testimony and help direct you to how to get in touch with me so that we can embellish on the things that you've started to say. So I appreciate that.

DR. ABBOTT: Thank you.

DR. SIMON: Okay.

DR. HELMS: Dr. Abbott, actually I thought you made a point very close to Dr. Moore's, and that is we need to understand that what rural pharmacists provide -- or I guess all pharmacists, but I'm concerned about rural pharmacists -- is two things.

They've provided a product, a retail product, but they also provide access consultation to a skilled knowledge set. And what suggestions do you have about how -- do we need to tease those functions apart -- notwithstanding Dr. Moore's comments about the government shouldn't promote web-based access, and my guess is more and more people are going to go that way with or without government involvement.

But my concern is how do we maintain payment flow, cash flow, access to the professional services of a pharmacist. Do you have any ideas about that?

DR. ABBOTT: Of course, the simplest way is the online adjudication. That's the simplest way for the government, the PDPs, as well as the pharmacy. But there is no recognition for the professional knowledge that is put forth by the pharmacist.

Everybody is focused in on this is a dispensing fee. But oh, in addition, you must provide these other clinical aspects which are knowledge-based, and they're not reimbursed for that.

DR. HELMS: And that -- I just -- maybe not put words in your mouth, but my understanding is what you just said was how do we frame our regulations, how do we frame the construct. And traditionally, we piled it all into the fee for that --

DR. ABBOTT: Correct.

DR. HELMS: -- for the pills. But you're saying, at least from a regulatory perspective, we could reframe how we purchase these various items.

DR. ABBOTT: Well, I think it needs to be broken down by dispensing fee -- that is a certain

service, but that's a mechanical type of service -- and then a secondary fee for education, clinical issues.

As an example, Pharm Care provided over a hundred education seminars in the state of Oklahoma for Medicare D, totally funded by Pharm Care, not funded, not reimbursable in any way. That education was because -- the inadequacy of the website-based thought process.

DR. SIMON: Question, comment.

DR. ROGERS: I just want to make a very quick observation. I understand exactly how difficult your position is. It's a lot like being a manufacturer for WalMart. You're dealing with these big PDPs, and they can sort of take you or leave you.

What you're experiencing, actually, is the absence of regulation. You have been thrown into the free market. The way Congress created this benefit is basically CMS works with PDPs, and you're actually interacting with the free market rather than interacting with the government.

And I know there are some problems associated with that. But it's interesting that the problem is that there's an absence of regulations about how much you should be paid and how much you should be paid per

visit and how your costs will be covered if you don't get paid for a prescription.

DR. ABBOTT: The -- I would further that just a little bit that the CMS and Medicare govern the PDPs and the PBMs. They tell them, You've got to provide this service. The PDPs then have the ability and the decision making on how they're going to administer it.

But there is -- they're not requiring -- except by guideline, they're not requiring the PDPs do it in a certain way. That part I would agree with you on.

DR. ROGERS: You would be shocked at how little authority Congress gave CMS to regulate how the PDPs interact with the pharmacies and the beneficiaries. We have very little authority on those things.

DR. SIMON: Do I have any other quick questions from the panel?

(No response.)

DR. SIMON: Mr. Abbott, thank you very much.

Our next commenter is Val Schott.

Mr. Schott.

MR. SCHOTT: Good morning. I'm Val

Schott. I'm director of the Oklahoma Office of Rural Health at the Oklahoma State University Center for Health Sciences. And welcome to Oklahoma and to rural America. And while we're talking about rural, I want to tell you briefly about our College of Osteopathic Medical School.

It ranked thirteenth in the country in terms of rural health. The great majority of our students are Oklahoma residents who choose family care and primary care as their speciality. And more than 30 percent choose to practice in rural communities of less than 10,000 in Oklahoma. So we know something about rural.

We're certainly proud of our relationship with CMS, Dr. Farris. We're currently in our seventh year of an annual meeting with all the state office directors in Region 6, with Dr. Farris and his entire administrative staff to discuss these kinds of issues. Dr. Farris is also responsible for the open-door forum, which I think has greatly helped this process.

Regulatory process does provide a special burden for rural people. An example that's already been made was the proposed regulation for replacement for critical-access hospitals. I'll use that as an example because I think that's very clear as to what

happened there.

The first proposed regulation was very punitive. The rural community spoke, and through the rural community and our elected representatives, we got that changed. However, that whole process had a very chilling effect on the availability of capital in rural communities.

Now, I agree with Dr. Moore not only that healthcare's important from an economic perspective, but also CMS is not responsible to ensure the economic viability of rural communities. CMS, however, is responsible for ensuring adequate access to quality care for rural Medicare beneficiaries. And without access to capital, we simply cannot do that.

This rule has changed to a much more reasonable rule, the 75 percent rule, which is the general rule for replacement of hospitals with CMS. Why this couldn't have been done initially, I'm really not sure, except I think that those people in Baltimore have some sort of adherence to the PPS system versus the cost-based reimbursement for critical-access hospitals.

There needs to be some understanding, though, that one size does not fit all. And with small, low-volume providers, that same system simply

will not work. What it will mean is that we won't have hospitals and providers in rural communities.

You know, the access to quality care not only means that we have to ensure quality, which we do, but it also means that we have to have equitable reimbursement for those services for our rural providers. We have to be able to ensure that we invest in our infrastructure and technology.

The rules for a regulatory process, then, should include some plain old common sense, quite frankly, and I would suggest that CMS should include rural advocates like the National Rural Health Association, the National Organization of State Offices of Rural Health in that process so that the proposed rule could have some relevance and some materiality to what goes on in rural.

I thank you very much for your -- for the opportunity so speak here, and I would like to see this as a much more collaborative process rather than an adversarial one. Thank you very much.

DR. SIMON: Thank you, Mr. Schott.

May I open to questions or comments from the panel?

Yes. Tim.

MR. SIZE: I know it's dangerous to ask a

question I should know the answer for before I ask it, but I'm going to do it anyway.

DR. SIMON: Go for it.

MR. SIZE: Is there a formal process for, like, if Val or somebody else said, We have a case to make that regulation X -- the cost is way in excess of the benefit. I mean, I'm an old timer. I wouldn't know where to go with that. Is there such a process or --

And that's not to Val. I guess that's to anybody in the room. So it's a very unparalleled -- we make it -- there's a clear process which I'm aware of how to grow the regulatory body, but it's not very clear how to shrink it.

DR. ROGERS: Well, I can speak to that. We have eleven open-door forums, and these are basically open-mike calls where people can call in, and they serve the various stakeholders, partners, business associates that CMS has, long-term care, renal failure, physicians and allied health.

And each of these open doors is a great venue for bringing up regulations which are burdensome or not cost-effective, and then for providers, for physicians and other providers -- actually, the physicians regulatory agency is also very interested

in hearing about these regulations.

We have two rural-health issues that we're working on right now which have been found by the physicians to be -- seem to be burdensome and unnecessary.

MR. SIZE: And let me just say, I mean, it was Wisconsin boy Tommy Thompson that helped support the open forum, and I really do think it's been a major improvement in terms of the dialog. My question was really more around the concept of a formal process. Because again, I mean, I and colleagues have been on the call. You can say something, but then, you know, if there's some really nice caring person on the -- inside CMS that wants to take it up, maybe it gets taken up, but otherwise not. And that's not the degree of formality and dialog that I was thinking of.

DR. SIMON: I'll take a quick comment from -- yes, sir.

DR. ALLEN: Just a quick comment that, you know, I think the problem is --

DR. SIMON: Could you move to one of the mikes please, Dr. Allen?

DR. ALLEN: The problem is that CMS has to operate in the regulations that are passed by Congress, and Congress is the one that frequently

doesn't understand the problem. It's not that CMS doesn't understand the problem, it's that Congress doesn't understand the problem, and as a result, the processes are forced onto CMS.

Now, the carriers -- individual carriers in the states -- there is some latitude for addressing these issues with the individual carriers, as long as it doesn't violate the central CMS policy per se, you might say. There is some ability for rural physicians, for physicians in other areas to deal with the carriers and to take care of some of these problems.

So again, I think there is a little wiggle room in there to take care of this, as long as it doesn't violate -- and Dr. Farris may want to make some comment about that.

DR. SIMON: I think we'll -- yes. We'll go back to Mr. Schott briefly and --

MR. SCHOTT: One final comment. I do agree that the open-door forum has really increased the communication. However, that's around the peripheral of some of the issues we're talking about. If you're talking about some real innovation, that seems not to happen, because Baltimore, quite frankly, doesn't pay a lot of attention to what happens in the

regional offices --

DR. SIMON: Yes.

MR. SCHOTT: -- is my opinion.

DR. SIMON: Thank you very much, Mr. Schott.

Our next commenter is Dr. David Duncan.

Dr. Duncan.

DR. DUNCAN: If I look relaxed today, this is probably the first time in the last ten or 15 years that I'm absolutely certain I'm not going to break a Medicare regulation today. Because I can guarantee you every day I practice, I break one. I don't know what it is, but I'm sure I break one.

And everybody's talking about Plan D. It's cost me 147 hours already, unreimbursed, dealing with Plan D. It is -- it's something that we all have to take responsibility for birthing. And if there is anything that stands for abortion on demand, Plan D would.

We should back up, say, Whoops, we made a mistake; we're all going to start this over again, and do it right. This is -- what's done is crazy. Nobody understands it. So that's -- maybe we should have a moment of silence for Plan D.

Anyway, I had four points I wanted to

make. I'll try to do them kind of quickly. Physician reimbursement for nursing-home care and reimbursement in regulations at the solo-practitioner level are intricately intertwined.

Reimbursement for nursing-home care generally keeps physicians out of nursing homes. We end up with the lowest level of care, which is telephone care, followed by the highest level of care and the most expensive level of care, which is ER care, which is where you were, for patients that should never have to be there.

And the reason is, we get paid less to take care of a patient in a nursing home than we do in our office, and it takes a lot more time to do it. This is very expensive. It's produced by regulations.

The second point that I wanted to make was that the nursing homes basically fall into two groups, at least the ones that I deal with. There are the ones that I sort of call the private ones that received a lot of funding from individual patients. They compete with each other on service provided.

There's a world of difference between going into one of those and the one that takes care of the other 70 percent, which practices basically on an HMO-based type model where you get your money up

front. You got to make a profit, one minute to make a profit. And in that profit, the only way you can do it is reduce services. This is a bad situation.

The last point I will make here is that keeping up as a doctor with changes in Medicare or in medicine is a full-time job, more than a full-time job. I don't have time to go review the e-mail and the federal regulations every month. That's why I know I break them. I don't know what they are. I'll never know what they are.

There's an Indian proverb that I'm going to paraphrase here in deference to one of the panelists. I have two wolves in my head. One of them is the wolf of regulation. The other one's the wolf of medical care. They're constantly fighting with each other. Which one will win? The one I feed. Thank you.

DR. SIMON: Thank you. Actually, Dr. Duncan, if you could just remain --

DR. DUNCAN: Sure.

DR. SIMON: -- for the questions. Could you tell us a little bit about where you practice?

DR. DUNCAN: Actually, I started practicing in Jinks, the other sports area in Tulsa.

DR. SIMON: We don't want to make this

debatable, but --

DR. DUNCAN: And --

DR. SIMON: You're a solo practitioner in Oklahoma?

DR. DUNCAN: I actually had a horse and buggy when I first practiced. I now practice in downtown Tulsa. I've had a solo practice for 25 years.

DR. SIMON: Thank you.

DR. DUNCAN: I would suggest to the panelists a solution to this is something like the one we've been decrying on how we get paid. The whole time I've been practicing, my reimbursement has consistently gone down every year for what I do, every year.

I would like to see the regulations bounce back to 1985. Take whatever number of regulations we had then, work on a zero sum from that time, and decrease it by 5 percent a year. So if you come up with a new regulation, it better be good, because you're going to have to take something out to put it in.

DR. SIMON: Thank you.

DR. DUNCAN: That's not a joke.

DR. SIMON: On that controversial

proposal, I'm going to open this to the panel. Gentlemen, who wants to jump in first?

DR. DUNCAN: And where are all the doctors?

DR. SIMON: Uncharacteristic silence up here. Okay.

DR. ROGERS: I can just explain very quickly how your payment's calculated for nursing homes, for your nursing-home care and any other care you provide. You know, it's actually not done by CMS, but it's done by the RUC, which is a committee of physicians, mostly, who actually figure out how much inputs go into particular services.

So we had actually sort of farmed that out to the physician community to make those calculations, and that's the committee that has to realize how much more important nursing-home care is than it seems to be -- than the way it's rewarded right now.

DR. SIMON: Tom -- Tim.

MR. SIZE: Yes. There's always dangers in metaphors, and your thing with the wolves -- that works for me if, for me, regulation is what somebody up here termed excess regulation; i.e, it doesn't return benefit. But for me, a lot of regulation is simply what I call accountability. And you can't go

anywhere in a market economy or America where you sell something and someone buys something that there's not contractual terms. And so, I mean, to the degree that regulations are good, it's really a form of accountability. And I don't think that metaphor of accountability fighting with healthcare is a good thing. Now, healthcare needs the accountability. I think it's an issue of making it effective accountability.

DR. DUNCAN: I would agree with you completely if it weren't for Plan D. When I see Plan D, I wonder.

MR. SIZE: I have some other questions.

DR. SIMON: Go right ahead.

MR. SIZE: Part D -- for another person who hasn't spoken yet. I don't know what's out there. But --

DR. SIMON: Okay.

MR. SIZE: -- I wanted to talk about -- because I know what we're seeing in Wisconsin. We're having nursing homes that have 40 formularies. And that's a derivative condition of what we put in place, and I just think that's bad quality, but I don't know how we get out of this box that we're in. So if someone could address that, I

would be very grateful.

DR. SIMON: Well, I'm sure somebody will before the day is over.

Can I open to other questions from the panelists?

(No response.)

DR. SIMON: Dr. Duncan, thank you very much.

Our next commenter is Mr. Tom Coble. Did I get --

MR. COBLE: Yes. You did get that correct.

DR. SIMON: Excellent.

MR. COBLE: Thank you.

DR. SIMON: Thank you.

MR. COBLE: My name's Tom Coble. I'm a nursing-home administrator, a nursing-home owner. And I'm also the president of the Oklahoma Association of Healthcare Providers, which is made up of many providers, but mainly nursing homes. I live in southern Oklahoma in a town called Ardmore. And I'm very happy to be here today.

I presented my comments to you in some detail, and this discussion has just completely screwed up what I wanted to say, so I'm just going to

freelance it and go from here. The nursing-home industry is the second most regulated industry in the country, only second to the nuclear industry.

And I will ditto with everybody that said I will promise you there's no way you can keep all those regulations all the time. We spend a great deal of time, money and effort just trying to keep from being fined and blamed for things that are humanly not possible.

What we do in a long-term care setting is about process and quality and outcomes, and I think Christopher Reeve is the best example that I know of what is that. I would think that Christopher Reeve could purchase the best healthcare that money could buy, but his death was from a complication of an infection of a pressure ulcer.

So as we go through this process, we have to define quality. If we ask people in this room what is quality, we'd get a different answer from everybody.

When HHS started the National Nursing Home Quality Initiative and the QIOs were set up in each state to start working with nursing homes, we saw improvement in outcomes and quality of care. But it was because it was a collaborative effort where people

were sent in to work with providers rather than to judge us on some scorecard as to what we did.

If you think about it, the rules and regulations of over 20 years ago do not even fit the population that resides within a long-term care facility today. We've seen the continuum of care develop. And the people that were in nursing homes back in the mid '80s now live in assisted living, their own homes receiving home- and community-based services.

And so what I think we need to do is -- and I want to give Dr. Farris kudos on this, but only one man can do so much -- is we need to have an ongoing communication between all stakeholders to help deliver services that do deliver quality in outcomes and that we are paid effectively to do. And thank you very much for the opportunity to speak.

DR. SIMON: Thank you very much, Mr. Coble.

May I open to questions or comments from the panel?

Ted.

DR. FRECH: That's very interesting that you said -- I think you -- this is what you said -- that the nursing-home population now is much

sicker than it used to be 20 years ago. Is that --

MR. COBLE: That is correct. Yes, sir.

DR. FRECH: That makes perfect sense. Is there any way to kind of quantify that -- in an easy way that we can understand here?

MR. COBLE: Well, most of our patients today are either wheelchair-bound or bed-bound. They're not ambulatory. They can't go out on outings. There's a lot of things that they used to do. Twenty years ago, I was not in the healthcare business. I was taking care of offshore natural gas. So I don't know what that population was. I've heard a lot of people describe it and what happened in those facilities.

But I know in the 13 years that I have been in this business, I've seen an ambulatory population that may come for awhile, get better and go home turn into either two types of patient: rehab patients that we do through skilled nursing that do improve and go home, or patients who come there to be managed in the last days of their lives.

DR. SIMON: Chris.

DR. CONOVER: I just want to make one other observation. It seems like, in the other town meetings we've gone to, there's been much more of a

balance between sort of the industry point of view and the consumer point of view, if you will.

And I will just report to you that in the other town meetings, we've often had advocates speaking on behalf of patients saying we don't have enough regulation in nursing homes. And I just would like you to comment on that.

MR. COBLE: I think it's a perception, and I think it's also the expectation that when someone's loved one comes into a nursing facility, that they're going to get better. And that's what the regulations speak to. I mean, someone can be receiving oxygen at home on home health, and when they come into a nursing home, they're suddenly well enough that Medicare will no longer pay for it.

So I think that's part of the process, in my mind, that by the time we receive a patient today -- that they've had several strokes and have gone through the process at all levels so that long-term outcomes are not always positive.

DR. SIMON: Additional questions?

(No response.)

DR. SIMON: Mr. Coble, thank you very much.

MR. COBLE: Thank you.

DR. SIMON: Let me just pause for a second and let me tell you where we are at this moment. I'm going to ask Scott Pilgrim to be our final commenter before we break for, I think, a well-deserved break for lunch. We'll be breaking for approximately an hour, reconvening at 1:15 with the remaining individuals -- and I have another roughly nine or ten on my slate, and probably more outside -- allocated time after our lunch break.

So we're going to go -- Mr. Pilgrim, if you could give us our comments.

And then I ask you to sort of indulge Mr. Pilgrim's time, and then we will be taking a break for lunch. Thank you.

MR. PILGRIM: Thank you. My name is Scott Pilgrim. I own and operate several intermediate care facilities for persons with developmental disabilities. These are commonly known as ICFs/MR. Additionally, I own a skilled nursing facility here in Oklahoma.

My businesses, both the skilled nursing facility and the ICFs/MR, are subject to some of the most extreme regulatory regimes in our nation. A lot of it is necessary. There is an accountability that needs to be there when you're caring for people's

lives.

But every extra rule and regulation requires a lot of extensive paperwork in order for us to prove compliance with the regulations. This takes away my care givers' time from their primary job of taking care of my residents and my clients.

A report from the American Health Care Association states that there are more than 130,000 pages of Medicare and Medicaid rules and regulations. Now, I understand, my training is as a certified public accountant.

130,000 pages is more than three times the length of the Internal Revenue Code and all of the associated income-tax regulations that implement that code. This flood of ink wastes our time, increases our costs, drives our staff away, and most importantly, it doesn't necessarily correlate with quality patient care.

Now my written comments that you have copies of provide six specific items in detail in those examples. However, I'll probably only get the opportunity to cover one or two.

The survey process. The original intent of the inspection process, what we call a survey, was to be a resident-centered outcome-oriented system of

oversight. Over the last 20 years, it has regressed to a subjective process-oriented -- and is very punishment-driven.

Providers are forced to chase a carrot, a zero deficiencies, by having their paperwork all in order. While we're filling out some silly form, we've got a resident sitting there who's bored, who's lonely, and who wants to be taken outside for a walk on a beautiful day like today. We don't have time to do it.

We need to change that system so that it recognizes quality care when it sees it in action and not just on a piece of paper. It needs to reward quality care and improve it where possible. We need to foster an environment of partnership between the inspectors and providers.

And as partners, the inspectors need to be able to trust the judgment of our front-line staff who actually provide the hands-on care. A partnering environment will save significant money, and most importantly, it will improve care.

My second topic is the Medicare cost report. As a CPA, I am tired of filling out the Medicare cost report. This is an extensive and time-consuming report that not only requires a lot of staff

hours just to compile the data, it really takes trained accountants in order to fill out the form accurately.

Now this information, I am sure, is useful to somebody somewhere. However, with the implementation of the Medicare prospective payment system, this report is unnecessary. We need to slay this dragon and save several thousands of dollars per year per skilled nursing facility.

My other four topics you have in front of you, to summarize, you know, contrary to a lot of the bureaucratic thought, this vast array of overlapping regulations does not predict nor does it mandate improved patient or client care.

The overregulation actually hinders progress and leads to higher costs and lower patient outcomes due to the diversion of resources. Thank you. I'll be happy to answer any questions you have.

DR. SIMON: Thank you very much.

May I open the panel?

Bob.

DR. HELMS: Okay. Mr. Pilgrim, I have heard some analysis of criticism over the years about these inspectors that go out and that you have to deal with on a, you know, periodic basis that are sent out

to do the reviews and so on and how they're rewarded and so on.

Can you comment on that about how you think they are rewarded? I mean, in other words, they only -- is their job just to write up as many reports as they can, or is there a better way to do this?

MR. PILGRIM: I think certainly there are arguments that there are better ways to do it. How they are rewarded I can't comment to. I don't know. The surveyors, by public perception, are in our facilities because our facilities are bad in terms of the nursing homes.

Actually, that's not necessarily the case. They're in those facilities because CMS has hired them to be in our facilities. And that is as opposed to the regulatory system in other long-term care. Assisted-living centers, et cetera, don't have that same federal requirement, and nor is there regulation that -- the Department of Health's regulation of those facilities paid for by CMS.

DR. HELMS: Well, you used the term be able to recognize quality. When these people come, I mean, it's alleged that they are just rewarded for writing up deficiencies. How could you get a system where they could sort of have some incentive to really

recognize quality?

MR. PILGRIM: I can't tell you that I stand here and I know all the answers. I know that whenever we are written deficiencies -- an example would be we have mostly private rooms in my skilled nurse facility. In that private room, the door closes.

We were written a privacy deficiency because we didn't put a curtain across the room behind the door that leads to the hall, because, well, it's patients' privacy. Their dignity is at risk. If somebody opens the door, they could see the care being administered.

Well, that has some logic, but, well, if they could open the door, why couldn't they move the curtain, too? You know, it's that kind of overkill.

DR. CONOVER: One of the points you didn't get to talk about but which is in your written testimony is you say some federal and state regulations are in direct opposition to one another, and we've heard lots of testimony today about, you know, the complexity of regulation and no one can keep up with it all.

I'm trying to understand better how these situations arise. Do the state regulators who come in

with a regulation that is in, you know, direct contravention to a federal regulation -- are they aware of that and they just don't care, or -- you know, how does that play out on the ground in these instances?

Because we've also talked about the process of regulation. At the federal level, there's, you know, review and comment periods and things like that. And I don't know whether there's similar processes in place in your state.

MR. PILGRIM: Dr. Conover, the bulk of my business is in institutions for adults with developmental disabilities, small six and eight-bed type facilities.

DR. CONOVER: Right.

MR. PILGRIM: A specific example in there -- in California that jumps to mind is the state surveyors will require the facility -- now, this is a house, just like yours and mine, but it has six or eight bedrooms and six or eight adults in there.

The state requires the facility to lock up all the cleaning supplies, because, you know, those people -- they'll get in them and hurt themselves is the thought process. Well, there's a state regulation to that effect.

Well, in the federal look-behind surveys, which -- those are the folks that are surveying the surveyors -- come in and say, You have that locked up. That violates the residents' rights. You can't do that.

Well, when the contradiction is pointed out, both the federal surveyors -- maybe not the federal -- at least the state surveyors are in a catch 22, as well, because their regulations require them to right that deficiency.

But then the feds are coming back behind them and whacking them on the head for violating client rights, which is a much more subjective mechanism. But they're from the federal government, and they're here to help.

DR. CONOVER: But to just clarify. So in this instance, it's an issue of how the regulations are interpreted on the ground by the surveyors as they arrive at a facility as opposed to -- you couldn't take like a written document and show the discrepancy?

MR. PILGRIM: We may be -- may well be able to do that. But the surveyors -- and I don't know this for a fact. My perception --

DR. CONOVER: Right.

MR. PILGRIM: -- these are folks just

doing their job. And the way they're trained to do that job and the attitude that they're told to take in taking that job precludes them from veering off the path. If it's, you know, straight up and down, you know, you do this or do that, they seem to be in a bit of a catch 22, as well.

And it's the regulations that drive them into that situation.

DR. SIMON: Ted.

DR. FRECH: In other industries where there are conflicting regulations -- and I'm really -- I'm thinking first and foremost about telecom. If there are conflicting regulations, there's litigation right away.

Now, it seems like from what I've heard in this and also the previous one of these, in the nursing-home industry and in long-term care more generally, there are all kinds of problems like this that it seems like in other industries there would be litigation about them.

I don't really hear that happening in nursing homes. Is there some reason the associations are afraid of suing the states or the federal government?

MR. PILGRIM: I think there's -- I think,

yes, there is some of that fear. But another thing is we don't make any margin, so we can't afford any lawyers. That -- you know, that's a little tongue in cheek, but there is a substantial grain of truth to that as well.

DR. SIMON: Okay. Bill and then Tim.

DR. ROGERS: Very quickly, I'm very sympathetic to your position. I had spent a couple of years as a medical director at a nursing home, and I know exactly what you're talking about. And I think it gets to what Dr. Conover was talking about.

It is very appealing to advocates and patient-rights people interested in those sorts of things -- very appealing for them to demand that we regulate your industry.

They trust doctors. They trust hospitals to some extent. They trust ambulance companies to some extent. But there is a distrust of some nursing home facilities and a feeling that if there aren't regulations there to protect the patients, that the patients are going to suffer.

We recently went through a sort of hail of fire when we proposed that you wouldn't require formal training to feed a resident. And there was a huge hue and cry that to allow, heaven forbid, you know, a

mother to feed the disabled child was just crazy.

And those people are very persuasive, and they're busy on the Hill. And there's a whole industry of people pushing more regulations into your industry. And you're well aware of that, but I hope the whole room is.

DR. SIMON: Thank you. And Tim.

MR. SIZE: Yes. Maybe a partial answer to the question that Chris asked. I mean, I think part of the issue when we're dealing with people rather than things -- there's much more room for grayness and overlap. And so it isn't so much issues of contradictory regulations it's tensions between various needs.

And we use a pretty cut-and-dried black-and-white infrastructure to enforce and review these regulations. So I'm not so sure it's -- I mean, both those regulations made sense. And my guess is it's a tough judgment call what to do if you're responsible for those residents in that home to balance that out.

And again, it's that word balance, and maybe the lack of processes to achieve that balance as opposed to something inherently flawed about the individual regulation.

I think -- it hasn't come up this morning,

and hopefully it has in some of the other town meetings, but I know in our state, and I know many of the regulators, and they're good people, and they generally are well-accepted by healthcare providers in our state. And we have a few bad apples, wrong personality, power trip and stuff like that, but that's not typical.

But what I do sense is frustration of our state with the federal government. I know at one time we were able to get much more -- and this was important for smaller under-resourced rural providers -- technical assistance from our state surveyors. But now my understanding is that's largely not possible in terms of either the finances of what's available from the feds to the states.

And I think if I got my facts correct, it's important to note that many of the surveyors that we deal with are hired by the state and are responsible -- the federal presence, actually, in our state.

So there's another relationship going on, not just between us and the state surveyors, but also between state government and the federal government in terms of what's allowed and not allowed. So just more of a comment.

DR. SIMON: Response.

MR. PILGRIM: I guess kind of a last comment.

DR. SIMON: Sure.

MR. PILGRIM: You know, in my small facilities, we're usually using somewhere between two and a half to three full-time equivalent personnel to fill out a lot of the ongoing administrative paperwork. What I'm asking for is to free up, not all of them, but some of them, so they can take that bored, that lonely grandmother for the walk outside on a beautiful day like today. Thank you.

DR. SIMON: Thank you very much.

We're going to take an hour-long break for lunch. And so if we all want to synchronize our watches, I have 12:15.

(Whereupon, at 12:15 p.m., the meeting was recessed, to reconvene at 1:15 p.m., this same day, Thursday, January 12, 2006.)

DR. SIMON: Okay, folks. We're going to get started. Excuse me, please. Thank you.

I'd like to ask Ms. Beth Swafford.

Thank you, Ms. Swafford.

MS. SWAFFORD: Yes. My name is Beth Swafford. I work for HCA, and I'm here on behalf of

the Federation of American Hospitals. And like the man before lunch, I'm kind of going to, today, look at slaying the cost-report dragon.

I don't know how many people in the room are familiar with cost reports, but it's, like the man said, it's three, four times worse than the regulations for your income tax.

The Federation of American Hospitals has worked in the past on an effort to bring some reduction in cost-reporting burden. They first presented this to former Secretary back in 2001. It's important to examine periodically the cumulative impact of healthcare regulations to determine if they continue to achieve the purpose for which they are originally created.

We believe that the current Medicare cost report is especially rife for this kind of reexamination. It was conceived at a time when provider payments were cost-based, entirely cost-based. Yet over the years, Medicare's payment systems have evolved to the point where prospective payment has replaced cost-based payment for the vast majority of providers.

And paradoxically, over that time, the Medicare cost report has become much longer, much more

complicated, and significantly more costly to administer. There's approximately 5,500 hospitals. Those are acute, rehab, psych and long-term care hospitals with approximately 1,200 of these being your critical-access hospitals.

Critical-access hospitals continue to be reimbursed in part by use of the cost-based regulations, but we believe the Medicare cost report could be significantly simplified for critical-access comments. All our comments are directed primarily to the remaining 4,300 hospitals that are reimbursed under prospective payment system and account for the vast majority of healthcare expenditures.

We have a detailed packet that I gave when I registered that goes into specifics about the cost reports. And at the heart of the Federation of American Hospitals, our proposal is the notion that relevant financial data should be reported based on generally accepted accounting principles, or GAAP, for the accountants in the room.

GAAP is widely used and understood. Its adoption by Medicare would increase the accuracy and timeliness of the data Medicare needs to ensure proper payment, while eliminating the needless confusion and complexity.

We believe our report details why that much of the data currently collected is unnecessary for the purpose of ensuring accurate prospective payment or for other purposes such as documenting hospital performance.

We estimate that 4,300 hospitals, excluding the critical-access hospitals, spend resources on complying with cost-based regulations that are not beneficial to the Medicare program and are being done to comply with the antiquated cost-based regulations.

For example, chief financial officers, they have to maintain a separate depreciation lapsing schedule just for Medicare. And they have additional staff that the CFOs must segregate between allowable and non-allowable. That may be in advertising, public relations, non-patient cafeteria meals, et cetera.

We also still have to have staff to compile statistics, such as pounds of laundry used in every single department in the hospital, the meals, the time studies for the telephone operators that answer the telephones. I mean, it goes on and on.

We estimate that these hospitals incur personnel hours in the range of 2,000 to 4,000 for the

average-sized hospital. If you put that to the Federation's recommendations, that would reduce the cost report by 50 percent. If the recommendations are followed, that would cost out to about 1,500 hours.

And if you figure a salary for the accountants and the personnel plus benefits at about $75 an hour, we're talking that the salary and benefit would result in an estimated savings of $480 million to hospital providers.

While any estimation is just that, an estimate, we do know that hospital personnel are spending resources on activities that are required under cost-based reimbursement that no longer are applicable.

Without meaningful reform of the cost-based reporting, we have to seriously question whether the expertise at the hospital, the Medicare fiscal intermediary, and CMS levels will come in years to come when it's based on cost-based regulations.

GAAP-based reporting would not alter the need to carefully report and monitor payments such as disproportionate share, medical education, bad debts and wage index, things like that. We appreciate your actions to simplify it, and if you have any questions.

DR. SIMON: Thank you.

MS. SWAFFORD: May I turn to the panel?

DR. CONOVER: I just have a small question. The Medicare outlier payments, aren't they either cost-based or switching to being cost-based rather than charge-based?

MS. SWAFFORD: Well, yes. And a long time ago, they were either day outliers or cost outliers. And the threshold has gone up and down in recent years. To before -- the regulations stated that Congress said a certain amount had to be paid out in outliers.

And we found out in the last few years that was not being done, so they did increase the -- decrease the threshold so that payments would go up. And it is applied to your cost-to-charge ratio.

But there's still so many schedules. I mean, has anyone in here ever done a cost report? How about on the hospital level? Okay. I mean, we have staff after staff. And like you said, the regulations are miles long.

MR. SIZE: I mean, I totally understand what you're saying, and it's what I hear from people I work with. I just -- curiosity question. If we

weren't collecting what the cost to care was, do you have any concerns about how that would affect ongoing updates or --

MS. SWAFFORD: We're not saying -- that is still left in the cost report in a lot of areas. We're just saying simplify the schedules that are no longer needed. And in my packet, I went through schedule by schedule those that would still be used for regulations to collect, you know, things from the wages into, you know, the physicians and all the financials. So we're not saying cut it out --

MR. SIZE: Okay.

MS. SWAFFORD: -- just simplify it.

DR. SIMON: Gentlemen, anything else?

(No response.)

DR. SIMON: Thank you very much. And you've left a copy of your report with the folks in the back as well?

MS. SWAFFORD: Yes. If anybody wants one, I can e-mail it as well. I have two more copies, but I didn't know how many --

DR. SIMON: If you could give it to the gentleman in the white shirt up here, we'd appreciate it -- which probably defines half the room, doesn't it? The guy waving at you.

Next may I ask Lisa Cantrell to come to the microphone?

MS. CANTRELL: Hi. Can you guys hear me? I'm a little on the --

DR. SIMON: Are we good over there? Thank you.

MS. CANTRELL: Okay. My name is Lisa Cantrell. I'm a registered nurse. I'm cofounder and president of the National Association of Geriatric Nursing Assistants. NAGNA is what we call it. We're a professional association of more than 20,000 nursing assistants across the country, and we're striving to improve the quality of care through recognition, education, and motivation of these important front-line care givers.

My comments are actually pretty specific and pretty focused. Nursing assistants. I've always been very passionate about them. I started my career in long-term care as a nursing assistant in the early '80s. I was five at the time. And I eventually went on to LPN school and then RN school, and my whole career has been spent in long-term care.

And my comments are specifically geared towards the nurse-aide training program regulations. As we all know, CNA retention has been studied

considerably for the past several years. And I think everybody would agree that increased retention only leads to better quality of patient care.

Studies also document that the turnover of one CNA amounts to about -- the cost of about $2,500. Some studies show a bit more; some show a bit less. But turnover dollars start racking up the minute a potential nursing assistant hands their application to the provider.

According to Section 483.152 on the requirements for approval of a nurse-aide training program, there's prohibition of charges in any way, shape or form to the potential CNA who applies to the provider to take the nurse-aide training program at the skilled nursing facility.

This carries great significance from our point of view and from the point of view of over 20,000 nursing assistants who are members of our association. Primarily, it's skilled nursing facilities who conduct CNA classes, the nurse-aide training program.

They recruit the individuals. They pay the RN instructor. They teach the course. They pay for the textbooks. Many facilities -- many providers actually pay the nursing assistants for the hours they

spend in class. And of course, we all know that the minimum number of hours is 75 hours for the nurse-aide training program. Many states are more than that.

And so you look at the $2,500 for the cost of turnover. Nursing assistants get certified at the nursing facilities, and then in no time they quit and they go to other settings, primarily acute-care settings such as hospital, home health, that sort of thing, where the work is perceived to be more glamorous.

That's in large part due to ageism that our society believes in and the media that glorifies acute care over long-term care.

Because of the regulations regarding the nurse-aide training program, providers cannot charge, recoup their cost, or even enforce a committal agreement with CNAs.

When I started way back when as a nursing assistant, if you were going to take a nurse-aide training program at the facility, you could -- you had to sign a committal agreement, an agreement to work at the facility for, let's say, for example, six months, or they would deduct some of the costs of your nurse-aid training program out of your last paycheck.

Because of the regulations, facilities are

no longer allowed to do that. In our work through NAGNA, we -- there's lots of studies that show varying degrees of turnover, but we see it about a hundred percent nationwide. Most of the turnover occurs in the first few weeks.

So to put a dollar figure to the turnover of newly-certified nursing assistants, if you have a class of ten, you lose five right off of the bat.

That's $12,500 that's just walking out the door when you get them certified, not to count -- I mean, it's hard to put a dollar value on how that's impacting the quality of care, how it does not allow the existing CNAs who are counting on those nursing assistants coming out of the class to join them on the floor working --

It makes the existing CNAs unable to establish relationships with their patients, because they don't have the time. They have to drive home feeling guilty, because they don't have the time to do their work because of the turnover and retention issues, when a lot of that could be solved if they were able to enforce a committal agreement with the new nursing assistants.

And what we have found -- many facilities, many providers are teaching preceptor courses. We

have a program where we teach preceptor courses to nursing assistants, and that greatly increases the retention rates.

However, if you're losing many people within the first two weeks, you don't have the opportunity to sell them on long-term care and how great the work is and how valued the elderly are. And so we're losing people right and left.

And it's only going to get worse with aging baby boomers, zero population growth. It's a real crisis. And I want to thank you for being allowed to provide comment.

DR. SIMON: Thank you very much, Ms. Cantrell.

Panelists.

Chris.

DR. CONOVER: You said there was a hundred percent turnover rate. That's an annual turnover rate?

MS. CANTRELL: Many facilities are actually more than that. It's really, you know, different studies show different things. Studies are only as good as the data that's contributed.

DR. CONOVER: Right.

MS. CANTRELL: And when different

professional organizations put out the call for turnover information, usually the facilities who respond are the ones that --

DR. CONOVER: Right.

MS. CANTRELL: -- probably have less turnover.

DR. CONOVER: We call that selection bias.

On the $2,500 -- I want to make sure I understand the components of that. Is that the 75 hours of training times some wage or something like that?

MS. CANTRELL: Well, that's actually a very modest figure. There are --

DR. CONOVER: Right.

MS. CANTRELL: -- some studies that show that it's even as high as $7,000, depending on what part of the country that you're in. But that figure is made up of the estimation of teaching the CNA course, but it's also based on help-wanted ads in the newspaper to recruit potential nursing assistants as applicants.

It's based on all of the HR time involved in processing a new application, getting a person into the nurse-aide training program, paying the examiner to come in once the class is finished, depending on

which state you're in. They're all a little bit different.

But there's a lot of costs that's involved there. And then --

DR. CONOVER: But who's bearing that cost? Some of that is a nursing-home cost, but some of it I assume is borne by the trainee, the CNA themselves.

MR. CANTRELL: No. According to the regulations, CNAs cannot be charged for any of the nurse-aide training program --

DR. CONOVER: I see.

MR. CANTRELL: -- or books or anything.

DR. CONOVER: Okay.

MS. CANTRELL: And actually, if they take a class on their own, such as at a voc tech, which -- fewer and fewer voc techs are teaching --

DR. CONOVER: Right.

MS. CANTRELL: -- the nurse-aide training program. If they take a course there, it's usually much more expensive than a facility-based program. And also, if they are offered employment or take a job within 12 months, the facility has to pay for their training. And so it makes it very, very expensive.

DR. SIMON: All right. Thank you.

Other questions, comments?

MS. CANTRELL: Thank you.

DR. SIMON: Thank you very much, Ms. Cantrell. And we look forward to -- have you submitted written comments?

MS. CANTRELL: No, but I'm going to do that. I --

DR. SIMON: Because your testimony was very rich in some information that we'd like to be able to draw in.

MS. CANTRELL: I've had to condense it to the reader's digest version.

DR. SIMON: We understand the dilemma.

MS. CANTRELL: Thank you.

DR. SIMON: Thank you.

Okay. Let's go -- may I call Esther Houser to the microphone please?

MS. HOUSER: Good morning -- afternoon; sorry. You don't have to wait any longer for an advocate to speak. My name's Esther Houser. I'm state long-term care ombudsman in Oklahoma. I've been in that position for 27 years, and I thought I'd use some of that experience to describe some of the history of deregulation attempts and regulation development for the nursing homes.

Long-term care ombudsman program serves

the people who live in the long-term care facilities, the nursing homes, especially for today's topic. First attempt that I saw to deregulate, to reduce the regulatory burden for nursing-home providers, was during the Reagan administration.

They started with airline industries. We all know how well that went. And then they worked to reduce inspections and regulation in the nursing homes. Congress intervened and required that HCFA fund a study by the Institute of Medicine and the National Academy of Sciences to look at quality care in nursing homes.

The IOM brought in nursing-home providers, doctors, nurses, social workers, academicians, citizens who live in nursing homes, as well as advocates and ombudsman and regulators to discuss. And they deconstructed the system of the regulation and looked at successful models.

What were the sources of complaints and problems? What kinds of innovations were coming from industry itself, which were kind of staggeringly wonderful back then, and also what the standards of practice were.

They produced a report that was published in 1986 called Improving the Quality of Care in

Nursing Homes. And that study and its recommendations was the root source for the Omnibus Budget Reconciliation Act of 1987 portion that was the Federal Nursing Home Reform Law, the law that we still use today in nursing homes.

Now, from that recommendation -- those recommendations, the recommendations from providers were the most compelling things. They were the ones who suggested restraint-free care, reducing the use of chemical and physical restraints, and reducing unnecessary medications.

They individualized assessment, from which we got the MDS -- the planning for care with the person who is going to be receiving the care and trying to learn about that individual -- of who she was before she became a nursing-home resident and shaping the care around that individual's needs.

Reasonable accommodation of individual needs and preferences -- the nurse-aide training and certification, which did not exist as a requirement before, and residents' rights.

Implementation was slow. And one of the points I'd like to make is it's hard to know what those regulations cost, because we really haven't seen them implemented in many circumstances. The

enforcement regs didn't come until 1995.

There was another deregulation attempt, but consumer outcry, as you've mentioned, happened. And my experience is that no matter how conservative or liberal you are, politically or otherwise, if you've been exposed to nursing-home care as a consumer, you want strong regulation and strong enforcement, because you know how valuable it is to you in the bed.

Senator Grassley of Iowa exposed the failure of the enforcement system in 1998. There were some initiatives launched by the Administration back then. And finally, in this century, Oklahoma began to have enforcement of the nursing-home law that was passed in 1987 after the FBI intervened. And I'm proud to say that our health department has really been topnotch since that purge.

Now, currently CMS is funding the QIOs, the quality improvement organizations, to work with facilities on culture change. That's been mentioned. Culture change is nothing more or less than OBRA '87 actually carried through into the facilities.

It's resident-centered care. It's restraint-free care. It's empowering the staff and doing consistent assignment, which helps in retention,

in fact lowers it significantly, because it improves staff and resident satisfaction.

Those regulations will work, and the laws do work. In the result, it lowers the cost to the facilities for providing care. It reduces urinary incontinence, because people aren't restrained. It reduces the unnecessary medications. You have fewer preventable pressure sores.

And it's less costly, therefore, both to the facilities -- but also to the Medicare and Medicaid and private consumers, all those systems, because you have fewer hospitalizations, fewer meds, fewer doctor's visits, et cetera.

Those things save staff time. And with the reduced staff turnover -- of course, you've heard the lady who spoke about that.

DR. SIMON: Ms. Houser --

MS. HOUSER: The point is that current nursing-home regulation, properly followed and enforced, saves money for all of us and that if you reduce that regulation, I believe that costs will increase, especially to Medicare and Medicaid and to the private consumer in our lives.

DR. SIMON: Thank you very much.

Tim.

MR. SIZE: Thank you. I mean, I think you did a really good job of reminding us why we do have regulation. And I don't think any of us up here actually can claim responsibility for the Congressional language that framed this as reducing regulation. I think our dialog has been more around how do we make sure at any point in time with any industry we have the most effective set of regulations.

So I was wondering -- question -- what do you see as the process? Because I'm not sure, but one could infer from what you said that we're -- absolutely got it right now.

I mean, how do we choose what regulations to add? And we have a process for that. But how do we choose what regulations are out of date as our understanding of how to care for vulnerable populations -- or as technology or something else moves on? How do we grow with it?

I mean, that is the downside of regulatory approaches, that by definition they're kind of there, and they move slowly.

MS. HOUSER: I think you've seen more change in interpretive guidelines or in small steps related to the survey process, et cetera, with the

quality initiatives, especially those initiated after 1998.

I think that OBRA '87 and the regs -- the basic regs that came from that are still a living document and that, because they focus on the individual getting the highest practicable quality of life and care that can be provided, you have kind of wide-open approach to focusing on the individual, finding out what she needs for her care, and providing that.

And as the QIOs work in culture change, and private facilities have discovered in their work towards what's called culture change or the pioneer movement, it ends up costing them less. So I'm not sure we need to necessarily change those rules.

I would like to see them implemented, because truly, we don't have an idea of how much they cost to implement until we see them in practice, as we're starting to now.

DR. SIMON: Chris.

DR. CONOVER: You ended by saying the proper regulation saves money, and I'm curious to know your empirical basis for that statement. Are there --

MS. HOUSER: The proper

implementation -- I'm sorry. Did you have --

DR. CONOVER: But what's the empirical --

MS. HOUSER: Okay.

DR. CONOVER: I mean, that's an empirical claim right --

MS. HOUSER: When you -- okay. When you talk about, you know, the sources -- when you talk about preventable pressure sores --

DR. CONOVER: Right.

MS. HOUSER: -- 15 years ago, that was 4 to $40,000 for treating a preventable -- for treating and trying to heal that pressure sore in supplies and meds. Now -- and I think the nursing -- National Citizens Coalition for Nursing Home Reform presented you with some facts from various cases -- that that number is over a hundred-thousand dollars, in many circumstances, or $200,000 when you have the younger residents who are more vulnerable.

But when you have aggressive interventions to prevent those, you can save those with a higher quality outcome for the resident, as well as a better experience for the staff.

When you talk about reasonable accommodation of individual needs, whether that's allowing the resident to get up when she normally

would get up and feeding her then, as opposed to forcing her to get out of bed at five o'clock and making her wait for breakfast at 7:00, those are staff-time considerations that save money.

But one facility in Missouri indicated that when he went to a more humane or restaurant-style dining, it saved $20,000 the first year just in the food cost, the waste costs. The savings that he indicated was over a thousand dollars a month in saving on the high cost of dietary supplements for folks who wouldn't eat or couldn't eat at the times that were committed.

So there are -- there is material -- and I will send that to you -- that --

DR. SIMON: Appreciate it.

MS. HOUSER: -- documents those amounts.

DR. CONOVER: Okay.

DR. SIMON: Thank you very much. Thank you.

DR. CONOVER: But the other thing I'm curious about is if these things save money, why wouldn't any profit-maximizing nursing home go ahead and do them?

MS. HOUSER: My question exactly. The --

DR. SIMON: And on that note, I think we

have the global questions of this.

Thank you very much, Ms. Houser, and we'll look -- I encourage you to submit your comments, and we look forward to -- it's very important to hear your point of view.

I'd like to call Tim Martin to the microphone.

Mr. Martin.

MR. MARTIN: My name's Tim Martin, and I'm your second advocate person, but I'm different in that I represent myself as a private citizen and my 96-year-old mother, who I took responsibility for care of about 15 months ago.

My mother was in an assisted-living home walking. She had a kidney stone. In the two and a half weeks it took to diagnosis and fix the kidney stone, she had pressure sores that took six or eight months -- nurses changing them every day to recover.

It's taken her about eight months -- much of that paid by Medicare at $65 an hour three times a week, a lot of it paid by me at $65, to begin walking again, because they let her lay there with pressure sores, and she lost her muscles.

So that's who I represent. I don't represent an organization or a state agency. I

represent myself and my mother. With that, I just wanted to say that I believe -- and what I've read since then, because I'm becoming very interested in it -- that, you know, our elderly, especially these one -- people with dementia, which my mother has some -- they're very vulnerable.

And to neglect -- if they're neglected by nursing homes and other institutions, it could be a very high cost. The economic impact of this negligence results in the kinds of things I just mentioned, longer hospital cares, lots of extra care in the nursing homes, and things that were avoidable.

Within that two and a half weeks, we could have eliminated months of physical therapy and wound care or -- what do you call it -- pressure sores. The regulations -- I don't know how many there are or how many thousands or pages or anything else -- for these hospitals -- and she was in a rehab hospital and a nursing home now.

I think there should be enough regulations, and they should be effective -- reasonable, effectively and adequately enforced regulations to prevent declines in activities of the daily living for people as they're getting older and other physical conditions, such as pressure

sores.

And this would avoid these costly things in the future. The high costs of the hospitalizations due to these problems in various facilities, whether assisted living, hospitals or -- are often due, I believe, to understaffing, inadequate training of the staff, and improper supervision or not enough supervision of these primary care givers, the nurses, the nurse's aides, really, who are the ones that are there.

This must be avoided. So I believe we need effective regulations rigorously enforced in order to hold down the costs of things that are avoidable and give our elderly the dignity they deserve in the last years of their life.

DR. SIMON: Thank you very much, Mr. Martin.

(Applause.)

DR. SIMON: You guys want to see if you can get some applause?

MR. MARTIN: I tried to put quantities. I know the physical therapy was 65 an hour. I don't know what an RN putting two bandages on every day cost, but that went for eight months.

DR. SIMON: Questions.

Tim.

MR. SIZE: A comment. I mean, I -- I mean, this is obviously a complex discussion we're having today, but -- and I only know Wisconsin, not Oklahoma. But I know like, you know, we're -- about half the nursing homes are state or non-profit, and half are for-profit.

The ones I work with are non-profit. Many of them are losing money and only exist because there's a hospital that's able to make a little more to subsidize it. So I'm not so sure your comments -- and obviously, the individual instance with your mother -- none of us know that situation.

MR. MARTIN: Right.

MR. SIZE: But I know many of our hospitals and nursing homes are just struggling to break even and to stay in business. And so I'm not so sure this is regulatory issue as much as what we as a society are willing to pay to support our vulnerable populations.

And it's not to say there aren't many regulatory issues here, but I think this is a good example of one that's also interwoven with what as a people we're willing collectively to say we're going to pay.

Because I don't -- I think there's unscrupulous nursing-home operators somewhere, but I think in general most of them are caring people. And it's an issue of they're desperately trying to make it all work with limited funds.

MR. MARTIN: Well, let me -- I'd like to just sort of respond. First, my mother was in hospital -- kidney stone -- rehab hospital, assisted living before that, nursing home since, in two states. I've brought her here. So I agree with you.

And I also agree with you that most are reputable. But, you know, what you need is the regulations for the few. We don't care about the law-abiding citizens. We make bank robbery illegal for the bank robbers.

And so I think you need to think about on an individual level what do we need to do to -- not to overburden reputable operators. This cost report -- I have no clue about it. It sounds like it may.

DR. SIMON: Yes.

MR. MARTIN: But when you're talking about giving the care to the people that are needing it, I agree with you, think about the individual and the dignity and how much you're willing to pay.

MR. SIZE: I just thought of a good

example. I know what our state struggled with and I think would like to do. And I'm not sure of the status of this initiative, but, I mean, they would -- really wanted to focus their regulatory issues where they had the most cause for concern, which begins the interweave in --

If a home consistently is just outstanding in what it does and they have limited regulatory resources, should not there be at the state level some discretion how to use them? But my understanding -- the tradition has been they got to lockstep do everyone, even those they know are the really strong, good players.

DR. SIMON: That's a very good point. That's --

Mr. Martin, thank you very much for taking the time today.

Ms. Lynn Baker. Mr. Lynn Baker; my apologies.

MR. BAKER: I've been called all kinds of things during my life.

DR. SIMON: It's --

MR. BAKER: Well, let's see. We've got two people that haven't been mentioned. There are two. We got lobbyists and their yes-men, politicians.

And that seems to be the two people that run the nursing-home industry in Oklahoma, from my experience, my relatives, my friends, other people.

Now, I'm an advocate and a volunteer ombudsman. I've got a ten-minute speech here, and you already cut me off, so I'm going to read it.

The nursing-home business, of course, is a tough, demanding task. Are the nursing homes willing to perform and meet the challenge of providing the customers, the residents, what the customers need? I have three points here to make: the well-known desires of greed, money and power.

We all know about that from the lobbyists who've just recent -- news media. The administrator of a nursing home may have lofty visions of providing excellent customers services, but there are forces working against them, even with the reams of state and federal laws backing them up.

One of these laws only requires an administrator in Oklahoma to spend one-third of their time managing and supervising the nursing home they happen to be in during the workday. They can have three different homes that they can manage, according to law, not that this isn't enough to dampen one's ability to manage, the administrator has to answer to

the desires of the owners of the nursing home on the greed, money and power issues.

The administrator may say to the owner, I'm under the direction of the state and federal laws to manage this nursing home. The owner says, Don't concern yourself with -- about that. I'm in control of this with my political action or lobbyist, and I'm supporting -- that I'm supporting to be sure that nursing-homes non-compliance deficiencies issued by the state health department are not enforced and no fine will be collected from my nursing home.

Point 2, costs incurred because of abuse. Our enforcement don't have any costs that are charged, Medicare and Medicaid, for not providing the customer or resident of -- the proper care they signed up for when entering the nursing home.

All I can share is the fact that it's the term some -- you may recognize as a gravy-train food chain with minimal interest in the customers' or the residents' best interest. The ones on this gravy train are the owners, the administrators, doctors, director of nursing, x-ray services, food service, laundry service, and many more.

The point is, when the leadership makes it clear to not concern oneself on following the state

and federal laws and not to worry about fines being collected on the non-compliance deficiencies issued to the nursing homes, human nature takes over.

And the attitude of the nursing home is -- and the administrators and owners -- I can do as I damn well please, and no one is going to make me do otherwise.

Number 3, reform of nursing homes must happen. One other area about nursing home -- mentioned is the med cards, the dispensing of medicine to the residents from prescription order from the doctor, the ordering of the medicine, the receipt of the medicine from the pharmacy, the checking in of the medicine at the nursing home, and adding the medicine to the med card is usually a comedy of errors.

This is not noticed, as most customers or residents make the assumption that they receive their prescribed medication or that they are not aware enough that they did not receive their prescribed medication until a change occurs in their health.

Recently a syndicated columnist in the Tulsa World had a person write in to him, an expert. This is Dr. Peter Gott. The person that wrote in said, Daily visits, one or two, three hours, reveal

many issues I addressed through the chain of command, the staff, the ombudsman, the doctor, the state, corporate CEO. And they proved busywork for me and yielded minimal improvement, if any, for the length of time.

Dr. Gott says, State and federal inspectors are designed to identify improper care, documentation and good record-keeping. In my experience, these criteria often do not reflect the true situation, as you have indicated. Nursing homes for -- are, for most residents, a last phase of life. A structured but warm environment is more important than say documenting whether a resident refuses to eat Sunday pot roast.

The conclusion is -- point 3 -- is that I've just hit the tips of the iceberg. Growing old is perhaps the hardest thing we have to face in life. It is said, it's not for sissies. Growing old is about losses.

We devote most of our early life to acquiring things, but they are merely things we will lose as we age. We lose our strength, our looks, our friends, our job, et cetera. We may lose our wealth and independence and our sense of dignity and self-worth.

By serving the residents of a nursing home and having the much-needed reform of nursing homes, you have an opportunity to make the latter stage of life a much more pleasant experience for the crippled, disabled, elderly customers, the residents of our nursing homes. Thank you.

DR. SIMON: Thank you very much, Mr. Baker.

(Applause.)

DR. SIMON: Do we have any questions or comments from the panel?

(No response.)

DR. SIMON: Mr. Baker, thank you very much. Will you be leaving us a copy of your comments?

MR. BAKER: It's on your e-mail.

DR. SIMON: Super. That's perfect. Thank you very much.

DR. SIMON: Mary Ann Koepp.

MS. KOEPP: I'm confused. I've just heard so much today I've almost forgotten what I was going to say. But I'm a silver-haired legislator from Tulsa, Oklahoma.

And it seems like everybody's looking for balance and simplicity. Well, is it possible that those of us who are entitled to Medicare and Medicaid

could get a voucher from the government and let us go out each year and negotiate our own rules and regulations for our doctor and our hospital care?

Well, I'm really here to discuss something that I recently discovered after the death of my son. The biggest secret is that you cannot die in a hospital anymore. I was asked to take my son out ten hours before he had expired.

I had to get an ambulance. I had to find a place to put him. I was turned down 17 times, because he had used drugs and had liver problems. Well, I ended up, two hours of the ten hours that he had to live, talking to somebody in a hospice, just doing paperwork without being with him.

I did not go to a nursing home because I was turned down, like I said, 17 times. And I had to do all this when -- while he was dying. And I went to a place called Clara House, which I think -- excuse me. Well, why couldn't he stay in the hospital? He was already there.

Hospice has a staff. They have -- driving back and forth like the lady from Indiana said, why take the people out for dialysis when they were already in the hospital? Why take him out of the hospital? I had to go to another facility, pay the

ambulance.

And then the hospice people came out. They were not capable of giving him any pills. He was extremely uncomfortable the last hours that he lived because they could not give him any medication, because that was not what they were entitled to do.

Well, all along, Medicare picked up this tab. Why did he have to leave the hospital? Why couldn't he stay there? And if this is politically incorrect, then it can only be about money.

DR. SIMON: Ms. Koepp, thank you very much. I'm going to ask Mr. Rogers to respond to this.

DR. ROGERS: Obviously, this is a very hard thing to talk about and to think about. There isn't any regulation which requires that somebody be discharged from a hospital. In fact, there are regulations which give people rights of appeal if they're being asked to leave the hospital and they don't think that they're ready to leave the hospital.

So without -- I think, if you want, we can talk offline about the specifics of that case. Because obviously there's no requirement that somebody be discharged from the hospital, and I'm not sure why you were led to believe that you were being required to be discharged.

DR. SIMON: Thank you. And I encourage you to speak with Mr. Rogers afterwards. Thank you very much.

Okay. Now I have a name I can't read, so let's try this. It's either Jan or Ian Yost-Stadler.

MS. YOST-STADLER: Jan.

DR. SIMON: Jan. Thank you very much, Jan.

MS. YOST-STADLER: I'm a retired superintendent for the State Department of Education. I'm chair for our agency on aging education, and I'm a silver-haired legislator. I'm a strong advocate for the people in the state of Oklahoma who are senior citizens.

I strongly endorse the Silver Light and video cameras legislation that's coming up for all 6,000 of our Oklahoma silver-haired citizens. While in healthcare, they should be monitored for this quality service in conjunction with the processing of federal legislation on health education and welfare and therefore decreasing the increasing financial burden for our silver-haired citizens' healthcare. Thank you.

DR. SIMON: Do we have any comments?

Actually, if you could tell me, for

somebody who's not from Oklahoma, is what the silver-haired legislators are?

MS. YOST-STADLER: It's seniors --

DR. SIMON: Seniors.

MS. YOST-STADLER: -- who are silver-haired legislators. We do our own legislation -- I'm sorry.

DR. SIMON: We have this technological thing where we have to record every word, so this is --

MS. YOST-STADLER: Okay. Yes. We're senior citizens. We write legislation specifically for senior citizens in our specific areas. One of our problems was senior citizens that get lost. And while we have Amber Alerts for children, we do have Silver Light Amber Alerts for our senior citizens, so when someone gets lost, we can find them quicker.

The video cameras we heavily endorse, because we feel that if there's a camera in that room, if there is a camera at the nursing station throughout the nursing home or the healthcare facilities, this will clear up -- if a citizen such as my friend back here has been hurt very serious and has to spend more time in that nursing facility -- that it will be caught on camera. And she legally has the right to

use that video film to show she was hurt.

DR. SIMON: Great.

MS. YOST-STADLER: Thank you.

DR. SIMON: Great for -- thank you for the explanation. This helps us frame the comments and understand who many of the other individuals who I've seen -- we have other silver-haired legislators in the audience who you are representing.

MS. YOST-STADLER: Right.

DR. SIMON: Thank you.

Chris.

DR. CONOVER: Could you clarify? The video monitoring is a policy that's now in place in Oklahoma, or it's a --

MS. YOST-STADLER: It's --

DR. CONOVER: -- a voluntary effort, or --

MS. YOST-STADLER: It's legislation that we have coming up in --

DR. SIMON: Okay.

MS. YOST-STADLER: -- the Congress of the -- Oklahoma.

DR. CONOVER: Are -- does any state have this policy in effect? Are you --

MS. YOST-STADLER: As far as I know, they

do not. And they do not have the Silver Light. We will be the first state in the union that will have the Silver Light alert system.

DR. SIMON: Questions, comments?

(No response.)

DR. SIMON: Thank you very much.

MS. YOST-STADLER: Thank you.

DR. SIMON: Thank you.

Wes Bledsoe, I ask you to come to the mike. And I believe we have handouts that you've distributed, at least up to the panel. Thank you.

MR. BLEDSOE: My name is Wes Bledsoe. I am the president of A Perfect Cause; I'm commonly referred to as a nursing-home watchdog. When I found out about this meeting, it was through the Tulsa World on Monday afternoon, and the first thing I got was really angry when I went to this website and I saw language talking about reducing the burden of regulation.

It seemed like a little bit of bias to me. Obviously, the healthcare industry in Washington, D.C. was pressing for this. Understandable. We've heard from long-term care industry folks. They don't want regulation.

We have regulation because it's absolutely

necessary. Why is it necessary? Because we have a variety of people who are suffering across this country from little things like murder, rape, sexual assault, physical assault, physical abuse, verbal abuse, who are injured due to negligent acts, who are neglected, who are over-medicated, who are under-medicated -- that their belongings are stolen, and they're financially exploited.

Have I missed anything there? And yet we have meetings like this to talk about reducing regulatory burden. It's kind of like FEMA back when Hurricane Katrina had just happened. We've got dead bodies floating around. We have people who are looting and stealing, people who are suffering.

And if they'd held town hall meetings in the Gulf states saying, We want to reduce regulatory burden and paperwork, they'd have been burned at the stake. And that's exactly what we have happening here, only it's tenfold again and again with what's happening to our long-term care residents across this country.

What we need to do is we need to examine the quality of care in our long-term care facilities before deciding any reduction in regulatory burden. There has been federal and state agencies who have

documented clearly the need for more regulatory oversight in long-term care.

Again and again, GAO reports the conditions in nursing homes. And I take exception to the issue that the majority of nursing-home operators are providing quality care. That is not supported in the GAO reports.

What's the cost? I don't know. How would you feel about the cost for you if you're one of these residents lying in one of these beds, no one coming to reposition you? You have an open decubitus ulcer exposing your spine. No one coming to help you go to the bathroom -- so you urinate, and the urine flows into that open bedsore.

The rapes. There's been two reported rapes recently here just in Oklahoma City, one this week by a 23-year-old aide working in the facility who was forcing a 79-year-old resident to perform oral sex on him. When the witness came in and caught him in the act, the assailant did not flinch.

He didn't even make an attempt to pull up his scrub bottoms that he had dropped so the 79-year-old man could give him oral sex. My first response to that is, this guy's done that before. And as I understand, it appears well -- that this could be

happening. So we clearly support the issue of using video monitors in long-term care facilities.

In fact, if you look on the back page of the information I gave you, gentlemen, we have 25 recommendations. Now, yes, there is some legislation there that currently exists. Is it being followed? Absolutely not.

Our organization has been tracking the issue of criminal offenders residing in long-term care facilities across America. To date, we found over 800 registered sex offenders living as residents in nursing homes. And you say, Well, you know what? Sex offenders get old, so what's the problem?

45.2 percent are under 60 years of age. In fact, we found two 19-year-old registered sex offenders living as residents in nursing homes here in America. We've documented over 30 cases where criminal offenders resided with non-offenders.

And most of the time, these non-offenders have no idea that they're living under the same roof with no locked door between them and one of these criminal offenders down the hall.

Thirty documented cases of murder. We have three murders that were documented. We're not talking about murder from negligent acts. We're

talking about residents being stomped to death. Oh, and by the way, the resident in that facility -- that death wasn't reported to the state because the administrator thought, You know what? If the assailant is of diminished mental capacity, I don't have to report.

That facility has the most registered sex offenders, in the state of Ohio, than any other facility in the country, and they don't have to report if someone's stomped to death.

Folks, this is a sad state of affairs we have for our long-term care residents in America. I get calls every day from people desperately trying to find a safe place for their loved ones. So the thought of reducing regulation when we have people who are suffering like this, it's just not even -- it's just inexcusable even to consider it.

First things first. Let's make these a safe environment for our residents. Because you know what? If it's not these residents that are some distant strangers some place, one of these days it's going to be someone in your family or perhaps even you that's going to fall victim to this kind of negligent care that's taking place in these facilities.

When I hear these kind words like, if you

reduce regulation, we'll have so much more money we can turn around and put it right back in the facilities -- gentlemen, I'll be more than happy to sit down knee to knee with you and show you the numbers on these cost reports that show that is just a bunch of poppycock, absolute balderdash.

DR. SIMON: Mr. Bledsoe, if you could wrap up, please.

MR. BLEDSOE: So if you would, please ask me any questions about any of those 25 recommendations. I'd be more than happy to go through it with you.

DR. SIMON: Thank you.

MR. BLEDSOE: Even outside of this, I'd be more than happy to answer any questions and work with you gentlemen to resolve this situation before we reduce regulations.

DR. SIMON: Thank you very much.

And at that note, I'll turn to the panel.

(Applause.)

DR. SIMON: Chris.

DR. CONOVER: We've heard testimony today that the nursing-home industry is one of the most heavily regulated in the country. And yet all of the things you've described, none of which I think are

defensible, are occurring anyway. So clearly something is wrong.

And you've said, you know, do even more regulation. Are there no aspects of nursing-home regulation that you think could be lightened in order to free up the resources to implement the 25 recommendations that you think need to be done?

MR. BLEDSOE: Sir, when you're speaking of freeing up the resources, then you can implement these programs -- we have a lot of resources in place right now. Let me just give you a quick example.

We have one nursing-home chain, about 22, 23 nursing homes in this state. And between 2000 and 2001, what they did was they moved the nursing homes from -- the ownership of the nursing homes of the buildings from the facility to a different LLC.

And each different facility had a different LLC. They all had the same corporate address, the same corporate address as the chain that oversees all the nursing homes. Now, what it looks like to you and to me is this. You and I own the nursing homes. And they're just about paid for. We've owned these things for a long time.

And who paid for that? The citizens of America. About 80 percent of the dollars come in from

Medicare and Medicaid. Is that right? So we paid for those structures, and we're paying money to provide care in these facilities.

So you and I sell facilities to ourselves under another shell company. We stick the money in our pocket, because we have a bank carry the mortgage on it. And now we're leasing the facilities back to the nursing home again to the tune of $6.2 million a year, basically for facilities that you and I, the taxpayers, have already paid for.

Now, if you consider that here in Oklahoma that you can probably get away with paying a nurse aide with all the expenses a reported $15,000 a year. $6.2 million, that would be a little over 400 nurses aides.

Now, you tell me. If I'm managing the money and I'm a good steward and my goal is to buy quality resident care for my residents in these facilities, should I turn the mortgage and turn around and put $6.2 million back into paying for this note that I've now incurred, or should I put at least maybe four or five more nurse aides on every shift in every one of my 22 facilities?

So when there's that kind of behavior going on, sir, I don't know that giving them any

wiggle room or leeway here to produce a different result is going to do just that.

And I can go back and I can cite where we have one operator here whose facility is being inspected, and I have pictures here that'll just curl your ears, because these facilities -- this facility had one resident that came in in May with eight burns on her legs and left one week before they died with eight huge decubitus ulcers on their body in places I've never seen decubitus ulcers.

And they waited until the tips were going down to the bone from the knee to the ankle before they did that. And yet at the same time, that operator is in Florida buying a boat. And the note is under the name of the corporation.

Now, I don't know how the nursing home residents in Oklahoma are going to get down to Florida to get on the boat in the Florida Keys, but if you can help me with that -- I'm sure that they're probably, you know, watching those pennies so they can get the bus down there -- excuse me -- to get them on that boat.

But I don't think too many of those residents are going to benefit from that boat, do you?

DR. SIMON: Thank you, Mr. Bledsoe.

(Applause.)

DR. SIMON: Eleanor Kurtz. If I could call you to the microphone, please. Thank you.

MS. KURTZ: Thank you very much for being here. You'll have to excuse me. I'm having my two-time-a-year allergy attack, so I'll try to get through this. And some of the things I was going to say have already been said, so I'll try to skip over those.

I first wanted to speak as -- I am the deputy state long-term care ombudsman for Oklahoma. I work with Esther. I've been in this position for 25 years. I've also been an assistant administrator of a nursing home. I'm currently a care giver for a nursing-home resident. So I've seen it from several different perspectives.

But what I want to talk to you about today is that in my position, I'm also assigned as one of the stakeholders in the QIO program that CMS funds. And those are the folks that are doing the quality measures and working with providers to train them and help them come up with ideas for cases that they need to do better in and be able to improve the care in their facilities.

And what I thought you would hear today, so what I prepared to tell you, was that the paperwork

was so burdensome, because that's what we hear. The MDS is so burdensome, and the care plans -- there's so much paperwork and so much time.

But what I wanted to tell you is even though providers have said that since OBRA '87, when all that was implemented, the group that has joined in with the QIO to actually work on improving their own numbers and quality of care through extra training and consulting and all those things that are positive --

Then they have actually testified at some of the QIO presentations about how, even though they were dragged kicking and screaming into having to do all that paperwork and understand the purpose for it and spend the time to get to know the residents and what the things were that needed to be done in their individualized care plans -- that they were just basically amazed that if they took the time to implement it the way it was supposed to be implemented, that they saw tremendous improvements.

And these were directors of nursing that have said before, You know, it's just too much trouble. And now they're just, you know, Hurray. This is terrific. It works. And it did take time and effort, and it did take a lot of their time to do the paperwork and to do the background for what that care

plan is supposed to be based on.

So I wanted to share with you that if you haven't already inquired from the QIOs, that they have testimony, some of them on videotapes that they use for their recruitment of providers to come into the next scope of work, that's tremendous about providers seeing that those things that did seem to be burdensome are now being put into place appropriately and working.

So many participants in those activities are learning new ideas and methods to better implement best practices. We've had rules and regulations for a long time. You heard Esther say that it wasn't always implemented.

But in the last few years, we've seen great improvement. In the ombudsman office, we are under state law given the clearinghouse role of reading every single complaint, inspection survey, anything else that goes on in a nursing home.

And there are providers who have zero deficiencies, but there are also still providers that have hundred-page deficiencies. And when we look at those -- and they're in every arena of the facility. It's not just one area or not just housekeeping. It's every single area of the facility. Then we have to

conclude that those regulations are not being implemented as -- supposed to be.

And so what I would like to say is that I don't want to see any regulations reduced. I want to see them better enforced. I want to be able to share and support the best practices, the innovative ideas, the culture-change projects, to teach people how to better provide the care and solve the problems that they run into in their own facilities.

Because I don't think that until all the providers are meeting the minimum standards, that we can talk about, in financial terms or in human-life terms, about how to reduce those. Thank you.

DR. SIMON: Thank you very much.

(Applause.)

DR. SIMON: I want to thank you for respecting our time by highlighting the comments that haven't been made, but I also want to encourage you and everybody else here -- is that just because somebody else said it doesn't mean you shouldn't say it too -- that hearing this again and again adds weight to the evidence.

And that's why we need to hear from the advocates telling us what they want to hear and what they -- and that we need more thoughtful regulation.

We need areas where regulation can be expanded. We need areas where their quality has to be enhanced and protected.

We need testimony to the impact. And even if you've heard it before -- to tell it to us again and tell it to us with your own examples that we need to hear -- where we can streamline the process and where we can take resources that may be used duplicatively and unnecessarily, from your perspective, and funnel them back into good use. So I thank you for that.

And on this -- is -- do we have any questions for Ms. Kurtz from the panel?

Yes. Chris.

If I could ask you to return to the microphone for just a moment, please.

DR. CONOVER: We've heard repeatedly that we need regulation because there's bad apples in the industry. And we may debate what fraction of the industry, you know, bad apples, what fraction they are of the total.

But my question is you alluded to some facilities that have zero deficiencies. And I'm curious whether in your state there is enough flexibility in the regulatory process to allow the

regulators to -- in the cases where they have a facility with a track record of zero deficiencies, can they lighten up on the frequency of inspections or sort of, you know --

Or is it really a one-size-fits-all regulatory structure where in order to catch a few bad apples, we force everyone to jump through a whole lot of hoops that may be expensive?

MS. KURTZ: Well, I think the latter is the case, and I think that's a CMS decision, not individual states. We don't want one state lightening up on regulations where another state doesn't. Then you'd have a huge fluctuation of quality of care in those facilities, I'm afraid.

You know, I think providers are learning. But I think in Oklahoma, we're at a disadvantage, because for so long we didn't have enforcement. And now we do. And I think that is a surprise and an aggravation to a lot of providers. But it's a good thing.

And I think I see implementation of the rules and regulations. You're always going to have inconsistency. You're always going to have an individual surveyor who has a soapbox or who feels more strongly about a particular area. Maybe it's the

discipline that they're in, dietary or whatever, on the team.

But I -- you know, I have seen great improvement. And I don't know how else to say that. I think that's one size fits all, but I think that's a CMS design.

DR. SIMON: Do we have any additional questions? Any comments from CMS?

DR. ROGERS: Well, I appreciate your concerns about lightening up on the survey process. I mean, I think Mr. Bledsoe's comments were well-stated, maybe a little hard to listen to, but well-stated. And those are concerns that we all share about some facilities.

And the -- to the extent that we stop watching closely, that stuff is only going to increase.

DR. SIMON: Thank you.

Patti Davis, can I ask you to come to the microphone? Thank you.

MS. DAVIS: Good afternoon. I'm Patti Davis, executive vice-president for the Oklahoma Hospital Association. And I believe you have copies of my prepared remarks. But on behalf of Oklahoma's 140-plus hospitals, we applaud your efforts to examine

the regulatory burden on our industry.

We understand programs funded by the government must be accountable and must ensure taxpayer dollars are spent wisely. So our concern is not whether regulations are necessary, but rather the ways in which regulations are carried out.

Oklahoma hospitals, like those in other states, are struggling to employ and recruit an adequate number of highly trained healthcare workers to provide patient care.

Healthcare workers are increasingly frustrated when their time and energy is diverted from their primary purpose of providing quality healthcare to their patients by the need to comply with bureaucratic controls that often seem associated -- or unregulated to the delivery of quality patient care and efficient use of resources.

Healthcare workers entered their professions to provide care, not simply to push paper. In 2002, the American Hospital Association commissioned Price Waterhouse Coopers to study this issue. Many of you may be familiar with this report.

Just to reiterate for the purpose of the testimony today, on average, American hospitals -- for every one hour of care provided in the emergency room,

one hour of care is spent on paperwork. For every hour spent in surgery and the inpatient acute-care setting, another 36 minutes is spent on paperwork.

And outside the hospital walls, for every one hour spent on skilled-nursing care, correspondingly, 30 minutes is spent on paperwork. And for the average home health visit of one hour, 48 hours is spent on paperwork. This burden is being performed at the expense of patient care.

In addition to the paperwork requirements associated with clinical care, there's also been a significant increase in paperwork needed to document regulatory compliance. One question is why a Medicare patient arriving in the emergency room was required to sign eight different forms in order to comply with Medicare law.

For every hospital, for years, we have had patients have to complete a 30-page Medicare secondary-payer questionnaire at every admission. Ten years ago, I was a rural-hospital administrator. My mother, on admission, called me to her room with this 30-page thing and says, How many times do I have to tell your staff I'm retired? I'm not working. I don't have other insurance. It becomes increasingly aggravating.

In addition, every new rule, requirement or guideline demands a growing number of compliance and implementation activities by hospital personnel. It absolutely causes a ripple effect all the way through the hospital.

Correspondingly, there is simply no financial adjustments made when new government regulations are imposed upon healthcare organizations.

You've already heard from many of the other presenters that hospitals and other facilities are regulated by 30 to 40 federal -- different agencies. We also know we have local and state requirements as well, as well as private accrediting organizations. And there's very little coordination that exists when new rules come out, and that is certainly an issue.

I have put in your information some recommendations that we would like to see followed. And they're quite a few of them, but I'll just touch on a couple of them.

We absolutely believe that when new regulations come forward, that the cost of technology and productivity improvements that are necessary to enact those pieces should be included in the Medicare payment updates to help pay for the cost of those.

We know that we have issues about seamlessness that does not occur on the federal level among all agencies when a rule is implemented. We think additional work needs to happen there.

We would agree with a following -- excuse me -- a presenter before that the Medicare cost report is something that must be streamlined. I've worked in the healthcare industry my whole professional life. It never gets less. It always is more. And like she said, there are many pieces of that cost report simpler -- no longer applicable today.

I've included the rest of my recommendations, but for the sake of the hour, I will finish.

DR. SIMON: Thank you very much, Ms. Davis.

Questions from the panel, comments?

DR. ROGERS: Did you include with your submission the eight forms, because I can only think of two that are required by the federal government.

MS. DAVIS: No, I did not, but I'd happy to go back to the office and dig those out.

DR. ROGERS: Yes. We should look at that. Because a lot of times I find in talking to providers that many times what they thought was a federal

regulation either is a state requirement or has been required by the risk manager at the hospital because of concerns about medical-legal defense.

MS. DAVIS: Well, I do know that typically there are more than eight forms because of just what you said, because they'll be individual hospital policies and this and that, and some will be state requirements. But I thought I had my count right. But I'd be happy to double-check my number.

DR. ROGERS: You probably do have the count right. I'm just interested in how it breaks down to federal, state and risk management.

MS. DAVIS: Sure. I'd be happy to look at that.

DR. SIMON: Chris.

DR. CONOVER: The Price Waterhouse study is very interesting, and I like the numbers you cited from that. But it only talks about paperwork, and it doesn't really differentiate between the paperwork required to get paid for what you do versus the paperwork that might be required by regulation for various processes. And if you've got evidence about, you know, how that split is, that would be very useful, I think.

And on a related point, when we've asked

in other hearings -- we always try to ask the question, is Medicare different than private payers with respect to the paperwork that's required in order for you to be paid. Is Medicare in some fashion more burdensome, or would you be filling out pretty much the same paperwork to get Blue Cross Blue Shield or some other commercial payer to pay you?

MS. DAVIS: That's an excellent question. And I spend a lot of my time at the state legislature. What I see happening typically are most of the folks in the industry cite, Well, Medicare does this. Why don't we do the same thing, you know. And --

DR. CONOVER: So they're the driver.

MS. DAVIS: And, I mean, it's a very standard order. Well, the hospital's already having to do it because of this reason. Why don't we go ahead and ask the same thing? So that's more what I'm used to than the other situation you mentioned.

DR. SIMON: Bill.

DR. VOGT: Could you give a specific example or two of how you would like HIPAA to be revised that would be particularly valuable in reducing your costs?

MS. DAVIS: Oh, you know, we have been

through the HIPAA situation, and we're still struggling with that. And, you know, like you've heard a lot of Part D complaints today. When people get frustrated with hospitals, they get in the yellow pages or they call directory assistance. And they don't know who to call. They just want to call someone to get help.

And we get a lot of calls at the association because family members are frustrated when their family member goes to the hospital and they can't get answers about their care. They used to get the care. They used to get the information. And now we can't talk to you on the phone about this because all of these situations -- we get tons of complaints about that.

In terms of specific things you would like to see on HIPAA, I'd be happy to talk to you about that after this particular meeting. But we do still field a lot of complaints on HIPAA compliance.

DR. SIMON: Thank you. And actually, Ms. Davis, if -- to the extent that you could either submit those written comments or -- one of my colleagues will definitely see you at the end --

MS. DAVIS: Okay.

DR. SIMON: -- of this. It's exactly

those kind of examples that, you know, help us out tremendously.

MS. DAVIS: Thank you.

DR. SIMON: Thank you. We're doing great.

Mr. Stan Sweeney.

MR. SWEENEY: Good afternoon. I'm Stan Sweeney. I'm the executive director for the Home Care Association here in Oklahoma. Actually, I'm glad I'm following Patti, because a lot of her concerns were really what we have to deal with in home health too.

My -- a little bit of my background. I'm a registered nurse. I've worked both in the hospitals, hospice. I've even worked in the nursing home, which scared me. And also I was an owner of a home-care agency for about 20 years. So I speak as much from experience as I do from my -- representing my industry.

We're not here really asking for a reduction in a lot of the regulations, which I'm glad to be able to say. What we really would like to have is a little more understanding of what those regulations are sometimes. We tend to get regulations put upon us within a short period of time and then have a very short time to try and figure out exactly what that means on a practical level.

And I understand some of that is probably a Congressional issue. I know that CMS gets a mandate to do a particular item, and they've got to figure it out and get it down to us where we've got to figure out. And it seems like by the time we figure out -- especially like a payment system -- on how to work within that payment system, it changes.

We were under cost reimbursed in the '80s up until the Balanced Budget Act of '97. And then -- which is going from cost reimbursed to -- into the interim payment system -- was really a nightmare for a lot of our providers. As a matter of fact, we lost half of our providers in the state, just trying to figure out how to go into that system, because it was so different.

So that's one thing I'd like for us to -- for you to look at whenever regulations come down the pike. I mean, CMS has done a better job with the open-forum meetings and stuff like that, but still, there are times whenever we get regulations that neither us nor the state health department is able to figure those out before they're actually enforced.

And so try and think through that -- those issues whenever we're getting that type of regulation.

And we would certainly appreciate it on our part as well as our beneficiaries out there.

DR. SIMON: Thank you very much. And Mr. Sweeney, I understand that you will be submitting some written commentary to us as well?

MR. SWEENEY: Yes. I'm going to take all of Patti's comments and write ditto on them and then submit them as my own.

DR. SIMON: Well, per my previous comments, if the shoe fits, that's what we want to see somebody wearing.

Questions from the panel.

Bob.

DR. HELMS: Well, I was wondering earlier when we were going to hear from the home healthcare agencies, so I'm glad you are here.

I was thinking -- we heard this morning that the population of nursing home has changed over the 20 years and so on. As an economist, I generally look at consumers as making rational choices when they have the information and so on.

We hear stories like Mr. Bledsoe -- stories and so on. And it makes me think. I guess I'd like to turn this into a question. Has, sort of, the scare stories -- we all know there are

bad apples, but we think most of the people in the nursing-home industry are doing a good job.

But when you hear stories like this, does that increase the demand for home healthcare or for extended -- assisted-living facilities and so? This -- it seems to me this -- there's been an evolution in this whole industry over the last 20 to 25 years. It's really changed a lot.

MR. SWEENEY: Oh, it certainly has. I heard some of the comments this morning talk about nursing home -- the population in the nursing home has certainly changed. I just -- I worked in a nursing home as a relief nurse for about a year, and prior to that I had always worked in the home health or hospital or hospice and had probably a jaded view of what the nursing home was having to go through.

I got in there and found out really the acuity of the patients had changed tremendously from what I had experienced previous working as an aide, you know, 20 or 30 years ago in the nursing home -- that the patients in there were much -- was much sicker than what I had assumed that they were.

And so I think they have a difficult, daunting task to try to address with their patient load. And to tell you the truth, I -- whenever I went

in there, I didn't go for the pay. To tell you the truth, I took a cut in pay to go.

I really enjoyed working in the nursing home. Well, I have to say that. I enjoyed the patients, but I was always looking over my shoulder as to what I might be perceived as doing wrong. I don't know whether that answered your question or not.

DR. HELMS: Well, getting back to the thing about regulations and so on, has your association done any sort of particular studies about particular regulations that we ought to know about or --

MR. SWEENEY: Certainly. And I will submit those with my written comments. The cost report was one of those things that I -- yes, mark me off on that too, because we've been doing cost reports for 25 years. Even after we went into interim prospective pay and prospective pay, we are still doing cost reports.

And I understand there is some justification for doing some parts of that, but we're still doing the cost reports that we were doing 25 years ago.

DR. SIMON: Other questions, comments?

Mr. Sweeney, thank you very much.

Okay. We have a few moments left, and what I'd like to do is do a little bit of wrap-up now. We've heard a lot of commentary. And I'm going to ask each of our panelists to take a minute to give us a couple of top-line themes, a couple of big issues that they heard from today, some of our marching orders and our agenda moving forward in terms of the major themes that they've heard from.

And I do need a minute or two, and then to the extent that we have possible, we will see if there is any additional comments or questions back to the panel after they give you their top-line themes before we adjourn for the day.

So what I'm going to do is I'm going to start at the opposite end of the table in the alphabetical order that comes nearer to my heart and my last name.

So Bill, do you want to start by giving us a couple of, you know, sort of -- you can start with your top issue of the day.

DR. VOGT: Okay. I'll give my top issue of the day. So I thought that -- so I thought, actually, that the comments were remarkably consistent in that the key issue that regulators are typically trying to address is quality assurance.

They're trying to assure that -- ensure that patients receive high-quality care and that -- there's this tension between the inability to exactly measure quality -- if we could measure quality exactly, there would be no regulatory issue. We would simply say, You have to provide quality this good.

And then we'd just go and examine, and the places that provide quality that good we'd leave alone, and the places that provided quality less than that we would fine or put out of business or whatever.

The difficulty comes in that we can't do this identification perfectly, so we have to rely on surveys; we have to relay on command-and-control regulation; we have to rely on litigation and these other things. And those other things all impose costs, both on the bad actors and on the good actors.

So I think that the difficult problem in regulation -- and I think -- which came up over and over again -- is trying to resolve this tension, trying to get rid of the parts of the regulatory structure which impose big costs on the good actors and don't catch a lot of bad actors and strengthening the parts of the regulatory structure which catch lots of bad actors but don't put lots of costs on the good actors.

DR. SIMON: Bill, Thank you very much.

Tim.

MR. SIZE: He took all my points. I'm just going to pass. I think he did a great summary.

DR. SIMON: Okay. Bill.

DR. ROGERS: Well, there were a number of good ideas that came out of this that I'm interested in looking at. I think the cost reports came up over and over again, and I'm not sure that we've examined that recently, and there may be huge opportunities there.

I'm interested in the documentation requirements assertions. But I think we're going to have to do a careful analysis to see where those documentation requirements are coming from because I have a sense that -- I know on the provider side there's actually relatively little in the way of federal requirements for documentation.

HIPAA belongs -- actually, the part of HIPAA we're talking about belongs to the Office of Civil Rights. But we did make a huge improvement in the original HIPPA regulations when we allowed release without authorization for information when it's required for treatment, payment or healthcare operations.

And I know as a physician that simplified my life a lot, because if I had to have authorization when I talked to a doctor at another hospital about a patient's condition, that would be a nightmare.

And then the last thing I would say is with respect to nursing homes, you know, the nursing-home regulation volume sort of reminds me of an observation I've heard made about gun control. I'm not sure we need more gun control. Maybe we just need to enforce the laws that we already have on the books. And that may be the case with nursing homes too.

(Applause.)

DR. ROGERS: We may -- this is the first time a federal employee ever got an applause. I knew when I was in Oklahoma, I had to bring up gun control. But I think --

DR. SIMON: We've got that in the transcript, Bill. You can show that around.

DR. ROGERS: Okay. Well, I'll be making an extra 6,000 a year next year. But --

DR. SIMON: You can give it back to the nursing homes.

DR. ROGERS: Yes, back to the nursing homes.

I think we probably have enough

regulations to get the bad guys. We just may not be doing a good job of catching them before they hurt somebody.

DR. SIMON: Thank you.

Bob.

DR. HELMS: Okay. I also think Bill did a good job, so there's not much to add. But I -- going back to this morning, I do think there -- it started out -- there's sort of a conceptual confusion between what goes on in Washington about the budget and then a lot of the payment issues.

A lot of the things that are required that people view as regulation, they're really requirements about controlling the payment, because -- I don't want to always defend CMS and the bureaucracy and so on. They do some stupid things, I agree.

But the Congress also does some stupid things. I mean, they really put a lot of requirements onto them, particularly about controlling the dollars. And a lot of these things are, as the old expression in the army was, CYA, you know. Everybody's sort of, you know, covering their assets, you know, what's expected.

But anyway, the -- I think there's -- despite Mr. Bledsoe's very moving

testimony, I do think there are a lot of really stupid regulations out there, and they defy common sense. But to get them changed, I think you've got to do research.

I mean, I think the associations -- they obviously have an incentive to do this. Somebody's got to go do some good research and come up with some numbers and come up with some practical ways to get at the outcome you want rather than specifying all the details through regulation.

DR. SIMON: Thank you.

Ted.

DR. FRECH: Okay. I was struck at this hearing and also the one in Washington that I went to two months ago with how big a problem it is for nursing homes. That's really a particular big problem. And one thing that's amazing is the 130,000 pages of regulations. That's unenforceable, because it's unknowable, something that big.

And it's kind of like -- it reminds me of the old Soviet Union under the planning system where the plans were so detailed, everyone is always violating the plans. The plans are too complicated to know. Everybody was always violating them. That seems really to be a big problem.

Also for nursing homes, there's a particular problem with quality, particularly when the patients or the residents are demented, and so they have a hard time being sort of normal consumers. And that's gotten much worse, and that's probably why nursing homes get -- really get singled out. They get more regulation, and they have more problems.

One thing I want to -- a couple of special things also about nursing homes I want to note. One is that quality is -- it's not an objective thing. And there's an attempt to kind of reify it with all these rules, but it's really a subjective issue in the eyes of the resident. I'm focusing on nursing homes.

You can approximate it with various different objective measures, but that's not what really matters at the end of the day.

And then one other special thing with nursing homes and with this population is that even if you have a nursing home that's really run by bad apples and it's a terrible nursing home, research has shown that closing it down and moving the people would kill some of them. That's just very tough.

So it makes sort of ultimate enforcement of the bad apples especially difficult for nursing homes.

DR. SIMON: Thank you.

Chris, do you want to bat clean up?

DR. CONOVER: Yes. Well, Bill Rogers made my point about insufficient enforcement. Bill Vogt made my points about bad apples, although I will add that I really don't get a sense that in this room there's a consensus about the fraction of the industry that is made up of bad apples, and I was interested in the diversity of views on that point.

Ted just made my point about the sheer volume of regulation, just keeping up with it being problematic.

So two additional points I would make are that the process of regulation -- it's -- I got the sense that people think that sometimes regulation gets onto the books too quickly, and we don't really have a good process for cleaning up outdated regulations, and maybe we revise regulation too quickly. And maybe there are ways that we can improve on the process of regulation.

And I also want to close with the point about just questioning the premise that -- I think there's a presumption sometimes that it's obvious that the benefits of regulation out -- or -- I'm sorry; that regulation is self-financing, that somehow if we

do the smart thing in a regulatory sense, that we'll save more money than it would cost to regulate -- and I don't know that that's necessarily true.

And I think -- going back to Bob's point, I think that requires empirical work to verify. And then we ought to be thinking hard about that question, how to do that well and do it carefully.

DR. SIMON: Thank you.

See, I knew we'd come back to you.

MR. SIZE: Well, we didn't get like five minutes warning or anything when you started.

I guess -- I think even if we all agreed on an issue on regulation, which we clearly don't, in my mind regulation is, at its most important level, assuring desired outcomes. Regulation, by the way, is a construct that creates a floor, and it tells you nothing about how we can continue to get better and offer a better experience for the populations involved.

So I think there's some very important limitations to what regulations, even when done perfectly and wonderfully, can do. And I certainly know on the medical side we're looking at pay for performance. And that's a whole other complicated area, but at least it acknowledges that just doing the

minimum isn't good enough and we need incentives built into the system that we can continuously get better.

And so I think there's some extraordinary limitations even on the parameters of this discussion, if in fact we understand regulation primarily to be about getting the very best outcomes for our people.

DR. SIMON: Thank you very much.

We have -- I know the panelists up here who have -- are getting nervous, but bear with me. We have a couple minutes, and so I'm going to ask if there are any members of the audience that have a question that they would like to direct to the panel. I'm going to ask you to be very brief and very pointed and respect that there may be other folks here in the few minutes we have left.

MR. BAKER: Real brief. The surveys that you talked about, the federal and state. Remember that there, in Oklahoma, there's an advance warning of at least a week before those are implemented.

DR. SIMON: That's very interesting. Thank you.

MS. GARRETT: Sir, I am here waiting.

DR. SIMON: Yes. You may --

MS. GARRETT: All right. This --

DR. SIMON: I ask -- since we have lots of

people who are -- if you just want to get up and line up at the microphone, and we'll take the first person first.

MS. GARRETT: This is an unfair treatment about women. In some states, a pharmacist does not have to do a lady's prescription on birth control pills. And I just received a petition in the mail from Planned Parenthood about this.

DR. SIMON: Thank you very much.

Sir, did you want to make a comment? Microphone's -- all you got to do is stand up.

Oh, yes. And if you want -- thank you very much.

The lady who just spoke -- could you return to the microphone and identify yourself? Thank you very much.

MS. GARRETT: Not that I'm among child-bearing age, but my name is Eva Pope Garrett from Tulsa, Oklahoma. I am an ombudsman, and I'm also a volunteer for the Red Cross and member of Planned Parenthood and all other things -- and American Association of University Women.

And I am for women's rights, and I just feel that this is an unfair treatment for women. It's going back to the dark ages. They're going -- about

their conscious in not prescribing birth control pills for women.

That is really none of their business. And they should be objective if they're going to be a pharmacist.

DR. SIMON: Thank you very much.

MR. KAUFFMAN: I'm Ms. Kauffman. I'm representing myself and my family. My husband has had a series of small strokes, has been in a variety of nursing homes and several geri-psych hospitals as a result of being given Vioxx.

One of my concerns that I have not heard addressed today -- and I don't know how to address it. I know we have some MDs present. But it seems that the doctors who call on nursing-home facilities have no special training for dementia or elder care. They come maybe every 30 days. They dole out pills as though it were candy.

I have seen my husband severely overmedicated. And when he falls and hurts himself, he goes to the emergency room. I had a recent Medicare summary statement where -- one trip to the nursing home after he fell following being heavily medicated.

One night's stay was about -- this isn't

an exact figure; it's rounded, but about $3,900 plus $350 or so for transportation. That could have been avoided if he had had proper care in the nursing home.

I see aides who are not trained to know how to care for people. I've seen an aide try to hug and kiss him. He didn't like that, and so he just took his arm and kind of pushed her away. I think she is an okay person; she just has not been properly trained in how to be a caregiver.

But I would like to know how we address having physicians in nursing homes. And I heard your statements about low pay and all of that, but there needs to be some way that, if doctors are going to have authority to give drugs in nursing homes, they need to have some qualifications to do that. They also need to have some follow-up to know what the effects of that drug are.

And there needs to be some -- I've seen LPNs with authority to call the doctor and say, Hey, we want him medicated more because he's ambulatory. My husband is ambulatory, and there was a particular LPN who wanted him to sit in a chair and drool, and so she called the doctor and got medication so that he would do that.

He was almost comatose. He couldn't even

hold his eyes open. He didn't know who I was. And he fell one more time. He has been to geri-psych or emergency room multiple times since the 1st of April.

I don't know how to address this, but I think it's a consideration that needs to be made.

DR. SIMON: Thank you.

Do we have any response for --

DR. ROGERS: Well, we don't regulate the practice of medicine. That's left to the states. It would be -- the state would have the authority to require certain credential of somebody who worked in a nursing home, I suppose.

But basically, CMS's role is to pay for care delivered, and the states are responsible for making sure that the person really should have a license and really is qualified to do the things that they do. So it might be something that you might want to discuss with your state legislators about -- because I don't think we're going to have a federal solution to that problem, at least the physician qualification issue.

DR. SIMON: Thank you very much.

I want to take a moment to express my gratitude to the people who've come here today to present evidence to us to make my job easier, at

least, perhaps, to give it more information. I don't know if it's an easy job in any respect.

And I want to thank you for being here. I want to thank those of you who took the time out of your day for coming and for caring and for providing evidence. I encourage you to visit us on the web and give us more information that you possibly could have brought today.

And if you're on the West coast, in a month come visit us in San Francisco, because we'll do this again, and encourage your colleagues to do so as well.

Have a very pleasant afternoon and a safe journey home.

(Whereupon, at 2:55 p.m., the meeting was concluded.)

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