REDUCING REGULATORY AND PAPERWORK BURDENS ON SMALL HEALTHCARE PROVIDERS: PROPOSALS FROM THE EXECUTIVE BRANCH

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BEFORE THE

COMMITTEE ON SMALL BUSINESS
HOUSE OF REPRESENTATIVES

ONE HUNDRED SEVENTH CONGRESS

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REDUCING REGULATORY AND PAPERWORK BURDENS ON SMALL HEALTHCARE PROVIDERS: PROPOSALS FROM THE EXECUTIVE BRANCH

WEDNESDAY, JULY 25, 2001

HOUSE OF REPRESENTATIVES,
COMMITTEE ON SMALL BUSINESS,
Washington, DC.

The Committee met, pursuant to call, at 10:05 a.m. in Room 2360, Rayburn House Office Building, Hon. Donald Manzullo (chairman of the Committee) presiding.

Chairman MANZULLO. The Committee will come to order.

This is the Committee's third hearing to examine the regulatory problems at HCFA, which is now known as the Centers for Medicare and Medicaid Services (CMS). However, a new name does not make a new organization.

While I appreciate that Secretary Thompson and Administrator Scully are trying to bring a new attitude to the agency, personally I am not going to recognize the new name until such time as I am convinced that it has truly been transformed into a new organization that puts the interests of patients and healthcare providers before those of bureaucratic bean counters.

At the previous hearings, all the participants agreed that the regulatory burdens are distracting from their primary business—delivering healthcare services. Today's hearing asks the decision makers from HCFA and the Office of Management and Budget what administrative actions they can take to eliminate burdensome and unnecessary regulatory requirements. My objective is to work cooperatively with HCFA, and I will put a slash in there, slash CMS, and OMB to reduce and even eliminate these regulatory burdens.

It appears that the recordkeeping and reporting requirements provide little in the way of information and in fact may inhibit the practice of good medicine. Similarly, the burden of regulation would make sense if those covered by Medicare or the providers benefited from the regulations. That does not appear to be the case.

Rather, the regulatory scheme appears to burden those who have the fewest resources to wend their way through the Department's administrative maze, the small businesses. Regulations and record keeping requirements appear to frustrate Medicare beneficiaries and participating providers.

A regulatory morass exists at HCFA. Congress and the Executive Branch need to work together to reduce the regulatory burdens on

small healthcare providers so they will stay in the Medicare program. If the Executive Branch cannot solve the problem by administrative action alone, then we are certainly willing to do whatever is necessary for remedial legislation.

I would like to thank my colleagues, Mr. Toomey and Mrs. Berkley, for their leadership on this issue. I expect this hearing will be the foundation of a fruitful partnership that will bring accountability to a system that for too long appears to have been accountable to no one.

I will now recognize the Ranking Member of the full Committee, the distinguished gentlelady from New York, for her opening statement.

[Chairman Manzullo's statement may be found in appendix.]

Ms. VELÁZQUEZ. Thank you, Mr. Chairman.

Today's hearing is the third in a series on the Center for Medicare and Medicaid Services, the successor agency to the Health Care Financing Administration. If these hearings have shown us anything, it is that it will take more than a name change to reform how HCFA operates.

To that end, the purpose of these hearings is to work with the Administration to find solutions to the problems of a complicated and growing system. Today's hearing will focus on the role of OMB, specifically the Office of Information and Regulatory Affairs, in enforcing the Paperwork Reduction Act.

In addition, we will look at how effectively OMB has monitored and enforced federal agencies' compliance with the Regulatory Flexibility Act. As we know, reporting and regulatory burdens fall disproportionately on small business. One of this Committee's goals is to level the regulatory playing field for our country's entrepreneurs.

In our last two hearings, we heard about problems facing the public healthcare financing system and small health service providers. In 1999, Congress tightened enforcement in order to cut down on waste, fraud and abuse. That goal is close to being met, but it has had unanticipated complications.

We learned about the burdensome and often contradictory CMS paperwork endured by doctors simply to receive payment for their services. Often complying with CMS paperwork takes more time than the time they spend with their patients. The reporting requirements are complicated, often contradictory and prone to unintended errors. Then doctors must worry about unannounced audits for the errors they did not mean to make.

Such a confusing and adversarial system is very discouraging and has real consequences. When doctors are treated as suspects instead of caring professionals, often the result is an avoidance of Medicare and Medicaid patients, many of whom have the greatest need for medical assistance.

Mr. Chairman, this burden of paperwork and scrutiny falls hardest on the small healthcare provider. Doctors in private solo practice or partnership want to serve the poor and elderly, but they worry about complex reporting requirements that could just as easily result in an expensive audit as it could be a missed payment.

Today we continue to focus on solutions to problems that face small healthcare providers, and we will hear then from the agen-

cies responsible for running that system, CMS and OMB. I hope they provide this Committee with useful and constructive proposals that result in a solvent Medicare system providing quality services to the poor and elderly, reduce waste and fraud and protects the needs and interests of small healthcare providers.

In closing, Mr. Chairman, let me say that I look forward to hearing the agencies' proposals for a fair and effective alternative to the current way of doing business with the government.

Thank you.

[Ms. Velázquez's statement may be found in appendix.]

Chairman MANZULLO. Thank you very much.

We have a time clock here that is five minutes more or less, just an idea to help us run along. Our first witness, Tom Scully, is the administrator. His title is Administrator of the Centers for Medicare and Medicaid Services. That is his official title. We will recognize you by your official title.

Mr. Scully, we look forward to your testimony. I appreciate your stopping by the office yesterday and informally going over some of the many onerous burdens that you are facing. I appreciate the fact that you had the courage to accept the appointment.

Please?

STATEMENT OF THOMAS SCULLY, ADMINISTRATOR, CENTERS FOR MEDICARE AND MEDICAID SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. SCULLY. Thank you, Mr. Chairman and Mrs. Velázquez and other Members. I would be happy to go through all the wonders of the former HCFA, and hopefully in the next few months I can convince you that we have changed enough to start calling it CMS.

There are a lot of challenges obviously with the Medicare and Medicaid programs. As a first step, you talked of a change in the name. We changed the name for a variety of reasons. Secretary Thompson, before I even got confirmed, spent a week on what was then called HCFA with me. One day on the way up to Baltimore he said look, everybody hates HCFA. No senior knows what HCFA is. HCFA has a lot of baggage. As the governor of Wisconsin, he probably may have been tied with the Chairman for being the biggest HCFA hater.

What he found when he got up there, though, and I had already known from a variety of roles, is that HCFA/CMS actually is filled with a lot of people that actually do care about the programs, do a pretty good job. They tend to be very insular and do not really talk to the outside world enough, which I am committed to changing, but they really do a good job. But, people really, really did not like HCFA.

It was his idea to change it to CMS. We spent a lot of time talking to employees and had an employee contest and focus groups. We changed the name to CMS, even though some people have given us a little bit of a hard time about it.

Our view is if you try to change attitudes and change the way people look at you and change the way the employees think about themselves and their own agency, changing the name at least gives you a little bit of a new breath of fresh air to change attitudes, and it is all about changing attitudes.

I can tell you, having overseen HCFA in a prior life—I was at OMB and in various jobs in the White House for the first day and the last day of the first Bush Administration. I was the person responsible for HCFA's budget back then and for the Medicare and Medicaid programs for four years, both as the Associate Director of OMB and Deputy Domestic Policy Advisor in the first Bush Administration.

It is an unbelievably huge job. HCFA's combined or CMS' combined budget this year, if you look at Medicare and Medicaid together, is $467 billion. The Medicare program alone is $240 billion. They are the biggest program in the federal government.

C.M.S. is a very complicated place, as we will probably get into today. The Medicare program is run by CMS and managed by CMS, but it is really run by 51 contractors around the county largely by the Blue Cross plans, Mutual of Omaha and some other contractors. We have about 5,000 employees.

I am not complaining about my budget. I would never question what OMB gives us because I used to be there, but we do have 4,800 employees and a $2.5 billion roughly administrative budget for $467 billion of spending, so it is a very, very large, very complex program and very difficult to run.

There is no question there is need for changes in the rules and need for changes in updating the way CMS does its job. Secretary Thompson and I are planning to methodically and aggressively change it. Changing the name was the first step. We have done a lot of other things, which I will get into today.

You mentioned in your testimony—not in your oral testimony, but in your written testimony, which I just saw this morning—the 855 enrollment form that was 30 pages long for new providers. Totally unrelated to your testimony, I think you are going to find Secretary Thompson will have an announcement about that tomorrow that will hopefully be looked at as a first step towards convincing you we were serious about change. I just saw that in your testimony. He has a number of changes tomorrow, one of which will be that.

I have done a lot of things personally since I have been there in seven weeks. Three things we announced on Thursday. One is, and I will get into these more in a little bit. One is that we announced that we are forming under the Secretary's regulatory reform initiative three different things that we are going to do to initially try to make CMS a more open and responsive place.

One is that we will have seven different groups. One, which they first met for the first time on Thursday, is a group to deal with the physician community, a group for hospitals and rural health, a group for nursing homes, a group for health plans, a group for nurses and allied health professionals, a group for home health and hospice and a group for ESRD and dialysis centers.

Each of these groups, and I am chairing personally the long-term care group with the executive director of the National Governors Association, Ray Chapok, because the governors obviously spend more money and the states spend more money on Medicaid and long-term care than we do.

Each of these groups will be focused on getting everyone in the community—unions, hospitals, in my case unions, nursing homes,

the governors, the AARP, who all came to the first meeting, but every group in these areas—together once a month to talk about our problems.

You can imagine the nursing home world. The nursing homes and the unions are not always going to agree on the fixes, but I found that there are a lot of common problems in nursing homes we can fix, and we want to methodically get together with these people once a month, identify the problems and fix them.

Until I took this job after I was tossed out of the government eight years ago, my most recent job was running a hospital association. I know the hospitals sat around, and we talked regularly about what needed to be fixed. Then someone would courageously go approach HCFA about it.

What I am trying to do is get the CMS staff involved in every one of these groups around the industry with consumers, with unions, with hospitals, with nursing homes, with physicians, and find out what their problems are, have them have a forum to come tell us what their problems are and have the people who focus on this every day inside the beltway focused on fixing problems day to day. Not necessarily everything has to be a big healthcare forum. There are a lot of day-to-day problems we can fix.

A second step is that I am going to go around the country, and the Secretary will come on some of these as well, and have public listening forums. I assume that some of those will happen to be in congressional districts as well, so hopefully with some of you. I already have eight of them scheduled in the next two months. I think the first one is with Montana with Chairman Baucus.

To the extent I can still keep my family, I spend a lot of time traveling around the country trying to get outside the beltway and find out what people's problems are dealing with the Medicare program, Medicaid program and CMS.

The third step is that internally we have a lot of very smart people who have spent a lot of time working on Medicare and Medicaid. The Secretary directed me to put together an internal work group of all the smartest, most creative people in CMS to fix our program. Since that probably comes across as, you know, we are from the government and we are here to help you, people will not believe we will actually do that.

I recruited a fellow who the Chairman met yesterday, Bill Rodgers, who actually ran an emergency room, a doctor, a practicing physician, ran the emergency room at Alexandria Hospital for years, patched up my kids for years. He is now over at the emergency room in Winchester, Virginia. He is going to spend four days a month coming in to chair this internal work group to actually push our employees to come up with ideas that are actually going to fix real problems for real people.

The reason I did that is he actually has to go back to the hospital every day and deal with the other doctors and the other physicians and the other nurses, and he has to deal with the real problems. Sometimes I think it is helpful to have somebody who is operating in the real healthcare world to help you fix those problems, so he is going to chair that third group.

We are very focused on streamlining burden and paperwork. One of the other things we announced with probably a little fanfare,

and hopefully it will make the lawyers' jobs more easy too, is that we announced—I used to be a healthcare lawyer in another life, and I got paid outrageous fees to read the Federal Register and identify regs that were coming out when I was at Patton Boggs and Aiken Gump, two big law firms in town.

We announced a few weeks ago that we are going to have a compendium of all regulations coming out of the Medicare/Medicaid programs once a quarter. We are going to publish it once a quarter, and if it is not on that list of the menu of what we are going to put out that quarter it will not come out.

In addition to that, when we put out regs once a quarter we are going to put them in the Federal Register—assuming we can get them to agree to this; I am working on that—only one day a month. The reason for that is to give people in the healthcare world the notice of what is coming. If we do not tell them that it is coming in the fourth quarter of the year it is not going to be issued in the fourth quarter of the year.

The regs will only come out one day a month so that not everybody has to hire a lawyer at a couple hundred bucks an hour to go down and read the Federal Register so that they know what is coming if you are a physician or a nursing home or home health aid in hospice.

We are trying to make the regulations less burdensome, more predictable and give people a lot more heads up of when they are coming because I think the perception in the healthcare world, fair or unfair, is that the HCFA regulatory process, CMS regulatory process, tends to be just random strafing runs, and you have to watch for these regulations to come out. I think you will find that will make life a little simpler as well.

Another step that we are taking, which is important that I talked to the Chairman about yesterday, is contract reform. As I mentioned, when I was at OMB ten years ago we had 72 contractors, and we announced that we were going to get it down to ten contractors. I came back ten years later, and we still have 51 contractors.

Our goal, and the Secretary has said this, is to get the number of Medicare contractors down from 51 to about 18 to 20, and we believe by finding the best contractors who can work with us cooperatively and run the program most efficiently, come up with common systems, that we can run the program more like an efficient business.

The program was designed as a contractor structure in 1965, and very little has changed. We are determined to fix that and make it work better. We are already working voluntarily. We need legislative changes. We are working voluntarily with Blue Cross, who represent most of the contractors, to fix that now.

Finally, since I know I have gone over, I will just tell you that one of the other efforts that you will see this fall, and this is probably my personal biggest agenda item as I already went to the Appropriations Committees, and we have had $35 million reprogrammed for this fall. We are going to have a Medicare education campaign because my view when I came in is that seniors do not understand their own program. They do not understand where to

get nursing homes. They do not understand where to go to dialysis clinics.

I picked $35 million because that is what a Presidential campaign spends in two months, and that was the level of information and education effort that we wanted. We are going to spend $35 million between October 15 and December 15 educating seniors about where to get information, where to get choices, where to get more information about a nursing home where they want to put their parents or their spouse, how to pick a health plan, how to pick a dialysis center, just to get them to ask more questions and answer more questions.

We know that is going to generate more questions, so our Medicare 1–800 number, which currently operates eight hours a day, five days a week, as of October 1 will be running 24 hours a day, seven days a week. We are going to triple the budget for it. We are going to have people available to answer very specific questions.

If you are in New York City right now and you call up with a specific question about New York City, you cannot get an answer about New York City. You are referred to the state. We are going to fix that, and hopefully as of this fall when seniors have questions, whether it is about the Medicare prescription drug card which we announced last week or whether it is about picking a nursing home, they will be able to get very specific answers about their area and their town and where they should go for help.

We are going to make a very big effort not just to fix HCFA on a regulatory basis and make it CMS so you can call it that in the future, Mr. Chairman, but to also make seniors—they love Medicare. They are happy with the program. Most of the states generally like Medicaid, but to make people more aware of what their options are and get better services through the program.

Thank you for having me. Sorry I went over my few minutes.

[Mr. Scully's statement may be found in appendix.]

Chairman MANZULLO. That is okay. I appreciate it very much.

Our next witness is John Graham. He is the Administrator of the Office of Information and Regulatory Affairs, OIRA, at OMB.

I look forward to your testimony, Mr. Graham.

STATEMENT OF JOHN GRAHAM, PH.D., ADMINISTRATOR, OFFICE OF INFORMATION AND REGULATORY AFFAIRS, OFFICE OF MANAGEMENT AND BUDGET

Mr. GRAHAM. Good morning, Mr. Chairman, Ranking Member and Members of the Committee. Thank you for the invitation to testify. You invited me to speak about OMB's role in reviewing information collection requirements pursuant to the Paperwork Reduction Act, as well as our review of regulations governing Medicare and Medicaid programs.

I was confirmed by the Senate last Thursday night. Prior to that I was a professor at the Harvard School of Public Health, and I am pleased that I have the opportunity to testify as the OIRA Administrator this morning.

I hope to leave this hearing today with a better understanding of the issues that this hearing is addressing, of your concerns and ideas for further action that may be taken by my office in concert

with Mr. Scully and the Centers for Medicare and Medicaid Services, which I also know as HCFA.

I have appreciated the opportunity to read the testimony from the May 9 and July 11 hearings which constitutes a substantial part of my knowledge base on this issue.

In your letter of invitation, you requested my views on the following issues: (1) administrative changes that OMB can make in ensuring that it properly understands the impact of reporting and record keeping requirements on small businesses; (2) the adequacy of OMB's review of reporting and record keeping requirements imposed by CMS contractors on small healthcare providers; (3) recommendations on necessary legislative changes in the Paperwork Reduction Act; and (4) our opinion on OMB's review of CMS regulations.

These are important questions, and I look forward to working with the Committee and CMS to address the concerns that have been raised about the paperwork burdens that are placed on small healthcare providers. However, because I assumed the position at OIRA less than a week ago, I am not in a position at the present time to discuss what has happened in the past with respect to the relationship between CMS contractors and small healthcare providers, nor can I offer at the present time any views or recommendations regarding what deficiencies may or may not exist or how they can be remedied.

However, I can assure you that one of my priorities as OIRA Administrator is to reinvigorate the Executive Branch's implementation of the Paperwork Reduction Act, and I am committed to working with OIRA staff and CMS and this Committee to look into this matter in detail and to identify actions that need to be taken.

I would, however, like to briefly summarize the public and OIRA review that must occur before an agency can receive OIRA approval to collect information from the public. The 1995 Paperwork Reduction Act amendments mandate an extensive agency review process and provide significant opportunity for public participation in both the agency and OMB processes.

In accordance with the goals of the Paperwork Reduction Act, the Act requires agencies to plan well in advance when they develop new collections of information and they consider extending ongoing collections of information. This advanced planning is necessary because agencies need to estimate potential burdens on respondents and prepare to disclose certain additional information to the public.

Only after doing this and considering changes based on comments received do agencies submit their paperwork clearance packages to OMB for review and approval. OIRA then reviews each agency information collection requirement before the agency can collect it and reevaluates the collections for their continued use at least once every three years. In cases where outstanding concerns remain, OIRA may call meetings with CMS staff, other affected agencies and other commentators.

Our objectives throughout this process are to: (1) determine whether the agency's collection is necessary for the proper performance of the functions of the agency; (2) assure that the collection has practical utility; and (3) assess whether these benefits justify the burden imposed on the public. If the agency cannot dem-

onstrate to OIRA's satisfaction that the collection's need and practical utility justifies this burden, OIRA disapproves the collection, and the agency may not go forward with the collection until it is revised.

Through the PRA, OIRA must help agencies meet their obligations to the public by striking the proper balance. The Paperwork Reduction Act should not be used as grounds for denying the government the ability to collect from the public what is necessary to fulfill the mission that Congress has established. On the other hand, collection of unnecessary and duplicative information imposes unjustified costs on the businesses or individuals, in this case physicians, on the taxpayer and on the economy as a whole.

O.I.R.A. is continuing to make efforts in this area reviewing individual paperwork collection proposals and producing an annual information collection budget that identifies agency by agency the initiatives underway to reduce paperwork burden and improve the quality of federal data collection. I plan to place renewed emphasis on a coordinated effort to produce better results in this regard, and I am happy to hear from Mr. Scully that efforts are being made promptly to work in this area at the present time.

Thank you for this opportunity to testify. I look forward to working with you in the future.

[Mr. Graham's statement may be found in appendix]

Chairman MANZULLO. Thank you very much.

Our third witness is George is it Grob?

Mr. GROB. Grob.

Chairman MANZULLO. Grob. Thank you. Where is the E?

Mr. GROB. It is missing.

Chairman MANZULLO. I think it should be on there.

Mr. GROB. Maybe the government could add an E, and it would sound right.

Chairman MANZULLO. Mr. Grob is the Deputy Inspector General for Evaluations and Inspections for the Department of Health and Human Services. We look forward to your testimony.

I believe there is something a little bit unusual, Mr. Grob. When I read your testimony last night, I was nothing less than—my breath was taken away when I read on page 4 of your testimony, the middle paragraph, where it says we recommend that Medicare contractors and Administrative Law Judges apply the same standards.

Mr. GROB. Yes.

Chairman MANZULLO. You might want to mention that in your regular testimony. I think that could be the rub of most of the problems going on with the doctors that are having difficulty.

I appreciate your being here.

STATEMENT OF GEORGE GROB, DEPUTY INSPECTOR GENERAL FOR EVALUATIONS AND INSPECTIONS, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. GROB. Thank you very much. I appreciate being here, too. I was actually excited when I saw the invitation letter with the words that asked us to please come up with ideas on how to streamline the administration of the program without compromising program integrity.

The first thought that crossed my mind was that this is going to be complicated. Now, I knew it would be complicated long before we got the invitation from you because we work on this all the time, and we are constantly thinking and doing studies about things like the appeals system and the contractor system and all those details of the programs that we work our way through day after day and year after year.

If there were any doubt about it at all, when I reviewed in detail the testimony in the two previous hearings that you held on this subject it would remove all doubts that we are dealing with a very complicated matter. It may be because the program is big. Medicare is the biggest insurance program in the world. That may have something to do with it, but the fee for service parts and the Medicare Plus charts are essentially very complicated because of all the people that are involved in this.

Now, I think you knew that when you asked us to answer the question, and I am going to try to deal with this complexity by dealing at several different levels; from a very general level and then trying to get down to more and more specifics as we go. Five minutes will not be enough to do it, but I will look for other opportunities to discuss things with you and your staff.

In one way, the question that you asked is actually the beginning of the answer. I think it might be worthwhile for us to pause to lay out a principle that we can use in dealing with these, and the principle that I would like to articulate is the principle of balance.

Because the subject is so complicated, we need to get our bearing from time to time. I think the correct bearing is this. I think anything we do has to balance the needs first of the beneficiaries, the healthcare providers, and then the financial and program integrity of the program.

A statement I think that on the surface sounds trite, but those of us who have worked in the field know how hard it is, and every once in a while when we get lost it is good to have something we can grab back onto that sort of tells us where we should go. So I think if we start with that we can always get our bearing when we need to do it.

Now let me descend one level of generality here, and let me look at the infrastructure. I think that nothing will help the healthcare providers if the fundamental infrastructure of the program is not there. There are lots of aspects to it, but I would like to single out two. One is the Medicare contractors, and the other is the appeals system that you mentioned earlier.

Now, Medicare has these 51 contractors that Mr. Scully referred to, and we have actually found problems with the way these contractors work even with their own integrity. We have had 15 settlements with contractors for false representation of the work that they do, for turning off the codes that they use to detect integrity problems and a number of things like this amounting to $350 million ever since 1993. We have also had some problems with the effectiveness of their fraud units.

But there remain very fundamental problems with the contractors simply with accounting. The contractors to date do not have integrated dual entry accounting systems, which is a fundamental

aspect of any large business in this country, as I am sure that you know.

Above and beyond these procedural weaknesses, there are very fundamental weaknesses in the way the contractors are chosen. Only insurance companies can serve as carriers. As far as intermediaries are concerned, these are basically nominated by the National Blue Cross/Blue Shield Association, which chooses which ones to nominate, and they do that by consulting with the various provider groups. Only cost based reimbursement is possible, and no specialization is allowed except for the anti-fraud contractors.

There is no business in this country that could possibly function if its hands were tied with the same rules that Medicare has tied the hands of its contractors. Now, when this started it made perfect sense because we had to quickly muster the resources of large insurance companies to manage these programs. But right now the CMS has very little flexibility in how to choose its contractors.

Secretary Thompson has announced that he is going to reform this, as well as the reductions in the number of contractors that Mr. Scully mentioned earlier. We completely support these reforms. We think they are common sense, and they should be made as soon as possible.

The second one is the appeals system. It is fundamentally broke. Right now, for example, in Part B there are four levels of appeals. At the first level, a carrier reconsideration takes 45 days on average. At the second level of a hearing it takes 120 days. At the ALJ level it takes about a year, and then at the Departmental Appeals Board it takes up to two years on average to handle these appeals. It takes too long.

There is a very high reversal rate, which we believe is due to discordant standards at the different review levels, which is what you had referred to earlier. There is, we believe, somewhat of a breakdown in the communication and understanding at all these levels, and there is a very dysfunctional administrative system. If someone is worried about paperwork reduction, they ought to try to follow the files of an appeal as they work their way through the system and even across the country from office to office as they try to resolve these matters.

We believe that the solution to this is first to provide enough resources for the system to work. If it is taking too much time, it may be due to procedures, but it may be due to overload. If people would like their appeals addressed, there should be enough people involved in hearing the cases so that it can be resolved quickly.

We think the ALJs should be moved to the Department of Health and Human Services. Right now they function out of the Social Security Administration. In a sense they focus a residual of their activities on Medicare after trying to satisfy the needs of social security. Now, there is a cadre of Judges which do specialize in Medicare, although they do not hear all the Medicare appeals. We believe that these should be moved to HHS.

Communication should be approved at every level. The system should be subject to regulation. There should be a case precedent system. There should be reasonable time frames set out for the various levels of appeal, and there should be representation of the De-

partment at some of the appeals levels, where they are not currently represented.

Moving now to something more specific, which is the actual dealings with the providers and the beneficiaries of our program, I think that we strongly endorse what everyone has been saying, which is the need for outreach and education for the provider community.

Now, the primary responsibility for this lies with CMS. The Inspector General's Office has gone out of its way, though, to try to provide as much guidance as we can to the industry to respond to needs that they have brought forward to us. I think many of you are familiar with our voluntary compliance guidelines program, which we have issued for nine segments of the healthcare industry, including hospitals, home health, medical equipment, prosthetics, hospices, Medicare Plus Choice, nursing facilities and more recently for the physician community.

We also issue by statute, which required it in the most recent legislation, advisory opinions when questions are raised to our office to give an answer as to whether a particular service is allowed. We issue fraud alerts, safe harbor guidelines, and our website contains every audit we perform. Every evaluation which my office performs is on there. Our work plan is on there. Our hearing information is on there. Anyone who wants to know what we are doing and what we are saying, they can go to our website, and they can find it there.

Of course, CMS has also been aggressive in conducting education and plans to do even more. This really works. In 1996, we conducted our first payment error reduction study, and we found that the error in Medicare at that time was 14 percent, costing the government $23.3 billion. Last year, for the year 2000, it dropped in half. It is 6.8 percent. It is about $12 billion right now, so it is half of what it used to be, but it is still too high.

To show you that success is really possible here, I would tell you initially in the hospital community $1 billion worth of their error was due to documentation problems. In the last several years, not a penny of their error that we detected was due to documentation problems. I think this demonstrates that the education and the effort to deal with problems once identified can be very successful.

My time is now over, and there will be plenty of opportunities I think in dealing with your staff to answer other questions that you may have. I would really look forward to the opportunity to do that. I have gone through all of the material, and any way that we can meet with you or your staff to go over those problems one by one until we figure out how to do that would be most welcome to me.

I will just end by saying obviously Medicare should not just be the biggest healthcare program in the world. It should be the best.

Thanks.

[Mr. Grob's statement may be found in appendix.]

Chairman MANZULLO. Thank you for that testimony.

I have a couple of questions here. Mr. Grob, I would refer to page 4 of your testimony.

You know, I practiced law for 22 years. I did a lot of social security disability. We had guidelines. We had a hearing here a couple

weeks ago with Dr. Michael Hulsebus, who was terrorized, along with his brothers, by Wisconsin's Physician Services, WPS. We found out that that group does not know the difference between an x-ray and the X files. The only way that you can qualitatively state whether or not somebody needs an adjustment by a chiropractor is to take a look at x-rays. They did not even look at x-rays.

As far as I am concerned, performance contracts are nothing more than the same thing as telling a state trooper that he has a quota of tickets that he has to write. The terrorizing that has gone on by these contractors has got to come to an end.

What I do not understand is why? There is a local medical review policy and a contractor manual, which is what the so-called carrier hearing officers are. They are a joke. The ALJs are bound by statute, regulations and national coverage determination.

In fact, Dr. Hulsebus, after he was fined $250,000 and we beat it down to zero, then they came back with $40,000. We beat it down to $1,500. Then they decided to appeal the $1,500 after the Administrative Law Judge threw it out on its face. Again, they got three more letters.

The latest from Wisconsin's Physician Service, and I will mention names and names of people on the record and publicly to bring about accountability. They said well, here is your appeal. You can send a letter, and somebody may or may not respond to it.

My question both to you and Mr. Scully would be, you know, why are the contractors not bound by statute, regulation and national coverage determination?

Before you answer that, I am also concerned over the fact that the contractors are insurance companies. This is what answers the questions of why the insurance companies in non-Medicare situations are trying to pay the same rate of Medicare reimbursement. I just think it is a very cozy arrangement and that there should be an end to that. This is an administrative function.

I would like your comments on that, but if you could first comment on the first, both you and Mr. Scully. Well, whoever wants to comment on that.

Mr. GROB. On the first one I would say I think your point about the performance contracting is very valid. I think there is a good solution to that, and I think it is implied by what Secretary Thompson has announced, which is you can change the basis upon which you measure the performance of a contractor.

If the contractor is supposed to have timely appeals then their performance can be based on how timely those appeals are. If the contractor is supposed to handle appeals that are accurate and in which people are treated with dignity then that can be what the performance is based on.

I think that is a very good way to do it, which would be to structure those contracts so that there is a strong performance element to it.

Mr. SCULLY. Maybe I will switch to a couple of the other subjects you mentioned. The national versus regional coverage decisions. That is an ongoing policy dilemma. Obviously with a $240 billion insurance company, people can get coverage decisions that they do not like regionally and want national coverage decisions and vice versa. It is kind of like forum shopping as a lawyer.

Probably 80 percent of the coverage decisions about what Medicare covers are made locally by the carriers. Most people like that. Most physicians like it. Most hospitals like it because it leaves a lot of flexibility for local practice patterns and local decisions. There has been a lot of pressure to push more of that to the local areas.

On the other hand, big decisions like PT scanners, things like that, MRIs, which I was involved in ten years ago, how much you are going to cover on that, the bigger decisions tend to be in the multi-billion dollar range and tend to get pushed up to the national level and be national coverage decisions, but that is always going to be a problem because when a local carrier and a local contractor turn somebody down for coverage obviously those people are very unhappy.

On the other hand, in many cases they prefer the local coverage because they are more likely to get a more flexible decision locally than they would if they pushed it up to Baltimore and had the decision made nationally on a national coverage decisions. That is probably a pressure that is not going to go away, the balance between national and local coverage decisions. I have already spent quite a bit of time on it.

I am not sure which other ones you wanted me to cover, but as far as the fraud and abuse we discussed yesterday my views on fraud and abuse have probably been shaped as much by my experience the last ten years out of government as they have been in government. I was the co-chair of the Fraud Task Force in the first Bush Administration with the Deputy Attorney General when I was at OMB and spent a lot of time on it. There were a lot of great strides made in the last ten years on I think more aggressive Medicare fraud enforcement.

On the other hand, having been the chairman of the compliance committee of two large public corporations, Oxford Health Plans in New York City and Davida, as I mentioned to you yesterday, in having to put together compliance programs and trying to push large corporations to be compliant I think you could argue that there was maybe not enough done ten years ago, and maybe the last couple years the government has been arguably overzealous in some areas, which you have focused on.

I think finding a happy balance where we find people that are bad that are not partners that are big contractors and bad providers and go after them more aggressively while being more responsive to the people that are actually being good public partners with us as contractors for Medicare is a tough balance to hit. I hope working with the IG and the Justice Department in the next four years we can pull that off.

Chairman MANZULLO. My time has expired. My point was simply that the carriers should follow the laws, statutes and regulations. The problem with HCFA is the fact that it is not predictable, and that is why it is all screwed up.

Mrs. Velázquez.

Ms. VELÁZQUEZ. Thank you, Mr. Chairman.

Mr. Scully, on July 16 the Administration published a notice of publication in the Federal Register outlining their requirements for participation in the President's new Medicare prescription drug

card program. Is the Administration following the requirements under the Administrative Procedures Act during this rule making?

Mr. SCULLY. We have, but it is not a rule making. Actually we are not really making a rule. What we are effectively doing is putting together a consortium or cooperative and giving the Medicare seal of approval to drug discount cards. They are going to use it to hopefully draw more seniors, but that proposal is something that was largely mine. If you want to spend a lot of time having me explaining it I can, but it was around in the last Administration. I think there are a number of bills in the House and Senate.

Our view on that package was that no matter which Medicare prescription drug reform proposal you look at, getting people into organized purchasing cooperatives is from anywhere from one-third to two-third of every reform bill savings, whether Democrat or Republican.

Ms. VELÁZQUEZ. But are you not setting up a new program?

Mr. SCULLY. No. We are setting up a cooperative where the government is going to be a partner with private companies, and we have the ability under current law to allow people—only CMS, the Secretary of Health and Human Services, is allowed to give people the ability to use the Medicare name, such as Medicare Select, Medicare Plus Choice.

All we are basically doing is allowing our name to be used under certain circumstances to market these cards. We are also putting together a private cooperative to market them and then make sure that the enrollment is coordinated, but it is not a new federal program by design.

Ms. VELÁZQUEZ. Mr. Grob, many of the problems healthcare providers are facing is between themselves and the private sector Medicare contractors. Now the President wants to implement a prescription drug card program administered by the private sector.

Are we creating more new problems ahead where these contractors are out of control?

Mr. GROB. My office has not seen the specifications of the new proposal, simply the general announcements that were made of it, so at this time I am not prepared to talk about the ramifications of the specifications of it.

Certainly there will be a new administrative arm here through the private sector, and I think concerns like that need to be looked at.

Ms. VELÁZQUEZ. Mr. Grob, will you look at this new program and get back to me with an answer?

Mr. GROB. I certainly will.

Ms. VELÁZQUEZ. Mr. Scully, often times regulations that were considered burdensome by a regulated community were not only required by statute, but required within a certain time frame.

Do you believe that the growing amount of CMS paperwork requirements are the result of recent Congressional mandates?

Mr. SCULLY. Well, they probably are. I was pretty involved in I think the 1990 bill, the 1993 bill, the 1997 bill, the 1999 bill. Every time you update and try to improve the program, obviously you get much more guidelines both in Medicare and Medicaid.

I would say that one of the problems of CMS in the last few years, in fairness to Nancy Min-Pearle, my predecessor, who hap-

pened to also be my successor at OMB and is a good friend, is that through the 1997, 1998 and 1999 bills the agency was largely overwhelmed with work. I think I have had the good fortune of I would not say it is a quiet time, but as a post-legislative period a relatively quiet time to come in and try to fix some things.

I think it is fair to say that the paperwork burden was overwhelming as a result of the legislation.

Ms. VELÁZQUEZ. What is the difference between the BPA provisions that apply to the appeals and coverage process and the provisions contained in MERFA?

Mr. SCULLY. I am sorry. What?

Ms. VELÁZQUEZ. Is there any difference between the BPA provisions that apply to the appeals and coverage process and the provisions contained in MERFA? This is the legislation that we just held some hearings about.

Mr. SCULLY. I am not sure where they conflict. We have spent a lot of time. I actually have not talked to them in two months, but spent a fair amount of time talking to Mr. Toomey and other sponsors about MERFA. There are some things in there that we support and some we do not.

Ms. VELÁZQUEZ. Mr. Grob.

Mr. GROB. A quick reaction is that they generally do not conflict with one another, but rather they deal with different aspects of the problem.

The BPA provisions on the appeal system are primarily intended to constrain the amount of time that is taken at each level of the appeal system so that things can move rapidly through it, whereas the provisions in MERFA tend to deal with appeals that relate either to the status of the provider in the program, or they try to provide a more rapid hearing of matters that are related either to constitutional issues or to issues related to the authority of CMS.

Ms. VELÁZQUEZ. Should we be giving the agency time to promulgate the BPA regs before we start reforming the system again?

Mr. GROB. It is my opinion, and I do not know that everyone shares it, that with respect to the appeal system we really need to look the whole thing over from top to bottom.

As you know, we have recommended that the ALJs be moved into the Department, and I think if that should happen, and we believe that it ought to happen, that at the same time all the other things should be considered.

I would agree with you that these things need to be looked at together. We are very much in favor of a much more rapid handling of the appeals, but we do have some misgivings about the automatic raising of them to the next level because we are afraid that if that is done either too soon or without adequate attention it could actually have the opposite effect of basically encumbering the higher levels of the appeal system with issues that have not been fully reviewed yet, and it may not only move the backlog to a different place, but it may be more difficult then to deal with that backlog at the place.

Having said that, I do not want anyone to misconstrue my remarks as saying that we do not want it to move faster. I just think we need to look at it very carefully and make sure that it works right.

Ms. VELÁZQUEZ. Thank you.

Chairman MANZULLO. Thank you, Ms. Velázquez.

I am going to go a little bit out of order here to accommodate Congressman Christian-Christensen, who is an M.D. I want to make sure her testimony gets in.

Mrs. CHRISTENSEN. Thank you, Mr. Chairman. I also might have to leave to vote in another Committee.

I want to welcome you here. It is great to have you. You can imagine as a physician of 20 odd years and having worked with HCFA that this is a day that, you know, most physicians would relish having HCFA in front of me. I started to come here, you know, in an attack mode to try to get even for all of the problems that I have had, but maybe it is because I got stuck in an elevator this morning. I have kind of changed my mode.

You know, we are having serious problems in my district. I used to think it was just my district, but I see it is all over. We are pretty much facing a crisis in that physicians are opting out of the system. There have always been those physicians who have never charged Medicare beneficiaries because it was just too horrendous to go through the process, but now, because there is an option to opt out, they are opting out. That is going to have a very terrible effect on beneficiaries being able to get service in a small community as ours.

I am hoping that as we go through this morning through the question and answer period you will help me to develop some confidence in the changes that are going to be taking place so that I can go back and find some way to encourage my physicians not to opt out, but to stay in the system. I am still looking for some of that. In answering the questions I am going to pose, I hope you will help me to develop that confidence so that I can go back and encourage my physicians and other providers.

I have gotten many complaints, and actually all of my providers want to change the carriers, whether it is Part A or Part B. They just want those carriers out of their lives. I met with providers before I came back this week, and nothing has changed in ten, 15, 20 years with our providers.

Could you, Mr. Scully, explain? You talked in your written testimony about flexibility and specialization and how that would improve the contractor relations with providers. Could you explain how that is going to improve the relationship with the providers?

Mr. SCULLY. Well, I think the biggest thing that will improve the relations with providers is incentivizing the contractors. I personally, and this is my own personal opinion, and I actually agree with the IG on most of what they said about contract reform. Virtually everything. I hate to start agreeing with the IG too early. That could be dangerous.

We really do need to fix the program. There is no place in the Medicare system we have had cost based programs that have worked. I mean, basically with these contractors we pay them on cost, which, as I said to some of my staff, anybody that thinks the people are making money on a cost based program is silly. They are charging their plant and equipment and their systems and other things, but their incentives are not appropriate, so this is the backwater of most Blue Cross plans.

Just even in my personal experience, when I was a lawyer I represented Blue Cross of California, which is chaired by Leonard Schaefer a former HCFA administrator and friend of mine. They had disastrous problems. One of the best run insurance companies on the private side in the country, and maybe at that point—they have gotten out of the Medicare contracting system. Maybe at that point one of the worst run.

The reason was it was not profitable for the company because they were non-incentivized. It was a cost based contract. It was a way for them to cross subsidize their computer systems and their building and equipment, but they had the worst people in the company running the Medicare program, at least at that time. It got a little better. Blue Cross is not out of the Medicare program.

I believe, as with any other contractor system of the federal government, we have to incentivize them right. Part of the Secretary's contract reform proposal, and the IG supports this, is to start paying these people as other government contracts and incentivize them appropriately and allow them to make a predictable government contractor profit so that they start looking at this as a good business opportunity because they are not incentivized appropriately.

As a result, the Blue Cross plans and Mutual of Omaha and EDS and the other people that run this program do not have appropriate incentives to focus their best people in the company in the long term on running this program efficiently. We do have our hands tied.

Mrs. CHRISTENSEN. Okay. Mr. Scully, you talked also about looking at the different areas, whether it is home healthcare, hospitals and so forth. Are providers involved in that process on an ongoing basis in looking at the reforms that are going to be taking place——

Mr. SCULLY. Yes.

Mrs. CHRISTENSEN [continuing]. Of groups that are looking at hospitals and other providers and home healthcare? Are the providers involved in that discussion?

Mr. SCULLY. That was the whole point of the groups that I announced on Thursday, as I obviously used to run a provider association, so I tend to be focused on that. In the nursing home area, for instance, the group that I am chairing is the unions, the major nursing home groups, the AARP, the other patient advocacy groups.

The whole point is to get out to those groups and find things they want to fix. Hopefully we will fix them fast enough that we can get the Chairman to start calling us CMS sooner or later.

Mrs. CHRISTENSEN. If I could just throw in one last question? I guess I would ask this of Mr. Grob, who talked about balance. We are really looking forward to balance because from a provider point of view we have shared most of the burden and the suffering in the system, so we are looking forward to some balance.

Everybody acknowledges that the carriers are a big part of the problem. You also acknowledge that when physicians are investigated or audited you do not find really fraud and abuse. You find honest mistakes.

While you are reforming the system, while you are changing the carrier, the way that the contractors are contracted with, would it not be a good idea to put a moratorium on some of those investigations of the providers? We are really not involving ourselves in criminal activity. They are honest mistakes. The system is so bad that I am sure that it is responsible for a lot of the reasons why they are audited, investigated, et cetera.

Mr. GROB. Okay. Let me address this one. I think I am going to pick up the principle of complexity to answer this one because it is very complex.

We have always said, and I will emphasize it now. I will say it again a dozen times if we have to. Most providers are honest. They are hard working. They are very concerned about their patients. They come through for them all the time. There is a handful that are not, and they besmirch the name of all the rest that do.

Having said that, however, I do not think that I could agree that all the problems that we are having are simply due to mistakes. On the other hand, I do not know that it is all due to fraud either.

What I really think is that there is a spectrum in there. It runs from someone who made an innocent mistake to someone makes a lot of innocent mistakes, to someone who does not care very much, to someone who might just want to press it and just see what they can get out of this program without crossing the fraud line, all the way up to people who systematically sit down and say "let us see if we can take this thing for all it is worth." It really runs the gamut like that.

Now, the error rate study that we produce every year is not capable of detecting what the underlying reason is. It can only detect whether or not a payment was not made correctly. We are not able to look underneath that to see whether it was due to fraud.

There is something about the statements that go around, and, as I said, I would really like to take this opportunity to put it on the table. I think that part of the reason for the fear that physicians and others have about being investigated is that they do not understand that not all that many are. The number of physicians who have been criminally convicted or for whom fines and administrative remedies have been taken is very small. For example, it has averaged about 25 a year. Most people think it amounts to much more than that.

I believe that there are several ways to handle the question of the fear that people have of being criminalized, if you will. One is to make sure that the systems do not do that wrong. We have always said we try to be very professional about this. We do not want to cross that line. We are very open. As we have always said, if anyone knows a specific case, anything they want to bring to us where this has not worked right, let us know.

I think that another way to deal with the problem, though, is to deal with the fear. I think part of the education and understanding that we have to bring about is for everyone to gain an understanding as to what the limits of those authorities are and how they are practiced, so that if there are any fears that are not justified we can take care of those.

Chairman MANZULLO. I appreciate your testimony.

Mr. Pence.

Mrs. CHRISTENSEN. Thank you.

Mr. PENCE. Thank you, Mr. Chairman. I want to thank Mr. Scully for being with us, as well as our other distinguished guests today in the Small Business Committee.

I would compliment you, Mr. Scully, already by saying that on the House Floor yesterday, following your meeting with our Chairman of this Committee, you were responsible for the first reference to HCFA that I have ever heard the Chairman make where I did not feel that he was restraining himself from using expletives. I congratulate you for that, for good first impressions, and I am confident that they will go forward with good actions.

My question more has to do with a process that has come to my attention. I serve as Chairman of the Subcommittee of the Small Business Committee on Regulatory Reform and Oversight, and I am very encouraged to hear that the Centers for Medicare and Medicaid Services recently announced the formation of in-house expert teams across its program areas to think innovatively about new ways of doing business that will reduce the administrative burdens and simplify rules and regulations, very much a goal I know of the Chairman of this full Committee and very much part of our vision for the Subcommittee that I chair.

I would like to congratulate you in this effort and encourage you strongly as you pursue this process of innovation and reform. I would also suggest, though, as you go forward that you establish a team to investigate specifically the survey process for skilled nursing facilities. I serve an east central Indiana district that is home to many of these facilities that you have I think accurately spoken well of today.

What I hear from the folks in east central Indiana is that in effect this system is broken, and the current survey process does not really measure quality; that in fact they tell me that it only really provides a snapshot of compliance on that particular day.

I would like to encourage you and just simply invite your comments, Mr. Scully, in particular on this recommendation. I want to encourage you to review the process, including the frequency of surveys, and take a hard look at the shortcomings of the survey process itself.

I would also invite you beyond today's hearing to share with me in our Subcommittee capacity any of your thoughts going forward. I would just invite you to comment in any way about this new process and specifically in the area of skilled nursing facilities.

Mr. SCULLY. Well, as I mentioned earlier, there are seven outreach groups, and I not by accident picked the long-term care and nursing home group to chair myself. One, as a former hospital person I think I should do the hospital one.

The executive director of the National Governors Association, Ray Chapok, one of the chief people at the AARP, a senior person at the SCIU, the biggest union in the nursing home business, and I met last Thursday to start working on this working group. It is going to be expanded to virtually anybody in the nursing home business that wants to be involved. And Chip Rodman—I am sorry—the president of the American Association of Health Care Associates, which is the largest nursing home group. We are going to look at everything from top to bottom in the nursing homes.

I have already started working on the survey and cert process. We are pretty much tied by statute. I personally think it is nutty that every nursing home in the country is surveyed and certified every 12 to 15 months, the best to the worst. My view is the really bad ones we should be in every three or four months, and the really good ones we should be in every three years. It is not tied to quality.

When I came in, at one of my first staff briefings I said are you telling me we survey every nursing home. I picked one company's nursing homes with the exact same frequency as the bad ones? The answer was yes. That is a statutory requirement.

I am hoping that we can convince Congress to change that based on a quality initiative. I do not want to preempt the Secretary, but we are working very, very, very aggressively and cooperatively with a lot of different parts of the nursing home business on a nursing home quality initiative that I think will be done this fall, and I think it will significantly change the way we work with nursing homes for the better.

I think you will find that hopefully we will come back to you pretty quickly with an entire approach to refocus and restructure the review and surveys and certification and overall regulation of nursing homes. I mean, the good thing in a strange way about the nursing homes—they have masked their problems in the last three or four years. As you know, five of the top six chains are in bankruptcy. It has been a tough couple of years for nursing homes.

They are willing to look at a lot of the things, which has been good for me, that they probably would not have talked about three or four years ago. They have been very cooperative partners so far in trying to get things changed. I hope to work with them and the unions and others to get some significant regulatory forum for nursing homes.

Mr. PENCE. Very good. Thank you. I will just reiterate my desire in my Subcommittee chairmanship role to ask your forbearance in keeping us informed as that goes forward——

Mr. SCULLY. Sure. Absolutely.

Mr. PENCE [continuing]. In how we can be helpful on this side of the process. Thank you.

Mr. TOOMEY [presiding]. I think we have time for one more questioner before we return for the vote, so the gentleman from New Jersey, Mr. Pascrell.

Mr. PASCRELL. Thank you, Mr. Chairman.

Mr. Grob, what part does the bureaucracy play in precipitating fraud? We noticed a reduction in what we know of in fraud. What part does the bureaucracy play in this? You started to touch upon that.

Mr. GROB. I am not quite sure I understand your question, sir.

Mr. PASCRELL. Well, the fraud in Medicare. We talked about $25 billion reduced to about $12.5 billion.

Mr. GROB. Right.

Mr. PASCRELL. The $12.5 billion that still remains that we know about, you know.

Mr. GROB. Yes.

Mr. PASCRELL. We are conjecturing here.

Mr. GROB. Yes.

Mr. PASCRELL. What leads to that fraud? Is it because we have set up a system that is unmanageable, or is it because we just have crooks out there?

Mr. GROB. Okay. I see what you are saying. Okay. Thank you. I think if I could mention, this is a further extension of the answer to the question previously raised about this. Again I would like to emphasize that our error rate study does not measure fraud. In other words, we do not have a six or seven percent fraud rate, but it is an improper payment rate. I think that goes a long way to answering your question.

There is no doubt in my mind that a good part of that is that people may have trouble understanding the rules in some cases, or maybe their own management is just not tight enough, you know. In other words, I believe that the weaknesses run the gamut from something that is purely innocent, but also includes some things like some management that may not be as tight as it should be.

That certainly would be exacerbated by complex program rules. The frequency of change of program rules I think is something that contributes to that as well.

Mr. PASCRELL. Much of it precipitated by us on this side of the table.

Mr. GROB. Yes. It is interesting at several hearings that I have participated in how readily various Members of Congress initiate the discussion about the changes that have been due to the legislation that can make program management more difficult. I think there is an overall general awareness of the fact that the frequency of change does contribute to that.

Mr. PASCRELL. Do you think that all the agencies are in this room to redesign a new delivery system for Medicare and Medicaid?

Mr. GROB. Well, I think going to remarks made earlier that certainly the provider community has to play a big role in that. I do not think it would work very well if CMS, for example, were to design all the rules. I think it would get bogged down.

I actually think that a big step here is this listening process that Mr. Scully has put into effect. I think that in looking at the questions that were raised in the testimony in the previous sessions, I find that a lot of them go to the structure of the program they were trying to manage, as well as to the structure of accounting and hearings and things of this nature.

There really are underlying questions about who is eligible for the benefit, how do you enroll in the program, what benefits are covered, how well people know that, and so I really think a process of continuous improvement or continuous engineering is what is called for, and I think the idea of forming the groups with the different provider groups is probably a very critical and essential element of that.

Mr. PASCRELL. Would you, Mr. Scully, believe that in one year if we put all those agencies and providers together, the representatives in a room, we could devise a system that was less bureaucratic and much more to our liking with a reflection to the questions that are being asked today and the last two times we have met?

Could you envision a new system, a delivery system being put together that you could recommend to the Congress? I mean, otherwise we are spinning our wheels here.

Mr. SCULLY. Well, not to be a cynic, Congressman, but I have been involved in every major health reform since 1986 I think. RBRBS, which was the biggest, in 1989 was something I was negotiating on behalf of the first Administration.

I think it is a big program. Everything you do is politically controversial. Believe me, I am hopefully a big change agent, but I also think that big change in Medicare comes slowly. We are very hopeful we get significant reform in Medicare. We are totally committed, the President is, to prescription drugs and Medicare reform this year, but I also think that you have to look back a long ways to find significant change in the healthcare system. Politically it just does not happen.

I like to think that rather than give up, I try to go for small changes. One of the reasons for taking this job was to get Medicare reform and prescription drugs this year, and I am going to spend a lot of time on it, but I also think smaller changes like RBRBS, small changes like some of the things we did in 1993 and 1997, do help. It is a big ship to turn. We are committed to doing whatever we can to make small changes.

Mr. PASCRELL. I want to commend the Chair for offering legislation to begin that process. I think that is a very serious kind of thing because part of the fallout is fraud. Part of the fallout is a system where nobody really understands who is participating.

We do have to start someplace. It would seem to me that if we had a full year of concentration that we could put a delivery system together. I do not believe you are really a cynic at heart. I think you have had enough experience perhaps, maybe too much. The same thing for the folks on this side of the table. We can do something about this if we put our minds to it.

Thank you, Mr. Chairman.

Mr. TOOMEY. Thank you. We have probably six or seven minutes left in this vote, so we will adjourn for the vote. There are three votes. We will reconvene immediately following the last vote.

[Recess.]

Chairman MANZULLO [presiding]. We are going to proceed. If we are suspended, it happens again.

I would recognize Congresswoman Millender-McDonald.

Ms. MILLENDER-MCDONALD. Thank you, Mr. Chairman.

I apologize for not being here through most of your opening statements, but I certainly got the feel of the rhythm of this hearing with the questions that were raised by my colleagues.

The one thing that I guess I want to touch on is the education outreach. Mr. Scully, in your presentation you spoke of wanting to hear from local seniors and large and small providers, state workers and the people who really deal with Medicare and Medicaid in the real world.

My question to you is what are you doing for an education outreach to those because those are the ones that we get a myriad of complaints and concerns with and from with reference to the horrendous paperwork and regulatory processes that go along with Medicare and Medicaid.

What is your education outreach, for a beginning question to you, on trying to hear from these folks, you know, albeit through AARP, older seniors or whatever? What are some of your outreach efforts?

Mr. SCULLY. Well, I mentioned in my statement there are three basic things we are going to do, and we are certainly happy to do more.

One is that I am going to, to the extent I can still stay married and have a family, I am going to be traveling around the country this year to do personal hearings probably with Members of Congress.

Ms. MILLENDER-MCDONALD. Starting with me, of course.

Mr. SCULLY. Well, I hate to say that I already have eight scheduled I think through the end of September as of this morning in my staff meeting, almost one a week, with alternating Members of each party in the House and Senate. I am getting somewhat booked up, but we are planning to do a lot of those around the country. The Secretary directed me to do those.

We also created last Thursday seven industry outreach groups so that inside the—the hearings are basically intended to get input from people around the country outside the beltway. We also created seven working groups which represent basically every sector of healthcare.

I am chairing the one on long-term care and nursing homes with the executive director of the National Governors Association, but in that case we will have the unions, all the nursing home groups and basically anybody that wants to come in. We are going to meet with them once a month to try to methodically go through all the issues that can be resolved and try to fix them all. One of them is hopefully survey and certification of nursing homes is the first one.

In the hospital sector, the first thing the Secretary committed to doing the other day when we created these is to fix cost reports, which if you know about hospitals we are determined to I do not know if we can eliminate cost reports, but we are certainly determined to size them down to the absolute bare bones needed for us to get information about managing hospital reimbursement.

We announced the other day that we are recalling and reconsidering the whole ENM payment guidelines for physicians, and we are trying to go through and focus in every area of the health professions where we have serious problems and fix them.

The third effort that we are making is really an outreach effort. The Secretary announced that he is putting together sector work groups within my own agency to come up with new ideas to fix the place and to make it work better. To make sure that we do not end up being captives of our own agency, I appointed a fellow who actually runs an emergency room at a Winchester, Virginia, hospital. He is going to work with us four days a month to come in and chair this to actually make sure that the ideas my current staff come up with actually work in the real world because he has to actually go back and run an emergency room every day.

Those are the first steps, the hearings around the country, an effort within the beltway and an effort within the agency to try to shake things up and change things.

Ms. MILLENDER-MCDONALD. Well, I do appreciate those outlines that you have articulated to us, but I would certainly like to en-

courage you to put any education outreach information inside of journals that are endemic to these respective groups because that is important and is key to providing the type of education and information. Communication is the key. Information to those groups.

The home healthcare folks came to see me last week, and part of their problem were these over burdensome regulations with reference to Medicare and Medicaid. They are not really understanding a lot of its processes, so there lies one group that is critical for you to engage in.

Your sector work groups that you have outlined. Who do they comprise? What is the composition of those groups and the persons who work within the groups?

Mr. SCULLY. Well, they are chaired by senior people at CMS——

Ms. MILLENDER-MCDONALD. Right.

Mr. SCULLY [continuing]. Which is me in the nursing home case, my deputy, Reuben Kinshaw, in the physician case and down the line.

We are going to stagger those so that hopefully I can go to a lot of them, but basically anybody that wants to participate. For instance, in the nursing home area I had an organizational meeting last week, and it was the senior representative from the SCIU, which is the biggest union of nursing homes, the head of the American Health Care Association, the biggest nursing home trade association, the executive director of the National Governors Association, one of the senior people at AARP and me.

Ms. MILLENDER-MCDONALD. So it is a plethora of folks?

Mr. SCULLY. We are trying to get everybody involved——

Ms. MILLENDER-MCDONALD. Absolutely.

Mr. SCULLY [continuing]. On all sides of politics, you know, in every issue. I mean, we are not trying to—I have found, and I ran a hospital association until seven weeks ago. I found that, you know, 90 percent of the day-to-day operational problems are not political.

There are a lot of common problems we can fix. I think getting people to identify those is a good first step. There are plenty of political things to fight over, but there are a lot of operational things we can fix right away.

Ms. MILLENDER-MCDONALD. I think so, and I think it is critical that we do that. Leave the politics to us, but try to fix the operational aspects of it.

You said you want to hear from rural offices and inner cities. I do represent Watts and Willowbrook, Compton, some of the most impoverished areas, as well as some of the suburban areas. I am from the most impoverished to the affluent.

Given that stretch, we still have problems irrespective. I think as you begin to schedule your time across this nation I certainly would like for you to think of Watts. I would be more than happy to receive you there to talk with persons from that region to come in.

Mr. SCULLY. I am certain we will have a hearing at some point in Los Angeles.

Ms. MILLENDER-MCDONALD. Okay. Fine.

Mr. SCULLY. I think I had 180 hospitals in California in my former trade association, so I spent a lot of time there over the years.

Ms. MILLENDER-MCDONALD. I understand. The cooperatives that you talked about. You said that it is not a new culture. It is not a new concept, but it is a complement to that that you have already been engaged in. Can you explain that more to me?

Mr. SCULLY. I am not sure. Do you mean on the prescription drug card or on the——

Ms. MILLENDER-MCDONALD. I think the Ranking Member spoke about you are changing a whole new system, and you said no, you are just integrating the existing system with some cooperatives.

Mr. SCULLY. I think I was talking about the Medicare prescription drug card.

Ms. MILLENDER-MCDONALD. Yes. That is right. It was that.

Mr. SCULLY. This is something that is not a new concept. Actually the way that developed, and I have said this publicly before, is when I came in before I was confirmed by the Senate I asked the staff at CMS why do you not give me the 20 crazy ideas that have been sitting around here for years that nobody wanted to do. They did it. Probably 19 of them were not things that I thought were viable.

The one that I thought was a great idea that somebody should have done years ago was the prescription drug discount card. Senator Hagel had a bill similar to this last year in the Senate. There have been other people that have done it. I brought it to Secretary Thompson, who also liked it. We brought it to the White House, and the President liked it and so the President announced it.

For whatever reason, it seemed to get more press than our Medicare forums, which in some ways is unfortunate, but it seemed to me to be an intuitively smart thing to do even if you look at Senator Graham's bill, the leading Democratic bill for Medicare prescription drugs.

Thirty-five to 70 percent of those savings to seniors over the next ten years come from organizing seniors into prescription purchasing cooperatives. The only people in the country right now that walk into a pharmacy and pay over-the-counter costs for drugs are the uninsured and seniors. I thought that was crazy.

We do not have the ability to subsidize seniors' drug purchases, though we will hopefully negotiate that with Congress this fall. We do have the ability to do what most people, including all Members of Congress and me do, which is belong to a pharmaceutical benefits manager who is going to negotiate prices for you and save you a little money.

This is not the fix for all seniors, but we believe it is going to save them between 15 and 25 percent on average on their prescriptions, and that will help.

Ms. MILLENDER-MCDONALD. But not all seniors have bought into this concept, so we are still guarded to some extent.

Mr. SCULLY. We have not even started yet. It will not even be in place until January 1.

Ms. MILLENDER-MCDONALD. I understand, but in even talking about it I think there is a lot of concerns about this.

Mr. SCULLY. I really think it is not intended to be political. I happen to live in Jim Moran's district. He is my Congressman from Alexandria. I have lived there for 20 some years. I went over and explained to a group of his seniors at his town hall meeting last week how this worked. He is an old friend. He came in a little late and started beating up the cook.

Ms. MILLENDER-MCDONALD. Again, it is an education.

Mr. SCULLY. I said that is my idea. Once I explained it to him and his seniors and how it was going to work, I think generally—it is not intended to be political. I think it is going to help people. I do not think it is going to be the be all and end all for all seniors. I think it is going to be of marginal help. It is going to save them money.

It is not a substitute for prescription drug reform. We are committed to doing that. It is going to save seniors money, and it is going to work. I think that if you actually look at the details of how we structured it it is a good idea, and it is kind of unfortunate it has become political because I had hoped it would not.

Ms. MILLENDER-MCDONALD. The operative word is it is not a substitute.

Mr. SCULLY. It is not a substitute.

Ms. MILLENDER-MCDONALD. That is the operative word. Again, you have educated portions of the masses who are still guarded on this whole concept. Then I think education is the key to all of this.

Mr. Chairman, I have just one more. I just have one more question, if I may.

Chairman MANZULLO. You have gone ten minutes. If you would not mind?

Ms. MILLENDER-MCDONALD. Okay. Fine. I thank you.

Chairman MANZULLO. Thank you.

Ms. MILLENDER-MCDONALD. I have a statement for the record, Mr. Chairman.

Chairman MANZULLO. All the statements will be put into the record without objection.

Ms. MILLENDER-MCDONALD. Thank you.

Chairman MANZULLO. Mr. Shuster.

Mr. SHUSTER. Thank you, Mr. Chairman. I would like to thank the panel for being here today. I appreciate your testimony.

My question is to Mr. Scully. There is a crisis in rural healthcare, and that is due in large part to the reimbursement of Medicare. It has been decreased, and I know that is a legislative correction we need to make, as well as costs going up, those types of things. I applaud your efforts to streamline the paperwork and to make a change to make it more user friendly, your organization.

The question I have is another problem that is being caused, my administrators are telling me, is, of course, the paperwork. The nurses are saying for every hour of care they have about a half an hour of paperwork. What I need to get from you is what is the goal of I want to say HCFA? I have not got myself changed over yet.

What is the goal to reducing that amount of paperwork and streamlining it, and what are the measurements we are going to use? This measurement here, that hour and half hour that I have put out to you. I do not know if you think that is accurate, but it seems to me a measurement like that is something that we can put

out there that we can all see. Nurses can see. People on the ground can use that as a measurement of how much you are going to decrease the paperwork from that half hour down to 25 minutes, down to 15 minutes, something like that.

Mr. SCULLY. It is a complex program. I think the measurement is balance. I think the issue is we have a gigantic program, $240 billion. The last time I was in the government eight or nine years ago we had 15 percent a year Medicare inflation. There were a lot of factors behind that, but I do not have any desire, as I consistently tell my staff, to be back in the system of providing double digit Medicare/Medicaid inflation.

A piece, and I do not think it is the biggest piece, but I think a piece of getting that inflation, is Medicare inflation went from 15 percent in I think 1992 down to negative one percent in 1999. A piece of that was more aggressive anti-fraud efforts to make sure that people were not abusing the program. I do not think that is the biggest piece. The biggest piece was the 1997 BBA, which probably took a little bit more out of the system than people expected.

My goal is to find the right balance between having not enough regulation and having enough regulation where the program treats taxpayer dollars responsibly, but not so much regulation that we torture people in the outside world. We have seen instances where there was clearly rampant fraud going on in the home health area. There were a lot of people sending in home health bills that were wrong. If you do not have appropriate billing rules and appropriate structures, you have a disaster on your hands.

On the other hand, between 1997 and 2000 home health spending went from $18 billion to $9 billion, so we racheted down on them so fast that that was one of the reasons that home health has become a huge political issue. We wiped out a lot of home health providers, probably some good ones along with the bad ones.

My goal is to have a more gentle policy, a more rational progression in home health spending from $3 billion to $9 billion without the $18 billion in between. My goal is to find a rational policy balance where we spend taxpayer dollars wisely and have enough regulation and enough structure to make sure people do not cheat and do not over bill the program, but to the point where nurses do not want to get out of the profession and doctors do not want to get out of the profession because they feel tortured by Medicare and Medicaid regulations.

That is a tough balance to have in a gigantic public program, but I think that is the goal.

Mr. SHUSTER. No number figure on that? Ten percent? Fifteen percent?

Mr. SCULLY. It is hard.

Mr. SHUSTER. Can you quantify?

Mr. SCULLY. We are trying in home health. Believe me, I was on the provider side for years, so I am highly sensitive to the regulations.

You know, cost reports in hospitals are largely a creature of the past that needed reform. The OASIS guidelines for home health we are trying to streamline. The regulatory burdens for nursing home filings, which I think we are going to have an announcement on soon so that nursing homes will file less information.

The goal is to collect enough information to make sure that we can make sure that people are being paid correctly and to make sure that we can track patient quality, which is a big focus of mine as measuring and putting out information about patient quality, without just correcting enough so that in a lot of cases you will find, you know, like in hospital cost reports why did we require 25 percent of the information? Because somebody would like the data.

That is not to me a good reason to collect it because it is a convenient source of data for an academic. I mean, there are a lot of ways to do it. It is an incredibly torturous process to go through every area sector by sector and come up with this balance.

Mr. SHUSTER. I am a small businessman myself. Going about trying to make the organization more user friendly, it is a cultural change. Do you have the ability, and this may sound cold-hearted, but you can educate some people, and some people just do not want to change.

Do you have the ability to remove those people so that the people who are not going to be user friendly, and I see government agencies that do not have the will or do not have the ability to remove people who just are not doing the job. Again, somebody would be in there for 20 years. Some of them just do not want to change.

Mr. SCULLY. There are limits, and that probably calls for another set of hearings, but there are limits of what you can do in the federal government. You know, in general I think, and Secretary Thompson found this, the people at CMS are actually very good. I have known that for years.

I guess my major goal is I was a hospital lobbyist for a number of years when I was out of the government, and I spent a lot of time going to Baltimore. I knew all the hospital people, and I thought they were great. If you had asked me during that period was CMS/HCFA responsive, they were, but it was because I knew how to go up there and talk to the people. That was my job.

The average administrator in Harrisburg or Pittsburgh or Philadelphia thinks the place is a big black box. I think part of that is because the agency got pummeled over the years by Congress and people in the outside. The people tend to be I think very hard working, very well intentioned, but very insular. They did not talk to the outside world.

Part of what I have been trying to do is convince people in the agency, and I think they are starting to do it. They should talk to the outside world more. They should explain what they are doing. My view is, and part of this comes from being a mean-spirited OMB guy for all those years. Just joking. I firmly believe that if you have the substantively correct answer it may not be popular, but if you give it to people straight they are generally happier than if they get yanked around.

My goal is, you know, you cannot run a $240 billion Medicare program and a Medicaid program and tell everybody what they want to hear all the time because we would have 50 percent inflation. You have to say no a lot. My preference is to push people to give people a straight answer and give them a straight no if that is the case because I think the perception is in the past that the answer at CMS and HCFA has generally been to yank people

around as long as possible and not give them an answer because they might get mad at you.

Chairman MANZULLO. Thank you.

Mr. Baird.

Mr. BAIRD. Thank you, Mr. Chairman.

Mr. Scully, I applaud your efforts. This is like cleaning the proverbial stables I am afraid. One of the biggest problems we have in Washington state where I represent is the inequity in compensation formulas, both in fee-for-service compensation, but particularly Medicare Plus Choice.

What thoughts have you got about ways we might remedy that? It is a terrible problem for our hospitals actually in terms of how it affects cost shifting, et cetera, and impacts small business as well.

Mr. SCULLY. Well, Congressman, you may not know that I worked for a Senator from Washington state for five years, so I am pretty familiar with Washington state. It has been a long time. I left in 1985. That shows how old I am.

I think it is a problem, and I think you are going to find a shifting of that with a shifting in Congress. I do not mean to cause any political controversies, but in the hospital business if you sat down purely on a public policy basis and looked at the formulas for how hospital money is spent, it is not totally based on policy. A lot of it is based on historical positioning and who was chairman of what committee and what states were they from. I think you would find there are certain parts of the country—Washington state was not one of them—that probably did not benefit from that.

I do think it is an incredibly complicated program. There are new chairmen, for instance, in the Senate that are from Montana and Iowa, as opposed to where they used to be for years from other parts of the country. I think you will see some of that policy be more rationally redistributed.

Hopefully it will not be so irrationally redistributed that all the urban areas will get hit and the rural areas will be overcompensated, but clearly there are a lot of different issues out there from the hospital wage index, which is probably what you are referring to, back to many, many, many other formulas in Medicare that I think need to be reassessed on the merits. I think the IG has made suggestions about that over the years. I think GAO has made suggestions about that over the years.

One of the surprising things to me in Medicare over the years is that even though most Congressional districts probably get at least as much financing for their people out of Medicare/Medicaid as they do out of the Appropriations Committee is because the programs are so complicated rarely does Congress actually focus on how they are delivered, but I hope to help restore some equity over the years.

Mr. BAIRD. I applaud that. We were part of the Fairness Caucus last Congress and worked hard to raise the floor, et cetera. Anything we can do to help on that we would surely pitch in on.

Let me ask kind of a theoretical question. I was looking at page 6 of some of the commentary for today. One of my questions was, and I am not sure whose testimony it was. It may be just back-

ground. The tremendous amount of fraud that we have from these contractors.

You know, the Administration and the Majority party spends an awful lot of time bashing big government bureaucrats and talking about contracting out, yet here we have private enterprise screwing the people. I do not think that is very good. I just wonder what your thoughts are on that and how we can correct that. Does it teach us anything about whether contracting out is necessarily the panacea it is often proposed to be?

Finally, when contractors do not make enough money, be they these contractors here or HMOs, we say well, we have to throw more federal money at it and incentivize them. When public employees are deemed to be not doing their job, we attack them as faceless bureaucrats who do not want to serve the public. Could you comment on that?

Mr. SCULLY. That is a tough one to comment on. I think realistically Medicare has a lot of problems. I mean, philosophically and fundamentally I think Medicare is a wonderful program and seniors love it. I do not think that any person, Republican and Democrat, would have sat down today and said let us spend $240 billion a year on 40 million seniors and design the program the way it works.

I do not like price fixing any place. The federal government sets prices in Medicare/Medicaid for every physician and for every hospital across the board. That is the only place in the economy we do it. For 13 or 14 percent of the economy, I think if you sat down and redid it again that is probably not the best way to start.

On the other hand, I think the contracting system, even though I think it needs to be drastically reformed, has served pretty well considering the fact that it is a giant program, $240 billion, and we spend $2.5 billion a year administering it, including the contractors and including my budget. It is kind of miraculous that it holds together. I think it barely holds together some days, but it holds together.

Generally the biggest response I get from Congressmen who visit Baltimore, and even Secretary Thompson has said it, is where are the people paying the claims? There are not any people paying the claims. I do not think the government could possibly do it. I mean, it is basically the Blue Cross plans that do it. I think they are incentivized inappropriately, but I think generally the contracting out system has worked reasonably well. For 35 years it has paid a lot of Medicare claims.

Even though there are a lot of problems and a lot of angry docs and a lot of angry hospitals and a lot of angry people out there, generally they are angry at the appeals process, which tends to be the ALJs and sometimes the fiscal intermediaries and the carriers rather than the payers. I mean, if you talk to insurance companies every day like I do—I have been trying to keep a lot of the Medicare Plus Choice plans from bailing out—and you talk to hospitals, generally Medicare is one of their quickest and best payers.

The program clearly has problems, and fundamentally I am not a big fan of the government price fixing anything. Given the system we have, I think it works okay. There is certainly a lot of things

we can fix, but I think the contracting out system actually works all right.

Mr. BAIRD. I appreciate that. I guess my fundamental question was why is it that when there is a private enterprise that is found to be not necessarily treating the public fairly and the solution to that seems to be throw more money at them, but when government workers are criticized the solution to that is lay off government workers? It just seems paradoxal.

Mr. SCULLY. Well, I hope I have been supportive of my workers at CMS. Everybody hates them, but I think generally most of them are pretty dedicated.

Chairman MANZULLO. I have not been supportive of the people at Wisconsin Physician Services because of the very unprofessional way that they have handled working with my Medicare Part B providers in Illinois and Wisconsin.

I would hope that by mentioning Wisconsin Provider Services or Wisconsin Physician Services that they would get their act in order because they may be the next witnesses at a hearing. That hearing is not going to be as gentle as this one.

They need a warning that when they send a letter to a doctor with a carbon copy going to the patient accusing the doctor of fraud and that doctor sends back a letter saying I would like an explanation and those clowns say well, you my or may not get an explanation, that has to stop.

Mr. Scully, I would like to have you personally contact those people at Wisconsin Physician Services and tell them to treat my constituents humanely.

Mr. SCULLY. I talked to them yesterday, and I will talk to them a little more.

Chairman MANZULLO. Thank you.

Mr. SCULLY. Believe it or not, Secretary Thompson years ago worked at that company, so I talked to him about it last night as well.

Chairman MANZULLO. Mr. Toomey.

Mr. TOOMEY. Thank you, Mr. Chairman.

Let me start by saying, Mr. Scully, I am delighted you are in the position that you are in. You have the exact kind of background and perspective that we need at that agency that was formerly known as HCFA.

As a very quick point, I would just like to also thank you for working with us on the bill that I have co-authored with Shelley Berkley. We call it MERFA, H.R. 868, which, as you know, attempted to make some modest but I think very important reforms to the way HCFA does business.

I think you have indicated that there are some things about our bill that you can probably support, some things that I know you would like to do differently. I would like to touch on a couple of those briefly, and if we could do it briefly because I have some questions I would like to ask Mr. Grob also.

One, you mentioned improving education, and you emphasize a program of improving education for seniors. I support that effort, but I think it is also important, and I think you agree, that part of this effort has to be improving physician and provider education. Our bill does make an effort to do that, to require that there be

a greater effort to educate providers in the arcane rules and regulations of HCFA.

I think what is more important, frankly, is providing some due process rights to healthcare providers and balancing what is now an extremely unleveled playing field in which HCFA is enormously powerful, enormously intimidating, and providers are often deemed guilty before they are proven guilty and not given really the fair hearing that they ought to have.

Specifically, I was hoping you would reflect on a couple of the provisions in this bill, in my bill, that try to address this perceived imbalance perceived on my part and certainly on the part of most healthcare providers. One is that my bill would allow repayment plans for overpayments, not require that physicians who make an honest mistake and acknowledge that, that they not be required to pay all the money at once, but rather could pay in a series of installments.

A second provision would prevent HCFA from unilaterally recouping alleged overpayments while the appeals process is still underway. That is something I want to discuss further with Mr. Grob also, but the fact is that appeals very, very often go in favor of the provider. It seems to me fundamentally unfair for HCFA to keep the money when in fact most of the time HCFA is wrong when a claim is in the appeals process.

Lastly, if you could comment on providing some kind of safe harbor for physicians who honestly discover that they have made a mistake, and they want to pay the full amount of their mistake? They would I think in that case deserve immunity from, you know, punishment.

If you could comment on those three things? There are other features in the bill, but I think those are three of the most important features.

Mr. SCULLY. Well, one thing I learned over the years is I cannot take administrative positions with OMB, so subject to me not taking administrative positions I think as we discussed I guess a month ago or so we are sympathetic to some of the ideas in MERFA and certainly the concept, what you are trying to do with MERFA.

The more specific details of what we do with repayment plans. I have talked to Chairman Thomas, and Senator Grassley and Senator Baucus and others are working on taking your bill and looking at it and overall reform bills about some other approaches that I think, for instance, there are various issues about repayment plans. Repayment plans can be troublesome I think if we stretch them out too much. We have a history that we have allowed some providers with bad histories to escape repaying the government.

On the other hand, I think we should treat people the same way the IRS does. The IRS does it the other way around. Basically if you lose you repay the government with interest. I think that is something that we are going to look at. Right now what happens is, as you say, you pay up front. If you end up being right later we pay you back. That is it. You lose the time value of the money.

I think that we have looked at, and this is not the Administration's position, but I have discussed with the other Committees who are looking at kind of taking a lot of your provisions, as you know,

and trying to fold them into their bills, some middle ground ideas that hopefully will be more workable. That is one of them.

I think the IRS basically allows you to withhold payment to tax penalties, and if you lose you pay it with interest. I think that is something we should look at. We require providers to pay things up front immediately. Again, it is not the Administration's position, but it is discussions I know that are going on.

As far as safe harbors, as I said, I was a provider until recently. I totally see the sense in creating some safe harbors, and there are safe harbors in the law now. We want to make sure that we create the appropriate safe harbors without creating safe harbors that are going to allow people who really are not the two percent of bad providers to find ways to avoid any kind of FI carrier, IG or CMS enforcement activities. That is a concern. We are totally sensitive.

What you are trying to do in MERFA is absolutely right. I think some of the provisions are overreaching, and we would look forward to trying to work with you this summer and this fall to get the pieces of MERFA that we can work with the IG on and with you and make sure that we make the system significantly more friendly to the providers.

Mr. TOOMEY. Thank you.

Mr. Chairman, do I have time for one other question?

Chairman MANZULLO. Let me go first to Mr. Thune. I want to make sure everyone gets in. Then perhaps we may have some more time.

Mr. Thune.

Mr. THUNE. Thank you, Mr. Chairman. Thank you for holding this hearing. I think it is important. This does have an impact on a lot of people across the country.

I think if there is one thing I hear that is just uniform from providers across South Dakota it is we need to enact MERFA, so I congratulate Mr. Toomey and Ms. Berkley for introducing this. I think it is high time that we look at what we can do to improve the function, the way that this work is done, the process that is used, because it is clear at least right now that there are just serious problems out there.

I am glad you changed your name the agency formerly known as HCFA. I think it will buy a little time. When people figure out the new acronym it might buy us a little bit of time, but then it will be that blankety-blank whatever the next iteration is in terms of an acronym because there is just a tremendous amount of, at least in my state, maybe disgust is the right word in the way things operate.

The question I would have for you is how do you go about getting at the bad actors without penalizing the good guys? I mean, we have in South Dakota, partly because as a result of our ethic in our state, we just do not have people who are trying to circumvent, with rare exceptions. This is not something that is a common practice. We do not have people who are trying to beat the system. We have people who want to play by the rules.

I am just curious to know in sort of a general philosophical way what your thoughts are about being able to get at those people that are chronic rule breakers and not at the same time penalize and

inordinately put burdens upon people who are trying to do things by the book.

Mr. SCULLY. Well, I guess you want me to answer that one. That is probably one of my I could not agree with you more on that——

Mr. THUNE. If you must.

Mr. SCULLY [continuing]. Having been on the other side of it seven weeks ago and seeing some people I consider to be extremely honest, decent providers be repeatedly pounded and some of them run out of business for what I thought was not particularly legitimate reasons.

I think one of my frustrations, and I do not have any announcement to make today, but I have talked to the Secretary a lot about it. The new Inspector General I hope will be confirmed soon. Janet Rehnquist was here—I do not know if she is still here—who I have known for quite a long time, since college actually, and the Justice Department. Those are really the three prongs of making this thing work better. We hope to work much more efficiently to find some ways to fix these things.

My own frustration is that I think we need to come up with a mechanism, and we are talking about a variety of them, where we can basically find people who are doing the right things. I can give you two examples. I spent $25 million when I was on the board of Oxford Health Plans as the chairman of the board of the compliance committee, another $30 million at Davida Healthcare Dialysis Company when I was chairman of the board of the compliance committee putting together very expensive compliance plans. Those companies I think are about as compliant as you can possibly get right now. Their shareholders made a big investment in it, but they get nothing for it. I mean, they find out they have a problem.

In my view, when you find people who are trying to do the right thing, whether it is a small hospital in South Dakota or a big HMO or a physician practice group, there ought to be a way for them to put together the appropriate compliance guidelines to make the IG and to make the Justice Department and to make CMS show that they are serious about it or they have some self-policing where they get somewhat different treatment. That is a big structural challenge to come up with something like that. I personally feel strongly about it. As I said, I cannot do that alone.

The IG. I went in, and again I had a good relation with the IG. I went in with Mack Thornton, who is the chief counsel at the IG's office. I brought the CEO of Oxford in. I brought the CEO of Davida in. I said we are trying to do all the right things. They said congratulations. You are doing the right things. That is great.

They do not have the staff to go through and certify compliance plans or to go through and regulate everybody across the country, so we need to come up with some hybrid way of telling people that are trying to do the right thing that you are going to get some credit for doing the right thing so that we can focus our enforcement actions on the bad actors that are out there.

Mr. THUNE. I appreciate your comments and also in looking through your testimony the sort of user friendly, responsive tact that you are taking in terms of the relationship with the provider community.

I guess one follow up question would be, you know, as you look at the way that we do things today the enormous amount of paperwork, the enormous amount of red tape which is always alluded to irrespective of who you talk to, which provider group. It is the same message over and over again, and that is that we cannot provide quality care for our patients because we spend all of our time filling out forms and paperwork.

Is there a way that we can construct a different model in the computer age—you talk about figuring out ways to comply where it just literally is not consuming in terms of the time requirement and commitment that is imposed upon providers who are just trying to do a good job, so it is sort of I guess again maybe of a more general, philosophical question.

Mr. SCULLY. I think the biggest gain to me in fraud abuse activities, aside from the increased enforcement activities addressed in the IG, is capitation. I mean, the thing that moves us forward the most is moving towards capitated systems because in the past when you have a government run fee-for-service system, let me just tell you in the hospital business that when you come in a lot of the "fraud", and you can either call it fraud or people adjusting to dumb rules. When you are in the hospital business and the government comes in and capitates your hospitals in 1993 with DRGs, what do you do? You start building a nursing home on a cost basis next door or a rehab hospital.

It is kind of wack-them-all system, or it has been over the years, with finance. A lot of the stuff that was "fraud" was based on crazy, poorly structured reimbursement systems. Part of this was the government chasing people around for doing what was marginally, you know, probably unethical stuff, but was arguably legal.

Personally, the biggest advance in Medicare is going to a capitated payment strategy where you do not have to oversee as much, and there is not as much opportunity for abuse. For instance, we are putting out a reg shortly on capitating rehab hospitals, which I think will help in that area. We have one in the works for long-term acute care hospitals.

We went to skilled nursing facility prospective payment last year, which I think will do a lot to reduce fraud. It just provides people with the right incentives, and I think the more you can get towards capitated systems where you get the government out of the micro managing of business and you give people prospective payment systems, you are moving in a big way towards incentivizing rational behavior and getting the government out of micro managing and micro enforcing.

Mr. THUNE. I appreciate you comments.

Mr. SCULLY. Thank you.

Mr. THUNE. I obviously want to work with you. My time is expired, but we all want to try and solve some of these problems.

Thank you.

Chairman MANZULLO. Mrs. Kelly.

Mrs. KELLY. Thank you very much, Mr. Chairman. Thanks for holding this hearing.

Mr. Scully, I found your testimony very interesting reading. On page 5 you say you want input from folks like group practice managers, physician assistants and nurses and so on, and then you say

also CMS is going to conduct public listening sessions across the country.

I invite you into the 19th Congressional District. I represent a medical school plus an enormous amount of people who are practicing medicine north of New York City and have a lot to say on this subject because they have been saying it to me. I hope that you will come.

I really am very hopeful that you are going to try to do something to reduce this enormous paperwork load that every doctor has to bear. My father was a doctor. One of the reasons he quit being a doctor was the government was finally demanding just too much. He was having to charge too much.

I lived in a town where he dealt with farmers and people who were generally blue collar workers in factories. He could not charge a great deal. He had to constantly be cutting back on services he wanted to offer his patients because of the government demands. He had to put his time into filling out forms. I think that is wrong. I think doctors need to practice medicine and not worry about these forms.

I agree with my colleague, Mr. Thune, that in the environment we have today with the ability to electronically do things there certainly ought to be a way that we can construct some models that are rather permanent and do not need to constantly be refilled out. I would hope that would be something you would look at.

There are a couple of other things. I have had some serious concerns about the authority that the HCFA people have used with regard to declaring doctors to be fraudulent in their claims. It seems to me to be an attitude of aha, gotcha, instead of working with the doctors to find out what happened and to help them do whatever they have done to take a look at it and see whether in fact it is fraud or it is somehow a mistake on papers that have been filed because sometimes that is what happens. It is reclassifications. It is different kinds of things. I really hope that you will do something to try to restructure the attitude in that particular department of the new CMS.

One other thing that I am concerned about. There was a decision that would allow the nurse anesthesia givers to be able to give anesthesia without medical support, without somebody standing there, an M.D., overseeing what they are doing. These people have been doing it for years. I do not understand why the HCFA anesthesia care final rule was not implemented.

I wonder if you would be willing to get back to me on that because I think that the idea was to remove a lot of restrictions and reduce a lot of the regulatory burdens on the hospitals. The other thing is it allows nurses to perform that function in greatly under served areas where there is no anesthesiologist available. Nurse anesthesiologists are very good at what they do. I would like, if you do not mind, for you to get back to me on that.

Mr. SCULLY. I am extremely familiar with that issue. It is hard to miss. It is kind of like watching Joe Frazier and Muhammad Ali go after——

I was in the hospital business for the prior six years, and we have obviously a lot of anesthesiologists and nurse anesthetists. I think we wisely stayed out of that one, but that was obviously con-

troversial. It was a change to the regulations to allow nurse anesthetists to do that. It was in the proposed rule.

In the final rule, which that came out with I think an appropriate compromise, basically obviously, you know, we are federalists. We believe in states' rights. We basically pushed it back to the governors and said if a governor wants to certify that in his state nurse anesthesiologists can appropriately provide the care the governor can effectively apply for a waiver.

I believe that is the final rule. I am not sure. I am pretty sure that is what it is.

Mrs. KELLY. The governor can issue a waiver?

Mr. SCULLY. Can apply to us for a waiver. Yes.

Mrs. KELLY. And you would approve those waivers, I take it then, from what you have just said?

Mr. SCULLY. I think they are under the reg all virtually presumptively approved. Yes.

Mrs. KELLY. Okay.

Mr. SCULLY. Obviously this was a hotly debated issue over many years in the Medicare program. It was more interesting to be in the hospital business watching it than it is to be at CMS having to work it out.

Mrs. KELLY. Well, I would hope that this will all work out, and I am just greatly relieved that you are there at the head of the helm and going to make some changes. We need those changes desperately, the sooner the better.

Mr. SCULLY. And I apologize because I have looked into your other hospital issue. I will call you about that later today.

Mrs. KELLY. Thank you very much.

Mr. TOOMEY [presiding]. Thank you.

I appreciate the cooperation of the witnesses. We would like to have one more very brief round of questions, which will consist of a question from Ms. Velázquez, myself and Ms. Christian-Christensen, and then we will be finished for this hearing, which has gone on some time.

Ms. Velázquez.

Ms. VELÁZQUEZ. Thank you.

Mr. Scully, we may disagree on whether or not the prescription drug card initiative is a program, but are you willing to go back and perform an impact assessment on the effect this program is going to have on small businesses; for example, community pharmacists?

Mr. SCULLY. You know, to be honest with you, Congresswoman, under the rules it is not a federal government program.

Certainly we are very sensitive to the concerns the community pharmacists have. I have obviously been hearing from them virtually every day. The small pharmacists are very concerned. The chain drugstores—my former boss in my former campaign life, Craig Fuller, runs that. We are very sensitive to the concerns that the chain drugstores and the small pharmacies have because they are concerned the discounts are going to come out of them.

We hope and believe that we structured this so that the discounts—the entire intent of this program was to structure it to give enough market clout to these purchasing negotiators that the dis-

counts would come out of the manufacturers and not out of the chain drugstores.

It is certainly within the ability of CMS to do it because it is not a government program. We are certainly happy to go back and look at it. We are highly sensitized to it. I am certainly happy to go back and do a study on the impact of it.

Ms. VELÁZQUEZ. I take very seriously the fact that you say we want to hear from a broad range of providers, including——

Mr. SCULLY. We do.

Ms. VELÁZQUEZ [continuing]. Community pharmacists. If there are concerns that this is going to have an impact on them, I think it would be sensitive for you to go and to listen to their concerns.

Mr. SCULLY. I am happy to meet with them. I have tried to talk to as many as I can. I am happy to talk to them any time.

I will say that in a system where the only people in the world paying over-the-counter pharmaceutical prices are seniors, the Administration's number one concern is saving seniors money. Number two would be helping to make sure we do not hurt community pharmacists. Number three, probably way, way, way down the line, would be worrying about manufacturers appropriately making sure everybody pays a reasonable price.

Clearly the goal here is to save seniors money. A number of people said this will not work. To be honest with you, it will not work. It is going to work. If it does not work, there will probably be people mad at us, but we are clearly, clearly intending to do everything we can to make sure that the impact is not on the pharmacist.

Ms. VELÁZQUEZ. Thank you.

Mr. TOOMEY. Thank you.

Mr. Grob, I would like to ask a couple of questions and actually take issue with a statement that you made in your written testimony and ask a question in another area if I could.

In the area of immunity from investigation, you addressed that on page 8 of your testimony. This has to do, of course, with the safe harbor that we would provide a physician or another healthcare provider who discovers an honest mistake and wants to correct it.

Mr. GROB. Yes.

Mr. TOOMEY. Your statement here on page 8, and I will quote, says, "There is no need for such immunization. Physicians and other healthcare providers are not subject to civil or criminal penalties for honest mistakes, errors or even negligence."

It seems to me the fact is that absent this immunity providers face other tactics—audits, the use of extrapolation, a terrible appeals process—all of which can drive providers right out of Medicare, sometimes even out of their practice. These kinds of very onerous outcomes strike me as every bit as severe as civilian penalties.

I would cite a case—there are so many, but just one in particular—of AIDS patients in San Francisco whose clinic was closed because the HCFA carrier refused to allow the alleged overpayments to be repaid in installments, or the Pittsburgh physician whose carrier decided after the fact that the care he provided to critically ill patients was not medically necessary and demanded that he pay $339,000 within 30 days.

Now, neither of these medical practitioners were accused of fraud. They were not convicted of any crimes, yet their practices and their lives were torn apart. These are not rumors. These are facts that happened to real people, and I believe it is because HCFA's practices lack sufficient due process and fairness.

I think the immunization we are talking about, first of all, would only occur on the first audit. There is nothing to stop HCFA from doing a subsequent audit. We did not amend the False Claims Act. Any kind of fraud that is suspected or has been committed would still be prosecuted.

Frankly, your suggestion that some doctors will use this provision to actually decide to commit fraud, risk losing their practice, risk going to jail by deciding to systematically over bill Medicare, knowing they are doing this, and then repay their over billing within a year, and also that they can collect interest from HCFA in the meantime, strikes me as extremely implausible.

At the end of the day, I do not think this is a vehicle that is going to facilitate or allow or encourage physicians or other providers to commit fraud. I think it is a measure of fairness for honest providers that discover a mistake.

My question for you actually is related to this, but it goes more directly to the appeals process. In light of the fact that such a huge percentage of appeals go in favor of the provider and in light of the fact that it takes such a long process, do you not think it is reasonable and do you not think it is only fair that healthcare providers be able to keep the alleged overpayment until the appeals process is finished?

Mr. GROB. Okay. I would recommend against going all the way to the end of the appeals process as a general matter of practice, but I do think there are some good options that can be considered.

For example, we find that the longer the time period that you take in trying to get the money back, if you will, where an overpayment is due, the more your ability to get the money back drops off. I think some tradeoff needs to be taken with regard to the time frame.

I think one of the things that could be considered, for example, would be how far down that process do you want to go? Perhaps, for example, having the money not paid back, say, until after the first reconsideration—which results in agreement with about 70 percent, for example, of the appeals that occur at that time might be a move in the right direction.

I also think that a remark that Mr. Scully made earlier is also germane. I think the interest might even things out because right now the interest is kind of a one-way street. So I think if the interest were paid back the other way that would tend to mitigate that somewhat as well.

Mr. TOOMEY. Well, I think that would help, but I do not think it is enough. I would cite the fact that in the carrier fair hearing stage of the appeal process in fiscal year 2000 my figures show that 42 percent of cases appealed at that level were decided in the physicians' favor.

At the final step in the process, the ALJ level, which occurs over a year on average after that process begins——

Mr. GROB. That is correct.

Mr. TOOMEY [continuing]. Which is way too long——

Mr. GROB. Yes.

Mr. TOOMEY [continuing]. Sixty percent of those cases are decided in favor of the healthcare provider.

Mr. GROB. That is correct.

Mr. TOOMEY. I just do not understand how HCFA can justify holding onto the money when 60 percent of the time they are wrong.

Mr. GROB. Okay. Again, my remark would be that it has to do with the numbers that we are talking about. There are actually very few cases that go that far. Most of them are resolved at a much earlier stage.

I think a concern that we would have, for example, is if holding onto the money were an option all the way to the very end of the process that that might in fact incentivize some additional appeals.

Mr. TOOMEY. But maybe they are justified when the providers are winning 60 percent of them.

Mr. GROB. On the other hand, if a person could hold onto the money longer, there may be more frivolous appeals.

Mr. TOOMEY. I think the evidence suggests so far that given the outcomes they are obviously justifiable appeals.

I will yield the balance of my time and recognize Ms. Christian-Christensen.

Mrs. CHRISTENSEN. Thank you. If I could just follow up somewhat on your question? I would like to go to page 9 where I think in H.R. 868 there is a provision whereby a payment plan could be instituted. I think you are also opposed to that in the bill. Is that correct?

Mr. GROB. We have been working with the staff on this bill for quite a bit of time, and we have really appreciated the opportunity to go back and forth on that.

In the bill, the part we had a problem with was the automatic entitlement to a payment plan for a particular period of time no matter what the circumstance, but I think that very much the idea that a repayment plan could be developed for providers is certainly very viable, and we think some attention ought to be paid to that.

Mrs. CHRISTENSEN. To me, the agency is trying to go in the direction of cooperation and working together. I think we should go a little more to the side of really doing that and allowing for a payment plan and really to compare trying to get your money back from an HMO, which has a lot of resources, or from a telephone company is not the correct comparison when you are talking about a physician's office or a provider that does not have that kind of money readily available.

Mr. SCULLY. The problem, Congresswoman, just to defend and to help him out a little bit maybe because we have had even differences, and we are working together with Congress and the IG to try to work out some of our views on MERFA.

I think repayment plans in a lot of cases may be appropriate, but there are also cases, and not to pick on any one group, but there are a lot of home health providers that had a lot of not particularly legitimate claims four or five years ago that disappeared from the face of the earth pretty quickly.

Part of the problem we have is a lot of bankruptcies. In a lot of cases if you give people a repayment option where you know they are not going to be around to repay it, they will have 15 different shells, and they will go bankrupt.

There are a lot of really functional problems with giving everybody a guaranteed repayment option. There are certainly appropriate places that will happen, but there are an awful lot of cases, and I am sure the IG has 1,000 more examples than I will have where providers have provided numbers, over billed this, we went after them, and then all of a sudden they have disappeared never to be found again. We have hundreds and hundreds of millions of dollars of outstanding claims like that.

I am totally supportive of what you are saying, but I think we have to balance.

Mrs. CHRISTENSEN. And I appreciate the fact that you are working with the Congress on the bill and that we will be able to work out something, but it just seems unfair.

I was trying to figure out where I saw the statistic about most of the claims being accurate. Actually, Mr. Grob it was in your testimony——

Mr. GROB. Yes.

Mrs. CHRISTENSEN [continuing]. In one of the other——

Mr. GROB. That is right.

Mrs. CHRISTENSEN. In the Senate, I believe. It talked mainly about the payment, the request for payment, being free of error.

Mr. GROB. Yes.

Mrs. CHRISTENSEN. To go back to our previous conversation, I would really like to see what the record really is on investigations and audits and if we could get a more specific breakdown on those and how many actually end up going to criminal prosecution——

Mr. GROB. Right.

Mrs. CHRISTENSEN [continuing]. Or some kind of a sanction.

Mr. GROB. Yes.

Mrs. CHRISTENSEN. I wanted to talk a bit about I am glad that there is going to be an educational process for the beneficiaries because in my experience and in the experience of my providers a lot of the information that goes out to the beneficiaries is just unintelligible to most beneficiaries, and in the case where there may be a question of payment it almost makes the provider look like a criminal.

It really sets up a bad situation in the case of a physician that has a more personal relationship with their patient that the physician has done something wrong. It is really an interference with the patient/physician relationship.

Mr. SCULLY. Can I put in my two cents on that?

Mrs. CHRISTENSEN. Sure.

Mr. SCULLY. Having lived through the last 15 years in Washington doing health policy, part of that is, and the IG is responding to the pressure that is largely from the Hill, as was the former HCFA, now CMS, as was the Justice Department, for most of the late 1980s and early 1990s the perception on the Hill was that all Medicare problems and reform problems could be solved if you wiped out Medicare fraud, which I think was an overly simplified view, so you had this clamoring to crack down on Medicare fraud,

Medicare fraud, Medicare fraud, and everybody in the agency has responded to that.

Now you are getting a little bit of a push back with Congress to find a balance. I think that is appropriate, but all the provider notifications that go out to my mom and dad to tell them every time there is a problem, those are all statutorily required. I think there are an awful lot of things that Congress has pushed us to do that may have been overcompensating.

I think again, as I said earlier, there probably was not enough being done ten years ago. Arguably, there are a few things we might rein back in a teeny bit now, and I think that is part of what the MERFA process is all about.

Mrs. CHRISTENSEN. Thanks. I am very much interested in having a listening session. I see that my time is up. A listening session in my district.

Mr. SCULLY. Well, Congresswoman, if I have the choice of going to a lot of other district or the Virgin Islands——

Mrs. CHRISTENSEN. I think you need to come back and see the safer hospitals where your daughter was treated.

Mr. SCULLY. I have been there with my daughters. Yes, I have.

Mrs. CHRISTENSEN. Right.

Mr. SCULLY. They did a great job. Thanks.

Mrs. CHRISTENSEN. Thank you.

Mr. TOOMEY. I would like to thank the witnesses for their patience and their cooperation.

The hearing is adjourned.

[Whereupon, at 12:15 p.m. the Committee was adjourned.]

Congress of the United States

House of Representatives

107th Congress

Committee on Small Business

2361 Rayburn House Office Building
Washington, DC 20515–0515

Statement of Donald A. Manzullo
Chairman
Committee on Small Business
United States House of Representatives
Washington, DC
July 25, 2001

This is the Committee's third hearing to examine the regulatory problems at HCFA which is now known as the Centers for Medicare and Medicaid Services (CMS). However, a new name does not make a new organization. And while I appreciate that Secretary Thompson and Administrator Scully are trying to bring a new attitude to the agency, I will not recognize the new name until I am convinced that it truly has been transformed into a new organization that puts the interests of patients and healthcare providers before those of bureaucratic bean-counters.

In the previous hearings, the Committee received testimony about the burdens of paperwork and regulation straining the capacity of small healthcare providers. All the participants agreed that the regulatory burdens are distracting them from their primary business -- delivering healthcare services. Today's hearing asks the decisionmakers from the Department of Health and Human Services and the Office of Management and Budget (OMB) what administrative actions they can take to eliminate burdensome and unnecessary regulatory requirements.

The simple transaction of reimbursing a healthcare provider for rendering service to a covered beneficiary requires more than 130,000 pages of federal laws, regulations, and informal guidance. It also covers more than 200 separate reporting and recordkeeping requirements. When the regulatory issuances from HCFA, as approved by OMB, consume more pages than the information imparted during four years of medical school something has gone terribly wrong with the system. Placing blame, while cathartic, does not solve the problems faced by small healthcare providers. My objective is to work cooperatively with HCFA and OMB to reduce the regulatory burdens on healthcare providers that participate in Medicare.

It appears that the recordkeeping and reporting requirements provide little in the way of information and, in fact, may inhibit the practice of good medicine. Form 855 is a thirty page enrollment application; by contrast, the Department of Veterans Affairs only requires an eight page form in order to provide service to our veterans. What purpose is served by the additional 22 pages? Physicians are required to maintain voluminous medical records on their Medicare patients so that they can demonstrate that a specific procedure was performed. In emergency situations, finding critical medical history facts in these evaluation and management records may be like trying to find a needle in a haystack. Should not OMB consider the utility and potential consequences to the patient when it approves such onerous recordkeeping requirements?

The burden of regulation would be explicable if those covered by Medicare or the providers benefited from the regulations. That does not appear to be the case. Contractors audit providers at the direction of the government in order to protect the Medicare Trust Fund. Substantial resources are devoted to these audits by the contractors and the providers. And this figure does not measure the inconvenience to the beneficiaries of a provider distracted by an ongoing audit. Yet, as the Committee has heard, the result can be a repayment of a mere two

hundred dollars to the Medicare Trust Fund. I am sure that all parties involved spent well in excess of the two hundred dollars that was returned to the Trust Fund. Is America better off by the expenditure of the resources needed to return two hundred dollars to the Medicare Trust Fund? Audits often require providers, most of whom are small businesses, to make reimbursements back to the Medicare Trust Fund for overpayments. Most small businesses do not have the resources to wend their way through the Department's administrative maze and get the contractor audit overturned on appeal. Is the regulatory process fair when it depends not on the on the correctness of the position but on the ability of the provider to afford good lawyers or intervention from a member of Congress? Finally, contractors, in interpreting the guidance provided by HCFA, may require a durable medical equipment supplier to obtain more information before providing equipment specified in a physician-signed certificate of medical necessity. What purpose exists to have a non-physician second guess the determination of a licensed physician? These are only some of the examples of problems facing the healthcare community from the onslaught of regulatory overload.

Contractors can always blame HCFA for the requirement that the contractor take a particular action imposing undue burdens on healthcare providers. On the other hand, HCFA can blame the contractors because the decision was made locally, based on the discretion afforded the contractors by HCFA. Unlike President Truman, the buck apparently does not stop anywhere with respect to HCFA and its contractors.

The lack of accountability is only exacerbated by HCFA's ability to adopt irrational regulations because Congress has exempted the rules from review or the statutory exhaustion of administrative remedies process is so long and convoluted that few groups even bother trying because it represents an exercise in futility. Would HCFA produce better regulations if they

faced the same test that all other agencies face – the certainty of swift judicial review when regulations make no sense?

A regulatory morass exists at HCFA. Congress and the Executive Branch need to work together to reduce the regulatory burdens on small healthcare providers so that they will stay in the Medicare program. If the Executive Branch cannot solve the problem by administrative action alone, then I certainly am willing to back necessary legislation. In fact, I am a cosponsor of the Medicare Education and Regulatory Fairness Act of 2001 (MERFA). Is MERFA the solution? It represents a good start at providing accountability within the system. I would like to thank my colleagues, Mr. Toomey and Mrs. Berkley, for their leadership on this issue. I expect that this hearing will be the foundation of a fruitful partnership that will bring accountability to a system that for too long appears to have been accountable to no one. Now I will recognize the ranking member of the full committee, the distinguished Gentlelady from New York, for her opening statement.

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CONGRESSIONAL PROGRESSIVE CAUCUS

Congress of the United States
House of Representatives
Washington, DC 20515

NYDIA M. VELAZQUEZ
12TH DISTRICT, NEW YORK

2241 RAYBURN BUILDING
WASHINGTON, DC 20515
(202) 225-2361

DISTRICT OFFICES:

815 BROADWAY
BROOKLYN, NY 11206
(718) 599-3658

173 AVENUE B
NEW YORK, NY 10009
(212) 673-3997

16 COURT STREET
SUITE 1005
BROOKLYN, NY 11241
(718) 222-5819

HEARING ON THE CENTER FOR MEDICARE AND MEDICAID SERVICES:
PROPOSALS FROM THE EXECUTIVE BRANCH
2360 Rayburn HOB
July 25, 2001 10:00 a.m.

Statement by Rep. Nydia M. Velázquez
Ranking Member, House Small Business Committee

Thank you, Mr. Chairman.

Today's hearing is the third in a series on the Center for Medicare and Medicaid Services, the successor agency to the Health Care Financing Administration. If these hearings have shown us anything, it is that it will take more than a name change to reform how HCFA operates.

To that end, the purpose of these hearings is to work with the Administration to find solutions to the problems of a complicated and growing system.

Today's hearing will focus on the role of OMB, specifically the Office of Information and Regulatory Affairs, in enforcing the Paperwork Reduction Act. In addition, we will look at how effectively OMB has monitored and enforced federal agencies' compliance with the Regulatory Flexibility Act. As we know, reporting and regulatory burdens fall disproportionately on small business. One of this committee's goals is to level the regulatory playing field for our country's entrepreneurs.

In our last two hearings, we heard about problems facing the public health care financing system and small health service providers. In 1999, Congress tightened enforcement in order to cut down on waste, fraud and abuse. That goal is close to being met, but it has had unanticipated complications.

We learned about burdensome and often contradictory CMS paperwork endured by doctors simply to receive payment for their services. Often, complying with CMS paperwork takes more time than the time they spend with their patients. The reporting requirements are complicated, often contradictory, and prone to unintended errors. Then

doctors must worry about unannounced audits for the errors they did not mean to make.

Such a confusing and adversarial system is very discouraging and has real consequences. When doctors are treated as suspects instead of caring professionals, often the result is an avoidance of medicaid and medicare patients, many of whom have the greatest need for medical assistance.

Mr. Chairman, these burdens of paperwork and scrutiny fall hardest on the small health care provider. Doctors in private solo practice or partnership want to serve the poor and elderly. But they worry about complex reporting requirements that could just as easily result in an expensive audit as it could in mispayment!

Today we continue to focus on solutions to problems that face small health care providers. And we'll hear them from the agencies responsible for running that system --- CMS and OMB. I hope they provide this committee with useful and constructive proposals that preserve a solvent medicare system providing quality services to the poor and elderly, reduces waste and fraud and protects the needs and interests of small health care providers.

In closing, Mr. Chairman, let me say that I look forward to hearing the agencies' proposals for a fair and effective alternative to the current way of doing business with the government.

Congresswoman
NYDIA M. VELÁZQUEZ
Representing New York's 12th Congressional District
Ranking Democrat, House Small Business Committee

FOR IMMEDIATE RELEASE
July 25, 2001

CONTACT: Wendy Belzer, James Snyder
(202) 225-2361

Small Business Committee Seeks Relief for Small Health Care Providers

Oversight agencies to propose CMS regulatory burdens solutions

WASHINGTON – In a third hearing on the regulatory and administrative problems experienced by small health care providers dealing with the Center for Medicare and Medicaid Services (CMS), the House Small Business Committee expects to hear solutions proposed by the agencies responsible for reducing those burdens.

This hearing explores legislative and non-legislative actions that can be taken by CMS and the Office of Management and Budget (OMB) to reduce the regulatory and paperwork burdens on small health care providers while maintaining the integrity of the system and its ability to provide quality services to poor and aged beneficiaries.

"Often, complying with CMS paperwork takes more time than the time they spend with their patients,"Velázquez said. "The reporting requirements are complicated, often contradictory, and prone to unintended errors. Then doctors must worry about unannounced audits for the errors they did not mean to make."

"Burdens of paperwork and scrutiny fall hardest on the small health care provider," Velázquez continued. "Doctors in private practice or partnership want to serve the poor and elderly. But they worry about complex reporting requirements that could just as easily result in an expensive audit as it could in mispayment."

The first hearing held May 9 focused on the reporting and record-keeping requirements imposed on healthcare providers due to legislative changes under the Paperwork Reduction Act (PRA). A second hearing July 11 explored the administration of payments to providers from Medicare contractors, appeals of CMS decisions and audit practices by the agency. The hearing also discussed the proposed Medicare Education and Regulatory Fairness Act (MERFA), that would restructure CMS investigations and limit actions against health care providers. In particular, the bill would require advance notice of audits and bar up-front payment of disputed penalties.

In hearing the testimony directly from CMS, OMB, the Office of the Inspector General (OIG), and industry representatives on a series of regulatory issues, the House Small Business Committee hopes to be another step closer to finding more efficient and cost-effective alternatives to current CMS procedures dealing with small health care providers.

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Statement of

Congresswoman Stephanie Tubbs Jones

Reducing Regulatory and Paperwork Burdens
on Small Business Health Care Providers

House Committee on Small Business

Wednesday, July 25, 2001

Mr. Chairman, Ranking Member Velazquez, and Invited Guests:

Thank you for continuing to examine the issue of Medicare. Hearings such as this are important because administrative burdens weigh heavily in the ability of providers to assist patients. The regulatory burden imposed on health care providers is of grave importance to the efficiency and efficacy of our health care system.

I represent the Eleventh Congressional District of Ohio. Within my District, we have experienced several hospital closings, which have seriously affected my constituents' access to health care. I have convened the Eleventh Congressional District Taskforce on Healthcare to hold dialogues with the community involving physicians, nurses, other providers, and administrators. We examine these issues on a regular basis. Medicare is particularly important to me because many of my constituents are senior citizens who are dependent on Medicare for their health care.

Therefore, I am familiar with the burden imposed on doctors by excessive paperwork. Like other regulatory scenarios, these burdens reflect policy choices that weigh costs and benefits. But unlike other small businesses, the regulatory burdens imposed on health care providers affect not only their revenue, but more importantly, their ability to care for patients.

This is the third in a series of hearings that have dealt with this issue. Today, we are examining how CMS and OMB might find non-legislative or regulatory ways to reduce the burden on small businesses. We have a growing problem where our family doctors, pharmacists, and other health care providers are taking more time filling out Medicare paperwork and consulting with lawyers and accountants than caring for patients. Some physicians estimate between 20% to 50% of their time is spent on paperwork.

With the passage of the Balanced Budget Amendment of 1997 and the requisite authorizing legislation over Medicare reforms, CMS has scrambled to implement these new regulations in a timely fashion. As a result, public comment has sometimes been subverted in favor of expediency. Public comment is essential in order to understand the real-world effects of regulation.

Moreover, while regulations are critical to ensure patient safety, they can also limit the capability of a program like Medicare to deliver services and frustrate providers who seek to serve patients.

Many of my constituents in the Eleventh Congressional District, both physicians and seniors, have expressed frustration with this system. Congress has a duty to provide CMS with the tools needed to serve people in need of care. It is crucial that we work together to improve the current situation and improve access to health care.

Along with my colleagues, I will continue to examine this issue, and it is my hope that these discussions will result in practical solutions.

MIKE ROSS
4TH DISTRICT, ARKANSAS

WASHINGTON
514 CANNON HOB
WASHINGTON, DC 20515
1-800-223-2220
(202) 225-3772
(202) 225-1314 FAX

COMMITTEES:
FINANCIAL SERVICES
SMALL BUSINESS
AGRICULTURE

Congress of the United States
House of Representatives

Congressman Mike Ross
Statement in front of the Committee on Small Business
at the hearing on the Centers for Medicare & Medicaid Services'
Paperwork Burdens
July 25, 2001

I appreciate the Chairman and the Ranking Member for convening today's hearing, which will explore the Centers for Medicare & Medicaid Services' paperwork burdens. I own, along with my wife, a pharmacy and home medical equipment business, in the small, rural town of Prescott, Arkansas. As owner and manager of Holly's Health Mart for seven years before coming to the Congress, I dealt day in and day out with Medicare regulations.

I am keenly interested in today's hearing for two reasons. First, as a small business owner, health care provider and cosponsor of the Medicare Education and Regulatory Fairness Act (MERFA; H.R. 868), which will require CMS to document the costs of its regulations to health care providers, I believe efforts to help health care providers will in the long run help patients. Second, the Bush Administration's most recent proposal, the prescription drug discount card proposal, is of great concern to me.

Our nation's neighborhood pharmacies (i.e. small business owners) will be detrimentally impacted by the prescription drug discount card proposal. The number of neighborhood pharmacies is already declining. Add to that the pharmacists' shortage and forcing pharmacies to reduce what they can charge for prescription drugs, without doing anything to impact the price the pharmacy pays for the drugs. Medicare beneficiaries will be no better off than they are now—stretching an often-meager retirement benefit to pay for big drug bills, groceries, utilities, or other quality of life necessities.

I look forward to hearing today's witnesses and working with my colleagues on the Committee and in the Congress on commonsense and efficient regulatory reporting requirements.

PINE BLUFF
1617 OLIVE STREET
PINE BLUFF, AR 71601
(870) 536-3376
(870) 536-4058 FAX

HOT SPRINGS
112 BUENA VISTA
HOT SPRINGS, AR 71913
(501) 520-5892
(501) 520-5873 FAX

EL DORADO
CITY HALL RM 202
204 NORTH WEST AVENUE
(870) 881-0681
(870) 881-0683 FAX

PRESCOTT
221 WEST MAIN STREET
PRESCOTT, AR 71857
(870) 887-6787
(870) 887-6799 FAX

Questions submitted by Congressman Ross for
Mr. Tom Scully, Administrator of the Centers for Medicare and Medicaid Services

1. In 1999, I was a lead sponsor of Arkansas' Cash Discount Law. Under this law, specific guidelines are set up to reduce and prohibit the sale of deceptive health-related discount cards. One of the provisions includes health care providers listed as accepting the card must have a **separate contract**. It seems that the Administration's prescription drug discount card will add to the health care providers', specifically pharmacists, paperwork burden. What are your thoughts on this issue?

2. The prescription drug discount card puts the burden of reducing prescription drug costs on the pharmacy. Many pharmacies already "price match" if a senior finds a lower prescription drug price at another pharmacy. However, pharmacies will bear the brunt of further price reductions under this program since pharmacy benefit managers (PBMs) are not required to pass along manufacturers' rebates. When the pharmacies are already operating at 2 percent net profit margins, its tough to squeeze "blood from a turnip." What is the Administration doing about addressing the real issue—the increased cost of new drugs—to the pharmacists and pharmacy owners who are small business owners?

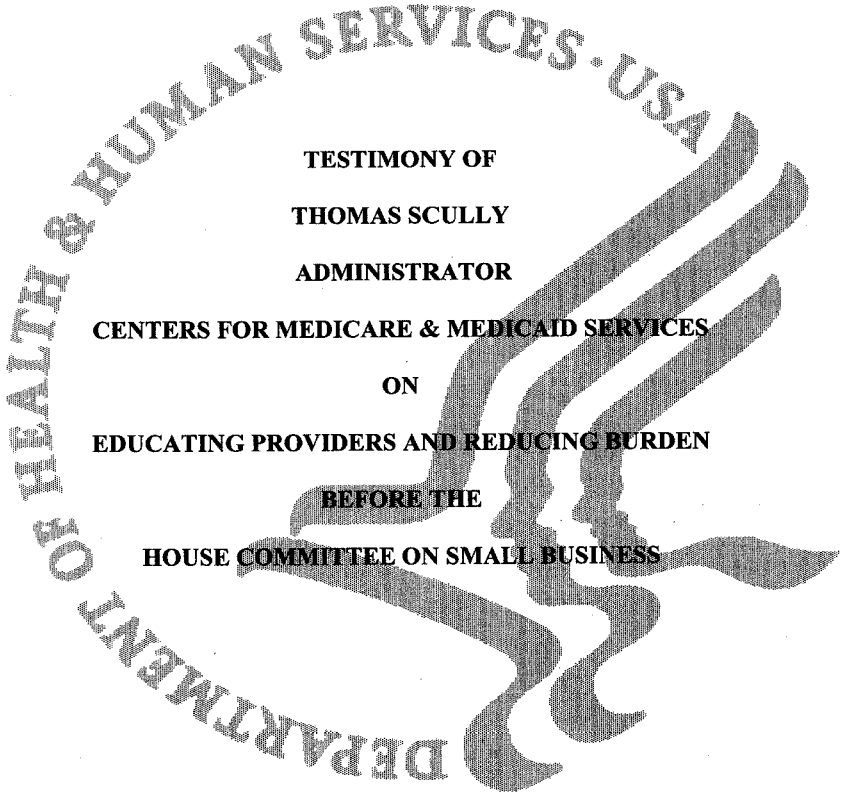
Opening Statement of Rep. Millender-McDonald
For the Small Business Committee
07/25/2001

Good morning Mr. Chairman. We are hear today to examine "Reducing Regulatory and Paperwork Burdens on Small Healthcare Providers: Proposals From the Executive Branch".

This issue is important because the members of the committee have heard testimony regarding the difficulties that confront providers as they

attempt to navigate the maze of rules imposed on them. The result has been a decrease in the level and quality of care provided, and an intensification of anxiety about the consequences of errors in filing paperwork by providers. Providers have recounted stories of being harassed and almost financially ruined while investigations were conducted.

Although the Health Care Financing Administration's name has been changed to the Centers for Medicare and Medicaid Services



TESTIMONY OF

THOMAS SCULLY

ADMINISTRATOR

CENTERS FOR MEDICARE & MEDICAID SERVICES

ON

EDUCATING PROVIDERS AND REDUCING BURDEN

BEFORE THE

HOUSE COMMITTEE ON SMALL BUSINESS

July 25, 2001

TESTIMONY OF
THOMAS SCULLY
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BEFORE THE
HOUSE COMMITTEE ON SMALL BUSINESS

JULY 25, 2001

Chairman Manzullo, Congresswoman Velázquez, distinguished Committee members, thank you for inviting me to discuss the Centers for Medicare & Medicaid Services' (CMS's) work to streamline Medicare's regulatory processes and our provider and beneficiary education efforts. Many physicians, health plans, providers and Members of Congress have raised concerns about Medicare's regulatory and paperwork burden and the cost of doing business with the Medicare program. We can appreciate these concerns, and are taking every effort to identify and address areas where improvements can be made. Physicians and other health care providers play a critical role in ensuring that Medicare beneficiaries receive quality health care. We know that to make sure that beneficiaries continue to receive the highest quality care, we must streamline Medicare's requirements, bring openness and responsiveness into the process, and make certain that regulatory and paperwork changes are sensible and predictable. In the coming months, we will take aggressive action to meet these critical goals.

In June, Secretary Thompson and I announced that as a first step in reforming the Medicare program, we were changing the Agency's name to the Centers for Medicare & Medicaid Services. The name-change is only the beginning of our broader effort to change the face of the Medicare program and bring a culture of responsiveness to the Agency. These are not empty words: creating a "culture of responsiveness" means ensuring high-quality medical care for beneficiaries, improving communication with providers, beneficiaries and Congress, and redoubling our education efforts. As we work to reduce Medicare's regulatory and paperwork

burden and further improve our provider education efforts, we look forward to our continued partnership with Congress and the physician and provider community.

BACKGROUND

This year, Medicare will pay approximately $240 billion for the health care of nearly 40 million beneficiaries, involving nearly one billion Medicare claims from more than one million physicians, hospitals, and other health care providers. CMS strives to ensure that Medicare pays only for the services allowed by law while making it as easy as possible for qualified health care providers to treat Medicare beneficiaries. We have to carefully balance the impact of Medicare's laws and regulations on physicians and other providers with our accountability for billions of dollars of Medicare payments.

Medicare's requirements, as outlined in the law, generate many of the concerns that our constituents bring to your attention and mine. Of course, there is a genuine need for some rules. But rules should exist to help, not hinder, our efforts to assist people, help control costs, and ensure quality, though the rules must remain consistent with our obligation and commitment to prevent fraud and abuse. When regulations, mandates, and paperwork obscure or even thwart the services providers are trying to give, those rules need to be changed. Our constituents, the Americans who depend on Medicare, and the physicians and other health care providers who care for them, deserve better. And so I am working with the Secretary to reform the way Medicare works, making it simpler and easier for everyone involved. We are dedicating ourselves to listening closely to Americans' concerns, learning how we can do a better job of meeting providers' needs, and serving them in the best way we can. We also have to ensure that we focus our efforts appropriately, and that means being less intrusive to the providers who participate in Medicare and more responsive to the beneficiaries who depend on Medicare.

IMPROVING AGENCY RESPONSIVENESS

As I mentioned, we are taking aggressive steps to bring a culture of responsiveness to CMS. This culture, this spirit, is rooted in a commitment to compassion and responsibility to beneficiaries and the physicians and providers who serve them. We intend to reinvigorate the entire Agency with a spirit of responsiveness to our constituents – to you, members of Congress;

to our colleagues in government here in Washington and throughout the nation; and to the men, women, and children our programs protect. To promote responsiveness, the Agency is:

- ***Creating Senior-Staff Level Primary Contacts*** for beneficiary groups, plans, physicians, providers, and suppliers to strengthen communication and information sharing between stakeholders and the Agency. We recently designated senior-level CMS staff members as the principal points-of-contact for each specific provider group, such as hospitals, physicians, nursing homes, and health plans. These designees will work with the industry groups to facilitate information sharing and enhance communication between the Agency and its business partners. The designees will help ensure that each of these important voices is heard within CMS. I will discuss this effort in greater detail later.

- ***Enhancing Outreach and Education*** to providers, plans, and practitioners by building on the current educational system with a renewed spirit of openness, mutual information sharing, and partnership. The Agency is developing and improving training on new program requirements and payment system changes, increasing the number of satellite broadcasts available to health care industry groups, and making greater use of web-based information and learning systems for physicians and providers across the country.

- ***Establishing Key Contacts for the States*** at the regional and central office level. Similar to the senior-staff level contacts for industry and beneficiary groups, these staff members are available to work directly with the Governors and top State officials to help eliminate Agency obstacles in obtaining answers, feedback, and guidance. Each State now has one Medicaid staff member assigned to them in the regions and another in Baltimore, both of whom are accountable for each State's specific issues.

- ***Responding More Rapidly and Appropriately to Congress and External Partners*** by promptly responding to their inquiries. We are developing an intra-Agency correspondence routing system and timeliness standards to respond more efficiently and promptly to congressional inquiries. We also are also exploring ways to make data, information, and trend analyses more readily available to our partners and the public in a timely manner. In

addition, CMS will make explicit and widely publicize the requirements for obtaining data and analyses from us, including protecting the confidentiality of the data.

REGULATORY REFORM

A culture of responsiveness alone will not alleviate the regulatory and related paperwork burdens that far too long have been associated with the Medicare program. Thus, the Secretary is forming a new regulatory reform group to look for regulations that prevent hospitals, physicians and other health care providers from helping Medicare beneficiaries in the most effective way possible. This group will determine what rules need to be better explained, what rules need to be streamlined, and what rules need to be cut altogether, without increasing costs or compromising quality. To assist this group, we have developed a multifaceted approach, focusing on listening and learning, which will get us on the right track. This methodical, sector-by-sector approach will enable us to administer our health care programs as effectively and efficiently as possible.

Under the first aspect of the plan, CMS will conduct public listening sessions across the country to hear directly from physicians and health care providers, away from Washington, DC, and away from Baltimore, and out in the areas where real people live and work under the rules we develop; where these people may not have such easy access to policymakers to share their good ideas and legitimate concerns. Most of you in Congress have these kinds of listening sessions with your local constituents on a regular basis. I want to hear from local seniors, large and small providers, State workers, and the people who deal with Medicare and Medicaid in the real world. I want to get their input so we can run these programs in ways that make sense for real Americans in everyday life. We hear from some of these people now, but we want to get input from many, many more.

We want to hear from the broad range of providers, from those in rural offices and inner city clinics to the suburban health centers and urban hospitals. I want to hear from the large hospital systems and the small, two doctor practices and the solo providers. I want input from folks like group practice managers, physician assistants, and nurses. These professionals who are in the field every day can give us good ideas that improve our management of these vitally important programs. This type of input is good for our beneficiaries because regulatory reform will allow

physicians and providers to spend more time caring for beneficiaries, and it will encourage physicians and providers to remain in the Medicare program.

The second part of the plan is to meet with the various health-sector workgroups – these are the industry folks here in Washington. Some of the people who we hear from the most are the individual and institutional providers who are dealing with our rules every day. They are the ones caring for our beneficiaries, and they are the ones filling out many of the forms, trying to understand the rules, and working to do the things they spent years training to do – making people healthy. And so the second aspect of our approach will focus specifically on the collective expertise of the industry groups who represent these physicians and providers, working with CMS senior staff. We are convening seven health-sector workgroups with a senior CMS person as each group's principle contact. The purpose of these groups is to suggest ways that we can improve their interactions with CMS and the Medicare program to reduce regulatory complexity and burden. For example, the American Hospital Association (AHA) recently released a report, "Patients or Paperwork: The Regulatory Burden Facing Hospitals." The AHA found that due to regulatory burden, every hour spent providing actual patient care generates at least 30 minutes – and sometimes an hour – of paperwork. We need more input like this to improve our operation of Medicare, so that health care professionals can spend more time delivering the care for which they were trained, and so that beneficiaries can spend more time with their doctors and other providers – not in waiting rooms.

Like the physicians, providers, and beneficiaries who live and work with Medicare every day, CMS staff have dealt with the system for years, and they have suggestions about how we can operate the Medicare program more simply and effectively. They certainly have heard from all of you and from many, many providers about what could be fixed. To examine these important concerns, the third aspect of our plan is forming a group of in-house experts from the wide array of Medicare's program areas. I am asking them to think innovatively about new ways of doing business, reducing administrative burdens, and simplifying our rules and regulations, without increasing costs or compromising quality. Today, providers are forced to spend more time keeping up with the latest rules and interpretations rather than keeping up with providing patient care. Frankly, the complexity of the program makes it difficult for those of us who administer it

to keep up. It is difficult to educate beneficiaries, providers and our business partners when there is so much complex information to explain. This group of experts will develop ways that we can reduce burden on providers, eliminate complexity wherever possible, and make Medicare more "user-friendly" for everyone involved.

In no way will we diminish our interest in fighting fraud and error in the Medicare program. Most physicians and other providers are honest and want only to be fairly reimbursed for the high-quality care they provide, but for the small percentage of people who take advantage of the system, we will continue our aggressive efforts to protect the funds that taxpayers have entrusted to our use.

Finally, we continue our efforts to implement the Paperwork Reduction Act (PRA). We have an important obligation to work with industry early in the PRA process, and OMB reinforces our efforts. We hope to improve our coordination of paperwork issues so that fewer emergency OMB reviews will be necessary. In addition, we will examine programmatic areas necessitating additional clarification, in particular contractor operations, and identify opportunities for more predictability and less burden. In the next month we are scheduled to meet with OMB staff to formulate a plan and timeline for evaluating and resolving issues. We hope to present new approaches to this issue in our next submission for PRA clearance. We also will continue our town meetings and other industry consultations to improve the content and implementation of paperwork requirements before they are submitted to OMB for final clearance.

These outreach efforts will allow us to hear from all segments of people who deal with Medicare and Medicaid, from the beneficiaries and the public at large, to the physicians and providers, to the CMS employees. We are going to listen to them, and we are going to learn how we can do a better job. But listening is not enough. Getting together and generating great solutions is not enough. So we are going to take action. To improve the way we do business and make Medicare and Medicaid easier for everyone involved with them without increasing costs or compromising quality, the Secretary and I have already announced some important changes and we plan to announce more in the coming weeks.

STREAMLINING THE REGULATORY PROCESS

In addition to easing the regulatory burden on health plans, physicians and other providers, we are working with providers and Congress to streamline the regulatory process. Although the Agency has made some progress on this front, we still have important work to do. I am committed to making common-sense changes and ensuring that the regulations governing our program not only make sense, but also are plain and understandable. The Secretary has made this a priority for the Department and I am committed to this effort. Streamlining will go a long way towards alleviating providers' fears and reducing the amount of paperwork that has all too often in the past been an unnecessary burden on the providers who care for Medicare beneficiaries. In the coming months, with the leadership and support of Secretary Thompson, we will take important steps towards reaching these goals.

As a first step, we will develop a quarterly compendium of all changes to Medicare that affect physicians and other providers to make it easier for them to understand and comply with Medicare regulations and instructions. The compendium will be a useful document for predicting changes to Medicare's instructions to physicians and providers, and will contain a list of all regulations we expect to publish in the coming quarter, as well as the actual publication dates and page references to all regulations published in the previous quarter. All changes – both regulatory and non-regulatory – will be treated the same, regardless of whether the change results in increased or decreased payment, coverage, or reporting burden. The compendium will be published only at the beginning of a quarter, unless the Secretary or Administrator directs otherwise. By publishing changes in the quarterly compendium, physicians and other providers will no longer be forced to sift through pages and pages of the *Federal Register* – or pay someone to do it for them – for proposed rules, regulations, and other changes that may effect them. The compendium will include all program memoranda, manual changes, and any other instruction that could affect providers in any way. It will provide predictability, and will ensure that physicians and other providers are fully aware of Medicare changes and that they have time to react before new requirements are placed on them.

In addition to the quarterly compendium, we will develop a system of electronic rulemaking to make the rulemaking process more efficient and to reduce the flow of paper between providers and CMS. Today, in an effort to make updated regulations more readily accessible, we routinely post them on our website, www.hcfa.gov. These postings coincide with the display of these documents in the *Federal Register* and have been well received by providers and other interested parties. Over the next six months, we will further explore the use of emerging technologies and the electronic exchange of information, such as posting proposed rules and taking comments on-line. We will work closely with the provider, plan and practitioner communities, as well as with Congress and other parts of the executive branch, to better understand their needs as we move towards an electronic rulemaking environment.

IMPROVING PHYSICIAN AND PROVIDER EDUCATION

As part of our efforts to reinvigorate the Agency and bring a new sense of responsiveness to CMS, we are enhancing our provider education activities and opening lines of communication to our physician and provider partners. The Medicare program primarily relies on private sector contractors, who process and pay Medicare claims, to educate physicians and providers and to communicate policy changes and other helpful information to them. Working with the Medicare contractors, we have taken a number of steps to ensure the educational information that is shared with physicians and providers is consistent and unambiguous. CMS is responsible for providing policy guidelines to these private contractors, and ensuring that the contractors then perform their activities in a timely and accurate manner.

We recognize that the decentralized nature of this system has, in the past, led to inconsistency in the contractors' communications with physicians and providers, and we have recently taken a number of steps to improve the educational process. For example, we have centralized our educational efforts in our Division of Provider Education and Training, whose primary purpose is to educate and train the contractors and the provider community regarding Medicare policies. We are also providing contractors with in-person instruction and a standardized training manual for them to use in educating physicians and other providers. These programs provide consistency and ensure that our contractors speak with one voice on national issues. For example, in coordination with the Blue Cross/Blue Shield Association, we developed train-the-

trainer sessions for implementing both the Hospital Outpatient and Home Health Prospective Payment System regulations, which included a satellite broadcast that was rebroadcast several times prior to the effective date of the regulation. Following these sessions, we held weekly conference calls with regional offices and fiscal intermediaries to enable us to monitor progress in implementing these changes. We are continuing to refine our training on an on-going basis by monitoring the training sessions conducted by our contractors, and we will continue to work collaboratively to find new ways of communicating with and getting feedback from physicians and providers.

Just as we are working with our contractors to improve their provider education efforts, we also are working directly with physicians and other health care providers to improve our own communications and ensure that CMS is responsive to their needs. We are providing free information, educational courses, and other services through a variety of advanced technologies. We are:

- ***Expanding our Medicare provider education website.*** We provide a variety of resources online at the Medicare Learning Network homepage, www.hcfa.gov/MedLearn.htm. MedLearn provides timely, accurate, and relevant information about Medicare coverage and payment policies, and serves as an efficient, convenient provider education tool. The MedLearn website averages over 100,000 hits per month, with the Reference Guides, Frequently Asked Questions and Computer-Based Training pages having the greatest activity. I would encourage you to take a look at the website and share this resource with your physician and provider constituents. We want to hear feedback from them on its usefulness so we can strengthen its value.
- ***Providing free computer and web-based training courses.*** Doctors, providers, practice staff, and other interested individuals can access a growing number of web-based training courses designed to improve their understanding of Medicare. Some courses focus on important administrative and coding issues, such as how to check-in new Medicare patients or correctly complete Medicare claims forms, while others explain Medicare's coverage for home health care, women's health services, and other benefits.

- ***Creating a more useful Agency website.*** We are creating a new website architecture and tailoring it to be intuitive and useful to the physician user. We want the information to be helpful to physicians' and their staffs' office and billing needs. The same design is being used in creating a manual of "Medicare Basics" for physicians. We just completed field-testing the first mock-ups for the project at the recent American Medical Association House of Delegates meeting. Once this new website is successfully implemented, we will move to organize similar web navigation tools for other Medicare providers.

In tandem with our efforts to improve physician and provider education, we are also focusing on improving the quality of our provider customer service. Last year, our Medicare contractors received 24 million telephone calls from physicians and providers, and it is imperative that the contractors provide correct and consistent answers. Now that we have toll-free answer-centers at all Medicare contractors, the need is even more pressing. We have performance standards, quality call monitoring procedures, and contractor guidelines in place to ensure that contractors know what is expected and so that we can be satisfied that the contractors are reaching our expectations. This year, for the first time, Medicare contractors' physician and provider telephone customer service operations are being reviewed against these standards and procedures separately from our review of their beneficiary customer service. During these week-long contractor performance evaluation reviews, we identify areas that need improvement and "best practices" that can be shared among our other Medicare physician and provider call centers. As a result of the reviews, performance improvement plans will be instituted when needed, and CMS staff in our Regional Offices will continue to monitor the specific contractor throughout the year.

We also want to know about the issues and misunderstandings that most affect provider satisfaction with our call centers so that we can provide our customer service representatives with the information and guidance to make a difference. To improve our responsiveness to the millions of phone calls our call centers handle each year, we are:

- ***Creating Call Center Profiles.*** Earlier this year, we visited eight of our largest Medicare contractors to collect information on their operations, their use of technology, their

performance data, their most frequently asked provider questions, and their training needs. We are now collecting similar information from all of the remaining Medicare call centers via an online profile. The profiles will be completed by early August, and we will analyze them to identify additional training needs and other improvements we can make at our contractors.

- ***Creating a Customer Service Training Plan.*** Based upon the call center profiles we have gathered, we have drafted a Customer Service Training Plan to address the training needs of our Medicare customer service representatives'. This training plan will bring uniformity to the contractor training, and improve the accuracy and consistency of the information that representatives give to physicians and providers across the country. Our first training effort will focus on the widely misunderstood Correct Coding Initiative. Customer service representatives will be trained on the language and concepts of coding issues so that they can properly direct physicians and providers to the best sources of information. We plan to offer this and other training via a satellite network. We expected to provide training to all of our contractors this fall.

- ***Holding Telephone Customer Service Conferences.*** In March, we held our first National Telephone Customer Service Conference for Medicare contractor call center managers and our Central and Regional Office staff. The conference emphasized our goal of making Medicare customer service as uniform in look, feel, and quality as possible.

- ***Conducting Monthly Call Center Meetings.*** We currently hold monthly conference calls with contractor call center managers and CMS Central and Regional Office staff to identify problems, give contractors additional information, and increase the accuracy and consistency of call center service nationwide.

At the same time, we are working to develop effective standards for appropriately meeting the customer service needs of physician and provider communities we serve. We are:

- ***Analyzing Baseline Performance Data.*** Medicare call center managers were required to report data from October 1999, through May 2001 (and monthly thereafter), on a variety of performance measures. We are analyzing this data to determine contractors' relative performance and the impact of the installation of toll free lines on contractor workload and performance.

- ***Modernizing Customer Service Representative Workstations.*** To the extent resources permit, we are looking at modernizing the workstations and other tools used by our customer service representatives to ensure that they have instant access to the most current information in responding to provider inquiries.

- ***Monitoring Call Quality.*** We also formed a contractor workgroup with CMS staff to review and improve the scorecard and criteria chart that was used to measure beneficiary telephone customer service, so that it also could effectively measure the customer service of our provider customer service representatives. This new scorecard, now used by both groups, places greater emphasis on accuracy of information given in determining the final score.

IMPROVING AND EXPANDING BENEFICIARY EDUCATION

As Medicare requirements frustrate plans, physicians and providers, beneficiaries also have difficulty understanding the program's benefits and options. We know, from our research and focus groups, that far too many Medicare beneficiaries have a limited understanding of the Medicare program in general, as well as their Medigap, Medicare Select, and Medicare+Choice options. We firmly believe that we must improve and enhance its existing outreach and education efforts so that beneficiaries understand their health care options. In addition, we will tailor our educational information so that it more accurately reflects the health care delivery systems and choices available in beneficiaries' local areas. We know that educating beneficiaries and providing them more information is vital to improving health care and patient outcomes.

With that goal in mind and in an effort to ensure that Medicare beneficiaries are active and informed participants in their health care decisions, we will expand and improve the existing

Medicare & You educational efforts with a new advertising campaign. We will launch a multimedia campaign using television, print, and other media to reach out and share information and educational resources to all Americans who rely on Medicare, their families, and their caregivers. We are also:

- ***Increasing the Capacity of Medicare's Toll-Free Lines*** so that the new wave of callers to 1-800-MEDICARE generated by the advertising campaign receive comprehensive information about the health plan options that are available in their specific area. By October 1, 2001, the operating hours of the toll-free lines will be expanded and made available to callers 24 hours a day, seven days a week. The information available by phone also will be significantly enhanced, so specific information about the health plan choices available to beneficiaries in their state, county, city, or town can be obtained and questions about specific options, as well as costs associated with those options, can be answered. Call center representatives will be able to help callers walk-through their health plan choices step-by-step and obtain immediate information about the choices that best meet the beneficiary's needs. For example, a caller from Rockford, Illinois, could call 1-800-MEDICARE and discuss specific Medigap options in Illinois. Likewise, a caller from Brooklyn, New York, or Texas, could call and get options and costs for Medigap or Medicare+Choice alternatives in their areas. If requested, the call centers will follow-up by mailing a copy of the information discussed after the call.

- ***Improving Internet Access to Comparative Information*** and providing a new decision making tool on the Agency's award winning website, www.medicare.gov. These enhanced electronic learning tools will allow visitors, including seniors, family members, and caregivers to compare benefits, costs, options, and provider quality information. This expanded information is similar to comparative information already available, such as *Nursing Home Compare* and *ESRD Compare* websites. With these new tools, beneficiaries will be able to narrow down by zip code the Medicare+Choice plan options that are available in their area based on characteristics that are most important to them, such as out-of-pocket costs, whether beneficiaries can go out of network, and extra benefits. They also will be able to compare the direct out-of-pocket costs between all their health insurance options and get more detailed information on the plans that most appropriately fit their needs. In addition,

the Agency will provide similar State-based comparative information on Medigap options and costs.

CONCLUSION

Physicians and other providers play a crucial role in caring for Medicare beneficiaries, and their concerns regarding the program's regulatory burden must be addressed. Enhancement of our communication and education efforts is essential to the success of Medicare, and we believe will ultimately reduce the level of physicians' and other providers' frustration with the Medicare program, as well as increase beneficiaries' options and satisfaction. We recognize we have a number of issues to address and improvements to make. We have already taken some critical first steps, and we are seeking input from the health care community and Congress as we work towards our goals. I appreciate having had the opportunity to discuss these issues with you today, and I am happy to answer your questions.

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STATEMENT OF JOHN GRAHAM

ADMINISTRATOR

OFFICE OF INFORMATION AND REGULATORY AFFAIRS

BEFORE THE

COMMITTEE ON SMALL BUSINESS

HOUSE OF REPRESENTATIVES

July 25, 2001

Good morning, Mr. Chairman, Ranking Member Velazquez, and members of the Small Business Committee. Thank you for your invitation to testify today. You invited me to testify about the Office of Management and Budget's (OMB) role in reviewing information collection requirements pursuant to the Paperwork Reduction Act (PRA), as well as our review of regulations governing the Medicare and Medicaid programs. I was confirmed by the Senate last Thursday in my new position as Administrator of the Office of Information and Regulatory Affairs (OIRA), and I am pleased that my first opportunity to testify as the OIRA Administrator is before this Committee. I look forward to working with this Committee to reduce the paperwork and regulatory burdens that the Federal Government imposes on this country's small

businesses. I hope to leave this hearing today with a better understanding of your concerns and ideas for further action that may be taken by my Office in concert with Mr. Scully and the Centers for Medicare and Medicaid Services (CMS). I have appreciated the opportunity to read the testimony at the 5/9 and 7/11 hearings.

In your letter of invitation, you requested my views on the following issues: 1) administrative changes that OMB can make in ensuring that it properly understands the impact of reporting and recordkeeping requirements on small businesses; 2) the adequacy of OMB's review of reporting and recordkeeping requirements imposed by CMS contractors on small healthcare providers; 3) recommendations on necessary legislative changes in the Paperwork Reduction Act; and 4) our opinion on OMB's review of CMS regulations. These are important questions, and I look forward to working with the Committee and CMS to address the concerns that have been raised about the paperwork burdens that are placed on small healthcare providers. However, because I assumed the position of OIRA Administrator less than a week ago, I am not in a position at the present time to discuss what has happened in the past with respect to the relationship between CMS's contractors and small health care providers, nor can I offer at the present time any views or recommendations regarding what deficiencies may exist and how they can be remedied. However, I can assure you that one of my priorities as OIRA Administrator is to reinvigorate the Executive Branch's implementation of the Paperwork Reduction Act, and I

am committed to working with OIRA staff and CMS to look into this matter in detail and to identify actions that should be taken to address any deficiencies that we identify.

I look forward to the challenge of administering the PRA in the Medicare and Medicaid programs. The PRA strikes a balance between the costs and benefits of government information. The PRA directs agencies to collect or create only information that is necessary for the proper performance of agency functions and that has practical utility. It seeks to maximize the usefulness of information collected, used and disseminated by the Federal government, while minimizing the Federal and private costs of providing and managing that information.

Our review of draft regulations under Executive Order 12866 must also complement our efforts under the PRA. Many information collections, recordkeeping requirements, and third-party disclosure requirements are contained in, or authorized by, regulations as monitoring or enforcement tools, while others appear in questionnaires and their accompanying instructions. When regulations operate by requiring the public to report, maintain, or disclose information, OIRA's information collection and regulatory reviews become closely intertwined.

There is no question that there are very substantial costs to the public of responding to the Federal Government's paperwork requirements. Americans spent some 7.4 billion hours complying with such requests in FY 2000.

I would like to briefly summarize the public and OIRA review that must occur before an agency can receive OIRA approval to collect information from the public. The 1995 PRA amendments mandate an extensive agency review process and provide significant opportunity for public participation in both the agency and OMB processes. In accordance with the goals of the PRA, the Act requires agencies to plan well in advance when they develop new collections of information and they consider extending ongoing collections of information. This advanced planning is necessary because agencies need to estimate potential burdens on respondents, prepare to disclose certain additional information to the public (e.g., time limits for recordkeeping requirements), and seek public comment in notices published in the Federal Register. Only after doing this, and considering changes based on any comments received, do agencies submit their paperwork clearance packages to OMB for review and approval. OIRA then reviews each agency information collection requirement before the agency can collect it, and reevaluates collections for their continued use at least once every three years. In cases where outstanding concerns remain, OIRA may call meetings with CMS staff, other affected Federal agencies, state groups, professional organizations, and other interested commenters. Our objectives are to (1) determine whether the agency's collection is necessary for the proper performance of the functions of the agency; (2) assure that the collection has practical utility and (3) assess whether these benefits justify the burden imposed on the public. If the agency cannot

demonstrate to OIRA's satisfaction that the collection's need and practical utility justifies its paperwork burden, OIRA disapproves the collection and the agency may not go forward with the collection.

Through the PRA, OIRA must help agencies meet their obligation to the public by striking the proper balance. The PRA should not be used as grounds for denying the government the ability to collect from the public what is necessary to fulfill its statutory mission. On the other hand, collection of unnecessary or duplicative information imposes unjustified costs on the businesses or individuals that must respond, on the taxpayer, and on the economy as a whole.

OIRA is continuing to make serious efforts in this area, reviewing individual paperwork collection proposals and producing an annual Information Collection Budget that identifies, agency by agency, the agency initiatives under way to reduce paperwork burden and improve the quality of Federal data collection. I plan to place renewed emphasis on a coordinated effort to produce better results in this regard.

Thank you for this opportunity to testify and I look forward to working with you in the future.

Testimony of
George F. Grob
Deputy Inspector General
for Evaluation and Inspections

Good morning, I am George Grob, Deputy Inspector General for Evaluation and Inspections in the Office of Inspector General (OIG), Department of Health and Human Services. Thank you for the opportunity to address the Committee on Small Business regarding the regulatory burden on small health care providers. You asked us for our views on what administrative changes can be made in the operation of the Medicare program without compromising program integrity. We appreciate the opportunity to share our ideas on this subject with you.

This is an extremely important issue, but one that is also complex and defies quick fixes. As such, it must be addressed at several different levels, and it will require the attention and concerted efforts of all of us--providers, program managers, oversight and law enforcement officials, and the Congress--to find manageable and efficient solutions. I hope that my testimony plays a constructive and helpful role in that respect.

I will offer principles and a framework for addressing the issue of regulatory burden; identify some related infrastructure issues that need to be addressed; and discuss education and outreach to health care providers. As you requested, I will also discuss H.R. 868, the Medicare Education and Regulatory Fairness Act of 2001 and some of its implications for program integrity and burden on providers. Finally, I would like to make some observations about providers' concerns about oversight activities in general.

General Principles

First, let me state the obvious: Medicare is one of our most cherished governmental programs. It provides excellent, quality health care coverage to almost 40 million aged and disabled Americans. It provides insurance coverage to a population that historically has had great difficulty in obtaining insurance. Because of the vast amounts of money involved (in excess of $220 billion annually), there are significant vulnerabilities to fraud, waste, and abuse. But concern regarding these issues must not overly interfere with the mission of the program to provide high quality, timely health care to eligible beneficiaries.

Therefore, I would suggest to you that what is needed above all is balance--balance among meeting beneficiaries' needs, protecting the financial viability of the program, and minimizing burdens placed on providers. Only by focusing on all three can we run an effective program that meets the expectations of all involved.

Meeting Beneficiaries' Needs

Medicare beneficiaries have a right to expect high quality, timely health care. Reimbursement should be sufficient to encourage adequate provider participation to ensure access to covered services. Beneficiaries should feel confident that they are obtaining services from legitimate providers and ones that are in compliance with State and Federal licensure and certification requirements. They should

not be subjected to onerous paperwork or other regulatory burdens. Finally, they should be able to obtain timely, understandable information regarding their benefits and health care choices.

Protecting Financial Integrity

Another paramount principle is the protection of the financial viability of the Medicare trust funds. Medicare is funded both by taxes paid by participants (and their employers) as well as revenue from the general treasury. We have an obligation to protect the financial viability of the trust funds so that the program is there for future generations.

Burdens on Providers

The vast majority of health care providers are honest, hard working professionals dedicated to the care of their patients. They have legitimate concerns about program complexity, inconsistency, burdens, and hassles associated with the Medicare program. Providers need to be able to do what they were trained to do--deliver health care--and not be subject to unreasonable regulatory or administrative burdens. Their concerns deserve careful consideration.

Infrastructure

Keeping in mind the broad principles discussed above, we can now drop down one level to begin focusing on the practical mechanics of program operations. First, we must consider the broad contours of Medicare administration--the infrastructure. No matter how much attention is paid to the details of regulations and relationships, they cannot possibly work if the broad systems upon which they depend do not function effectively, efficiently, and seamlessly. Of critical importance are Medicare contractors and the appeals system.

Contractors

We believe that Medicare needs greater flexibility in the methods it uses to select, organize, and supervise the contractors who handle the day-to-day operations of the program. This includes authorities to use entities other than insurance companies, select them competitively, pay them on other than a cost basis, organize them according to functions or benefits areas, and hold them accountable for performance.

CMS administers the Medicare program with the help of approximately 50 contractors (Part A intermediaries and Part B carriers) that handle claims processing and certain payment safeguard functions. Over the years we have detected serious problems with contractor operations, including fundamental problems with accounting, electronic data processing, and fraud control. We have even uncovered integrity problems with some of the contractors themselves--altering documents and falsifying statements that specific work was performed. In some cases, contractors prepared bogus documents to demonstrate superior performance, which Medicare then rewarded with bonuses and additional contracts. Our investigations have resulted in 15 civil settlements and criminal convictions since 1993, with total settlement amounts exceeding $350 million. Two contractors pled guilty to obstruction of Federal audits. A number of investigations are ongoing. CMS has been working to correct problems with contractors. However, some serious concerns remain.

Under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), CMS was granted new authorities and flexibility in contracting for program integrity functions. It may enter into contracts or work orders for specific program safeguard functions, such as medical review, fraud detection, cost report audits, and reviews to identify primary payers to whom Medicare is the secondary payer. We have consistently supported these authorities and look forward to the changes in Medicare contracting that are taking place under the new Medicare Integrity Program.

In contrast to these new and promising developments for integrity functions, the Medicare statute places substantial limits on how CMS obtains contractor assistance to administer the Medicare program. For example, it limits CMS to choosing only insurance companies to process Part B claims. Similarly, most intermediaries are selected by the National Blue Cross/Blue Shield Association companies that are nominated by providers (e.g., hospitals). All contracts must be cost based; other reimbursement methods such as firm fixed price cannot be used. Furthermore, beyond the program integrity functions mentioned above, CMS is not allowed to let contractors specialize according to function.

No modern corporation could or would operate with similar limitations. Medicare, the world's largest health insurance program, should not have to either. While these legal structures might have made sense as a way to quickly muster structures, processes, and expertise when the program was first enacted, they are no longer appropriate.

CMS has proposed broader, more flexible contracting authority in the past, but these proposals were not approved. We have supported such proposals in past congressional testimony, and we continue to do so. So does the General Accounting Office.

Another promising development is the designation of specialty contractors such as the durable medical equipment regional carriers. They review and pay all claims for medical equipment and supplies. There are only four of them, which appropriately concentrates their expertise in this complex area. They are bolstered by a data analysis unit, staffed by one of these carriers but supporting them all. This enables them to analyze payment and usage patterns, which may suggest possible improper or questionable conduct. They are also able to effectively collaborate on the formulation of national coverage policies and payment control systems. A recent OIG evaluation found that these entities were successful at meeting their intended objectives. This approach, however, has not been used elsewhere, except for home health and hospice care. However, even these specialized intermediaries are not supported by the kind of data analysis unit that the medical equipment carriers utilize. We believe that specialty contractors, with a supporting analytic unit, would make sense for problematic areas and recommend that they be more widely used.

More flexibility and specialization will, we believe, bring greater expertise and efficiency to contractor operations. Providers have fewer entities to deal with; medical review and utilization parameters are more standardized; information is dispensed more consistently. All of this can improve their relations with providers and facilitate provider education and understanding of Medicare rules and regulations.

Appeals

An OIG report released in September 1998 examined the ALJ appeals level because of numerous reports of extensive problems in and related to that area. The report established that the number of Part B ALJ hearings increased a dramatic 99 percent from 1996 to 1998. It also confirmed that ALJs reversed a considerable percentage of cases that reached them. An important reason for the reversals was that ALJs are not bound by the same standards as carrier hearing officers. More specifically, carrier hearing officers are bound by Local Medical Review Policy and contractor manuals, while the ALJs are bound only by statute, regulations and National Coverage Determinations.

There was also evidence of positive changes in the appeals process. The report identified a group of SSA ALJs who conduct the most complex and highest dollar value Part B cases. It was their work, in part, that supported our conclusion that a permanent cadre of judges hearing only Medicare cases would significantly improve the appeals system.

We made several recommendations to CMS intended to correct the structural problems of the administrative appeals system which were related to the development and establishment of: a dedicated ALJ corps, dual administrative appeals processes for providers and beneficiaries; adversarial hearings for provider appeals; parallel training for Medicare contractors and ALJs; regulations for conducting Medicare ALJ Appeals; a case precedent system for Medicare Appeals Council rulings; and formal communication and information networks. We also recommended requiring Medicare contractors and ALJs to apply the same standards. Although many of these recommendations would lead to a simpler and more efficient process, to date, none of these recommendations has been implemented.

The recently enacted Benefits Improvement and Protection Act of 2000 (BIPA) modified the appeals process by establishing time limits on earlier stages of the appeals process which, if breached, give the appellant the option to move to the next higher level. These new provisions, which will go into effect on October 1, 2002, could lead to inappropriate decisions due to unrealistic time spans to address complex questions, a clogging of the appeals channels, and an inability to prioritize decision making.

The BIPA provisions were intended to address legitimate concerns of providers to get prompt answers to their appeals and coverage questions. However, some of these new procedures are likely to cause additional rather than fewer burdens and aggravations by overwhelming the appeals and review channels. Furthermore, they do not address the weaknesses in the fundamentals of the appeals and grievance systems--resources, guidance and standards, organizational locus of ALJs, rules of precedence, appropriate adaptation of procedures to beneficiaries and providers, and timeliness of reviews. We believe it is time for a comprehensive reform of the appeals system, considering input from all the affected parties. Some improvements can be made through administrative actions under the current statutes; but fundamental reform may require, and could well benefit from, new legislation. This could be accomplished while preserving the ideas, and even many of the procedural details, of the BIPA amendments.

Outreach and Education

Far and away, the best way to both protect the financial integrity of the Medicare program and reduce provider burdens is to reduce payment errors. Health care providers have been strong in their desire for training and education that will help them understand Medicare rules and regulations.

Training of health care providers is properly the responsibility of CMS and Medicare intermediaries and carriers. The OIG has frequently made recommendations to CMS to provide additional training on matters that we have discovered to be problematic in our audits and evaluations. The need for continuing training is prominent in the recommendations that we have made in our payment error rate study in each of the last several years. Specifically, we have recommended that CMS continue to:

- direct that Medicare contractors expand provider training to further emphasize the need to maintain medical records containing sufficient documentation, as well as to use proper procedure codes when billing Medicare for services provided;

- highlight to Medicare providers specific procedure codes and DRGs having the highest incidence of error in our audits, as well as those codes and DRGs identified by Medicare contractor payment safeguard projects; and

- refine Medicare regulations and guidelines to provide the best possible assurance that medical procedures are correctly coded and sufficiently documented.

The OIG itself can also contribute to training, and the Congress has specifically mandated that we do so through a program of advisory opinions. Following is a brief summary of our educational programs.

Health Care Provider Compliance Program Guidance

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) established a national Health Care Fraud and Abuse Control Program under the joint direction of the Attorney General and the Secretary of HHS, acting through the OIG. This new program was designed to coordinate Federal, State, and local enforcement activities with respect to health care fraud and abuse. Since HIPAA's enactment, the OIG has embarked on a major initiative to promote voluntary adoption of compliance programs by provider organizations. Our goal has been to help health care providers bill the Medicare program more accurately. When they do, Medicare pays the right amount for a covered service delivered to an eligible beneficiary.

In order to encourage the adoption of compliance measures by health care providers, the OIG has worked with health care industry groups to develop model, voluntary compliance plans. They identify steps that health care providers may voluntarily take to improve adherence to Medicare rules.

The OIG guidances are very specific in identifying risk areas for a particular health care industry sector. Since enactment of HIPAA, nine health care industry sector compliance guidances have been issued, including specific ones targeted to hospitals; home health agencies; clinical laboratories; third-party medical billing companies; durable medical equipment, prosthetics, and orthotics suppliers;

hospices; Medicare+Choice organizations; nursing facilities; and individual and small group physician practices.

The OIG and the health care industry, through various organizations such as the Health Care Compliance Association (HCCA) and the Council of Ethical Organizations, have engaged in an ongoing dialogue on health care compliance to better understand and resolve the challenges associated with creating effective compliance programs. We were pleased to read in the recent HCCA annual survey of health care compliance professionals that 71 percent of health care organizations now have ongoing compliance programs in place. The General Accounting Office (GAO) has concluded that the voluntary compliance of hospitals and other Medicare providers is crucial to reducing improper payments. Hospitals reported to GAO that compliance programs foster an improved culture for "doing the right thing" and that reduction of improper payments and their attendant liabilities is a benefit that exceeds the costs of their compliance programs.

Health Care Industry Guidance

An important core element of the new HIPAA fraud and abuse control program is the provision of guidance to health care providers regarding potential liability for activities that may be considered fraudulent or abusive. Specifically, HIPAA requires that the OIG:

- issue upon request advisory opinions regarding the applicability of the criminal and administrative sanction provisions of the Social Security Act;

- issue special fraud alerts, upon request or otherwise, advising "the public of practices which the Inspector General considers to be suspect or of particular concern under the Medicare or Medicaid programs;" and

- issue annually a public solicitation for proposals for issuance of both new and modified existing "safe harbor" regulations regarding the applicability of the Medicare/Medicaid anti-kickback statute.

The centerpiece of the OIG's implementation of the HIPAA guidance provision has been the advisory opinion process. It is through this that parties can obtain binding legal advice as to whether their existing or proposed health care business transactions run afoul of the Medicare/Medicaid anti-kickback statute, the Civil Monetary Penalties Law, or the program exclusion provisions. Congress recently extended the authority for the "advisory opinion" process in the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000. Over 60 formal advisory opinions have been issued since establishment of this function in 1997. The advisory opinion process also serves to improve the OIG's understanding of new and emerging health care business arrangements and guide the development of new safe harbor regulations, fraud alerts, and special advisory bulletins.

Since HIPAA's enactment, the OIG has promulgated nine new "safe harbors" under the Medicare/Medicaid anti-kickback statute, and clarified or modified seven existing regulatory safe harbors. These OIG issuances have all been published in the Federal Register and are also available on the OIG's web site (www.dhhs.gov/oig).

In addition, the OIG's final audit and inspection reports, as well as its annual work plan and other issuances, are published on its web site. Health care providers and other interested parties are regularly advised of new OIG issuances through a free "List Server" on its web site, which currently has approximately 9,000 registered subscribers.

Recent Successes

The education and training programs of CMS and the OIG are paying off. Our most recent annual report on Medicare payment errors found that Medicare made $11.9 billion in improper payments in FY 2000, 6.8 percent of all Medicare fee-for-service payments. This is down substantially from the $23.2 billion, or 14 percent, first reported for 1996. Thus, 93 percent of all bills are free of error when they are submitted.

The decrease in improper payments has had a positive effect on Medicare's financial situation. from 1991 to 1996, the Congressional Budget Office (CBO) reported that Medicare's rate of inflation averaged 10.9% per year. In FY 1998, the rate of inflation for the Medicare fee-for-service program dropped to the lowest in the program's entire history (since 1965): 1.5%. Overall, CBO calculated the average Medicare inflation rate for FY 1997 to FY 2000 at 3.2%. CBO commented that: "Most of the decline can be explained by a strong effort to ensure compliance with payment rules." (The Budget and Economic Outlook: fiscal Years 2002-2011, CBO, January 2001.

This demonstrates that error reduction is possible through the concerted efforts of health care providers and Medicare administrators. But it is still too high. Billions of dollars are at stake, and years of Medicare solvency will be lost if we do not control this error rate. We believe that continued, even intensified, ongoing efforts are necessary to help further reduce improper Medicare fee-for-service payments.

I wish to digress for a moment to emphasize that there are many reasons for the improper payments covered by the annual payment error report. They range from inadvertent mistakes to outright fraud and abuse. However, our annual payment error rate audit cannot determine whether an inappropriate provider payment is the result of an innocent error, a misunderstanding of Medicare coverage, pricing, or payment rules, carelessness, mismanagement, or outright fraud. It is sometimes characterized as a "fraud error" rate. But this is incorrect. It should not be construed as such. In fact, there are no reliable estimates regarding the level of fraud in the program.

Medicare Education and Regulatory Fairness Act of 2001

The Medicare Education and Regulatory Fairness Act of 2001 (H.R. 868) has been introduced to address some of the concerns of providers which I have discussed in my testimony. You asked the OIG to comment on this bill in our testimony, and I appreciate the opportunity to do so.

We recognize and appreciate the tremendous amount of thoughtful work that has gone into the development of this bill as well as the subsequent discussions and reviews that have been occurring since its introduction. We have also appreciated the opportunity to comment on its provisions.

Because your staff already have our detailed comments, I will limit my discussion here to the key principles underlying the bill and some of its key provisions.

Provider Education

First and foremost, as should be obvious from our discussion above, we strongly support increased education for health care providers. They deserve the best possible explanation of Medicare. Obviously, every attempt should be made to simplify the program so that it is easier to understand. But to the extent that complexities remain, every effort should be made to make program rules easy to understand. This will result in Medicare paying right the first time, thereby avoiding the frustrations of the overpayment collection and appeals systems.

Training can and should take on many forms--seminars, pamphlets, bulletins, dial-in question and answer services, and more formal advisory services. All these and more should be available. I have already mentioned some of the educational programs of the OIG. However, the main responsibility for provider education rests with CMS, which already provides such training and education through its intermediaries and carriers and various procedural guidances. Secretary Thompson recently announced new initiatives, including the identification of individual senior staff members to work with stakeholders, an expanded role for the Physicians' Regulatory Issues Team, more information on the Internet, and satellite broadcasts.

Thus, we support increased funding and new forums for provider training and education. We would urge the Congress, though, to make this funding available *in addition to* rather than *instead of* other administrative and program integrity functions such as claims review, as the bill now provides.

Immunity from Investigation

One area of concern for us is the granting of immunity from investigation under certain circumstances, such as the voluntary repayment of amounts received for erroneous claims, inquiries about Medicare policy, or participation in training programs. There is no need for such immunization. Physicians and other health care providers are not subject to civil or criminal penalties for honest mistakes, errors, or even negligence. However, those relatively few providers who would deliberately and fraudulently steal from the Medicare program would not hesitate to use this provision to immunize themselves from investigation and prosecution and, in essence, obtain interest free loans from Medicare.

Extrapolation

Extrapolation is the scientifically valid method of statistical sampling. It and has been fully accepted by the Federal courts as a method of estimating liability for overpayments. The bill would prohibit recoupments or offset payment amounts based on extrapolation for the first time that a provider is alleged to have received overpayments or when a provider submits a claim for advice of suitability (as provided for later in the bill in the section on education components). These provisions deprive the Medicare trust funds of the full amounts owed it and would eliminate an important tool in evaluating overpayments.

In discussing these provisions with various staff members and stakeholders, it appears to us that the objections to using extrapolation stem from two different concepts. One appears to be the idea that if a provider voluntarily acknowledges receipt of payments made in error, there need not be an obligation to repay the entire amount owed. Perhaps the thought is that erroneous bills may have been innocently submitted for some period of time before the error is discovered, and that the amount of overpayments is so high as to create a serious financial problem for the provider. Perhaps the thinking is that some recognition should be given for voluntarily owning up to the mistake or some recognition of the burden of a paying back large overpayment.

While on the surface these concepts may appear to be understandable, they do not represent sound business practice. To see this, one only need imagine what it would be like to be on the other side of this equation. If any of us were to discover that a medical insurance program had underpaid us over a period of, say, a year or two, we would probably expect to receive back the entire amount owed to us. If a telephone company overcharged a medical care provider for 12 months, the provider would probably expect credit on the whole bill, not just a recognition from the telephone company that it had made an error and will now credit only the last month. Similarly, a medical care provider might not be so understanding if Medicare had mistakenly underpaid it over a period of time.

Clearly, the correct business principle is that the amounts owed to Medicare should be fully paid, and vice-versa, providers should receive all that is due to them. However, the process whereby the amount owed is determined and the process of paying back should be reasonable and should take into account such things as cash flow needs. Thus, the proper response to this aspect of the problem is a careful examination of the overpayment collection system to ensure that it operates reasonably and efficiently. We would fully support any reasonable accommodations with regard to time frames, amounts of payment installments, methods of collection, interest rates, etc., that are needed to ensure the financial viability of providers who have received overpayments in error, while still recovering amounts owed to Medicare.

The second concern raised in connection with extrapolation is distrust of the reliability of statistical estimates. Some providers seem to believe that Medicare contractors will make assumptions that if one payment is made in error for a particular service, then all such payments are in error, and the that the contractor will demand full repayment of all such payments made. Alternatively, some providers may believe that samples used are too small to use for reliable projections. We have found that Medicare contractors do use probe samples as an initial estimate of repayment amounts, but they also offer the provider the option of a statistically valid random sample to develop a reliable estimate. Such sampling reduces burdens on providers considerably when compared to making a thorough claim-by-claim review, which is usually impractical and extremely burdensome to providers. Thus, the use of extrapolation is a way of minimizing, not increasing, provider burdens. It is also an essential tool for Medicare to recover the amounts owed to it.

Other Concerns and Opportunities

Immunity and extrapolation are not the only concerns we have about the bill as currently drafted. Others pertain to the length of time allowed for repayment, availability of documentation, and the like. At the same time, the resolution of the issues surrounding immunity and extrapolation as discussed above reflects what we believe is a promising approach to resolving concerns about burdens

on providers. We believe that most of these concerns can be addressed through a thoughtful examination of the overpayment collection process, with adjustments as necessary to provide reasonable procedures to secure for Medicare the amount due to it, while at the same time respecting the practical needs of providers who are doing their best to comply with Medicare rules. We will continue to work with your staff and stakeholders to accomplish this.

Fear of Prosecution

Providers' concerns follow two general lines of thought. The first is about burdens and complexity, a sense that things are too complicated, too hard to understand, and that paperwork requirements are excessive. I hope that many of the ideas discussed in this testimony will be helpful in alleviating these concerns.

At the same time, there seems to be a general concern that providers, however honest and responsible they may be, will be subject to audit or criminal prosecution just because they make mistakes. Some of the provisions of the proposed Medicare Education and Regulatory Fairness Act of 2001 are intended to address this aspect of provider concerns--by providing some degree of statutory protection from unreasonable audit, investigation, prosecution, and penalties. I thought it would be worthwhile to end my testimony with a brief discussion of this issue.

The Office of Inspector General has repeatedly stated its conviction that the great majority of health care providers are honest and committed to providing high quality medical care to Medicare beneficiaries. They need not fear unjust prosecution. Under the law, providers are not subject to civil, administrative, or criminal penalties for innocent errors, or even negligence. The government's primary enforcement tool, the Civil False Claims Act, covers only offenses that are committed with actual knowledge of the falsity of the claim, reckless disregard or deliberate ignorance of the truth or falsity of a claim. The False Claims Act does not cover mistakes, errors, or negligence. The OIG is very mindful of the difference between innocent errors ("erroneous claims") and reckless or intentional conduct ("fraudulent claims").

Rumors of unjustified arrests, investigations, and audits; non-specific allegations about excessive enforcement actions; and sweeping characterizations of the motives and attitudes of oversight professionals are simply not warranted by the record. Such statements themselves contribute to rather than alleviate the concerns of health care providers. The solution is to improve understanding of the oversight functions and to increase, through communication, the mutual trust and respect of the medical care and program integrity professions. This is far better than further increasing the complexity of the Medicare program through additional unnecessary laws and regulations. I hope my statement here will contribute to that result.

Conclusion

Our Medicare provider community is important to all of us. I hope that the suggestions provided here from the Office of Inspector General will be useful in protecting the financial integrity of the program, reducing frustrations of providers and administrators alike, and making the program better for Medicare beneficiaries. We are ready to help this committee and all parties involved to find a better way to manage this program. Thank you for the opportunity to present these ideas to you.

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