PREPARING THE HEALTH CARE FINANCING ADMINISTRATION FOR THE 21ST CENTURY

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

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PREPARING THE HEALTH CARE FINANCING ADMINISTRATION FOR THE 21ST CENTURY

THURSDAY, JANUARY 29, 1998

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The Subcommittee met, pursuant to notice, at 10:08 a.m., in room 1100, Longworth House Office Building, Hon. William Thomas (Chairman of the Subcommittee) presiding.

[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
January 21, 1998
No. HL-17

CONTACT: (202) 225-3943

Thomas Announces Hearing on Preparing the Health Care Financing Administration for the 21st Century

Congressman Bill Thomas (R-CA), Chairman, Subcommittee on Health of the Committee on Ways and Means, today announced that the Subcommittee will hold a hearing on "Preparing the Health Care Financing Administration (HCFA) for the 21st Century," with the new HCFA Administrator Nancy-Ann Min DeParle. **The hearing will take place on Thursday, January 29, 1998, in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 10:00 a.m.**

In view of the limited time available to hear witnesses, oral testimony at this hearing will be from invited witnesses only. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

BACKGROUND:

The Balanced Budget Act of 1997 (P.L. 105-33) made the most comprehensive reforms to Medicare since the inception of the program. The Congressional Budget Office now estimates that by the year 2002, 25 percent of beneficiaries will choose to enroll in a private health plan and by the year 2008, 38 percent of beneficiaries will make this choice. As the Medicare program undergoes historic changes, the role of the agency that administers Medicare must change as well. HCFA must shift from an agency that focuses on fee-for-service Medicare to one that is flexible to enough to foster, rather than impede, innovation among private plans.

Compounding this challenge are two significant changes--the agency has a new Administrator, and after more than a year of planning, the entire agency was recently reorganized. According to one senior HCFA official, the reorganization which "radically changed the composition of the agency" has resulted in low morale among staff and difficulties in determining priorities. These problems must be resolved now so that the agency can address the new challenges confronting Medicare in the next century.

In announcing the hearing, Chairman Thomas stated: "The Congress worked hard last year to make important policy changes that will save the Medicare program from bankruptcy and will provide our seniors more private health plan choices. The Administration must now ensure that these important changes are implemented in the manner intended. In addition, I want to begin a discussion of the structural changes that will need to be made to prepare HCFA for the challenges that it will face in the 21st century."

FOCUS OF THE HEARING:

The hearing will examine the Administration's plan for implementing the recent Medicare changes that were part of the Balanced Budget Act of 1997. It also will look to the future to identify what structural changes will be necessary to prepare HCFA for the 21st century.

(MORE)

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Any person or organization wishing to submit a written statement for the printed record of the hearing should *submit at least six (6) single-space legal-size copies of their statement, along with an IBM compatible 3.5-inch diskette in ASCII DOS Text or WordPerfect 5.1 format only, with their name, address, and hearing date noted on a label*, by the close of business, Thursday, February 12, 1998, to A.L. Singleton, Chief of Staff, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. If those filing written statements wish to have their statements distributed to the press and interested public at the hearing, they may deliver 200 additional copies for this purpose to the Subcommittee on Health office, room 1136 Longworth House Office Building, at least one hour before the hearing begins.

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages including attachments. **At the same time written statements are submitted to the Committee, witnesses are now requested to submit their statements on a 3.5-inch diskette in WordPerfect or ASCII format.**

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. A witness appearing at a public hearing, or submitting a statement for the record of a public hearing, or submitting written comments in response to a published request for comments by the Committee, must include on his statement or submission a list of all clients, persons, or organizations on whose behalf the witness appears.

4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and the public during the course of a public hearing may be submitted in other forms.

Note: All Committee advisories and news releases are available on the World Wide Web at "http://www.house.gov/ways_means/".

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202-225-1721 or 202-226-3411 TTD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

Chairman THOMAS. If the Subcommittee would come to order—I'd like to welcome our guests and witnesses to today's Health Subcommittee hearing with a rather broad title: Preparing the Health Care Financing Administration for the 21st Century. And I do want to welcome the Health Care Financing Administration's new Administrator, Nancy-Ann Min DeParle, who is going to take quite a large role in setting the tone for the underlying theme of the hearing.

In the past few months, the Health Care Financing Administration has undergone three significant changes. Obviously, a new Administrator. Secondly, the agency recently underwent a comprehensive reorganization affecting virtually every one of the more than 4,000 employees. And third, pretty obviously, the Congress passed and the President signed the Balanced Budget Act of 1997 which contains the most comprehensive Medicare reform since the inception of the program.

These reforms have, and will have, a dramatic impact on the Medicare program. Our seniors will be able to choose from a vast array of privately run, Medicare-plus-choice plans like Medicare savings accounts, provided-sponsor organization plans, health maintenance organizations, private fee-for-service plans, while maintaining the option of remaining in traditional fee-for-service Medicare.

The latest Congressional Budget Office estimates predict that many of our seniors will choose to leave fee-for-service Medicare and enroll in a privately-run plan. In just four years, one-quarter of beneficiaries are expected to choose to enroll in a private plan, and by 2030, it's projected that perhaps half of all beneficiaries will make a similar choice.

As a result of the Balanced Budget Act, there will also be significant payment changes, as many of us have heard about, to modernize the fee-for-service part of the program; shifting from a 1960-style cost-based reimbursement to prospective payment systems. There will also be several new preventive benefits, like the diabetes self-management, prostate screenings, and others, that need to be implemented.

Finally, the agency must ensure that taxpayer dollars are spent wisely by implementing some of the historic steps Congress has taken in the past two years. For example, the Health Insurance Portability and Accountability Act—and the fraud and abuse sections of that act—and the Balanced Budget Act combined offer about 65 concrete steps to fight waste, fraud, and abuse in Medicare and the American health care system.

Clearly, Ms. DeParle, you have your work cut out for you. In the short-run, you have to implement these new provisions. However, you also have to continue those structural changes to the management of the Health Care Financing Administration, some of which we are only now beginning to appreciate the depth and breadth of in operating a private-plan-focused environment in the 21st century.

I am concerned that an agency that historically focused on regulation and micro-management and paying the bills may have some difficulty without a lot of open understanding and positive critiques in transforming itself into one that protects seniors and fosters in-

novations among private plans. It is not easy for bureaucracies to make these kinds of fundamental shifts which go at the core of the culture of a particular bureaucracy.

This is the issue that we will begin to explore today with Mrs. DeParle, Mr. Scanlan from the General Accounting Office, and our panel of experts who will help us understand the changes that are needed to prepare the Health Care Financing Administration for the 21st century. And before we recognize the new Administrator, I'd ask my colleague from California, Mr. Stark, if he has any remarks.

Mr. STARK. Thank you, Mr. Chairman, I do have remarks. I'm not sure which you want first—good news or bad news. But I appreciate, on the good news side, I appreciate your holding this oversight hearing on HCFA's ability to administer the Medicare program and implement the changes required in the Balanced Budget Act. The bad news is that HCFA's administrative budget is inadequate to do any of the things that many of us might want. I hope we can work on a bipartisan basis to urge our colleagues who are the appropriators to give the agency the resources it needs. We're all aware that the best way to end an agency in this town, is to starve it for funds. If we really don't want HCFA to do anything, then we ought to just let the appropriators not give it the money. If we really want to get them to a program that we can agree on, we've got to see that they get adequate funds. We'll talk about that in a little bit.

But basically, the money HCFA gets to review claims, or the pennies per claim, is now 43 percent lower than it was in 1989. And I don't care how you slice that, when you cut the per-claim dollars darn near in half, the agency can't keep up. We've also added the fight for fraud which gets more sophisticated all the time. Still, with an ever declining budget, their volume of work goes up. Now, HCFA must get some volume discounts, but I think we have a responsibility to see that they get the funds to do whatever it is that this committee charges them to do—or this Congress does.

The administration is proposing a package of antifraud legislation, and I hope we'll enact it. Included in it is an idea that I'd like to advocate and that's doubling the number of audits for cost-based providers and paying for it with a fee to cover those costs. Many of those providers—Columbia and it's private accounting firm, KPMG in Florida—have proven that there's more than just smoke there. Audits there would have saved us a lot of money.

Part of the cost of doing business with Medicare must include the cost of an independent audit. By charging a fee, we'll be able to provide some of the resources it takes to protect the Medicare trust funds.

Explaining the new Medicare choice programs to seniors will be a daunting task for HCFA or anybody else. If they don't have the money to explain it, they can't do it. We authorized $200 million this year, but the appropriators only gave them $95 million. This fall, HCFA is likely to be flooded with calls from confused beneficiaries about the new array of plans and the wave of advertising that will come out. We all know that's going to happen.

Our staff this week just placed calls to HCFA's 800 number, and the results were troublesome. There were lengthy delays, and that

was the rule not the exception. And as any of you who have tried to get past 800 numbers to check your credit card know, I'm not sure whether money will solve all those problems. But I do know that these plans will be complex they will be confusing. Our own offices will hear from beneficiaries and we ought to do whatever we can: one, to encourage HCFA to see that the phones are answered promptly and there are people who can give you good information, and secondly, that we see that they get the resources to be able to do it.

Finally, you asked, Mr. Chairman, whether HCFA's reorganization produced a structure that is appropriate for the 21st century; and I'm afraid it isn't. We've got a situation like we've had—and criticized often—within the FAA. HCFA is in the business, or will be in the business, of promoting managed care at the same time it is trying to regulate it. And those are conflicting roles. You can't order people to promote something on the one hand, and then on the other hand come back and say you've got to investigate them and tell people when they aren't working correctly. I think we have to look at that issue and look for independent patient's counsel, or separating, if not explicit, implicit promotion of managed care and its regulation.

While the Cshairman may not like the ideas for regulations that are currently being circulated, we do need them. We've got to stop the cheers in the movie "As Good As It Gets" and somehow make the public convinced that they do have somebody on their side. And I hope our Subcommittee will look at that important issue.

Thank you for starting out the year with this hearing and I look forward to hearing from our witnesses.

Chairman THOMAS. I thank the gentleman.

This is a new year and a second session and I believe the spirit in which the gentleman made his comments is a constructive one and I did not go into any detail in my opening remarks rather than to just set the frame. I think you'll find, and now I guess I'll prompt our first witness, that our intention was to make sure that there was adequate funding for the administrative changes. We have tried to work in a cooperative way to make sure that if necessary the movement of money within the structure, and indeed additional money, could be made available. I had no intention whatsoever of creating new ways to deliver services and then not make sure they weren't adequately financed to do that. You and I could share some time discussing the appropriators and the way in which all of us have concerns about the appropriators.

Beyond the gentleman's concern for an organization that's not only going to regulate managed care but also supervise and run it, the same might be true for fee-for-service, and in fact they have almost a monopoly on that. We will have panelists who have looked at this problem and who have the same concern from adjustment within the culture of HCFA to eliminating HCFA. And I just think it's appropriate at this stage, maybe, to remember that the President has played a relatively significant role in getting us to refocus on the question of health care delivery in Medicare and in putting people first.

On page 21, the President said as part of his vision, if he were to be elected president, quote, "We will scrap the Health Care Fi-

nancing Administration and replace it with the Health Standards Board made up of consumers, providers, business, labor, and government that will establish annual health budget targets and outline a core benefits package." He didn't use the phrase, "whither away"; he used the phrase, "scrap." But what we're trying to do is make sure that these bold visions, although the end product might be something that we would agree with, the hastiness of a phrase like scrap clearly would not serve the beneficiaries.

What we need is planned change. And Mrs. DeParle is now in charge of an immense bureaucracy that has major responsibilities, frankly, significant economic impact if things aren't done correctly for the economy, and she's anxious to tell us about what she's already done as a new administrator and what she plans to do.

So, if my colleagues have any statement, we'd be willing to put a written statement in the record, but I'd like to turn now to the new director of the Health Care Financing Administration, Mrs. DeParle. The time is yours. Your written statement will be made a part of the record as always, and you can address us in any way you see fit.

STATEMENT OF NANCY-ANN MIN DE PARLE, DIRECTOR, HEALTH CARE FINANCING ADMINISTRATION

Ms. DEPARLE. Thank you, Mr. Chairman.

Mr. Chairman, Mr. Stark, and Members of the Subcommittee, I'm very pleased to have this opportunity to discuss with you my priorities as Administrator of the Health Care Financing Administration and their relationship to your theme today in preparing HCFA for the 21st century. Before getting into my priorities, I want to begin by describing what HCFA's recent reorganization is all about and how it's helping us meet our goals.

When HCFA was created in 1977, running the Medicare program primarily meant paying bills on time. After 20 years of significant changes in the health care environment, it is time to address whether the agency was organized in the best way to fulfill it's responsibilities.

Chairman THOMAS. Nancy-Ann.

Can you hear in the back? You need to turn that mic directly towards you and speak directly into it very closely. For some reason, the sound system, although we didn't have the best before, has gotten worse and it's no fun sitting there not hearing because what you have to say is important. You are going to have to talk directly into it and get relatively close. I'm sorry, go ahead.

Ms. DEPARLE. Thank you.

After 20 years of significant changes, we felt it was time to address whether we were organized in the best way to fulfill our responsibility. So, in 1996, the agency began a process that included consultation with a broad spectrum of individuals and groups with whom we interact: beneficiaries, the States, and health plans and providers. These are our three core markets.

We looked at private sector health plans and insurance companies. And the primary focus of the reorganization which was implemented last July was to structure the agency in such a way that these three core markets are at the center of what we do and that they have a one-stop shopping to address their needs.

The processes involved in reorganizing are difficult, as you all know. Even positive change can be traumatic. But we consider them to be growing pains; and I consider the reorganization to be something that was long overdue.

Our ultimate goal is to ensure that changes to the agency are implemented in a manner that makes Medicare and Medicaid stronger and more efficient, not only for today's beneficiaries, but for future generations.

My priorities as the Administrator of HCFA are simple to state but much harder to accomplish. I think they are very much consistent, Mr. Chairman, with your theme today, "Preparing HCFA for the 21st Century." They are: first, to reform and strengthen Medicare and Medicaid starting with implementing the Balanced Budget Act which expands choices for beneficiaries and guarantees Medicare's solvency until 2010; second, to implement the new Children's Health Insurance Program; third, to sharpen our focus against fraud and abuse; and, fourth, to ensure that HCFA's information systems are ready for the millennium.

Since the Children's Health Insurance Program and Medicaid are not within the oversight of this subcommittee, I'm going to focus on the other priorities.

My first priority is to ensure that we implement the Medicare reforms in the Balanced Budget Act, and not just that we implement them, but that we do it right. As you well know, Mr. Chairman, there were about 300 separate provisions that must be carried out to fully implement this law. Some of the provisions are simple, but some of them are extraordinarily complex. Our staff is working tirelessly to meet the deadlines, and they are working with your staff here very well. We're doing everything we can to get the job done with the resources we have, but as both you and Mr. Stark have acknowledged, the fact remains that our resources have diminished in real terms while our responsibilities have grown.

Let me put this in perspective. Between 1993 and 1997 Medicare's administrative spending in real dollars decreased by around 11 percent while the number of claims that we processed has gone up by about 25 percent. The number of managed care plans with Medicare contracts has more than doubled and the number of skilled nursing facilities and home health agencies has increased by over 30 percent.

Despite the new responsibilities that we received in the Balanced Budget Act and the Health Insurance Portability and Accessibility Act, our program management budget for this fiscal year increased only one-half of 1 percent. Many of our new responsibilities will require additional work in Fiscal Year 1999 and subsequent years.

And I do want to say that I thank the members of this subcommittee for their help with the 1998 budget, because, as the chairman noted, you and your staffs were helpful in trying to work with the appropriations committees and express to them the importance of the work that we're doing.

When the administration's budget is released next week, I hope we'll be able again to work together to ensure that we have adequate resources to do the good job of running these programs that you want us to do.

I'm committed to a smooth implementation of the Balanced Budget Act. I want to continue to work closely with this subcommittee and its staff.

Mr. Chairman, I am committed to stepping up the crackdown on fraud and abuse begun by the President in 1993. Since I've been at HCFA, we have taken several new steps to combat fraud and abuse. Just last week, we published a proposed regulation to tighten standards and strengthen enforcement against unscrupulous durable medical equipment suppliers. We are requiring on-site inspections before these new suppliers are approved. And also this month, we set tougher requirements for home health agencies and lifted a moratorium that we imposed last September on new agencies entering Medicare.

Beginning next month, the Inspector General's toll-free number—1–800–HHS–TIPS—will appear on every statement that we send to Medicare beneficiaries, so that they will know where to call to report Medicare fraud. And later this spring, we will host a National conference to bring together our colleagues in the Federal Government and the private sector as part of a process to develop a comprehensive anti-fraud and abuse plan.

We've made some good progress, but, as you know, the nature of health care fraud demands that we continuously find new ways to stay ahead of those who would misuse Medicare trust fund dollars.

I want to thank this committee for its support in the past and the work that you did last year in the Balanced Budget Act to give us some tools that we need, and we look forward to continuing to work with you this year in this effort.

Mr. Chairman, your theme today, "Preparing HCFA for the 21st Century," could not be more in tune with my third priority, which is the year 2000. I view the threat of a major problem with our National information flows and the potential impact that could have on Medicare with the utmost seriousness. And, I want you to know that we're working to do everything we can to ensure that the 74 mission-critical external systems that we have are millennium compliant no later then December 31 of this year. We're using on-site inspections and we're monitoring our contractors to ensure that we make the transition smoothly and in a timely manner.

In the next few years, HCFA will be challenged as it has never been before. But I believe we can do the job. The list of HCFA's accomplishments and innovations is long and distinguished, as this subcommittee knows.

I look forward to working with all of you to achieve our mutual goals of strengthening Medicare, extending the life of Medicare's Hospital Insurance Trust Fund, and providing beneficiaries with the best possible care in the most efficient manner. And I view this hearing today as good news, because I view this as a sign that you'll be working together with us as partners in this effort. Thank you.

[The prepared statement follows:]

STATEMENT OF

NANCY-ANN MIN DEPARLE

ADMINISTRATOR,

HEALTH CARE FINANCING ADMINISTRATION

ON

"PREPARING THE HEALTH CARE FINANCING ADMINISTRATION (HCFA) FOR THE 21st CENTURY"

BEFORE THE

HOUSE WAYS AND MEANS COMMITTEE

SUBCOMMITTEE ON HEALTH

JANUARY 29, 1998

HCFA
MEDICARE • MEDICAID
Health Care Financing Administration

INTRODUCTION

Mr. Chairman, Mr. Stark, and Members of this Subcommittee, I'm very pleased to have this opportunity to discuss my priorities as Administrator, and to explain how the re-organization is helping the Health Care Financing Administration (HCFA) achieve our mission, and to present a status report on our implementation of the Balanced Budget Act (BBA) passed last year. This ground-breaking piece of legislation provides for the most significant changes in Medicare and Medicaid since the original legislation was enacted more than thirty years ago. Implementing the Medicare and Medicaid BBA provisions, launching the new Children's Health Insurance Program (CHIP), fighting waste, fraud and abuse, and preparing our computer systems for the Year 2000 Millennium are among my highest priorities as Administrator. To achieve these goals in a tight fiscal environment, HCFA must be a finely tuned and smoothly running organization. The goals of the recent re-organization were to eliminate redundancies, improve the sharing of information, streamline processes, and maximize the efficient use of resources. We have concentrated on re-aligning agency components for the new organization into three main building blocks with a customer-based view in mind, recognizing that our primary audiences are beneficiaries, States, and health care providers and plans.

HCFA'S RE-ORGANIZATION

At the time HCFA was created in 1977, running the Medicare program primarily meant paying the bills on time. As the health care environment evolved in the following years, introducing new health care models such as managed care, it was clear that these changes needed to be addressed in HCFA's organizational structure. In the past, such activities as managed care responsibilities were added but not integrated into the organization in a coherent manner. After 20 years, it was time to address whether the organization was functioning efficiently. HCFA's recent re-organization was, in fact, the first comprehensive one since the Agency's inception. In early 1996, HCFA began a process of examining whether it was organized in the best way to fulfill its responsibilities. This process included consultation and discussion with a broad spectrum of individuals and groups with whom we interact. We carefully considered comments and recommendations from many sectors and tried to learn from many of the innovative approaches to management in the health care and business communities.

The culmination of the process was the reorganization that HCFA began six months ago. The primary focus of the reorganization was to structure the Agency in such a way that the primary groups with whom we interact --beneficiaries, the States, and health plans and providers-- have "one-stop shopping" to address their needs. An important decision was to combine the responsibilities for managed care and fee-for-service policy development and operations into a single organization. This allows HCFA greater flexibility to respond to changes in the environment as new and different delivery systems are developed. Another important focus was the creation of full-scope organizations for a Chief Information Officer (CIO) and a Chief Financial Officer (CFO) in response to Congressional direction that federal agencies should learn from private sector management experience and to comply with recently passed legislation.

HCFA has recently recruited its first-ever CIO from Los Alamos National Laboratory who brings current computer technology expertise as well as a specialized background in computer and network security issues. He is responsible for defining an information architecture and a capital asset plan for HCFA, as well as fostering the development of agency-wide information systems, including the critical efforts to achieve Millennium compliance of all computer data systems by December 31, 1998.

As with any agency adjusting to a major reorganization, there are both brand-new working relationships, and new policies and procedures. We are still in the process of "fine-tuning" our organization. I began my tenure as HCFA Administrator soon after HCFA's re-organization, and after my confirmation, I made a few changes. First of all, I ensured that critical staff, such as the CIO and the Program Integrity Director, had direct access to the Administrator, cutting away some of the layers of bureaucracy that sometimes prevent timely decisions from being made. Secondly, as specified by the BBA, the Office of the Actuary is now a separate office also reporting directly to me. I have attached a HCFA organizational chart to this testimony which shows these changes. In every sense, HCFA is making a fresh start, which we believe will strengthen the organization and allow us to meet our tremendous responsibility of being the nation's largest health care purchaser.

Some comments have been made about the re-assignments of employees and re-configuration of components within the agency, and I would like to say a word about this. As exemplified by private industry and noted in the National Performance Review, cross-training and sharing of personnel expertise is vital to the health of an organization. The processes involved in re-organizing are difficult at times, but we consider them "growing pains" that other agencies have experienced as well. However, we are beginning to see the benefits of agency streamlining and re-alignment, and it is clear that the benefits accrued outweigh the disadvantages. Through employee mentoring and staff rotation opportunities, we have tried to make the transition to the new organization as trauma-free as possible, and I believe that most HCFA staff support the objectives of the re-organization. My ultimate goal as HCFA Administrator is to ensure that changes to the agency are implemented in a manner that makes Medicare and Medicaid stronger and more efficient, not only for today's beneficiaries, but for future generations.

HCFA PRIORITIES

My priorities as HCFA Administrator are simple to state, but much harder to accomplish. As I stated earlier in my testimony, they are: first, to reform and strengthen Medicare and Medicaid, starting with the provisions of the Balanced Budget Act of 1997 that expand choices for beneficiaries and guarantee Medicare's solvency until 2010; second, to expand health care coverage to children through the new Children's Health Insurance Program (CHIP); third, to sharpen our focus against fraud and abuse; and fourth, to ensure that HCFA's information systems are ready for the Millennium. Since CHIP and Medicaid are not within the oversight of this Subcommittee, I will focus on the other priorities:

Priority #1 -- BBA Implementation

My goal is not only to ensure that the Balanced Budget Act provisions are implemented, but that we do it right. There are about 300 separate provisions that must be carried out to fully implement the law, and because some of them are extraordinarily complex, our project management staff is keeping track of implementation status of each item in a document that we plan to share with the staff of this Subcommittee and others. During just the month of December alone, we made significant headway in our BBA implementation plans. We completed 16 of the 18 regulations on our December agenda, and the remaining two were well on their way through the clearance process. This was double our pre-BBA average during a month that, historically, has decreased productivity due to reduced staff availability because of the holidays. Our staff worked tirelessly to finish these regulations in late-December and early January, a time which they otherwise would have spent among family and friends.

Under the best of circumstances, implementing the provisions of the new law would be a daunting challenge for HCFA. As it happens, we are taking it on at a time when the agency has just undergone a much-needed structural re-organization. As if this were not enough, we are also working with unusually tight deadlines and tight budgets. Our approach has been to organize ourselves internally to be as efficient and effective as we can be. We are combining resources and setting up new internal communication structures designed to share information without sacrificing valuable analyst and management time. We are working actively with our colleagues in the Department and at the Office of Management and Budget (OMB) to speed up internal review and clearance processes. In short, we are doing everything we can to get the job done with the resources we have, but the fact remains that our budgets have decreased in real terms, while our responsibilities have grown.

Between 1993 and 1997, HCFA has successfully met growing workload demands while decreasing its administrative spending in real dollars by about 11 percent. In this same period of time, the number of claims processed has gone up by 168 million, or about 25 percent. The number of managed care plans with whom we have contracts has increased from about 200 to over 400. At the same time, the number of skilled nursing facilities and home health agencies has increased by over 30 percent. With the addition of major new responsibilities through legislation such as HIPAA and BBA, HCFA faces considerable challenges in continuing to meet our goals.

We appreciate the fact that in action on the Fiscal Year 1998 appropriation, the Congress and in particular, this Subcommittee, worked to provide $95 million of the $200 million authorized for the beneficiary information requirements of BBA. The Congress also indicated that funds for BBA implementation were included. However, HCFA's program management budget increased only 0.5 percent over the previous year. Many of the new activities such as Medicare + Choice will require additional work in Fiscal Year 1999 and subsequent years. When the Administration's budget is released next week, I hope we will be able work together to ensure that HCFA has adequate resources to carry out the programs for which we are responsible. Secretary Shalala will be transmitting to Congress legislation implementing user fees to fund certain program management

activities. We will need your assistance to enact this legislation in early 1998.

At the same time, I intend to continue working closely with members of Congress to keep you informed of our progress and to let you know what we need to maintain the momentum. You understand the magnitude of the task we face and you know that we will be seeking more appropriations including additional user fees to complete implementation, particularly for our Beneficiary Information campaign. By maintaining a dialogue with you, I believe we can achieve the support and flexibility we will need to get it all done. At this point, I wish to describe the progress which we have made implementing some specific provisions of the BBA within this Subcommittee's jurisdiction.

Preventive Health Benefits

As of January 1, Medicare beneficiaries can receive a new set of preventive health benefits, which will include annual screening mammograms for women over 40; screening pap smears and pelvic exams every three years or more, depending on risk; and colorectal cancer screening exams for all beneficiaries over 50. In July, bone density measurements to detect osteoporosis will be covered. And in January, 2000, we will cover prostate cancer screening for men over 50. We are carrying out a comprehensive media and outreach campaign to get the word out to both providers and beneficiaries to take advantage of the new benefits.

Medicare+Choice

Another major provision of the budget law is the new Medicare Part C, known as the "Medicare + Choice" program. This program provides Medicare beneficiaries with a wider range of health plan choices, similar to those that are currently available in the private sector. It establishes a new authority permitting contracts between HCFA and a variety of different managed care and fee-for-service entities, including Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), and Provider-Sponsored Organizations (PSOs).

Implementation of the Medicare+Choice program is extraordinarily complex, cutting across every aspect of the Medicare program. We are on track with this effort. Starting on January 1, 1998, we began paying all risk-based Medicare contractors using the new Medicare + Choice payment methodology. We are on track for publishing solvency standards for PSOs by the April 1 deadline. Finally, we are on track for publishing interim final regulations for all other contracting standards by the June 1 deadline. Medicare +Choice and the new prevention benefits will be launched along with a nationwide information campaign that will be user-friendly and comprehensive.

Beneficiary Information Campaign

This information campaign is unprecedented in the history of Medicare and constitutes a fundamental change in the way we collect, store, and share information about plans and providers. We are offering beneficiaries an Internet-based resource that draws on all of HCFA's current data

and systems, along with new health plan information and a completely new enrollment process. This knowledge base will serve as a resource for enrollees, their families and friends, community-based organizations, insurance counselors, and other interested parties. In concert with this information campaign, our new Internet capabilities should be on-line next month and will enable users to access detailed comparative information on health plans through the "Medicare Compare" location at our HCFA web page. HCFA's Internet capabilities offer a revolutionary change in the ability to access Medicare and Medicaid information, since it will literally be available 24 hours a day, every day of the week.

Our Center for Beneficiary Services is developing a detailed plan for our 1998 information campaign. We will be using printed material, the Internet, a toll-free telephone system and community-based resources to make the information about options available to Medicare beneficiaries. Thanks to the caliber and dedication of the staff working on this, I am optimistic about this campaign, despite the uncharted territory incumbent in this enterprise.

Prospective Payment Systems (PPS)

Effective payment systems are vital to achieving quality health care and preventing waste, fraud, and abuse. The three new prospective payment systems for home health agencies, skilled nursing facilities, and outpatient departments will help us to achieve these goals. These prospective payment systems will provide incentives to make the most appropriate use of resources and, over the long-term, will help control overall expenditures. The cost-saving value of these payment systems is widely recognized and well-accepted in the industry. As an example, the Home Health PPS provision allows HCFA to establish a PPS that will pay providers a unit of payment for an episode of care. It also will end "periodic interim payments" to home health agencies that are made in advance and not reconciled until the end of each year. The law provides the authority to establish a prospective payment system by October 1, 1999, and we are working hard to meet that date with the necessary research and infrastructure development. Meanwhile, in accordance with the BBA, a home health interim payment system is being implemented.

Priority #2 -- Combating Waste, Fraud and Abuse

We must continue to fortify our programs so we can prevent incursions by those who view them not as the vital national resources they are, but as targets for money-making scams. As a bold step in the fight against fraud and abuse, the Administration imposed a moratorium on new home health agencies (HHAs), effective from September 15, 1997 through January 13, 1998. This moratorium allowed HCFA sufficient time to strengthen its entry requirements for HHAs. The Agency published a regulation on January 5, 1998, which requires surety bonds of all HHAs and initial capitalization standards for new HHAs. In addition, HCFA is requiring new HHAs to serve a minimum of ten patients before entering the Medicare program. Lastly, HCFA instituted a requirement that HHAs provide information on related businesses which they own.

The Health Insurance Portability and Accountability Act (HIPAA) and the Balanced Budget Act gave us new methods of preventing fraud and abuse and of identifying and punishing perpetrators; but we will not be satisfied with these efforts alone. Our strategy, which allows us to best manage our anti-fraud and abuse resources, has four basic principles: prevention, early detection, collaboration, and enforcement. As an example of our prevention and detection efforts, we have increased our efforts to review claims before payments are made, and as I mentioned before, we screen more carefully home health agencies and providers before certification, and require that they post surety bonds for home health agencies. We have also closed some loopholes with our new proposed regulation requiring surety bonds and strengthened our standards for durable medical equipment suppliers. These enhanced fraud prevention efforts contributed to a record number of civil and criminal prosecutions in FY 1997 --- double the number of prosecutions in the previous year. As the President announced just last week, in Fiscal Year 1997, we have collected nearly one billion dollars in fines for health care fraud. In addition, the Budget Submission for Fiscal Year 1999 will contain a number of new and previously submitted proposals to address waste, fraud, and abuse for consideration by this Subcommittee.

To enable beneficiaries to do their part in fighting fraud and waste, HCFA will begin publishing the HHS Inspector General's toll-free anti-fraud hotline on beneficiaries' Explanation of Medicare Benefits (EOMB) statement. Initially, the 1-800 numbers will appear on beneficiaries' EOMB in about half of the States, and will be expanded to the rest of the country in the spring. The hotline also offers assistance in both English and Spanish.

I consider a strong anti-fraud and abuse program an essential part of building public confidence in the future of Medicare and Medicaid, and our goal is to develop a comprehensive anti-fraud and abuse plan. We will meet early this spring with a broadly representative group from both the Federal and private sectors to listen their views and experiences. We plan to consider all possible avenues to combat fraud and abuse. I would like to acknowledge past Congressional support for these efforts in our budget requests, and note that the FY 1999 Budget will include increased funding for our increased responsibilities in BBA implementation and enhanced fraud and abuse prevention programs .

Priority #3 -- Year 2000 Millennium Initiatives

As we look to the future, the Year 2000 looms close on the horizon. In regard to the Millennium, I just want to say that we view the threat of a breakdown of our national information flows -- and its potential impact on Medicare -- with the utmost seriousness. Medicare represents approximately one-fifth of the nation's health care economy and we simply cannot afford to let this problem interfere with continuity in Medicare payment operations. We are working to ensure that the 74 mission-critical external systems are millennium compliant no later than December 31, 1998, and are monitoring our contractors to ensure that we make the transition smoothly and in a timely manner. I would like to emphasize that our regional staff are making on-site inspections to ensure that each and every item required is being completed on schedule, and at the present time, over half of the fiscal intermediaries and carriers have completed their assessments. I also intend to submit

legislation to amend the existing carrier and intermediary contracts to allow HCFA to terminate the contract and/or migrate to other contractor types if the contractor falls behind the project schedule.

At this point I would like to directly address an area which this Subcommittee has been concerned with -- the Medicare Transaction System project. We have recently received the final deliverable from GTE and the contract is now over. We do not yet know the final costs because they cannot be determined until the HHS Office of the Inspector General has completed the audit of the GTE contract. With the termination of the contract we are no longer continuing the Medicare Transaction System. I want to be clear, however, about the status of our efforts. We are moving forward on two tracks. First, we are beginning the process of developing an overall information architecture and a capital asset plan, the prerequisite to any future systems development efforts. This is a complex effort, but we plan to keep the Subcommittee informed of future developments. We are committed to meeting the spirit as well as the letter of the Information Technology Management Reform Act (ITMRA) to ensure that HCFA systems resources are wisely invested to meet our highest priority business needs. In the meantime, we are continuing to make modifications to the current systems needed to implement BBA and HIPAA requirements. Without these changes, the significant Medicare savings enacted in BBA could not be achieved. We welcome your continued interest in information technology and will work with you to ensure that business needs are met and resources invested wisely.

CONCLUSION

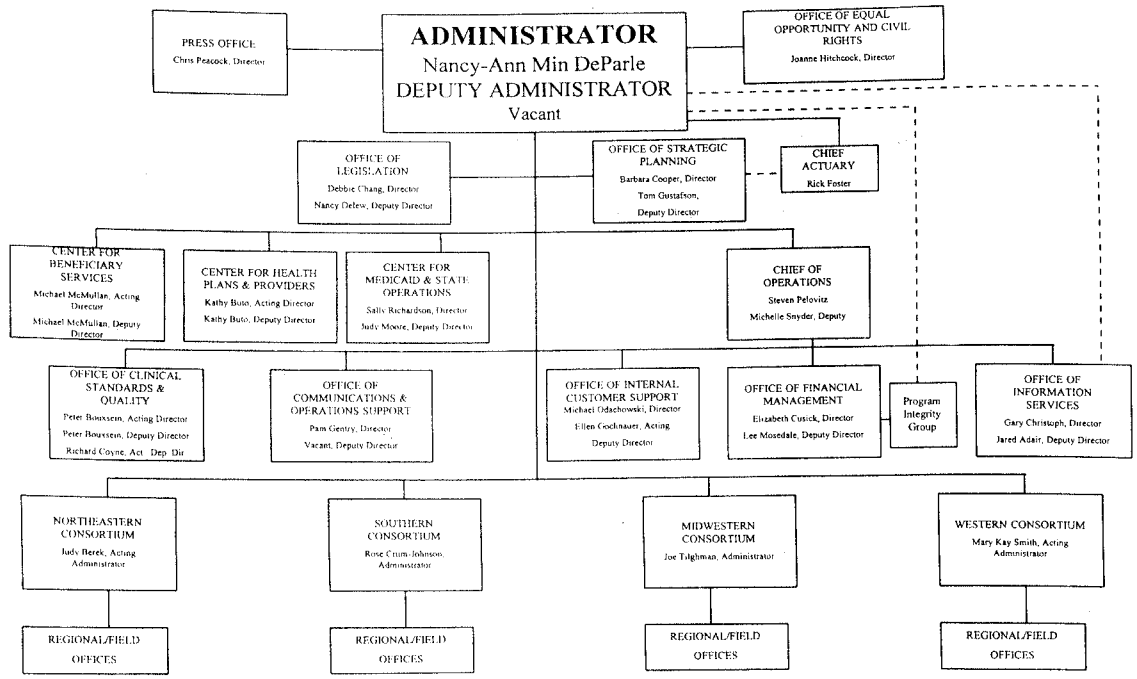
Agencies, like individuals, are often faced with multiple and sometimes conflicting responsibilities. In 1998, HCFA will be challenged as never before to meet new and expanded needs of Medicare and Medicaid beneficiaries. We are witnessing an unprecedented demographic shift, as greater numbers of elderly than ever before become eligible for Medicare. This is why BBA implementation takes on such a great significance, since it will add 10 years of additional solvency to the Medicare Hospital Insurance Trust Fund. At the same time, many HCFA personnel will be asked to carry a heavier burden of added tasks and adjust to new offices and co-workers. I can say without hesitation that I have great confidence in the ability of HCFA employees to meet these challenges, and I have been consistently impressed by their ability to get the job done.

I would also point out that, though my observations reflect our recent efforts, the list of HCFA's accomplishments, past and ongoing, is long and distinguished. This is the agency that pioneered fee schedules, and it is my expectation that it will likewise be the agency viewed as a pioneer in setting quality, risk-adjustment, and purchasing standards in the future. HCFA established a common set of expectations for 50 diverse Medicaid programs in the past and we will work with our partners in State government to bring Medicaid program administration into the twenty-first century. This same partnership will serve to launch the new Children's Health program and enable more than 5 million of society's most vulnerable members to get off to a healthy start in life.

Thanks to the BBA, we will see concrete improvements in our programs that will provide tangible improvements in services for our beneficiaries. Our highest priority will be to work closely with Congress on implementation of BBA, and to keep you informed of our progress. We are making every effort to meet the required deadlines and will seek extensions only when absolutely necessary. I am confident that together, we can achieve our mutual goals of strengthening Medicare and Medicaid, extending the life of Medicare's Hospital Insurance Trust Fund, and providing beneficiaries with the best possible care in the most efficient manner.

HCFA ORGANIZATIONAL STRUCTURE

Date: 01/21/98



Chairman THOMAS. Thank you very much. And obviously in your oral presentation, you could not go into the depth or the breadth that your written statement provides, and I urge all members to, if they possibly have time, not just look at but read the written statement, because it does provide, I think, a clear understanding of the magnitude of the problem in front of us. And I don't think anyone should take lightly the difficulty in one, running this organization, and two, in getting it to change, as I've said several times now, the basic culture.

And my friend from California points out rightly, and I'm pleased that you indicate, that if we're going to ask you to do certain things that we ought to provide you with the wherewithal to do them. We will continue to try to do that since there are a number of people who have differing priorities than we might, and we have to get other people to buy our priorities and change theirs.

So there is, to a certain extent, always going to be tight dollars, and I'm always willing to fight for sufficient funds to run a program right. But what would concern me is if I fought to try to get funds to run a program, and then I found out that those funds were being used for something else. I do not think in the long run it's wise to rob Peter to pay Paul. For example, I'll ask a hypothetical and hopefully elicit a reaction from you.

We obviously had some priorities in making changes and funded some areas perhaps adequately with a concern that some other areas that someone else's priorities would indicate needed more money were not funded as adequately. And my hope would be that you would never use, for example, Medicare program integrity dollars to finance fee-for-service contractor training, outreach activities, physician-provider satisfaction surveys; things that really are more administrative in nature from a program that we had kind of indicated should go in a particular direction. I would invite a response from you about trying to move money from areas that we've cooperated to put money in to run other areas.

Ms. DEPARLE. Well, sir, the area that you mentioned in particular, Medicare program integrity funding, is one of my top priorities, as I've said. And we fought hard together to get that money, and it is very important that we have it. As Mr. Stark pointed out, we are not able to review the number of claims and audit the number of providers that we want to do right now, so I would not be pleased to hear we were using those moneys on other things. I can understand the chairman's view on that.

Chairman THOMAS. I understand you would not be pleased to hear that, but you are, I think, in a position to assert yourself so that it doesn't happen, or at least make it clear that it is not your desire if it is imposed.

Ms. DEPARLE. I would make that clear.

Chairman THOMAS. Thank you very much.

You have not been on board that long, I want to make it clear. I believe your confirmation was November 10.

Ms. DEPARLE. I believe it was November 8.

Chairman THOMAS. November 8. Good. Because on November 7, I asked GAO to investigate the Technology Advisory Committee in terms of the manner in which it was meeting. I believe that the GAO has provided us with what I thought was the case: that it

was, in fact, in violation. And I would invite a brief reaction from you, on the record, of the GAO's finding of the manner in which the Technology Advisory Committee was meeting.

Ms. DEPARLE. Well, sir, as you know, I'm a lawyer, and I'm not acting as a lawyer in my current job, but I learned a lot about the Technology Advisory Committee in my first week on the job, thanks to you, and I think that the GAO is exactly right. It was not operating in a lawful manner and we won't operate that way in the future. And I believe our response from the staff acknowledged that, sir.

Chairman THOMAS. Thank you very much.

Mr. Stark. Do you wish to inquire?

Mr. STARK. Thanks, Mr. Chairman.

Some of these home health agencies are apparently now frightening seniors into calling our offices. They are frightening the seniors with a story that says that their benefits will be cut off and they'll no longer be eligible for services. Now, we know that's not correct, but is there anything that you can do—when we can identify these scare tactics to end them? Could suggest to these groups that it doesn't help their case?

Ms. DEPARLE. It does appear, Mr. Stark, that there is a concerted campaign going on to scare some of our home health beneficiaries on a couple of these provisions that were enacted in the Balanced Budget Act. I've confronted it myself when I was traveling last week and meeting with beneficiaries.

We're writing a letter to all the home health companies warning them that if they persist in trying to scare beneficiaries and we have evidence of that, that we will consider that to be a complaint that would require an investigation of the agency. And we're also doing everything we can to let beneficiaries know that it's not accurate to say that they're going to all lose their services. We've also met with the industry representatives here in Washington to let them know of our view on that.

Mr. STARK. That's great. And could I ask a favor? I know most of my colleagues are more adept at understanding these regulations than I am, but could I get from you a letter or a memo with some short declarative sentences of what these complaints are and why they are wrong? It would be helpful for me to use either in a newsletter or in answering my own constituents to be able say "Here's what the Government says; you are being unnecessarily frightened by these people, please report to me if that happens." And it would be helpful to us to put those rumors to rest. I'd appreciate that.

Now we've got another problem. There is a fund-raising group known as the United Seniors Association who are spreading false information on the issue of private contracting and the Kyl amendment. Could you state for the record, and I'll clip it out later, as concisely as you can, what the law is. Do my constituents need a private contract for something that Medicare doesn't cover?

Ms. DEPARLE. No, sir, they don't and they never have.

Mr. STARK. And if it is questionable whether Medicare covers a particular service or not, can you explain what this advance beneficiaries notice option is, again for the record, so I can tell my constituents?

Ms. DEPARLE. I think I can, sir. In a case where Medicare's coverage is questionable—an example would be a test that might be for screening purposes instead of diagnostic purposes, where the physician just isn't sure—the law provides that the physician should give the beneficiary an advance beneficiary's notice. That's just a statement that says that they acknowledge that Medicare might not cover the service and that if Medicare doesn't cover it, the beneficiary is responsible. And then the carrier medical directors make the decision about whether it's actually covered.

So, that's a simple process in those few instances where there's some question about it. And it's done that way to protect both the beneficiaries and the physician, because in that way the physician has notified the beneficiary that they may be responsible for paying for it. It is not necessary that a private contract be entered into for a physician to supply a service to a beneficiary in that way.

Mr. STARK. Thanks. Before the light goes, let me just ask you then to comment on the fact that in 1998, we're going to spend $216 billion in benefits. By 2008, almost regardless of what the various commissions do, we're scheduled to spend some $450 billion in benefits. That is almost a 100 percent increase over the next 10 years. The CBO estimates that we'll spend $3.7 billion for administration in 1998. That will only increase to $5.8 billion in 2008. This is an increase of maybe 50 percent—55 percent. So the administrative resources will decrease from 1.7 percent to 1.3 percent. At the same time, all the other private plans spend 20 percent on average in administrative costs. One of the lowest cost plans is in California—Kaiser. I think they are at 12 percent Administrative costs. HCFA is running this in single digit. Some people might want to do the intermediaries' costs, but you're still in single digit overhead.

Can you give us some idea of what you think that portends for our ability to go after fraud and to administer the variety of new plans that are coming? Are you prepared to give us some idea of how much more money HCFA will need to handle the increased volume and the increased complexity?

Ms. DEPARLE. Well, it's not a very pretty picture. The numbers that you have cited don't portend well at all for our ability to do the job that we need to do. I think we are managing now, but we are just managing. I don't think we're able to do everything that this subcommittee wants us to be able to do, certainly not in the area of combating fraud and abuse. And with a ratio like the one you mentioned, the number of claims that we could review, the number of audits that we could conduct, will be even less. Now, one answer to that is doing a better job at the front end, which is what we're trying to do with some these new provider enrollment standards.

But, sir, even that, at the order of magnitude that you've talked about and with the growth of claims and growth of the program, won't allow us to keep up. So, we have some very serious work ahead of us. And I think this year's budget, if we can work with this committee and your colleagues to get it enacted, is a step in the right direction. But we certainly need more help there.

Mr. STARK. Will you indulge me for one more request, Mr. Chairman?

What I'm leading up to, for my colleague's sake, is that in the Medicare plan we probably have fewer employees than most large insurance companies and we are spending less, or at least the same. Yet, we're often criticized for running big bureaucracies. I think that the HCFA bureaucracy is a reasonable bureaucracy by any private industry standard. To that end, Nancy-Ann, would you send me information about how many employees are active in administering Medicare, and include how many employees the fiscal intermediaries have? We'll then try to see what we can get from the private side to see how HCFA compares. I will provide that to my colleagues to have some measure of how efficient or inefficient the bureaucracy is. That will come up anyway and we might as well face it headon. I'd appreciate whatever you could send to the chairman and myself on that issue.

Thanks very much. Thank you, Mr. Chairman.

[The information was not available at the time of printing.]

Ms. DEPARLE. Thank you.

Chairman THOMAS. That would be useful.

Does the gentleman from Louisiana wish to inquire?

Mr. MCCRERY. Yes, thank you, Mr. Chairman, and welcome Ms. DeParle.

Ms. DEPARLE. Thank you.

Mr. MCCRERY. We look forward to working with you. Just a brief follow-on to Mr. Stark's last line of questioning, though. It would also be interesting, I think, if we could get reliable data on the level of fraud and abuse in the Medicare program as opposed to private sector plans, and also, perhaps, overutilization in Medicare programs compared to private plans. But, that's not what I wanted to ask you about.

Two things, since you brought up the BBA, I'd like for you to address the practice expense relative values for the physician fee schedule, and payment methodology for EPOGEN under the ESRD program.

With regard to practice expense, as you probably know, the BBA outlined two specific mandates on HCFA: No. 1 to require HCFA to use to the maximum extent possible generally accepted costing principles and those principles would recognize all staff equipment, supplies, and expenses, not just those which can be tied to specific procedures; and, No. 2, it required HCFA to develop actual data on equipment utilization and other key assumptions for the May rulemaking.

So, if you could comment on those two requirement in the BBA, I'd appreciate it. And then, when you get through, I'll follow up with the EPOGEN question.

Ms. DEPARLE. Yes, sir. Well, as you know, the practice expense requirement is something that has been in place for some time but this year Congress asked us to hold up on implementing it to give more time for the kind of data that you just mentioned to be produced. We published a notice of pre-rulemaking in the Federal Register back in October asking for help from the physician community and others in obtaining the kind of information on actual resource use that you're talking about.

We've conducted three major activities involving the physician community regarding data. On October 6 through October 8, we

held 17 medical specialty panels in Baltimore and they were charged with validating the resource data for the high-volume CPT codes for each specialty. And all the major medical specialty societies were represented. We held a forum on indirect practice expenses on November 21. And again, all the major medical specialty societies were there. And we held a cross-specialty panel in December—for two days in December—and the main purpose of that was to standardize the resource inputs for the direct practice expenses across specialties.

I'm also aware, sir, of the comments about the accounting principles because we have started getting comments in to our pre-rulemaking. And we will continue to look at that and to work with the physician community on it. But I do believe we are doing what Congress asked us to do in terms of meeting with these groups and making sure that we give them a process and a forum to get their input into this process.

Mr. MCCRERY. And do you anticipate that you are going to incorporate data—new data—into your May rulemaking?

Ms. DEPARLE. I cannot comment at this time on where that process is. I, in fact, have a briefing on this on Friday. So, I don't know where they are after the December meeting, but I'd be happy to get back with your staff on that.

Mr. MCCRERY. Okay. We would appreciate it if you would give that some attention. It is of some interest to the physician community.

No. 2, on the question of EPOGEN. And, again, if you're not prepared to address this specifically, I understand, but I do want to bring it up because it is important. I've heard from a number of constituents, including a treating nephrologist from the Oschner clinic in Louisiana, that some patients have to be hospitalized as a result of this change in policy. I believe the entire provider population is unified behind a position in support of changing this policy and have offered some specific changes to HCFA. Could you comment on where that is and what your opinion is on it?

Ms. DEPARLE. We're looking at it, sir, and I have seen, in addition to letters from the provider community, on a bipartisan basis, letters from you and your colleagues about this which is what brought it to my attention. There was a program integrity problem in this area. We want to make sure we have the best procedure possible to make sure that the patients get what they need, but also that we don't create a situation that is subject to abuse. And if we need to make some changes, then we'll do that.

Mr. MCCRERY. Well, I would ask you to make sure that in analyzing the potential costs, that you look at overall costs, including hospitalization and transfusions, as well as just the cost of the hematocrits, because it could make some difference in your analysis.

Ms. DEPARLE. Yes, sir.

Mr. MCCRERY. Thank you.

Chairman THOMAS. Does the gentleman from New York wish to inquire?

Mr. HOUGHTON. Thank you very much, Mr. Chairman. Ms. DeParle, it is nice to see you. Thank you very much for coming here.

I guess I want to hone in for a second on the question of fraud and abuse. You have it with the fee-for-service; you really don't have it for the managed care because the incentive are—there isn't any incentive——

Chairman THOMAS. Amo, I apologize, but these mikes aren't working. You need to really get close to them, because I can't even hear you.

Mr. HOUGHTON. You don't like my soft, dulcet tone?

Chairman THOMAS. I do, if I knew what it meant. [Laughter.]

Mr. HOUGHTON. Well, anyway, let me start again by saying I'm delighted you are here; thank you for being with us today.

Ms. DEPARLE. Thank you.

Mr. HOUGHTON. I guess I wanted to concentrate on the issue of fraud and abuse because as you move more toward managed care, there is probably less incentive, because of the direct payments to the government, as contrasted with the fee-for-service. But I guess the question I've got, as you lessen that input, the question is one of quality and how we're able to ensure and emphasize the quality aspects where the money aspects are taken care of in an entirely different way. You may want to comment about that. And also, maybe you might talk a little bit about child care expansion in the limited period of time you have. Thank you.

Ms. DEPARLE. I'm sorry, about what?

Mr. HOUGHTON. Child care expansion, you mentioned that.

Ms. DEPARLE. Child care expansion?

Mr. HOUGHTON. Child care expansion program is one of your main goals, as I understand it.

Ms. DEPARLE. Oh, I'm sorry; the Children's Health Insurance Program.

Mr. HOUGHTON. Yes, right.

Ms. DEPARLE. Yes, sir, I thought you meant day care for a second. I was trying to think about what I knew about that.

Mr. HOUGHTON. No, that's only for senior citizens like me.

Ms. DEPARLE. I'd be happy to talk about the Children's Health Insurance Program.

We are off to a good start. We have 16 plans from States around the country that are in and being reviewed on a very tight timeframe. And we're moving along very quickly on that. And, we've also been out meeting with a lot of the States to provide them with technical assistance. There is a lot of enthusiasm out there, and at this point, my prediction is that all 50 States will come in some time before the end of the year with a plan, and I hope we'll be able to approve them so they'll be able to get their funding and we can begin to cover as many of the 10 million uninsured children as possible.

I'm not sure sitting here whether New York is one of those plans or not. Is it? New York has been submitted. And I know we talked about that when I met with you earlier.

On your other question on quality—that is, of course, one of the big questions that I didn't even get to in my opening statement—we are certainly trying to move in the direction of ensuring that the new Medicare-plus-choice format for managed care plans in Medicare will include a focus on quality. And I think this subcommittee supported that effort with some of the provisions in the

Balanced Budget Act. We have acquired all of the science to submit on quality. We're also going out in the field to our consumers with the consumer assessment of health plans that will be incorporated into the kind of data that we provide them when they get their new Medicare-plus-choice information through the beneficiary campaign this fall.

So, I believe those kinds of indicators will be available to our beneficiaries, and then the issue is: how do we focus our resources on ensuring that quality is occurring. And that is a big problem and I hope your colleague sitting two down from you, Dr. Cooksey, can help with that. So we do have efforts underway there but we will need to continue working with the subcommittee to make sure we're going in the right direction.

Mr. HOUGHTON. Thank you very much.

Chairman THOMAS. Does the gentleman from Georgia wish to inquire?

Mr. LEWIS. Thank you very much, Mr. Chairman.

First, let me welcome you in your new position and wish you well.

Ms. DEPARLE. Thank you.

Mr. LEWIS. Your agency is facing many important challenges and I am very confident, with your background, your talent and skill, and your smarts, that you will lead the agency very well. And I also want to add that I think HCFA has done a very good job in many areas. But I do have one or two questions.

Like many Members of Congress, I have been contacted by individuals who are concerned about the provision in the Balanced Budget Act regarding venipuncture. They're concerned that very needy people will lose their home health benefit. I would like to see HCFA monitor this situation. In light of your new responsibility, and in light of GAO testimony, I am concerned that you do not have enough resources to monitor this situation. Do you feel that HCFA has enough resources to monitor this situation, or what do you think you need to do about this?

Ms. DEPARLE. Well, as you know, sir, the venipuncture provision was designed to reduce unnecessary utilization in the home health program. And what our Inspector General and our staff were finding was that a number of people were getting the full range of home health care services—24-hour nursing care and things like that—simply because they needed their blood drawn. Now if a Medicare beneficiary needs his or her blood drawn, Medicare will pay for that; and if they cannot leave their home or don't want to leave their home to get it, Medicare will pay for that too. But the point is that Medicare can't afford to bear the cost of several hundred dollars—multiples of hundred dollars a day—for them to get the full array of home health services if they simply need their blood drawn.

The unfortunate thing is that some of the home health companies are trying to scare many of these beneficiaries, and perhaps that's what you've been hearing, and other members have been hearing.

Someone who's diabetic, someone who is frail and elderly, is likely to qualify for home health. And it's not fair for the home health companies—in fact, it's wrong for them—to go out and tell the

beneficiaries in your district that none of you are going to get this anymore, because that is not the case. If they are qualified, if they are homebound and they need skilled or intermittent nursing care, they will be qualified for this benefit. The people who will no longer be qualified are simply those who only need their blood drawn, and the actual drawing of the blood of course will continue to be covered by Medicare.

And we do want to work with you, sir, to monitor the situation and make sure that beneficiaries who need this service are continuing to get it. And I hope once this confusion is cleared up, that problem will not be as apparent any more.

Mr. LEWIS. Thank you. Let me ask you another question. Nearly 40 percent of the end-stage renal disease population are African-American, even though we make up only about 11 percent of the population. It is my understanding that the outcome for the African-American end-stage renal disease population is not as good as with other populations. Could you comment on this situation? What steps could you take that might improve this situation?

Ms. DEPARLE. I'm not as familiar with the situation on end-stage renal disease, sir, but I do know that in many of the health indicators—health status indicators—that we look at for our population, we find that African-American beneficiaries don't get the services they need as often. Immunizations is an example; flu shots; mammograms. In many of those areas, we find that that community is not as well served.

We are working in partnership with historically-Black colleges and universities around the country to try to do some focused campaigns to reach that population. And I might also add that we've been talking today about HCFA's reorganization, and one aspect of that that I think is positive for our ability to do a better job here is that we've created for the first time a center for beneficiary services. That center will be the one conducting the beneficiary information campaign. And one of their goals is to try to make sure that they do things not just for the population as a whole, but that they try to figure out what the best ways are to reach other populations that may be particularly needy or vulnerable so that, with the new preventive benefits that Congress just enacted that are very positive, we can make sure that our African-American beneficiaries receive the full promise of those new benefits.

Mr. LEWIS. I appreciate you responding. I look forward to working with you.

The Surety Association of America has reported that the way home health agency surety bond regulations have been written, their members are unwilling to write bonds. Will you describe for the committee your understanding of the situation and what will be done to resolve this issue before the bond due date of February 27?

Ms. DEPARLE. Well, as you know, Mr. Lewis, this provision that we are talking about here is the new surety bond provision that was enacted in the Balanced Budget Act, and it gives us the ability to require a home health provider to post a surety bond so that if Medicare is defrauded that Medicare will have some ability to recover from them. And that is a good step forward. That's been done in the State of Florida, and it has had a very good result.

There appears to be an issue with the surety companies about the cumulative liability that they might have and the length of the liability. And our staff met with the surety companies recently. Our goal is to have the best regulation possible that protects Medicare. And we are working with them on it. And if we need to make some technical changes, we're willing to do that.

Mr. LEWIS. Thank you very much. Thank you, Mr. Chairman.

Chairman THOMAS. I thank the gentleman from Georgia for his inquiry in that area. We are working. This is a specific example of where everyone on all sides, I believe, is honest and willing, it's just that the technicalities and the way in which the conditions have to be set clearly have to be adjusted so that folks can enter into arrangements with a clear understanding. And I'm convinced that we're going to clear this up before any critical date might arrive. I appreciate the gentleman's question on the matter.

Does the gentleman from Texas wish to inquire?

Mr. SAM JOHNSON of Texas. Thank you, Mr. Chairman.

We've been having an argument up here, so I would like to ask you the question and let you straighten the facts out. Do you have a board that helps you run this HCFA operation, or are you——

Ms. DEPARLE. No, I don't.

Mr. SAM JOHNSON of Texas. Okay, but there is a Part A and Part B board, correct? Advisory board, or trust board?

Ms. DEPARLE. Yes, sir, there are trustees. There is a trust fund board for Part A and Part B; yes, sir.

I am the Administrator and we have an executive council that is the leadership of our organization that runs it. But we do not have an outside board. But we do have trust funds for Part A and Part B and those have trustees.

Mr. SAM JOHNSON of Texas. Okay, and your internal organization sets the rates for each county. Is that correct?

Ms. DEPARLE. Well, not exactly, sir. Most of the fee-for-service payments, and for that matter managed care payments, the payment methodology for everything Medicare buys is pretty much set in statute.

Mr. SAM JOHNSON of Texas. Yes, but you change it every year.

Ms. DEPARLE. According to a formula; yes, sir. Some of those things are changed every year according to a formula.

Mr. SAM JOHNSON of Texas. Are there any doctors involved in that change process?

Ms. DEPARLE. There are a number of doctors in our agency, sir. And we also have a——

Mr. SAM JOHNSON of Texas. Yes, but that didn't answer the question. Are they involved in the change process?

Ms. DEPARLE. I don't know. I believe there are some——

Mr. SAM JOHNSON of Texas. You see, you're a lawyer and you're trying to run a medical organization. I'm trying to find out if you've got any medical expertise in your organization to advise you.

Ms. DEPARLE. We do have medical expertise in the agency that advises me.

Mr. SAM JOHNSON of Texas. And who is your closest medical advisor?

Ms. DEPARLE. Well, each one of the centers has a medical advisor.

Mr. SAM JOHNSON of Texas. You're dodging the question again. I want to know who advises you personally.

Ms. DEPARLE. Probably the one who I work with the most is Dr. Jeffrey Kang, who is the medical advisor for the Center for Health Plans and Providers.

Mr. SAM JOHNSON of Texas. Do you know if he's ever practiced medicine, or is he an academic?

Ms. DEPARLE. I believe he has practiced, yes. I believe he practiced in the Boston area.

Mr. SAM JOHNSON of Texas. In Boston?

Ms. DEPARLE. Yes.

Mr. SAM JOHNSON of Texas. Thank you for that.

Let me ask you another question that we're discussing. I'm getting a lot of complaints from my military retirees about Tri-care. How does Tri-care interface with Medicare? And when they become 65, does Tri-care still have any jurisdiction over the retired veteran population?

Ms. DEPARLE. Well, I would like to get you more information for the record, sir, but I can tell you that Tri-care doesn't interact with Medicare very much, except that now, as a result of the Balanced Budget Act, we are entering into a demonstration with the Department of Defense to enable some of the military retirees who are not able to take advantage of Tri-care to come to the Medicare system and use their Medicare dollars to go to Tri-care.

Mr. SAM JOHNSON of Texas. Before 65, or after 65?

Ms. DEPARLE. After 65.

Mr. SAM JOHNSON of Texas. Okay. So what you're telling me is Tri-care should continue after 65. I thought it was a law that everybody had to get on Medicare at 65.

Ms. DEPARLE. It has been. But, what I'm saying is there is a demonstration that will allow a military retiree to take his Medicare coverage and go to a Tri-care facility. And that will be starting, I think, sometime in the next year.

Mr. SAM JOHNSON of Texas. And that means a veterans' hospital, does it not?

Ms. DEPARLE. No, it means probably a DOD facility and they contract in various areas. There is not a provision for veterans at this time, although I think this subcommittee has been working on that.

Chairman THOMAS. Will the gentleman yield on that point?

Mr. SAM JOHNSON of Texas. Sure.

Chairman THOMAS. The Department of Defense has been interested in the retired military and its possibility of utilizing Medicare dollars for military retirees at military hospital facilities or contracting out through the military in an effort to broaden the support structure for military hospitals. That is the program that you've been discussing.

Veterans, in what they call a vision program, worked on by the Veterans' Administration, have wanted to have a demonstration program, similar to the military retirees, for those veterans that fall into the category of A versus C kind of a veteran; that is those who have the wherewithal normally. We are—Chairman Stump of the Veterans' Committee and I the chairman of this subcommittee are going to offer—a piece of legislation which will model a vet-

erans' demonstration program for that aspect of the veterans' hospitals with the upper-income veterans, like the Tri-care demonstration. But we will go beyond that, and in dealing with the low-income Medicaid-eligible-type veterans, we're going to create a permanent program, rather than a demonstration because there is a clear need. And Dr. Kizer of the Veterans' Administration is in full agreement that we can go to a contracting-out basis so that veterans can get the filled prescription, outpatient medical care that normally had been delivered by outpatient clinics or veterans' hospitals closer to home, since we can't continue to invest in bricks and mortars for the veterans.

The short answer is: there is a degree of innovation going on among other government medical programs principally focused on the DOD and the veterans, to see if, since every World War II veteran is a Medicare-eligible person as well, if we can't tend to integrate these programs from the senior level back in so that we can mainstream some of these Government medical programs that have remained distinct and separate.

Mr. SAM JOHNSON of Texas. Thank you. I appreciate that. That leads to another question though. If there is private contracting within the Tri-care or Medicare system, how do you distinguish between what private contracting is and what it isn't? And how are you going to stop a doctor from doing a private contract with Veterans' Administration for a person that's over 65 and keep him from it in the Medicare system?

Ms. DEPARLE. Sir, I don't believe what we're talking about is private contracting in the way that you——

Mr. SAM JOHNSON of Texas. I know, I just brought it up.

Ms. DEPARLE. I don't believe the two are the same thing. What the chairman is talking about is a demonstration to allow certain veterans to use their Medicare dollars in a veterans' hospital.

Mr. SAM JOHNSON of Texas. I understand, but you were talking with Mr. Stark earlier about private contracting and you indicated that if the Medicare program does not cover something and a person can make that payment on his own it's not considered private contracting. The docs don't know that by the way. You need to get that word out. I'm getting a lot of complaints in my district over that—that they're, in fact, stopping their Medicare service because of that threat. So when you're going to authorize them to privately contract with the Veterans' Administration for care, I don't see the difference.

Ms. DEPARLE. Well, sir, as I understand the demonstration, and I'd be happy to provide a briefing for you and your staff on it, but as I understand it, it isn't private contracting. What we're saying is that veterans—it is more like allowing the veterans system to be one of the new Medicare-plus-choice plans. But it's on a demonstration basis. So, I don't believe it's the same thing as private contracting.

Mr. SAM JOHNSON of Texas. Well, then define private contracting for me.

Ms. DEPARLE. Well, as I understand private contracting as enacted in the Balanced Budget Act, what that says is that if a physician and a beneficiary want to enter into a private contract to cover some benefit that Medicare would ordinarily cover, then they can

do that. That has not been something that has been allowed in the past. So that's what private contracting is. This is different. This is saying that a Medicare-eligible veteran or military retiree could chose a health plan that is provided by DOD or VA.

Mr. SAM JOHNSON of Texas. Or a doc.

Chairman THOMAS. No, let me interject again, and I apologize. But when I used the term "contracting," it was contracting out its managed care services. It is a requirement, pretty obviously, in a military hospital that if you're going to treat Medicare-eligible patients, you have to be able to offer those services that are part of the Medicare package. If the military hospital does not have the ability to deliver all of those aspects of the required Medicare package, they can contract out for those aspects. But it is primarily envisioned as contracting out to those entities in those communities where there are military retirees that do this on an ongoing basis with ordinary Medicare beneficiaries. So it would be contracting out, but it is primarily managed care services. But I'd be willing to sit down with the gentleman and go over what I consider to be some relatively positive innovative approaches already underway at the DOD and the possibility of beginning at the Veterans' Administration to make sure that his concerns, if at all possible, could be addressed in the way in which the demonstration is designed.

Mr. SAM JOHNSON of Texas. Thank you, I appreciate that. You know, I would just like to know your views on that too, because private contracting is private contracting, you know, any way you cut it.

Chairman THOMAS. I understand that. And given the gentleman's background and current status, he's a practitioner and I want to listen to him.

Mr. SAM JOHNSON of Texas. Well, I tell you what, the guys in the military complain about the system and the way it's operating. And we need to protect them. And that's part of HCFA's job, I believe.

Ms. DEPARLE. We'd like to work with you on the demonstration and with the committee.

Mr. SAM JOHNSON of Texas. Thank you, ma'am. And thank you, Mr. Chairman.

Chairman THOMAS. Thank you very much.

The gentleman from Maryland.

Mr. CARDIN. Thank you, Mr. Chairman.

And let me welcome you here in your new responsibility. This is your first appearance, I believe, and we look forward to working with you, following up on last year's work of this committee in trying to improve the Medicare system and the other areas that fall under your responsibility. It is a pleasure to have you here.

I just want to make a comment about one of Mr. Johnson's statements, and that is I know we got a little bit off on the private contracting, but it is my understanding that you have sent notices to all physicians indicating that if it's a non-covered service there is no need for a private contract. And that notice has gone out.

Ms. DEPARLE. Yes, we did. That went out in November, and we sent it out to all the physicians in the country.

Mr. CARDIN I want to change gears and talk about the prudent lay person's standard for emergency care. And we very much ap-

preciate the help of the administration last year in putting that standard in law for the Medicare and Medicaid programs in requiring that on the renewals that there be that standard adopted. And I'm just wondering if you could update us as to what steps you're taking to make sure that all of the plan administrators and States are complying with the prudent lay person's standard in their managed care programs?

Ms. DEPARLE. Let me just say, Mr. Cardin, that we appreciate your work on that. And that's been something that I know that you have championed for many years, and I was glad that we could get it enacted last year. I think it's a good step forward.

We are working to make sure that all the State Medicaid directors are aware of the new standard and that they have it in place. And I believe your staff has made us aware that some of them may not be where they need to be, so we will take some steps to remedy that, and I will report back to you on it.

Mr. CARDIN. I appreciate that. It's been brought to our attention and we've got some material, from the State of Maine and the State of Georgia, which appears to be out of compliance with Federal law. We understand there may be some confusion, but we would urge that you give this a high priority to implement the law. It's becoming more and more common around the Nation for more and more managed care plans to adopt the prudent layperson's standard, so it should not be as difficult as perhaps it would have been a few years ago. And I would just urge you to continue your efforts in that regard.

Ms. DEPARLE. We will do that. Thank you.

Mr. CARDIN. Let me return, if I might, and spend a little more time on the private contracting issue. There has been a lot of misinformation out on the private contracting issue, and I really do applaud you for getting information out to the physicians. We may need to take a look at what we did last year in order to clarify the position, to make it clear that we haven't impacted the ability of a Medicare beneficiary to use private services and pay for it if it's not under the Medicare program. I would just urge you also to work with us, if we need to, to clarify that law without removing the protections that seniors currently have on balance billing protections. Because I don't think anyone here wants to subject our seniors to charges beyond what the Medicare system allows for services that are provided under the Medicare system.

Ms. DEPARLE. We'll be happy to work with the committee.

Mr. CARDIN. Thank you. Thank you, Mr. Chairman.

Chairman THOMAS. Thank you.

Does the gentlewoman from Connecticut wish to inquire?

Mrs. JOHNSON of Connecticut. Thank you, and welcome.

Ms. DEPARLE. Thank you.

Mrs. JOHNSON of Connecticut. We look forward to working with you. You certainly have many challenges facing you, as do we as a legislative body, to make good on our often repeated promise of making Medicare secure, not only for current retirees, but future retirees.

There are two little issues I want to raise with you, and then one larger issue. First of all, during the break I visited a large oncology office in my district and it is very clear to me that we are not reim-

bursing for many of the costs associated with delivering oncology drugs. And, it's my understand that HCFA has been reviewing the RBRBS in this regard and acknowledges that delivery services are not covered in the RBRBS. They have traditionally been covered through the drug costs. If that isn't going to be the case, I mean, we're going to have to get this together and look clearly at what's covered by the RBRBS and what's been covered by the drug cost. And if we're going to look at drug costs as the Inspector General's report does without regard to the cost of delivery, then we need to reexamine the RBRBS and make sure that it is an honest one and does cover all the services delivered by the physician. So, I would hope that you wouldn't move on the drug costs without a review of the RBRBS. I understand that the Department is in the process of that, or has at one time in the not too distant past been involved in that issue, and is cognizant that the RBRBS has problems. Are you conscious of that problem?

Ms. DEPARLE. I did hear about this, in fact just yesterday. And as the representative knows, there has been a problem with Medicare overpaying for some of these drugs, and that is a concern of ours, that I'm sure is of the committee's as well. But certainly, we want to be fair in the way that we provide reimbursement, and I will take a look at what you are pointing out.

Mrs. JOHNSON of Connecticut. I am very, very concerned about this, because if we do it wrong, then these services will simple move from the doctor's office to the hospital where they will be more expensive to deliver. Because infusion therapy takes time and a lot of that is now going on on an out-patient basis, if we do this wrong, we will simply shift the venue and increase our cost even though it might look to the public like we are saving. So, I look forward to working on this with you. I think it's an absolutely solvable problem. We want to be fair to everybody. We want to be sure that we don't overpay providers of drugs, or services. But I think in this situation, we have allowed reimbursement for services to slip under reimbursement for drugs, and we have to sort that out. So, I look forward to working on this with you because I'm very concerned about access to care. If we do it wrong, access will plummet, hospitals will have to gear up, and we'll have a significant problem on our hands for very sick patients. And we just have got to make sure that that doesn't happen.

Then, a second thing that's been of concern to me is that there's more than two-dozen regulations and reports that are due that haven't been completed, and one of them is in regard to the functioning of the Medicare select plans, and some of the other regulations that are so key for home health agencies. I wonder what your program is to get caught up on some of these?

Ms. DEPARLE. Well, if I can brag a little bit, we have made a lot of progress. In the month of December, we identified 18 priority regulations that we needed to get out, and I think we got 16 of them out in December, which is more than double what we normally do. And of course, that was supposed to be a holiday month. So our staff is really working hard.

I place a high priority on being as timely as possible. Given our resources and the priorities that this Congress has set and that I have to set, sometimes it's not possible, but, I'm going to do my

very best to see that we are timely. And I wasn't aware that there were two-dozen reports that were overdue. I am very aware of the Medicare Select Report, and have personally reviewed it, and I hope that we will be able to get it to you soon. I believe that one was due on December 31, so we are behind on that.

Mrs. JOHNSON of Connecticut. Yes, it was. Thank you very much, I look forward to seeing that move. I assume that's out of your shop at this point, since you have reviewed it?

Ms. DEPARLE. I believe it is.

Mrs. JOHNSON of Connecticut. Is it then at OMB?

Ms. DEPARLE. Yes, I believe that's where it is.

Mrs. JOHNSON of Connecticut. Well, we'll certainly look forward to the completion of this work. And any way we can help you, we're happy to because I believe timeliness is important. And it's a big problem. I chair the Oversight Subcommittee of the IRS. I can tell you, they are much further behind than you are.

Chairman THOMAS. That's not a compliment.

Ms. DEPARLE. I know that.

Mrs. JOHNSON of Connecticut. It's like justice delayed is justice undone, you know. If we don't keep the flow of information going we don't win. And I see, unfortunately, my time has expired, because I do want to just point out to you the terrible problem we're having with dual-eligibles. And I see you are reorganizing in a way that will create a more one-stop shopping approach to managed care and fee-for-service policy, but we really have to look at the dual-eligibles and I think we have to look at what I consider to be a real rip-off of Medicare: the Medicare maximization program. The States are spending tons of money on this. They are squandering their resources and ours on all the legalities. The home health agencies are really disadvantaged by the problem of going back for these records, of copying them, of reviewing them. It's really a tragedy. And when the whole system is under so much pressure to reduce costs, deliver quality services, I think we need to sit down about that Medicare maximization program and come to terms with it and settle it out, which we can do and we started doing three years ago, and it still isn't completed. Then that folds right into the dual-eligible project that we've got to start piloting in some of the states in order to give better service to low-income seniors, but also reduce the cost for federal and state government. So I'd like to work on that project with you.

Ms. DEPARLE. I'll look forward to working with you on it.

Mrs. JOHNSON of Connecticut. Thank you very much.

Chairman THOMAS. It's my pleasure to indicate that a Member who is not a member of this subcommittee is with us today. He is a freshman Member of Congress, but I have a hunch that one of the reasons he's more interested in this is not in that capacity, but because he is a medical doctor, doctor of ophthalmology. Gentleman from Louisiana, Mr. Cooksey, I assume wishes to inquire.

Mr. COOKSEY. Thank you, Mr. Chairman. And Ms. DeParle, welcome to the committee. This is my first committee meeting too.

I'm on the Health Subcommittee of Veterans Affairs, and there's a lot of confusion about some of the overlap here.

My question—the question I would like for you to answer—and I'm going to drive toward that—is, do you ever step back and look

at the overall picture? There are a lot of programs that are government paid, that are government financed. There's Medicare, there's Medicaid, there are veterans hospitals. Incidentally, I've asked the same questions in my health subcommittee.

There are many providers, there are many recipients. There must be some duplication occasionally. I personally think there's a lot of duplication, a lot of overlap. And I think there are a lot of regulators and a lot of regulations, and these solutions have always been done piecemeal to solve some problem. And it's been my impression when I was out in the private sector that there's been a lot of micromanagement by people in the bureaucracy, like yourself; a lot of lawyers, a lot of people that are in government, that are micromanaging the problems as they come up.

But I feel that we do need to eliminate this duplication. We need to downsize some of the bureaucracies. We definitely need to reduce the cost. And the way to do that is by quality health care. When you have really quality health care, a patient won't have to go back to have the same procedure repeated because it was not done right the first time, and that will reduce cost.

But my question is, is there anyone that is out there that ever steps back, and looks at the overall picture, and say, gee, who is representing the patients?

When the Balanced Budget bill was coming through, there was a firestorm of activity. You were not here then, I know. But there was every group being represented, except the patients, I feel. There were bureaucrats here, there were the managed care people, there were the insurance companies, there was organized medicine, there were physicians, there were specialists, home health, and yes, even the trial lawyers. But they were there ad infinitum. But nobody really seemed to be representing that patient that is out there in some rural area or some inner city metropolitan area that truly needed health care. And you've got a lot of special interest groups that are still micromanaging things for their best interest.

What is your agency doing to look at the big picture, and to really address the number one stakeholder, the patient?

Ms. DEPARLE. Well, I think one thing we've done, and I described it at the beginning of my statement, was, our reorganization was partly designed to try to get at those questions of, are we serving beneficiaries, and how do we organize ourselves so that we're thinking more about beneficiaries. That is why we created this Center for Beneficiary Services.

If we had not done that reorganization, the new Medicare Plus Choice Plan and the information campaign that we're going to do this year, those activities of providing the information, and the toll free lines, and the things that the Congress has asked us to do to interact with beneficiaries, would have been in five or six different locations within HCFA. Now we have centered in one place an organization that is designed to look at that.

I also think in respect to your comment about the veterans area, that's actually an area about which I think the Congress can feel good trying to look at what's best for the beneficiary, as opposed to how do these structures in Washington work. And the reason I say that, is because what that demonstration is designed to look at is, if you are a veteran and you are Medicare eligible, why

shouldn't you be able to go to a veterans hospital if you want to, and take your Medicare dollars with you? You couldn't do that before. You could only go there if you were in the high-priority category of veterans. And as you know, even though there are 171 veterans hospitals, not everyone can get to one, and not all veterans have a high enouogh priority to obtain VA care when needed.

But the beneficiary shouldn't have to worry about that; the beneficiary should be able to choose where they might want to go. And that's what that demonstration is designed to investigate. So, I agree with you that it is very difficult to get beyond the structures that we operate in, and I think we need to do a better job at that. And I think we can do a better job of that, and I think members like those on this subcommittee are going to help us with that.

Mr. COOKSEY. Good. One other quick question. Where does HCFA stand on implementing the BBA for telemedicine and for broader plans for telemedicine?

Ms. DEPARLE. We have some demonstrations that we had already started in telemedicine. I think they are in five states. In the BBA we got authority for 1 more demonstration, and I believe we have a rule that is on track, to go out in May that will announce how that new authority will be used, and how folks can become eligible for the telemedicine programs.

Mr. COOKSEY. Thank you, Ms. DeParle. Thank you, Mr. Chairman.

Chairman THOMAS. Certainly. Thank you.

Apropos the comments by a gentlewoman from Connecticut, what would your reaction be when we deal with—and hopefully we don't have to deal with them in the near future—reports or information that was required by the statute in terms of getting work product done? Your initial response is the one that we always get; it's in the process.

Given your experience, both being in OMB, and now over at HCFA, as an example, what does it mean when it's in clearance? How many different steps, not micro steps, but major steps, does a policy like Medicare, for example, have to go through before we get it, since it was our request in the first place?

Ms. DEPARLE. Well, in that particular instance, we were required to conduct some studies of Medicare Select, the demonstration, to see how it worked and whether it met your objectives.

Chairman THOMAS. Is that a good example or do you have a better example that would explain to us how the process works?

Ms. DEPARLE. I think it's a pretty good example—

Chairman THOMAS. Okay.

Ms. DEPARLE [continuing]. Because it was pretty matter-of-fact. We have done some studies and done some analysis. And then there are two processes. Most of these things are not reports from the HCFA administrator, but they are reports that you have requested from the secretary. And so, the secretary obviously is briefed, and her staff looks at whatever report it is, and then it goes from there over to the Office of Management and Budget. And at the Office of Management and Budget there are two processes.

Chairman THOMAS. Why does it go there?

Ms. DEPARLE. There is I believe an executive order that's been in place for 30 years—

Chairman THOMAS. A long time.

Ms. DEPARLE [continuing]. that requires that kind of review, and there are actually two review processes. One of them is the—

Chairman THOMAS. Just as the budget from HHS has to go over—

Ms. DEPARLE. Right.

Chairman THOMAS [continuing]. And be reviewed by OMB before its incorporated in the structure, these kinds of things do as well.

Ms. DEPARLE. That's right. And there are two processes generally. One is the Office of Information and Regulatory Affairs, which looks at whether something that we're putting out imposes a paperwork burden. For example, a regulation or that kind of thing. And then there is a substantive review of the policy by budget and program policy staff. And it's generally a fairly quick process.

Having been there, I know that the folks at OMB often feel that we give them very little time to review things to get them up here to you. But the purpose of the review is supposed to be to ensure that the report has been done in an adequate fashion and that it is consistent with the programs of the President; that's the general policy.

Chairman THOMAS. And then does it often times or occasionally go back for revision, refocus, adjustment, or does the adjustment, refocus occur at OMB in consultation with folks?

Ms. DEPARLE. It can operate either of those ways. In general, I think it probably goes back with comments and suggestions, and we often have meetings with the staff from the agencies to discuss comments and suggestions.

Chairman THOMAS. All this leads up to my question, from your experience—and it's useful because you've been in both areas. And I don't want to overly complicate the process. But it would be useful for us sometimes to know when, for example, you folks were finished with something. And I don't know that it needs to be more structured—if it does, we'll talk about putting it in legislation—so that we know that at least from a policy point of view it's out of HHS, and that it's someplace else, almost always OMB.

Or do you believe that that's a transparent enough process, that if you ask the right questions you know it anyway? Does it need to be more formalized in terms of our ability to know when it moves through stages?

Ms. DEPARLE. I don't think so, Mr. Chairman. I think that the process generally works pretty well. I think there's generally value added from the process, and it works pretty well. I regret that we're behind in scheduling these reports to you, and perhaps we should have gotten them over there earlier. I think that is maybe sometimes the reason why they're late.

Chairman THOMAS. Well, and I've discovered that you can eliminate a lot of legislation and a lot of particulars if you have honest people working together and you get honest answers. When you don't get honest answers, it's very, very difficult to put confidence in what people have to say.

It pains me a little bit to bring up, earlier in my chairmanship a time of visiting HCFA in Baltimore, and not getting what I considered to be honest answers about the Medicare transaction sys-

tem, which I believe has finally been owned up to. And in your written testimony, I'll refer to once again, a clear indication that you have finalized the contract with that, and that perhaps the concept at some time may have had a degree of viability, but it is no longer the case.

Ms. DEPARLE. That's right.

Chairman THOMAS. You're looking for another way or perhaps a fundamental rethink of the way of dealing with the tracking system, is that correct?

Ms. DEPARLE. That's right.

Chairman THOMAS. Would you consider you're entering into, fill in the blank, a $50 million, $70 million effort, which has really produced nothing, a kind of a failure, or did we learn something out of it?

Ms. DEPARLE. Well, I think we learned something; it was painful. I think we learned what a lot of private sector companies have learned, that a big effort like that was too big and too risky.

Chairman THOMAS. And I guess then, we're involved with questions of judgment; how things get started, how they get perpetuated, where you make decisions, where you stop. In private sector when you have failures of that magnitude, usually someone's out of a job.

My concern is, that for the last several years you—not you, the agency—has been run on a kind of a pass/fail basis, and I'm just wondering if anybody failed on the pass/fail judgment, based upon this multimillion dollar program that has now been completely terminated, with very little residual benefit?

Ms. DEPARLE. Well, I think, as you know, Mr. Chairman, because you visited us, we have a lot of talented people at the Health Care Financing Administration, and they're all committed to trying to do the best job they can for our beneficiaries. And I think that everyone who was working there learned a lesson from the Medicare transaction system, and we aren't going to do it that way again.

Chairman THOMAS. Has anybody received a failure on any of those evaluations on a pass/fail basis in terms of the staff at HCFA?

Ms. DEPARLE. I don't know the answer to that. I do know that most of our employees, since that pass/fail system was initiated, have received a pass. I haven't looked through the 3,000 or so evaluations to see how many of them got a failure. There have been some failures. I don't know if they were connected with that particular program.

Chairman THOMAS. And I don't want anyone to assume by my line of questioning that I don't think that there aren't a lot of talented hardworking people over there. It's just that when you're dealing with a fundamental change in the direction and culture of a bureaucracy, you have to look at your ability to be flexible in dealing with employment, and frankly, to make changes.

My concern is, the manner in which employees are evaluated, probably doesn't give you a sufficient ability to make decisions, except that you probably, as is the case when the formal monitoring structure's not adequate, you do it in an informal way, which is the way we want to do it, because then that can be argued to be subjec-

tive rather and objective. And I know through GAO examination that a simple bifurcated pass/fail maybe doesn't tell you as much as you'd like to know. You need more categories in which to evaluate folks, so that you can reward people who clearly are superior and show initiative. Because it's very difficult when you have people sitting next to each other, and someone's doing work, and someone else isn't doing quite as much or even any work at all, and they both get the same grade. The morale in that kind of an environment is very difficult to deal with.

Let me ask you a question which I don't consider unfair, some might, but it's clearly a hypothetical given the current situation. And that is, if Congress gave you the authority to examine critically a fixed number of folks, 5 or 10 percent of your entire work force, and you would make the decision on whether to keep them or remove them on purely a merit analysis, not constrained by any contract obligations, union, or otherwise, is that something that's desirable, not necessary, you would rather not talk about at this point?

Ms. DEPARLE. Well, let me just say that your questions are going to the issue that I think is the most critical one for us over the next few years, which is how do we manage our human resources. How do we make sure that people are getting recognized for the work that they do, which is very difficult in government, frankly.

It's hard for them, frankly when they continually hear that they're not doing a good job. They want to be recognized for improvement that they make and for the effort that they put forth. And that is a big challenge to me as a manager.

As to whether or not it would be a good idea to change the evaluation process, we discussed that, and it's certainly something that I'm willing to look at. I have operated under different evaluation processes. There have been times in my life when I liked pass/fail, like when I was in college, but I think in general it probably doesn't give us the kind of information that we need. But most of our problems are problems of managers being able to make those kinds of decisions, and I want to do everything I can to empower our managers to do that.

Chairman THOMAS. My interest and concern I want to place very carefully out front and objectively.

HHS and HCFA have extremely important jobs to do. We are dealing with a changing environment in the private sector, and obviously now in the government sector. Flexibility in dealing with the management and the employees who oversee this I think is as critical as flexibility in the marketplace on product. For us to be locked into, old-fashioned government and union regulations, which don't allow us to do the kind of innovative change that I think is going to be necessary, will ill serve the agency, and frankly fundamentally the beneficiaries.

I am not interested in busting up anything at all; I am interested in a viable functioning agency, carrying out a very critical job that's going to be more difficult in the near future. And I believe the gentleman from Louisiana wanted me to yield, and I'll yield to him.

Mr. MCCRERY. Thank you, Mr. Chairman.

Ms. DeParle, just one more question. With regard to the MSA demonstration project, can you give us an update on how it's going?

And when you answer the question, please tell us whether under an MSA Medicare product physicians or providers, generally, must bill according to the Medicare fee schedule or are they allowed to bill higher than 115 percent of the Medicare fee schedule?

Ms. DEPARLE. Well, I'm happy to report that the MSA demonstration project, our plans for that are on track. And in fact, I believe we've done some briefings of some of the committee staff on that, and we have been working with the folks at the Treasury Department, who have done a similar demonstration as you know in the private sector.

With respect to the balance billing limits, I believe that they would not apply, because the whole concept of an MSA is to have the beneficiary bearing more of the cost, and the idea is supposed to be that they will then be more sensitive to cost. And I believe that in that demonstration they will be, so to speak, on their own.

Mr. MCCRERY. Thank you.

Chairman THOMAS. Gentleman from Maryland, a brief intervention.

Mr. CARDIN. Thank you.

One additional point under BBA that I just want to bring to your attention, that is the GME payments to quality non-hospital providers gives you an opportunity for the first time to move into a somewhat different area. What we're concerned about is that we do have some public health departments that would be interested in looking at establishing residencies in public health that could help us in this area. It's probably not going to be allowed because they don't have contracts under Medicare.

But I would ask that you would take a look and work with us as to whether it would be worthwhile to look at a demonstration in this area. And I just really wanted to bring it to your attention, and hope that we could work in that area.

Thank you, Mr. Chairman.

Mr. STARK. Could I follow up?

Chairman THOMAS. This is a first, not a last. So if anybody's got anything—she's going to be back. Go ahead.

Mr. STARK. Well, I just wanted to follow up on the question that Mr. McCrery asked regarding Medicare MSAs. I understand how that works when beneficiaries are spending their own deductible—let's say it's a $2,000 deductible. But after that, would Physicians not then be required to, bill Medicare under the standard procedure? Would the balance billing limits apply? Would the Medicare DRGS be applicable?

Maybe you could enlighten me there? After the out-of-pocket-deductible is spent.

Ms. DEPARLE. I understand your question, Mr. Stark, and I know that this came up a month or so ago, and our Office of General Counsel was looking at it. And if I could, I'd like to get back to you for the record on it, because I don't want to say the wrong thing here. But I do understand the subtlety of your question.

Mr. MCCRERY. Could you copy me on that?

Ms. DEPARLE. Oh, certainly.

Mr. STARK. Yes. I mean, I——

Chairman THOMAS. Would you submit it to the subcommittee?

Mr. STARK. Yeah, that is——

Ms. DEPARLE. I would submit it for the record.

Mr. STARK. I don't know how else you would pay.

If it were my Medicare MSA and I'd paid the $2,000 deductible how would my physician collect after I paid my personal check for any future treatment? Wouldn't he bill Medicare in the standard way that he or she does now?

Mr. MCCRERY. Well, the way I understand it—and this is why we need to have this clarified. The way I understand is that under the MSA product, that government would give the patient, the beneficiary, a lump sum to cover the cost of the insurance product; therefore the doctor would bill the insurance company, not Medicare, for amounts above the deductible, but I could be wrong on that.

Chairman THOMAS. Yes, basically——

Ms. DEPARLE. I think I need to get back to the committee with a fuller answer. I understand the question. Thank you.

Chairman THOMAS. And let me for all the members of the subcommittee, thank you. I personally want to thank you for your availability, prior to be being formally I may had and since, and I look forward to working with you. You have an extremely difficult job that's challenging. I'll know you'll be up to the task, but in anyway that we can help, especially with fine tuning what was, as I said at the beginning, the most comprehensive change in Medicare. People vote and move on, and people don't realize that after you've voted we have a lot of work to do. And I look forward to working with you. Congratulations.

Ms. DEPARLE. Thank you. I will need the support and the constructive criticism of this committee, in doing what you want us to get done, as well as of all of our employees. So I appreciate this opportunity.

Chairman THOMAS. Thank you very much.

The next panel will be, once again, a panel of one, or one and a half, or two perhaps.

Dr. Scanlon, who is the director of the Health Financing Systems, part of the General Accounting Office, who has done some recent work for us at our request, and they have had an ongoing program as well. And with him is Leslie Aronovitz, who is the associate director in the same area of the Health Care Financing Systems of the GAO.

Dr. Scanlon, thank you. Your written testimony, as always, will be made a part of the record, and you can address us as you see fit.

STATEMENT OF WILLIAM J. SCANLON, PH.D., DIRECTOR, HEALTH FINANCING SYSTEMS, U.S. GENERAL ACCOUNTING OFFICE

Mr. SCANLON. Thank you very much, Mr. Chairman, and members of the subcommittee.

We are very pleased to be here today as you discuss HCFA's readiness to manage Medicare for the 21st century.

Chairman THOMAS. And let me indicate to you as well, although normally that distance would be appropriate, you're probably going to have to get a little closer to the mic, so people can hear you. Thank you.

Mr. SCANLON. Okay. All right, I'd be happy to.

The Congress and this subcommittee in particular has heard from GAO and others regularly about Medicare's vulnerabilities, including program management weaknesses, excessive spending, and trust fund deficiencies. You also heard from us in October that the Health Insurance Portability and Accountability Act and the Balanced Budget Act provided HCFA excellent new tools to fight fraud and to fix broken payment methods. However, substantial agency effort, as you indicated, will be required to implement the new provisions promptly and effectively.

In addition, the agency has undergone a major reorganization. In that context you asked us to comment on HCFA's capacity; that is, the ability of its work force to meet its newer challenges, while responding to the chronic problems of the past.

To provide a quick response, we spent the past month reviewing agency documents, conducting focus groups, and interviewing individuals. We heard from more than 60 senior level and mid-level managers at HCFA's Washington and Baltimore headquarter offices.

We want to thank Ms. DeParle and the HCFA staff for being so cooperative and congenial as we imposed our demands upon their already existing daunting workload. On the basis of the information we gathered, as well as the information that we have gathered over the years of working on different elements of the Medicare program, we make the following observations.

To begin, HCFA clearly has a lot on its plate. Under the Balanced Budget Act it must implement the new Medicare Plus Choice Program. It must develop multiple prospective payment systems, and improve Medicare's pricing of goods and services consistent with the concept of inherent reasonableness.

For each there's a considerable volume of choices about design details that must be formulated, evaluated, selected, and implemented. There's been a long-standing consensus that implementing changes, such as prospective payment or improved risk adjustment for managed care, are essential steps. What we have lacked is consensus and confidence in how to do these effectively and fairly. Now HCFA must seek to do so within tight timeframes.

HCFA's attention is also required to effectively implement the new contracting authority provided by the Health Insurance Portability and Accountability Act, the Medicare Integrity Program, the anti-fraud program under that act. The Inspector General's estimate of $23 billion in inappropriate payments dramatically underscores the urgency of this task.

At the same time the agency must solve its year 2000 computer problems, and start from scratch to develop a comprehensive information management strategy that will deal more effectively with identifying problems with inappropriate fee-for-service claims, and support the information requirements of the expanded Medicare Plus Choice Program.

Concurrent with these implementation challenges, HCFA is handicapped in a number of ways. Managers are feeling pinched by the Balanced Budget Act's command of existing resources. They express fears that because of the agency's concentrated efforts on the Balanced Budget Act, the quality of other work might be com-

promised or tasks might be neglected altogether. They also felt disadvantaged by HCFA's limited expertise to carry out certain new Balanced Budget Act initiatives, such as the upcoming nationwide comparative information campaign for the Medicare Plus Choice plans, or the Balanced Budget Act related work that was already underway, such as new prospective payment systems for home health and skilled nursing facility services.

Some of this work involves the need for new skills and expertise that HCFA did not require previously; however, managers also felt the agency's capacity has been compromised by the loss of experienced staff resulting from a work force turnover of nearly 40 percent over the last 5 years.

Regardless of the benefits that may ultimately accrue from HCFA's reconfigured structure, the reorganization also compounds the challenges for the agency. The normal stresses people experience with organizational restructuring have been accentuated by the full agendas and the tight deadlines of HCFA's new workload.

Managers feel that during this transitional period the situation is particularly acute in light of the fact that people have not yet even moved to the actual location of their new units. Physical proximity would help forge the new working relationships among individual staff essential to achieving the objectives within the new structure.

From some perspectives HCFA's substantial and growing responsibilities appear to be outstripping its capacity. Before such a conclusion about the extent to which the tasks are exceeding its capacity are made, it must be noted that the agency lacks a comprehensive plan, one that senior decision-makers could use to strategically handle the agency's workload and resource management. As a result, it appears that senior management is not in a position to assess fully the adequacy of its resources, whether they are properly distributed, or which activities could be at risk of being neglected.

In contrast, top management's expectations for completing Balanced Budget Act-related activities are very explicit. HCFA has a tracking system for the Balanced Budget Act mandates that enumerates activities, identifies responsible agency units, and specifies completion dates. It is also requiring lead units to prepare detailed project plans, outlining tasks, time periods, and resource needs. We did not find similar plans for other mission—critical functions.

In conclusion, while the Health Insurance and Portability and Accountability Act and the Balanced Budget Act have given HCFA many tools to tame and police excessive spending and abusive billing, HCFA appears to be struggling for various reasons to get them all assembled.

The concern is that while HCFA's responding to implement the Balanced Budget Act, other parts of Medicare may get only back burner attention—which they can ill afford. We believe that a detailed strategy that involves not just a planning document, but an approach that encompasses an ongoing process of focusing on objectives and priorities similar to what the agency has undertaken with respect to the Balanced Budget Act is a key first step in preparing for the next century.

Mr. Chairman, that concludes my statement, and I'll be happy to answer any questions you or members of the subcommittee have.

[The prepared statement follows:]

United States General Accounting Office

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Testimony

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Committee on Ways and Means, House of
Representatives

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MEDICARE

HCFA Faces Multiple Challenges to Prepare for the 21st Century

Statement of William J. Scanlon, Director
Health Financing and Systems Issues
Health, Education, and Human Services Division

GAO/T-HEHS-98-85

Mr. Chairman and Members of the Committee:

We are pleased to be here today as you discuss the Health Care Financing Administration's (HCFA) preparedness for administering the Medicare program in the 21st century. Because the $200 billion Medicare program is critical to nearly all elderly Americans (those aged 65 and older) and to many of the nation's disabled, program management, excessive spending, and depletion of the Medicare Trust Fund have been the subject of much congressional concern and scrutiny in recent years. We, the Department of Health and Human Services' (HHS) Inspector General, and others have frequently reported that too much is being spent inappropriately because of the fraudulent and abusive billing practices of health care providers, thus prompting congressional concern about program vulnerabilities. (See the list of related GAO products at the end of this statement.)

You asked us to comment on HCFA's ability to meet growing program management challenges. My statement today centers on HCFA's administration of the Medicare program, although HCFA also has shared responsibilities with the states for administering Medicaid, a program serving low-income Americans. More specifically, my remarks will focus on (1) HCFA's new authorities under recent Medicare legislation, (2) HCFA managers' views on the agency's capacity to carry out various Medicare-related functions, and (3) the actions HCFA needs to take to accomplish its objectives over the next several years.

To do this work, we obtained agency documents on HCFA's reorganization and revised processes and interviewed top agency officials, including the new Administrator. In addition, we conducted small focus groups attended by about 60 senior and midlevel managers. We also relied on our previous and ongoing work on Medicare.

In summary, substantial program growth and greater responsibilities appear to be outstripping HCFA's capacity to manage its existing workload. Legislative reforms have increased HCFA's authority to manage the Medicare program. Simultaneously, however, other factors have increased the challenges HCFA faces, including the need to make year 2000 computer adjustments and develop a new, comprehensive information management strategy; manage transitions in its network of claims processing contractors; and implement a major agency reorganization. In addition, officials report that the expertise to carry out HCFA's new functions is not yet in place and that HCFA has experienced a loss of institutional knowledge through attrition. In this environment, agency managers are concerned that some of their responsibilities might be compromised or neglected altogether because of higher-priority work.

HCFA's approach for dealing with its considerable workload is incomplete. Heretofore, the agency lacked an approach–consistent with the requirement of the Government Performance and Results Act of 1993 to develop a strategic plan–that specified the full range of program objectives to be accomplished. HCFA has developed a schedule for responding to recent legislative reforms but is still in the process of detailing the staffing and skill levels required to meet reform implementation deadlines. While addressing new mandates, the agency also needs to specify how it will continue to carry out its ongoing critical functions.

BACKGROUND

The size and nature of the Medicare program make HCFA unique in authority and responsibility among health care payers. Fee-for-service Medicare serves about 33 million beneficiaries and processes a high volume of claims–an estimated 900 million in fiscal year 1997–from hundreds of thousands of providers, such as physicians, hospitals, skilled nursing facilities, home health agencies, and medical equipment suppliers. HCFA is also responsible for paying and monitoring more than 400 managed care health plans that serve more than 5 million beneficiaries. Enrollment in these plans has been growing by about 85,000 beneficiaries monthly.

The Medicare statute divides benefits into two parts: (1) "hospital insurance," or part A, which covers inpatient hospital, skilled nursing facility, hospice, and certain home health care services, and (2) "supplementary medical insurance," or part B, which covers physician and outpatient hospital services, diagnostic tests, and ambulance and other medical services and supplies. In fiscal year 1997, part A covered an estimated 39 million aged and disabled beneficiaries, while a slightly smaller number were covered by part B, which requires payment of a monthly premium.

In Medicare's fee-for-service program--used by about 87 percent of the program's beneficiaries--physicians, hospitals, and other providers submit claims and are paid for each service rendered to Medicare beneficiaries. Medicare's managed care program covers a growing number of beneficiaries who have chosen to enroll in a prepaid health plan rather than purchase medical services from individual providers. The managed care program, which is funded from both the part A and part B trust funds, currently consists mostly of risk contract health maintenance organizations (HMO).[1] Medicare pays these HMOs a monthly amount, fixed in advance, for all the services provided to each beneficiary enrolled.

HCFA, an agency within HHS, has slightly less than 4,000 full-time employees, 65 percent of whom work in the agency's headquarters offices; the rest work in the agency's 10 regional offices across the country. In addition to the agency's workforce, HCFA oversees more than 60 claims processing contractors that are insurance companies–like Blue Cross and Blue Shield plans, Mutual of Omaha, and CIGNA. In fiscal year 1997, the contractors employed an estimated 22,200 people to perform Medicare claims processing and review functions.

LEGISLATIVE REFORMS SUBSTANTIALLY INCREASE HCFA'S AUTHORITY TO MANAGE THE MEDICARE PROGRAM

Two recent acts grant HCFA substantial authority and responsibility to reform Medicare. The Health Insurance Portability and Accountability Act of 1996 (HIPAA), P.L. 104-191, provides the opportunity to enhance Medicare's anti-fraud-and-abuse activities. The Balanced Budget Act of 1997 (BBA), P.L. 105-33, introduces new health plan options and major payment reforms. In correspondence to this Subcommittee last October, we noted that these two pieces of legislation addressed in large measure our concerns and those of the HHS Inspector General regarding the tools needed to combat fraud and abuse.[2] They also address many of the weaknesses discussed in our High-Risk Series report on Medicare.[3]

HIPAA created for the first time a stable source of funding for Medicare fraud control. For fiscal year 1997, the act provides for up to $440 million for program safeguard activities; the level will rise incrementally each year, reaching $720 million in fiscal year 2003, after which it will remain constant. This was a significant step in reversing the trend of declining program safeguard funds relative to program growth in the 8 years prior to fiscal year 1997, when HIPAA funding provisions became effective. This funding comes from a HIPAA-established fraud-and-abuse control account that also

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[1]The Medicare managed care program also includes cost contract HMOs and health care prepayment plans. Cost contract HMOs allow beneficiaries to choose health services from their HMO network or outside providers. Health care prepayment plans may cover only part B services. Together, both types of plans enroll less than 2 percent of the Medicare population.

[2]See Medicare Fraud and Abuse: Summary and Analysis of Reforms in the Health Insurance Portability and Accountability Act of 1996 and the Balanced Budget Act of 1997 (GAO/HEHS-98-18R, Oct. 9, 1997).

[3]See High-Risk Series: Medicare (GAO/HR-97-10, Feb. 1997).

funds other activities involving other HHS agencies and the Department of Justice. HIPAA also provides HCFA with explicit authority to contract with firms outside its existing claims processing contractor network to perform payment safeguard functions while avoiding conflicts of interest. HIPAA also adds new civil and criminal penalties to heretofore little-used enforcement powers.

BBA provides for a dramatic expansion of health plan choices available to Medicare beneficiaries and makes reforms to payment methods in traditional fee-for-service Medicare and managed care. Under the act's new Medicare+Choice program, beneficiaries will have new health plan options, including preferred provider organizations (PPO), provider sponsored organizations (PSO), and private fee-for-service plans. Medicare+Choice introduces new consumer information and protection provisions, including a requirement to disseminate comparative information on Medicare+Choice plans in beneficiaries' communities and a requirement that all Medicare+Choice plans obtain external review from an independent quality assurance organization.[4] These provisions address problems we have worked to correct with this committee and others in the Congress.[5]

BBA also provided for revamping many of Medicare's decades-old payment systems to contain the unbridled growth in certain program components. Specifically, the act mandated prospective payment systems for services provided by about 1,100 inpatient rehabilitation facilities, 14,000 skilled nursing facilities, 5,000 hospital outpatient departments, and 8,900 home health agencies. In addition, it made changes to the payment methods for hospitals, including payments for direct and indirect medical education costs. It also adjusted fee schedule payments for physicians and durable medical equipment and authorized the conversion of the remaining reasonable charge payment systems to fee schedules. Finally, the act granted the authority to conduct demonstrations on the cost-effectiveness of purchasing items and services through competitive bids from suppliers and providers.

HCFA'S CAPACITY TO ACCOMPLISH ITS MISSION IS DIMINISHING RELATIVE TO ADDED RESPONSIBILITIES

While legislative reforms are dramatically reshaping Medicare, other changes are occurring, thus compounding difficult management challenges. For example, HCFA is rethinking its strategy to develop, modernize, or otherwise improve the agency's multiple automated claims processing and other information systems. This will involve preparing systems for the year 2000, repairing the deteriorating managed care enrollment systems, and making the necessary modifications to existing systems. HCFA plans to make these changes as an interim measure until, consistent with the Information Technology Management Reform Act of 1996 (P.L. 104-106), comprehensive reengineering can take place, such as making claims processing systems and payment mechanisms more efficient, programming BBA payment changes, and modernizing the anti-fraud-and-abuse system software.[6] HCFA is also confronting transition problems resulting from the recent loss of large-volume claims processing contractors and the need for remaining contractors

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[4]BBA authorized the HHS Secretary, subject to appropriations, to collect $200 million in user fees to conduct information activities associated with Medicare+Choice. Subsequently, in the HHS appropriation, the Secretary was given authority to collect $95 million of the originally authorized amount for this purpose. HCFA was also appropriated between $20 million and $30 million for the administration of BBA-related activities.

[5]See Medicare: HCFA Should Release Data to Aid Consumers, Prompt Better HMO Performance (GAO/HEHS-97-23, Oct. 22, 1996) and Medicare: Opportunities Are Available to Apply Managed Care Strategies (GAO/T-HEHS-95-81, Feb. 10, 1995).

[6]See Medicare Automated Systems: Weaknesses in Managing Information Technology Hinder Fight Against Fraud and Abuse (GAO/T-AIMD-97-176, Sept. 29, 1997).

to absorb the workload. Finally, HCFA recently restructured its organizational units to better focus on its mission and is experiencing the kind of disruptions common to organizational transitions.

Against this backdrop, the themes that emerged from our individual interviews and focus groups with HCFA managers centered on (1) distribution of agency resources, (2) need for specialized expertise, (3) loss of institutional experience, and (4) reorganization issues.

Heightened Responsibilities Result in Redirected Priorities

"Robbing Peter to pay Paul" was the expression used to characterize one of the major themes from our focus groups. Specifically, managers were concerned that because of the concentrated efforts to implement BBA and solve computer problems that could arise in the year 2000, the quality of other work might be compromised or tasks might be neglected altogether. However, managers also noted that whereas some BBA-related tasks are completely new–such as conducting an open enrollment period for Medicare+Choice plans–and therefore add to the workload, others merely formalize work that was already underway but impose deadlines for completion, such as developing prospective payment methods for reimbursing several types of health care providers.

Regional and headquarters officials responsible for the oversight of claims processing contractors told us that their capacity to monitor contractors had seriously diminished. For example, one region that formerly had six staff members dedicated to contractor oversight currently has two; the others, they said, had been reassigned to work on managed care issues. This concerns us in light of our work on Medicare program management. Over the past several years, we have reported that HCFA has not adequately ensured that contractors are paying only medically necessary or otherwise appropriate claims.

Similarly, the HHS Inspector General's fiscal year 1996 financial audit found contractor oversight weaknesses. For example, some contractors selected for audit could not readily verify total Medicare expenditures, including paid claim amounts, to ensure that amounts were accurate, supported, and properly classified; did not adequately document accounts receivable; and did not have adequate internal controls over the receipt and disbursement of cash. Further, HCFA does not have a method for estimating the amount of improper Medicare payments; for fiscal year 1996, the Inspector General estimated that HCFA made about $23 billion in inappropriate payments.

New Initiatives Create Need for New Skills

Managers also expressed a common concern about the staff's mix and level of skills. They noted that HCFA's traditional approach of hiring generalist staff and training them largely on the job is no longer well suited to the agency's need to implement recent reforms expeditiously. Instead, managers are beginning to identify the need for staff with specialized technical expertise, such as computer system analysts, survey statisticians, data analysts, market researchers, information management specialists, managed care experts, and health educators. In our discussions, several managers placed "appropriate skill sets" at the top of their wish lists.

As an illustration, the Medicare+Choice program introduces new health plan types and requires the dissemination of information about the plans to beneficiaries in 1998. Called the Medicare+Choice Information Fair, this nationwide educational and publicity campaign will be the first effort of its kind for HCFA. Managers were concerned that staff without prior experience will need to pull together information that describes and evaluates the merits of various plans.

Similar concerns emerged from our discussions about the lack of specialists in other program and agency support areas. Some managers noted the need for highly trained staff to develop, maintain, and modernize Medicare's government-owned claims processing and other automated data systems. They also cited the need for specialists in contracting, facilities management, and telecommunications.

Retirements and Other Departures Drain HCFA of Experienced Staff

Many senior and midlevel managers and experienced technical staff have retired in recent years or are eligible to retire soon. Almost 40 percent of the organization has turned over in the past 5 years. Many were said to have spent their entire careers focused on a particular aspect of the Medicare program. A common concern in our discussions was the erosion of experienced staff to perform a variety of tasks, such as writing regulations and developing payment systems.

Managers cited the loss of experienced staff as a problem for developing and implementing the various prospective payment systems mandated by BBA. They also noted that developing one new payment system would have been manageable, but losses of expert staff make it difficult to implement multiple new payment systems concurrently. For example, experienced staff are needed to perform such technical tasks as those we mentioned in our October statement before this Subcommittee, including collecting reliable cost and utilization data to compute the new prospective payment rates, developing case mix adjusters, auditing cost reports to avoid incorporating inflated costs into the base rates, and monitoring to guard against providers' skimping on services to increase profits.[7]

Our focus group participants emphasized that it will be difficult to replace its experienced staff in the short term. Although HCFA is planning to hire new people, the time typically needed for recruiting, hiring, and orienting new employees is considerable. Managers commented that new employees, although highly educated and motivated, sometimes need extensive on-the-job training to replace lost expertise.

HCFA's Reorganization Is in Transition

In July 1997, HCFA restructured its entire organization. The new design reflected the agency's intent to, among other things, (1) combine activities to redirect additional resources to the growing managed care side of the program, (2) acknowledge a shift from HCFA's traditional role as claims payer to the more active role as purchaser of health care services, and (3) establish three components focused on beneficiaries, health plans and providers, and Medicaid and other activities conducted at the state level. It also established technical and support offices to assist these components. (See HCFA's organization chart in app. I.) In announcing the planned reorganization, the Administrator explained that as Medicare has evolved over the years, new programs and projects were layered onto existing structures. Over time, he noted, this became cumbersome and confusing.

Many managers we spoke with considered the reorganization to be theoretically sound. Some also told us that it was long overdue, because HCFA's structure encouraged work on narrow issues within self-contained groups--an approach that did not benefit from the expertise existing across the agency. However, a consensus of focus group participants and high-level officials believed that the timing of the reorganization's implementation is unfortunate. They explained that they are currently facing full agendas with tight deadlines, which add to the stresses associated with any organizational change.

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[7]Medicare: Recent Legislation to Minimize Fraud and Abuse Requires Effective Implementation (GAO/T-98-9, Oct. 9, 1997).

Managers described their difficulties in establishing new communication and coordination links within units as well as across the agency. For some, new efforts to coordinate have proved time-consuming to the point of being counterproductive. Managers commented that sign-off sheets formalizing coordination have enough names to take on the appearance of a staff roster.

They noted that the situation was particularly acute in light of the fact that people have not yet moved to the actual location of their new units. Managers in one division said staff were scattered in as many as seven places around HCFA's building. HCFA now hopes to have staff relocated by late spring, although this plan appears to be optimistic.

HCFA LACKS A COMPREHENSIVE PLAN
TO ACCOMPLISH ITS SHORT-TERM AGENDA

We observed that managers appeared to be clear on top management's expectations for completing BBA-related activities and for making sure that contractors claims processing systems would comply with the millennium changes. They were less certain, however, about the agency's strategy for meeting other mission-related work.

To articulate the importance of BBA, HCFA established a tracking system that enumerates all the activities related to BBA mandates, identifies responsible agency units, and specifies completion deadlines. HCFA recently required lead units to prepare detailed BBA project plans that outline tasks, time periods, and resource needs. However, we did not find a similar plans to detail the activities for other agency priorities or ongoing Medicare functions. As a result, HCFA does not have a comprehensive view of its workload that would enable the agency's senior decision makers to consider whether resources are, in fact, adequate or properly distributed and which activities could be at risk of being neglected.

One example that came to our attention concerned the legislative mandates for reporting to the Congress on specific activities and programs. Currently, neither top management nor the Office of Legislation compiles a list of reports due and their deadlines. Unit managers are concerned because, although they are aware that certain reports for which they are responsible will be late, there is no systematic way to keep top management informed. Top management, in turn, cannot decide to heighten the priority for a particular report or develop a strategy to mitigate the consequences of others being late.

The illustration above and our discussions with agency officials suggest that while HCFA may be ready to assert its BBA-related resource needs, it is not likely to be in a position to adequately justify the resources it seeks to carry out its other Medicare program objectives. This observation calls to mind our July 1997 report on the adequacy of HHS's draft strategic plan under the Government Performance and Results Act.[8] We noted that the plan failed to address certain major management challenges, including Medicare-related problems. Specifically, the plan did not address long-standing concerns about Medicare's existing claims processing systems or HCFA's efforts to acquire a billion-dollar integrated database system. In addition, it did not address the issue of information security that was identified in the fiscal year 1996 financial statement audit of HCFA, specifying that systems weaknesses created the risk of unauthorized access to sensitive medical history and claims data.

OBSERVATIONS

HCFA is an agency facing many challenges. Even before BBA made major changes, Medicare was a vast and complex program. Volumes of reports by us and others demonstrate, in numerous areas, HCFA's need to address program vulnerabilities.

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[8]The Results Act: Observations on the Department of Health and Human Services' April 1997 Draft Strategic Plan (GAO/HEHS-97-173R, July 11, 1997).

Because of the risks associated with a program of Medicare's magnitude, the need for HCFA to be vigilant cannot be overstated.

HIPAA and BBA have given HCFA many of the tools it needs to tame and police excessive spending. Although some resources accompanied HCFA's new authorities, senior and midlevel managers contend that HCFA is struggling to carry out Medicare's numerous and challenging activities. In addition, they assert that the loss of experienced staff has further diminished HCFA's capacity. Nevertheless, senior managers do not appear to be adequately informed about the status of the full range of Medicare activities or associated resource needs. Under these circumstances, HCFA seems to be focusing most of its energy on important deadlines and pressures, but other critical functions may be receiving back-burner attention.

We have work underway to assess the status of HCFA's efforts to implement aspects of HIPAA and BBA and modernize the agency's information systems. We will also continue to monitor the progress of HCFA's reorganization efforts.

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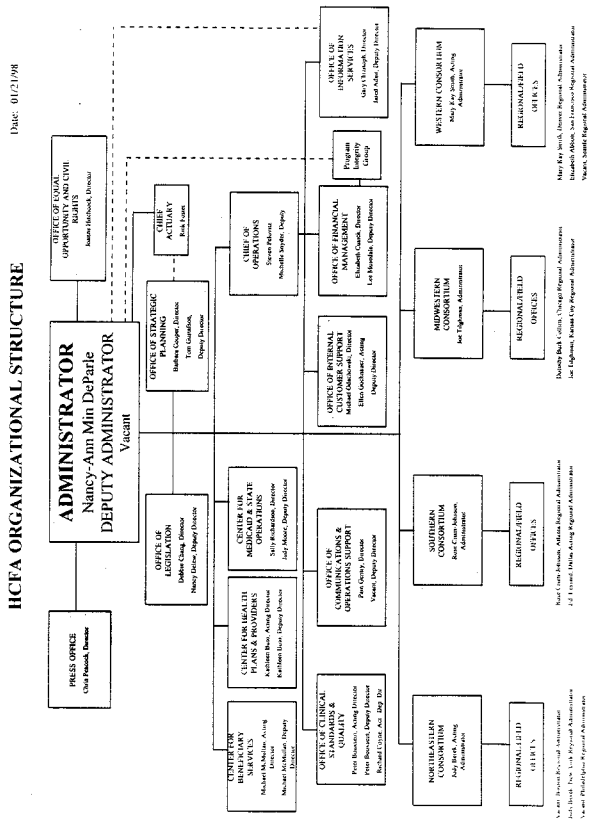
Mr. Chairman, this concludes my statement. I will be happy to answer your questions.

HCFA'S ORGANIZATION



RELATED GAO PRODUCTS

Medicare: Effective Implementation of New Legislation Is Key to Reducing Fraud and Abuse (GAO/HEHS-98-59R, Dec. 3, 1997).

Medicare Fraud and Abuse: Summary and Analysis of Reforms in the Health Insurance Portability and Accountability Act of 1996 and the Balanced Budget Act of 1997 (GAO/HEHS-98-18R, Oct. 9, 1997) and related testimony entitled Recent Legislation to Minimize Fraud and Abuse Requires Effective Implementation (GAO/T-HEHS-98-9, Oct. 9, 1997).

Medicare Automated Systems: Weaknesses in Managing Information Technology Hinder Fight Against Fraud and Abuse (GAO/T-AIMD-97-176, Sept. 29, 1997).

Medicare Home Health Agencies: Certification Process Is Ineffective in Excluding Problem Agencies (GAO/T-HEHS-97-180, July 28, 1997).

Medicare: Need to Hold Home Health Agencies More Accountable for Inappropriate Billings (GAO/HEHS-97-108, June 13, 1997).

Medicare Managed Care: HMO Rates, Other Factors Create Uneven Availability of Benefits (GAO/HEHS-97-133, May 19, 1997).

Medicare (GAO/HR-97-10) and related testimony entitled Medicare: Inherent Program Risks and Management Challenges Require Continued Federal Attention (GAO/T-HEHS-97-89, Mar. 4, 1997).

Medicare: HCFA Should Release Data to Aid Consumers, Prompt Better HMO Performance (GAO/HEHS-97-23, Oct. 22, 1996).

Medicare: Millions Can Be Saved by Screening Claims for Overused Services (GAO/HEHS-96-49, Jan. 30, 1996).

Medicare: Excessive Payments for Medical Supplies Continue Despite Improvements (GAO/HEHS-95-171, Aug. 8, 1995).

Medicare: Increased HMO Oversight Could Improve Quality and Access to Care (GAO/HEHS-95-155, Aug. 3, 1995).

Medicare: Inadequate Review of Claims Payments Limits Ability to Control Spending (GAO/HEHS-94-42, Apr. 28, 1994).

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Chairman THOMAS. Thank you very much. And I would once again refer members to the written statement. Although the oral one clearly covered key areas, there's still some very valuable information in the written statement.

Just to put in context, your statement that the work force has turned over 40 percent in the last 5 years, I have another hat I wear around here, which is the Joint Committee on the Library, and we're working with the Library of Congress because of the inordinate number of staff that will be retiring. And it's just one of those anomalies of when you were hired, and how long you worked, and who was leaving at the same time.

Is this 40 percent turnover in the last five years similar anomaly? That is people who have been there for a period of time, the agency was created, they started, they've reached the end of their employment. You used the phrase "turnover," which could mean disgruntled employees, lack of morale, uninteresting work, failure to recognize achievement. Or it could be that folks started in the program and are leaving because they're retiring.

Mr. SCANLON. It's a combination of factors. One is the problem that the agency in some respects is graying. The Medicare program, as you know, is 33 years old, and many people who began their careers at HCFA or its predecessor working with the Medicare program have reached the point of retirement. Managers expressed to us the concern that that's going to even become a more pronounced problem in the near future; more senior experience personnel will be leaving the agency because they've reached retirement age.

In addition, there are concerns about morale. How much that contributed to turnover, we could not assess. But there are concerns that the workload is considerable, the ability to reward employees and to recognize employees has some limitations, and that in that context you rely upon the dedication of employees to ensure that work is completed in a timely and effective way.

Chairman THOMAS. Well, your operation is none like that. You've got to make sure that quality work is produced, and there's always a deadline, which creates difficulties, and you have management problems.

What do you do in terms of rating folks? Do you have a pass/fail system?

Mr. SCANLON. We don't have a pass/fail system. We still have a system that maintains different categories of performance, and we also do not look at a person overall, we——

Chairman THOMAS. How am I suppose to take the context "you still have"? Does that mean that you're——

Mr. SCANLON. Well, I'm sorry.

Chairman THOMAS [continuing]. You're going to change?

Mr. SCANLON. No.

Chairman THOMAS. Okay.

Mr. SCANLON. Though I would say that in looking at personnel practices, our General Government Division group has identified that a number of private sector firms have switched to pass/fail systems. But I think there's an issue of how your appraisal system fits into your overall reward and incentive structure.

GAO has a system where we do have categories of performance, and we look at different dimensions of performance, so there's not a summary judgment, but there's some sense of a report card for performing. There's also a very careful examination of individuals' contributions to the work of the agency. And both of those things play a major role in determining the rewards that individuals receive because of their performance. And I think that's the key, is that you have to take the overall picture into account.

Chairman THOMAS. Well, let's go back then to your general statements about HCFA, and then the overall picture. Does their ability to recognize extraordinary work or excellent work, and reward for that—does that system tend to allow them to do that or does it inhibit their ability to do that?

Mr. SCANLON. We heard from a number of managers that there was difficulty in terms of recognizing outstanding work in a very visible, tangible way. While managers may reinforce the fact that individuals are excellent producers, the system doesn't necessarily make it easy to reinforce that.

HCFA does provide bonuses, but the bonus system—the amount of money in the bonus system is relatively limited, and the process for awarding bonuses involves a relatively deliberate process that interferes, in many managers' minds, with their flexibility of being able to respond quickly, and to identify that someone's performance was really outstanding.

Chairman THOMAS. What about peer group recognition or awareness? Is there a general understanding among people who would be considered peers, that people who do good work get recognized and move forward, or is there an understanding that there are people who don't do much at all still get moved forward as well, either in remuneration or otherwise?

Mr. SCANLON. Within HCFA's career ladder, which you have grades 5 through 12, there was concern that with the pass/fail system and the other personnel rules, there was considerable amount of sort of movement forward on a regular basis. And while most of that movement——

Chairman THOMAS. Regardless of performance?

Mr. SCANLON. Well, we couldn't assess how much might be regardless of performance. The concern was expressed that some may be regardless of performance, which would impact on the morale of others.

Chairman THOMAS. You heard the discussion between the doctor and myself about Congress' ability to track where inside the executive branch approval of various materials that Congress has requested are approved, and there is a multifaceted approval structure.

Is that because they don't have an internal tracking system? Should we try to make it more transparent? Her indication was maybe we should try to get it to OMB sooner. That creates a whole series of questions about how do they track stuff inside; what is the procedure.

What did you find about the ability to, at any time, no where they are, where they need to be? Tracking programs, deadline management, that sort of thing. What do they look like inside?

Mr. SCANLON. Knowing your interest specifically in congressional reports, we sought information about both what reports they had to provide you, and their status as well as their systems for tracking such reports. And what we found is that the information is not systematically available. And despite our efforts to get that information from various parts of the agency, we were not successful in doing that.

We do understand that there may be some information of that type in some offices, but it's not known at a senior management level where you would like it to be known widely, so that senior management could accept responsibility for ensuring reports get to you in a timely way.

Chairman THOMAS. Well, since your job is to critique others, my assumption is you have a tracking program in place, and it would be used as a model for others?

Mr. SCANLON. Well, we have a tracking program, and we think that it does an effective job. There is a great deal of accountability within the General Accounting Office, in the sense that every piece of correspondence or request that comes from the Congress is tracked. It's immediately logged in and assigned to a unit within GAO, and then that unit is responsible for ensuring that the request is dealt with appropriately, and the tracking system is updated to reflect that we have taken appropriate actions.

And I can tell you that management above me is constantly asking about what is happening in terms of anything that is out of place with respect to jobs that are assigned to us.

Chairman THOMAS. As we continue to request various agencies and departments to make change, although your model may not be the appropriate one because of size, or scale, or content, if we're going to critique, we've got to provide options or clear real world options available to these folk. And frankly, this is an area that I'm going to ask you to continue to look at.

It's one thing to simply say you don't have a good system; it's another to try to provide them with some guidelines as to where they can go, or at least some options. And if they don't follow the options, they should have a good reason as to why they don't.

So I appreciate very much what you've done for us in a relatively brief period of time, and look forward to visiting with you once again.

Mr. SCANLON. Thank you, Mr. Chairman. We'll be happy to follow up on that as well.

Chairman THOMAS. Does the gentleman from California wish to inquire?

Mr. STARK. What's your turnover rate in recent years at GAO?

Mr. SCANLON. Right. GAO's turnover is really not something that would be useful to compare at this point in time, because GAO has undergone a significant downsizing over the last five years. And so we have had a number of buyouts and early outs, and we have not done any hiring for about a six-year period.

So, I don't know the answer in numerical terms, but if I did, I'm not sure it would be a useful comparison.

Mr. STARK. Twenty-five, 30 percent, maybe?

Mr. SCANLON. Well——

Mr. STARK. It's not relevant. As you say, it may not be relevant——

Mr. SCANLON. If you deal with it in terms of people leaving, it's much harder than that, because we've gone from an agency that was 5,300 people to an agency that's 3,200 people.

Mr. STARK. Let me go over some math with you, and see if I can get you to start an audit.

We used to have AAPCCs average county payments. It would be within your province to audit how we calculate those county payments, right?

Mr. SCANLON. Right.

Mr. STARK. Try this. Somebody has suggested that there's around 14 percent incorrect payments; some of it's fraud, some of it's just mistakes. But we are overpaying in the whole Medicare system by 14 percent, right? Have you heard that?

So, take a county where we're paying $3,000 as the county payment, what we used to call the AAPCC. The government pays 95 percent of that rate which would be a payment of $2850, right? If my math is right.

Mr. SCANLON. That's correct.

Mr. STARK. Wait a minute. If you all were doing your job, you'd knock 14 percent out of that $3,000. Because why should we pay the HMO 95 percent of that 14 percent that's fraudulent payment? You follow where I'm going? And therefore, my contention is that we are overpaying the managed care plans in each of these areas, regardless of what you think about the 95 percent. By my cakulation, the payment would be reduced to $2,550. We'd be saving about $300 a patient if we just took out the fraud and abuse.

Could you review that for me in terms of what the law says we ought to pay, and what do we account in there for this fraud and abuse? It may be that a simple reinterpretation of the present law, based on whatever you can certify is fraudulent overpayment, would reduce our managed care payments substantially.

Mr. SCANLON. We'd be happy to look into that, both from a legal perspective, and I think there's also a question of the potential impact. Because fraud and abuse, at a 13 or 14 percent rate, which was identified in the Inspector General study, represents a national rate. And we know from our prior work that there are very great differences in the incidence of fraud and abuse in different areas of the country.

So in terms of the equity that one would want do in adjusting payments, we need to think about how to take that into account.

Mr. STARK. Oh, I have no quarrel with how you take it into account, but it's a big enough chunk that it ought not to be ignored.

Mr. SCANLON. It certainly—I'm sorry.

Mr. STARK. Yes. And so to the extent that you could shed some light on that, it would be helpful. I'd like a comparison among counties. For instances, in Minneapolis the AAPCS is $3,000. In Miami, it's $8,000. If you reduce 14 percent of $8,000, you're getting up to thousands of dollars that we've overcalculated for the payment of managed care. It is arguable that in a capitated system there isn't any room for fraud and abuse. We just pay them that fee, and it's up to the managed care plan to do as best they can. If they have fraud and abuse, it's their worry. The Government

shouldn't be financially compensating them that. It certainly is something I hope you'll look into.

Mr. SCANLON. We can look into it. The other thing I would notice, that in the 14 percent it's important also to remember that the basis for that is really inappropriate payments, not just fraud and abuse.

Mr. STARK. No. I said that at the beginning, Doctor.

Mr. SCANLON. Right.

Mr. STARK. I'm not suggesting it's all theft, but even if it's an inappropriate payment, that doesn't happen in managed care. It's a monthly capitated rate, and if we calculate that rate, knowing that there are inappropriate payments in the fee-for-service community, we are overpaying the capitated rate. You're right on target.

Mr. SCANLON. I was just going to add though that a significant number of the inappropriate payments were due to a lack of documentation documentation that might be provided if there were greater effort.

Mr. STARK. Again, no quarrel as to why. I'm not finding fault here, I'm just trying to deal with the fact that, if you and I agree that there is overpayment, for whatever reason—sun spots, the tooth fairy, that is creating an overpayment in the capitated payment, we shouldn't be paying it. We calculated the payment on the idea that they should collect a reasonable percentage of what we spend on health care in a community for managed care. But that phantom amount for fraud, whatever it is—and let's say it's 14 percent just for argument—whether it's theft or whether it's just entropy, we ought not to be including that.

Please——

Mr. SCANLON. We will look into it.

Mr. STARK [continuing]. Please give me some background on how those things are calculated, it would be helpful to the committee.

[The information was not available at the time of printing].

Mr. STARK. Thank you, Mr. Chairman.

Chairman THOMAS. Certainly. Does the gentleman from Louisiana wish to inquire?

Mr. MCCRERY. Thank you, Mr. Chairman. Just a note about Mr. Stark's line of questioning. The law does require, I believe, one-third of the managed care plans to be audited, if you will, every year; and if they are found to be charging more than the cost plus a reasonable amount, they are required to give more benefits. We don't cut the premiums that we pay, we require them to give more benefits. So we are looking at that already in the law.

Dr. Scanlon, have you had an opportunity to examine the work-at-home policies of HCFA? And if so, I have been told that HCFA management is currently considering expanding their work-at-home policy to a much greater number of employees.

Are you aware of that, and can you give us any opinion on that?

Mr. SCANLON. We are aware that the agency is in the process now of considering the inclusion of central office staff under the arrangement of flexi-place or kind of a telecommunicating, where there would be some work allowed at home. Within the regional offices this has been true in the past, but there's been great differences in the share of employees in those offices that have been participating in these kinds of arrangements, from a very, very

small number in some regions, to a more significant number, but still a much modest fraction in other areas.

We've also heard from managers about the flexi-time arrangements, which allow individuals to adjust their work schedule in terms of time of reporting: for example, whether they would work five days within a week, four 10-hour days within a week, or over a two-week period arrange their days differently than doing 10 days and two weeks.

There were some concerns expressed on the part of managers about the potential interference with needed work that the flexi-time arrangement may introduce, in that there was not an opportunity for people to have critical meetings because of certain individuals not being available.

In looking at this at other agencies and as well within GAO, the issue is one where these policies by themselves may be fine. The issue is managerial use of these policies. In both cases, flexi-place and flexi-time, there is a requirement for managerial approval of an arrangement. And a manager needs to consider the needs of the agency in terms of what arrangements can be approved or should be approved.

Mr. MCCRERY. But right now, I think in GAO and HCFA as well, the work-at-home policies apply to very few of the staff, mainly professional employees, Ph.D.s that might need to do a lot of reading at home, you know, things like that. And as I understand the proposal at HCFA, it's going to be much broader than that. It will apply to just general staff in HCFA. Is that correct?

Mr. SCANLON. Let me ask Ms. Aronovitz, who did more of the interviewing—or who did all of the interviewing up in Baltimore, to respond to this.

Mr. MCCRERY. Please.

Ms. ARONOVITZ. We heard that this is a provision that's under negotiation with the union right now. We don't know specifically how the provision will read. One of the concerns that the managers said, was that if in fact they had final judgment about whether somebody could work at home, then they wouldn't be quite as concerned, because there are occasions when, as you say, if there are proposals that need to be read, there are certain occasions when it's very conducive to working outside of the office.

The managers were concerned that they would not have the ultimate control in approving these, and that is a concern that is still unsettled in the negotiation process. So we're not sure yet how that's going to work out.

Mr. MCCRERY. What's your opinion of such a policy?

Ms. ARONOVITZ. We really support flexi-place, to the extent that it furthers the goals of the organization. But it's very important that there's a very strong balance between the individual's needs and the needs of the organization, and the organization absolutely has to be considered. And where it's not, then we would have concerns.

Mr. MCCRERY. So what does that mean? Does that mean managers ought to have the final say or——

Ms. ARONOVITZ. The policies are set up in a way to make sure that when people work at home it's only to further the needs of the

organization, that is, in instances where, if they couldn't work at home, they wouldn't be able to be doing work at all.

Mr. MCCRERY. Yes, that makes sense. But are you telling me that managers then within the organization ought to have the say so on who gets work at home, or flex time, or whatever, and make sure that they do have work that they can do at home, and that the work that they do complements the overall goal of the agency?

Ms. ARONOVITZ. Yes.

Mr. MCCRERY. Thank you.

Chairman THOMAS. No other member of the subcommittee wishes to inquire?

The gentleman from Louisiana, Mr. Cooksey.

Mr. COOKSEY. Thank you, Mr. Chairman.

The direction of my questions is about information systems. And my concern is that yours may be inadequate and can it be improved.

Prior to my joining this august body, I understand that there was a time when the people on the other side of the aisle were running Congress; they ran Congress with—the business of Congress with pen and paper, and a ledger book, presumably because that's the way it'd been done the previous 200 years. If my memory is correct, there were even some fraud and abuse in the banking—Congress' bank and their post office, but I can't really remember that in detail. But they had no information system. It was only after 1995 and eight-month transition, that they put Congress' business on an information system, on computers.

I have the feeling that probably HCFA's information systems could be modernized, updated to eliminate some fraud and abuse. What have your plans been? What would the cost be? And what would the timeline be?

Mr. SCANLON. We would agree with you wholeheartedly. In looking in the past, one of the real tragedies of the Medicare transaction system effort was that there was a real need for improving the management of information produced by HCFA's claims processing systems. Because a share of the fraud and abuse—the share of the dollars that we lose to fraud and abuse—comes about because we are not able to process information as effectively as we might, given today's technology.

The concern that we've expressed when the Medicare transaction system effort was underway was that there had not been a comprehensive plan, dealing with the kinds of objectives that you just stated, in terms of identifying the goals for this system, identifying the essential features that such a system would need in order to accomplish those goals, setting up a timeline, and identifying the cost of sort of putting that kind of system in place. Those were not done well, or at all, with respect to the Medicare transaction system. They need to be done with a system that HCFA needs for the 21st century.

At this point in time, our understanding is that HCFA is starting this process over, though given all the other things that they're doing, it's not receiving the highest attention; it does not have the highest priority. But it is something that they are fully aware of, and that they really need—that they recognize they need to address this quickly because it is critical.

The year 2000 problem is something that is of the highest priority, and is something that is related to the information systems, but I think that they will have to probably do this in two steps. One is deal with the year 2000, and then, secondly, design an information system that really is the system for the 21st century.

Mr. COOKSEY. Well, I'm not worried about the 2000 problem. I am convinced that some 18- or 23-year-old entrepreneur will come up with that problem, and will become a billionaire overnight. But the experience with the IRS has not been very good in developing an information system. They spent—I forget what—several billion dollars, and said, we give up.

The magnitude, the complexity of your problem I would think would be equal, or your responsibility. Do you think that you could do a better job in coming up with a system? Or would you do it yourself, or would you go to the private sector, or what would your plan be to come up with a better state-of-the-art information system?

Mr. SCANLON. Well, this will be HCFA's responsibility, and we will do the best we can in terms of providing constructive oversight of how they undertake this.

It's been a task of GAO for a number of years to monitor, not just for HCFA, but for the agencies of government, the movement towards improved information systems. And we've done a considerable number of reports on those. We can share some of that information with you about the principles that we've identified that are critical to this task.

In some respects there's no one solution, and HCFA's challenge is certainly unique. There's an estimate that by—or in—their early 21st century they will be paying over a billion claims every year. In addition to the challenge of dealing with the Medicare Plus Choice plans, where we would anticipate there will be more than 500 plans, we'll have a quarter of the beneficiaries in those plans, and have the freedom to change plans. And the net result will be that there will be considerable amount of work in tracking enrollments, disenrollments, and payments.

So the challenge isn't perhaps as daunting as the one facing the IRS. We have established some guidelines as to how agencies may proceed in pursuing this, and will be happy to share them with you; but at the same time we do need to wait for HCFA to take the lead in terms of laying out their initial plans, and then we can work with them to refine them.

Mr. COOKSEY. I would like to see where you are, if I could have that information.

One closing question, yes or no answer. Do you think you're doing a better job of managing your information system and your business than Congress did before 1995? You're not doing it on pen and paper, are you?

Mr. SCANLON. Beg your pardon?

Mr. COOKSEY. You're not managing it with pen and paper?

Mr. SCANLON. We are not managing with pen and paper. So I guess then the answer is yes.

Mr. COOKSEY. You can get out without answering it.

Thank you, Mr. Chairman.

Chairman THOMAS. Thank you very much. Thank you very much Dr. Scanlon, Ms. Aronovitz. No additional questions. We'll be calling on your expertise and your organization in the near future.

Last panel for today: Stuart Butler, who's obviously been before us in the past—we look forward to his testimony—the Heritage Foundation. Dr. Paul Ginsburg. And it's pleasant to find out that other folk who've been studying the concerns that we have as well, if not in direct context, at least in a general context, that Dr. Michael Gluck, National Academy of Social Insurance, and Marion Lewin, who was the study director of a Committee on Choice and Managed Care, Institute of Medicine.

I want to thank all of you for coming. Your written testimony will be made a part of the record, and you can address us in your timeframe as you see fit. And we'll start with Dr. Butler. Thank you.

STATEMENT OF STUART BUTLER, VICE PRESIDENT, DOMESTIC AND ECONOMIC POLICY STUDIES, THE HERITAGE FOUNDATION

Mr. BUTLER. Thank you, Mr. Chairman.

Congress last year enacted a series of reforms that modernized Medicare, as you mentioned in your opening statement. If HCFA is to carry out its new role under these reforms, it must respond to two challenges. It must be able to organize a market of competing health plans and provide the information necessary for beneficiaries to make wise choices within that market; and it must make the traditional fee-for-service system a more effective competitor to managed care and other private plans that are available now to beneficiaries.

Broad economic and managerial principles would suggest two key strategies are needed to respond to these challenges. First, the management of the market of competing plans and the provisions of information to consumers must be completely separate from the operation of any particular plan. That is a very basic principle of economic organization in a market. Those responsible for setting the rules of competition, and for providing consumers with dispassionate information on rival products, should have neither an interest in promoting any particular product, nor even the close relationship with one of the competitors. That is why umpires in baseball do not own baseball teams. But HCFA today carries out both of these conflicting functions.

Second, the managers of an in-house government plan in a competitive market should be given wide latitude to introduce innovations in organization and marketing. But today, as I note in my testimony, there are several obstacles that frustrate efforts by HCFA managers and staff to make the traditional fee-for-service plan more competitive and better attuned to the customer needs and desires.

With this in mind, I believe Congress should make two major organizational changes in Medicare. One, Congress should create a Medicare Board responsible directly to the secretary of HHS. In effect, Congress should create within HHS a body that is the functional equivalent of the Office of Personnel Management within the FEHBP. The function of this body and the focus of the staff within

it should be to organize and operate the market of competing plans, including the traditional fee-for-service plan; and to provide Medicare beneficiaries with the information they need to make the wisest choice possible. The board and its personnel should be separated completely from the personnel running the fee-for-service plan.

This step would effectively split HCFA into two separate agencies within HHS. One agency would set the rules of competition in Medicare, act as an umpire, and help beneficiaries make choices. The other, among other tasks, would run the fee-for-service plan, competing in that market. I suggest in my testimony how such a board should be structured.

The second step: Congress should give managers of the fee-for-service program greater discretion to be innovative and to modify benefits. It will continue to be difficult for HCFA to modify the fee-for-service benefits gradually in order to make them more competitive and modern, as long as Congress micromanages virtually all organizational and benefits decisions. On the other hand, as long as the fee-for-service plan is to be a benchmark standard plan available everywhere, Congress must have the ultimate control over the benefits package.

I would suggest that Congress resolve this dilemma by requiring HCFA to propose annual modifications in the fee-for-service benefits package, and that Congress restricts itself to an up-or-down date vote on the proposed benefit changes as a whole.

To improve this process further, Congress could designate a standard benefits commission within HCFA, with commission members selected for fixed terms by Congress. This commission would make the detailed benefit proposals to be considered by Congress.

Structural changes of the kind I've suggested should of course be considered very carefully and enacted slowly. In the meantime, I believe Congress should make some changes now to improve the organization of Medicare that will also help evaluate the probable effects of larger changes. And I mentioned those in my testimony, Mr. Chairman.

[The prepared statement follows:]

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Congressional Testimony

PREPARING THE HCFA FOR THE NEXT CENTURY

Testimony before
The Subcommittee on Health
Committee on Ways and Means
U.S. House of Representatives

January 29, 1998

Stuart Butler
Vice President
Domestic and Economic Policy Studies
The Heritage Foundation

Mr. Chairman, my name is Stuart Butler. I am Vice President for Domestic and Economic Policy Studies at The Heritage Foundation. The views I express in this testimony are my own, and should not be construed as representing any official position of The Heritage Foundation. I am also a member of the Steering Committee of the National Academy of Social Insurance project analyzing the options for long term reform of Medicare. My comments today also do not represent any position of the Steering Committee or its study panels.

I am pleased the Subcommittee has decided to hold a hearing on this important topic. Last year Congress enacted a series of reforms that modernized Medicare, creating new choices for seniors and introducing other reforms to improve the quality and financial ability of the program. Now it is important for Congress to focus more intensively on the organizational structure needed to carry out these reforms. I believe this will need far more than a minor reorganization of the Health Care Financing Administration (HCFA). It will instead need a rethinking of the whole institutional framework of the agency, and its culture.

THE CHALLEGES AND OBSTACLES FACING HCFA

If HCFA is to carry out its new role under the reforms of last year, it must respond to two challenges:

First, it must be able to organize a market of competing health plans and provide the information necessary for beneficiaries to make wise choices within that market. Unfortunately, as the GAO has pointed out in past studies, HCFA has a relatively poor track record in providing good information to beneficiaries to enable them to make wise medical decisions.

Second, the agency must make the traditional fee-for-service system a more effective competitor to managed care and other private plans that will be available to beneficiaries. This means it must acquire the skills and the freedom to examine and implement changes in benefit design, customer services and other features necessary to adapt the traditional program to customer demands in this new market. This is not an unusual challenge for a government agency faced with competition from private entities. But, as I will note in a moment, responding to this type of challenge requires agencies to alter their organization and the rules determining their incentives.

Broad economic and managerial principles would suggest two key strategies are needed to respond to these challenges:

1) *The management of the market of competing plans, and the provision of information to consumers, must be completely separate from the operation of any particular plan.*

2) *The managers of the "in-house" government plan in such a market must be given wide latitude to innovate in both in organization, marketing, and benefit structure within the goal determined by the government.*

Let me discuss each of these in a little more detail.

1) Separate the management of the market from the management of any plan.

It is a very basic principle of economic organization in a market that those responsible for setting the rules of competition, and providing consumers with information on rival products should have neither an interest in promoting any particular product nor even a close relationship with one of the competitors. That is why the Securities and Exchange Commission maintains a wall of separation from individual companies. It is why *Consumers' Reports* accepts no advertising from products it evaluates. And it is why umpires in baseball do not own baseball teams. It is also the reason, moreover, why state and local governments (and the federal government under the A-76 program) have a different agency evaluating competitive bids for government services from the agencies providing those services in-house. Entangling the running of a market with the management of any of the competing providers is a recipe for problems. It is interesting to note that in the federal health program that operates a market of dozens of competing plans made available to federal workers (the FEHBP), the agency responsible for running that market and providing information to beneficiaries (the Office of Personnel Management) does not run a plan itself.

This separation is not only necessary to avoid a conflict of interest, it is also necessary because the managerial cultures are very different for staff engaged in these two very different functions. Managers charged with dispassionately operating a market must display evenhandedness and pay close attention to the information that consumers need to make wise decisions. On the other hand, those managers engaged in marketing a particular plan, including a government-sponsored plan, must be highly competitive and concerned with the long-term viability of their particular product and the continued satisfaction of their customers. The cultural difference is much like that separating a judge from a trial attorney.

HCFA's current structure, statutory obligations, and general approach are ill-suited to maintaining a proper separation between these functions, and is a impediment to the agency's ability to carry out either function very effectively. This stems from the fact that HCFA historically has acted as a bill payer and regulator, rather than a referee in a market and a consumer information agency. As the Institute of Medicine (IOM) noted in its 1996 analysis of the Medicare market, "In the past HCFA has made little effort to inform Medicare enrollees of their choices regarding health care providers, treatment

options, or competing private plans."[1] And as the General Accounting Office noted in a 1995 study, HCFA amasses vast amounts of information but has a poor track record in providing information to beneficiaries that is useable.

To be sure, HCFA has been taking steps to provide better information to beneficiaries, including data on high mortality hospitals and better benefits information. However, this falls far short of what it needed to enable elderly Americans to make sensible choices when there are an increasing number of options available. Moreover, even with the recent reorganization, the conflicting functions of dispassionate market management and plan operation are still hopelessly entwined.

It is interesting to contrast the way in which HCFA functions as a manager of a market with the manner in which OPM functions within the FEHBP. According to James Morrison, the career civil servant who ran the FEHBP during the Reagan Administration, the contrast stems not from any inherent deficiency of HCFA staff as civil servants, but from differences in the structure imposed on the agencies running the two programs. This suggests that Congress must modify the program design if it is to achieve a change in the way HCFA functions. As Morrison explained to me in a recent note (which he has permitted me to make available to the Sub-Committee):

> "There is a profound difference in the way the Health Care Finance Administration (HCFA) deals with the private sector intermediary in the Medicare program and the way in which the Office of Personnel Management (OPM) deals with the private sector plans in the Federal Employees Health Benefits Program (FEHBP). This difference derives, in large measure, from the statutory difference between the two programs.
>
> Medicare is a highly prescribed, statutorily defined program with benefit levels and payment rates essentially fixed in law. The FEHBP, on the other hand, has very few statutory prescriptions. Beyond the bare outlines of a core benefits package, specifics of the plan's offering and its price must be negotiated between the government and the private sector carrier. These fundamental differences shape the values, roles, responsibilities, and indeed the operating culture, of the administering agencies. Thus, HCFA employs legions of regulators bent on prescribing every detail of the Medicare program, and scores of health policy "experts" to determine the needs of beneficiaries. OPM employs a small number of contract specialists who can assess the price and value of a plan offering while leaving the determination of customer needs to individual consumers. HCFA places a premium on employees with advanced degrees in health policy; OPM values private sector health plan experience."

2) <u>Enable "in-house," government-sponsored plan to innovate and compete</u>

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[1] Stanley B. Jones and Marion Ein Lewin (Edit.), *Improving the Medicare Market* (Washington, D.C.: National Academy Press), p.72.

When government permits people to obtain a service from a range of competing private providers, when previously that service was largely delivered through a government agency, it is crucial that the managers of the government-sponsored service be given the flexibility and the incentive to compete in the market. If that is not done, the government agency is competing with one hand tied behind its back. We see this issue raised recently in the context of public and private school education. Many public school advocates strongly support giving principals and parents much greater control over the running of public schools because they are frustrated that parents are deserting public schools that are unable to compete because of excessive bureaucracy and rigidity.

Consider also that many of the cities and states that have pioneered competitive bidding in government services. They have not merely put into place mechanisms to permit a bidding process to be conducted, but have also taken aggressive steps to give their government services agencies significant leeway to reorganize themselves and to implement innovations in service. In Phoenix and Indianapolis, and several other jurisdictions, city departments have been able to institute sweeping changes to enable them to compete more effectively. The result: city departments now often win head-to-head competitions with private bidders.

In general, the federal government had lagged behind other levels of government in introducing this greater flexibility for its own agencies. It is essential that Congress takes steps to permit such innovations in the structure and delivery of the traditional fee-for-service (FFS) Medicare program. If it does not, it will become steadily more difficult for the FFS program to compete.

Today there are several obstacles that frustrate any effort by HCFA managers and staff to make the traditional FFS more competitive and better attuned to customer needs and desires. Three obstacles are particularly problematic:

a) Organization and Culture At the moment there is no distinct group of people at HCFA whose only job it is to make the FFS program the best it can be. Instead, this objective is diffused throughout the agency and personnel and departments have conflicting objectives. Reinforcing this as Morrison notes, is the type of skill and experience of HCFA staff. While individuals may be highly competent and highly skilled, they are typically not the competencies and skills needed to serve customers and introduce innovations in a competitive market.

b) Limitations on Innovation Tight congressional control means HCFA has very little latitude to introduce innovations into the organization of the FFS plan or within the Medicare program generally. This makes it difficult for HCFA staff to improve the quality of Medicare's FFS plan or experiment with better ways to operate a market of competing plans. As long as Congress insists on micromanaging in this way, the traditional FFS plan will always be at a competitive disadvantage with private plans whose management is free to innovate.

c) Benefits Determined by Congress Just as Congress gives very little flexibility for HCFA to be innovative in the organization of a competitive market or in the provision of the running of the FFS plan, it also gives virtually no flexibility for HCFA to vary benefits in the traditional FFS plan. While competing private plans must include the comprehensive Medicare package, they have considerable flexibility in designing a cost structure and additional benefits package to be competitive. And in the FEHBP, competing plans have very wide flexibility in designing benefits and prices within general guidelines set down by OPM. In the FEHBP, there are very few statutory benefits imposed by Congress (although these have been creeping in recent years). But the benefits and costs of the FFS plan are determined by Congress.

This congressional determination of specific benefits and costs gives HCFA virtually no flexibility to structure the FFS plan such that it could compete more effectively in a changing health care market. It means that the FFS program is not able to enfold gradually in response to changing needs and desires of seniors. Innovation is constantly delayed and occurs only through major changes enacted by Congress. This means the FFS program constantly lags behind its competitors. Moreover, because Congress determines benefits changes, the process becomes a lobbying battle between competing provider interest rather than an appropriate change to reflect the desires of customers. This politicization of benefits frustrates HCFA staff and undermines the long-term quality of the FFS program and its ability to satisfy customers who now have alternative choices.

REORGANIZING THE ADMINISTRATION OF MEDICARE

Congress must focus on steps now to give the government greater ability to organize a market of choices for beneficiaries, give dispassionate information on alternative plans (including the traditional FFS plan), and turn the traditional FFS plan into a vigorous, innovative competitor on a level playing field with other plans. After setting out the broad structure to accomplish this by the end of the next Congress, the Congress should take incremental steps this year to begin creating that structure.

With this in mind, this or the next Congress should make two major organizational changes in Medicare.

1) Create a Medicare Board responsible directly to the Secretary of HHS

Congress should create within the Medicare program a body that is the functional equivalent of the Office of Personal Management within the FEHBP. The function of this body, and the focus of the staff within it, should be to structure and operate a market of competing plans, including the traditional FFS plan, and to provide Medicare beneficiaries with the information they need to make the wisest choice possible.

This proposal is very similar to a recommendation of the Institute of Medicine's Committee on Choice and Managed Care in 1996. In making its recommendation, the IOM committee emphasized that HCFA currently tries to undertake two very different functions that demand very different approaches and skills. The IOM committee noted, among other things:

- "The administration of the multiple choice program and the management of the traditional Medicare program's involve very different mission and orientations.

- The two functions require different types of management, staff expertise, backgrounds, and knowledge. The committee is concerned that staff and senior managers with extensive experience in managing various aspects of multiple choice in the private sector be recruited and employed for this effort.

- The functions call for different organizational and corporate cultures, one operating a stable traditional public indemnity insurance program and the other a purchaser-and customer-oriented program that is required to be responsive to a diverse group of private programs in a rapidly changing and dynamic market place."[2]

The creation of a Medicare Board would permit the function of managing a market of competing plans to be separated from the operation of the traditional FFS program as one of those competing plans. This would accomplish the economic and managerial objectives set out at the beginning of my testimony.

Creating such a board would effectively split HCFA into two separate agencies within HHS.

The new Board would answer directly to the Secretary of the HHS, and would have similar functions to those of OPM within the FEHBP. Among the boards functions:

- *Setting standards for all plans being offered to Medicare beneficiaries, and certifying that all plans meet those standards.* The standard setting should apply to the traditional FFS program as well as the new choice programs created by Congress.

- *Negotiating with competing plans regarding benefits and prices.* Just as OPM negotiates with individual plans before they are offered to federal employees during open season, so the board should use Medicare's purchasing power to push plans into providing the best options for seniors. One of the main reasons for doing this is to ensure that plans compete for business by offering good value rather than by introducing dubious marketing techniques (such as artificial boundaries for marketing areas, or benefits designed only to attract low risk customers). CalPERS carries out a similar function for California state employees, as do many large corporate purchasers of health care.

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[2] Jones and Lewin, *Improving the Medicare Market*, pp. 107-108.

- *Organizing payments to chosen plans.* The Board should evaluate and propose refinements of the payment system to plans, including the traditional FFS plan, and recommend these to the Secretary of HHS and Congress.

- *Providing data and information to consumers.* The Board would take on the function of providing consumer and benefits information to seniors and guidance on how to make wise choices. This function would include examining techniques to measure quality and incorporating prudent techniques into the information made available to beneficiaries.

In order to carry out its mission effectively, the Board itself should contain certain elements. One of these should be an Advisory Council, mainly representing consumers but also organizations with a general interest in creating a market for high quality health care. However, the Board, and the Advisory Council, should receive policy and technical advise on issues affecting the market for Medicare plans from an outside advisory body with experience of other health care markets. I would suggest the Medicare Payment Advisory Commission (MedPAC), with an expanded staff, could play this role.

In addition, the Board would need a full staff to undertake its broad functions. Some of these staff could be recruited from current HCFA personnel. But for the reasons mentioned earlier, and emphasized by the IOM committee, it would be wise to recruit some staff from outside HHS in order to introduce new skills and experience. Some individuals might be recruited from OPM, and others from the private sector.

2) Give managers of the Fee For Service program greater discretion to be innovative and to modify benefits.

For the reasons I mentioned earlier, it is currently very difficult for HCFA to make improvements in the FFS program, especially to modify the benefits to make the FFS plan more competitive and modern.

It will continue to be difficult for HCFA to modify FFS benefits gradually, to make them more competitive and modern, as long as Congress micro-manages all benefits decisions. On the other hand, as long as the FFS plan is to be a benchmark standard plan available everywhere, and as long as its benefits constitute the core of all plans, Congress must have ultimate control over the benefits package.

I would suggest that Congress resolve this dilemma by requiring HCFA to propose annual modifications in the FFS benefits package each year, and that Congress also enact legislation to restrict itself to an up-or-down vote on the changes as a whole. To improve this process further, Congress could designate a standing Benefits Commission within HCFA, with Commission members selected for fixed terms by Congress. This Commission would make the detailed benefit proposals to be considered by Congress.

Congress. This Commission would make the detailed benefit proposals to be considered by Congress.

To be sure, a determined Congress could under this arrangement still vote down a package of proposed benefit changes until they comply with Congress's own views. Still, as the Base Closing Commission indicated, the mechanism I propose has had the effect before of achieving orderly change by insulating the process from excessive lobbying or pressure from individual lawmakers.

WHAT CONGRESS SHOULD DO NOW

Structural changes of the kind I have suggested should of course be considered very carefully before enactment, because the organizational changes themselves would affect the nature of the program as well as carrying out the objectives of last years reform. But in the meantime, I believe Congress should take some changes now to make improvements in the organization of Medicare that will also help evaluate larger changes.

I would suggest three specific steps.

1) Create an advisory commission on consumer information

This commission, comprised of outside experts and appropriate HCFA personnel, would advise both Congress and the Secretary of HHS on steps that could be taken to enable Medicare beneficiaries to make better decisions regarding choosing plans and obtaining services. This commission would analyze such items as quality measurement, report cards etc.

The commission should have a small staff. These should include appropriate HCFA staff, experienced FEHBP officials from the Office of Personnel Management, and private sector consultants. The commission should receive advice from MedPAC. In order to help in this role, the staff of MedPAC should be increased.

A council of this kind would help HCFA's task of operating a choice market in Medicare, by providing the agency with more outside experience. But if the commission were successful, it could form the nucleus of the proposed Medicare Board.

2) Give HCFA more authority to experiment

Currently HCFA is given little authority to undertake experiments to find better ways of carrying out its mission, or to alter its procedures to incorporate successful innovations garnered from its own experiments or from the private sector. Instead, HCFA typically is instructed to carry out demonstrations by congressional statute. If the FFS program especially is to be as modern and competitive as beneficiaries should expect, HCFA must have greater authority to experiment.

The Secretary of HHS should be given greater discretion, by statute, to waive categories of statutory requirements to permit HCFA to modify its procedures and make small adjustments in benefits, providing the general congressional intent of the Medicare program is fulfilled. This flexibility would introduce a greater degree of experimentation and gradual improvement into the functioning of Medicare.

3) Create a benefits advisory commission

Experience in the private sector, and in plans offered through the FEHBP, suggests that small changes in benefits over time can substantially improve the quality of a health plan while keeping its costs under control. Unfortunately, because of a combination of bureaucracy and politicization, this orderly process is difficult if not impossible in Medicare. A benefits advisory commission would be no magic bullet, of course, but it could help to provide a focus and independence to the process of evaluating and improving the current Medicare benefits package. As in the case of the proposed advisory commission on consumer information, the members of a benefits commission should be predominantly outside experts and should receive technical advice from MedPAC as well as other sources. In the future this commission, if successful, could evolve into the body suggested earlier that would propose annual benefit changes for an up-or-down vote in Congress.

Mr. Chairman, Congress and the Administration took the first steps last year to ensure that today's younger workers will be able to count on a Medicare program that is both financially sound and modern. More steps are needed to complete both tasks. Further reforms will be needed to assure the financial viability of Medicare well into the next century. And additional steps will be needed to improve the program's benefits and plan choices. But as this hearing recognizes, key to all of these reforms is for Congress to overhaul the way in which the program is run, by restructuring HCFA to enable the agency's public servants to meet the challenges they face.

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Chairman THOMAS. Thank you very much, Stuart.

Dr. Ginsburg.

STATEMENT OF PAUL GINSBURG, PH.D., CHAIR, STUDY PANEL ON FEE-FOR-SERVICE MEDICARE, NATIONAL ACADEMY OF SOCIAL INSURANCE AND PRESIDENT, CENTER FOR STUDYING HEALTH SYSTEM CHANGE.

Mr. GINSBURG. Thank you, Mr. Chairman.

I am appearing as chair of an expert panel convened by the National Academy of Social Insurance, and am accompanied by Academy staff director, Michael Gluck. This panel's outstanding member have depth of experience in Medicare, private health plans, and health care delivery. And many have extensive experience in both government and the private sector.

The panel's report, "From a Generation Behind to a Generation Ahead: Transforming Traditional Medicare," is being released today, and my testimony is drawn from that report.

Even if Medicare+Choice develops rapidly, large numbers of beneficiaries will continue in the fee-for-service Medicare program for the foreseeable future. The structure of this program has changed little since 1965; its essence is to pay bills. While the Congress has accomplished a great deal in the 1980s in mechanisms for setting payment rates, little has happened to encourage more effective delivery of services to beneficiaries.

There are opportunities to improve quality and reduce program costs, especially for those beneficiaries with chronic illness. Leading private insurance plans have increased their activities to manage care over the past ten years, but Medicare has not followed.

A number of management tools used in the private sector hold promise for Medicare; these include disease and case management, incentives to use selected providers and competitive procurements.

We cannot say at this point precisely which tools will be most effective in fee-for-service Medicare. HCFA needs to test the potential of such tools and to encourage broader use of those that are successful. The limited progress in this area is not because of lack of interest by the leadership of HCFA, but rather, the substantial barriers to HCFA performing this role; the Congress tends to allow little latitude to innovate; and HCFA does not have the authority to integrate successful demonstrations into the regular Medicare program.

The Congress has begun to reduce barriers. Provisions in the Balanced Budget Act and in the Health Insurance Portability and Accountability Act move in this direction, but I would characterize these steps as reflecting innovation by exception. A more comprehensive approach is needed. HCFA needs a broad mandate to pursue ongoing improvement in fee-for-service Medicare by incorporating effective care management tools.

The Panel made specific recommendations. First, the Congress should mandate fee-for-service Medicare to move beyond its traditional role as a billpayer and take responsibility for quality and cost of care. Second, the Congress should direct HCFA to promote innovations in Medicare fee-for-service by adapting the best practices of private health plans to this program environment. These innovations should be targeted toward those geographic areas and

populations where they could be most effective. Third, to carry out these innovations, HCFA should have the authority to waive some statutory requirements and should be able to contract with a variety of qualified private organizations that specialize in particular services, such as patient education, case management, or utilization review.

Along with this additional authority, accountability should be demanded. The Secretary of HHS should report annually to Congress on how HCFA has used its authority to innovate, and what the results are. Congress should designate an advisory body, such as the Medicare Payment Advisory Commission, to review this report.

In conclusion, to advance the quality of care for Medicare's fee-for-service beneficiaries and to ensure that taxpayers' money is well spent, HCFA must have modern management tools at its disposal. In managing fee-for-service Medicare, HCFA should have the capacity to apply new knowledge from research and the private sector about how best to manage health benefits for older Americans and those with disabilities, especially as the number of beneficiaries living with chronic conditions continues to grow.

Thank you, Mr. Chairman.

[The prepared statement follows:]

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Statement of

Paul B. Ginsburg, Ph.D.
Chair, Study Panel on Fee-for-Service Medicare
National Academy of Social Insurance
and President, Center for Studying Health System Change

accompanied by

Michael E. Gluck, Ph.D.
Director of Health Policy Studies
National Academy of Social Insurance

on

"Fee-for-Service Medicare and Preparing the Health Care Financing Administration (HCFA) for the 21st Century"

Before the
Subcommittee on Health of the Committee on Ways and Means
U.S. House of Representatives

January 29, 1998
Washington, DC

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Mr. Chairman, I am happy to be here this morning to share the findings and recommendations of an expert panel convened by the National Academy of Social Insurance. This panel's charge has been to consider the future of Medicare's fee-for-service (FFS) program, the traditional part of Medicare that currently covers about 87 percent of all beneficiaries. Accompanying me is Michael E. Gluck, the panel's staff director.

The Academy's Work on Medicare

The National Academy of Social Insurance is a nonpartisan, nonprofit research and education organization made up of 450 of the nation's leading experts in Social Security, Medicare, and other social insurance programs elected to membership by their peers. This Study Panel is one of four convened as part of the Academy's on-going project on *Restructuring Medicare for the Long Term*. The work of this panel was supported by grants from the Robert Wood Johnson Foundation and the Pew Charitable Trusts. Three other Academy study panels are examining issues about Medicare capitation and choice, Medicare's larger social roles, and issues related to the program's long-term financing.

We are pleased today to release this Study Panel's final report, *From a Generation Behind to a Generation Ahead: Transforming Traditional Medicare*. The findings and recommendations of this report come after eighteen months of study. They do not represent an official position of the National Academy of Social Insurance, which does not take positions on policy issues. The Study Panel's twelve members (listed in Attachment A) are drawn from medicine, public policy, law, and industry. All have relevant expertise in Medicare or private health plans. I should also note that the views of each panel member are their own and not necessarily those of the organizations with which they are affiliated.

This Testimony

In my testimony, I will do three things:

- I will discuss the Study Panel's conclusions about why we should invest resources to modernize the FFS program given our hopes for Medicare+Choice.
- I will review the Panel's findings about innovations from the private sector and elsewhere that we conclude hold promise for FFS Medicare.
- And I will present the Study Panel's recommendations for bringing about these needed innovations.

As you will see, the central role of the Health Care Financing Administration in managing the FFS program figured prominently in the Panel's discussions and report.

Why Modernize FFS?

The Congressional Budget Office predicts that Medicare+Choice enrollment will grow to 38 percent of beneficiaries over the next ten years. Hence, with 62 percent of beneficiaries remaining in FFS Medicare, it continues to be the dominant means of delivering and paying for Medicare services well into the future. Its beneficiaries (as well as the taxpayers who help pay for the program) deserve to realize the benefits of management innovations developed in private health plans and elsewhere. Furthermore, by more actively managing the quality of care beneficiaries receive, FFS Medicare could set benchmarks for Medicare+Choice plans to meet or exceed.

The administrative structure of FFS Medicare remains much as it was established in 1965. Its architects built the program upon the model of private health insurance as it operated at that time. FFS Medicare primarily pays itemized bills for covered services provided to beneficiaries. Evidence accumulated over the past twenty

years indicates that there are significant opportunities to improve the quality of care that beneficiaries receive, and in many instances, reduce program costs. Of particular concern is the growing prevalence of chronic conditions among Medicare beneficiaries. FFS Medicare currently provides few incentives to providers to coordinate the array of services that constitute quality chronic care.

Managing Private Insurance

Over the last decade, private health insurance has moved away from a bill-paying orientation to adopt and develop many of the principles of managed care. The Study Panel found a number of management tools that it believes FFS Medicare ought to develop and try. In particular:

- **Disease and case management** -- Flexibility in benefits and the use of certain management techniques may hold particular promise for both the cost and quality of care given to FFS Medicare beneficiaries with special health needs. Among the conditions where research and the experience of private insurers suggest FFS Medicare might realize cost savings and/or quality enhancements are: (1) congestive heart failure, (2) chronic obstructive pulmonary disease, (3) diabetes, (4) hypertension, (5) arthritis, (6) falls (prevention), (7) chronic pain, and (8) end-of-life care.

  These techniques include: (1) case management, (2) prevention, (3) education to teach patients self-management of chronic conditions, (4) bundling of payments for physicians and other providers to coordinate care, (5) prior authorization and review for selected procedures, and (6) data analysis to help target such tools.

- **Incentives to use selected providers**--Although some private health plans restrict enrollees to providers who meet certain cost or quality criteria, others preserve enrollees' freedom of choice, while giving them financial incentives to choose preferred providers. FFS Medicare could also experiment with this latter approach, as it has done in some limited demonstrations.

- **Competitive procurement**--Private health plans use their buying power in the marketplace to realize savings in the cost of goods and services. Medicare is the nation's single largest payer of health care. HCFA could develop experiments with competitive purchasing appropriate for some of the unique characteristics of the FFS Medicare program, especially in those geographic and purchasing areas where prices paid by private health plans are significantly below those paid by Medicare for comparable goods and services. Some provisions in the Balance Budget Act of 1997 (P.L. 105-33) begin to move FFS Medicare in this direction.

To what extent has private insurance used these tools and with what results? Available evidence suggests that in developing managed care tools, most private insurers have focused initially on controlling costs with less emphasis on managed care tools mainly intended to enhance quality. In addition, little evidence exists to associate specific managed care tools with observed health outcomes. In recent years, however, some private insurers have begun to develop and implement disease management, including programs to screen for preventable, treatable conditions, to increase treatment compliance, and to manage closely the complications of chronic diseases. Furthermore, experience with managed care tools that have the potential to reduce costs and enhance quality will grow over time.

The Study Panel believes FFS Medicare needs the capacity to take advantage of these tools in a timely manner as research results and private sector experience make them apparent. It is even possible that FFS Medicare itself could provide leadership to

other health care organizations by developing and refining promising ways of managing care for elderly and disabled people that may not have been attempted among private health plans. HCFA needs the capacity to test the potential of such tools to enhance FFS Medicare beneficiaries' quality of care and to make broader use of those that work. HCFA currently does not have this ability.

Prospects for Innovation

Achieving innovation in the program's management will not be easy. Changes in program philosophy or procedure will require new authorization in law. FFS Medicare's current legal structure is designed to assure that public decisions are made in the public interest and that every qualified enterprise has an opportunity to do business with this public program. Non-statutory barriers also affect HCFA's ability to innovate. Among the limitations HCFA faces:

- Congress often does not allow the executive branch much latitude in decision-making and, over time, it tends to constrain latitude it does provide in legislation.
- Procedural regulations, the need for transparency in government decision-making, and limitations on hiring and contracting practices make most administrative decisions lengthy.
- The process for using FFS Medicare's current demonstration authority to test new ways of providing or paying for services is lengthy. It is also difficult for HCFA to integrate successful demonstrations into regular FFS Medicare operation without new statutory authority.
- The size and dominance of the Medicare program can present barriers for innovations that steer FFS Medicare business away from some providers. They can potentially cause economic disruptions in the marketplace because FFS Medicare accounts for such a significant portion of revenue for physicians, hospitals, other health care providers, and health care manufacturers.
- Executive branch or Congressional intervention at the behest of client or provider interests can hold up a decision or signal that a particular demonstration project or regulatory provision would likely provoke a punitive response.
- Although the health needs of elderly individuals differ from those of the younger population, there are significant gaps in knowledge about how best to treat the 65 and over population. In particular, there is minimal experience in how to apply the knowledge that does exist for an elderly population to the management of a health plan.

These difficulties underscore the need for a period of learning and experimentation in using managed care techniques to help assure that beneficiaries who choose to remain in FFS Medicare have the opportunity to receive appropriate, cost-effective treatment.

Innovation in the Current FFS Medicare Program

Even in the face of these limitations, Congress and HCFA have begun to explore the applicability of certain managed care tools for FFS Medicare. HCFA has undertaken some demonstrations on its own to test new ways of providing and paying for high volume services and care for beneficiaries with particular conditions. The Balanced Budget Act (BBA) of 1997 (P.L. 105-33) mandates a few additional experiments, and the Health Insurance Portability and Accountability Act (HIPAA) of 1996 (P.L. 104-191) provides new flexibility in how HCFA contracts with administrative organizations to prevent waste, fraud, and abuse.

Although these activities are important, they are significantly limited. Rather than encompassing a coherent, overall commitment to modernizing FFS Medicare, they represent innovation by exception. They lack a broad mandate from Congress for the flexibility necessary for on-going improvement of FFS Medicare and usually rely on Medicare's current demonstration process, which is lengthy and cumbersome. Furthermore, HCFA can not integrate successful demonstrations into FFS Medicare permanently without Congressional action.

Recommendations

To address these difficulties and allow HCFA to try these important new management tools, the Study Panel makes five recommendations:

Recommendation 1: Congress should mandate that FFS Medicare move beyond its traditional role as a bill-payer to become accountable for the quality and costs of services provided to beneficiaries.

Congress should provide explicit support for an overall change in program philosophy and a commitment to systematic, on-going innovation in FFS Medicare. A congressional commitment to such innovation would enable HCFA to place greater emphasis on assuring appropriate volume and quality of services paid for by FFS Medicare. It also would represent a commitment by Congress to assure that FFS Medicare is a viable, modern option as it "competes" with the private plans offered under the Medicare+Choice program mandated by the BBA of 1997.

Recommendation 2: Congress should direct HCFA to innovate in FFS Medicare on an on-going basis by adapting (and going beyond) the best practices of private health plans. HCFA should experiment with new ways of managing services including disease and case management, especially for beneficiaries with chronic and other conditions, providing beneficiaries with incentives to use selected providers, and a unique competitive procurement process for FFS Medicare. HCFA should target these innovations toward the geographic areas and populations where they have the greatest potential to improve quality and cost outcomes.

The Study Panel believes FFS Medicare's use of these managed care tools should be characterized by experimentation, planning and evaluation, selectivity, and adaptation. First, FFS Medicare should be able to innovate in the way a private sector corporation innovates-- i.e., to implement changes promptly based on the results of experimentation. HCFA should be allowed to try new ideas, abandon those that do not work, and replicate those that do. It should conduct these experiments within the context of a well-articulated and thoroughly reviewed innovation plan. In developing and updating this plan, HCFA should track developments in both clinical medicine and health plan management by monitoring research activities in the Public Health Service, the larger published research literature, and innovations among private health plans. As new opportunities to improve the management of health services become evident, FFS Medicare should be prepared to experiment promptly with their application among those geographic areas and populations of beneficiaries where they may have the greatest potential. HCFA also should remain open to adapting each new tool with which it experiments to make it appropriate for a public program like FFS Medicare and its beneficiaries.

Recommendation 3: In order to carry out these experiments in the management of FFS Medicare, HCFA should have the authority to waive some statutory requirements.

After concluding that the current demonstration authority is too limited and that reconstituting HCFA as an independent, private, or semi-public authority would not, by itself, address the challenges that FFS Medicare faces, the Study Panel concluded that HCFA needs new statutory authority from Congress to manage innovation.

Under this new authority, Congress would permit the Secretary of Health and Human Services to waive certain requirements under the federal statute governing FFS Medicare in order to experiment with the managed care tools outlined above. When new clinical or administrative approaches to providing or paying for cost-effective, quality care become apparent through research or the experience of private health

plans, this authority will provide HCFA with the flexibility to try them in a more timely manner than the current demonstration authority allows.

HCFA could contract with a variety of qualified private organizations such as health plans, groups of providers, or organizations that specialize in particular services such as patient education, case management, or utilization review. The managed care tools could be administrative, clinical, or non-medical support services that may improve the quality of health services and/or save money. HCFA would solicit ideas for experiments on a regular basis from the private sector as well as from state and local government. It would design each experiment to reflect beneficiary needs and the capacity of the health care system in each geographic area. Such geographic targeting will minimize the risk of widespread implementation of any unproven and potentially inappropriate technique.

Congress should grant HCFA the freedom to learn from this process of experimentation. Because some experiments will not live up to expectations of cost savings or quality improvement, HCFA should have the flexibility to abandon promptly or alter approaches that do not work. Furthermore, the Secretary should have the authority to make successful experiments part of the regular FFS Medicare program.

Congress should limit this new waiver authority so no enrollee is eligible for fewer benefits than those already provided under Medicare. In addition, FFS Medicare should preserve beneficiaries' freedom of choice of providers (even if some experiments incorporate incentives for beneficiaries to choose selected providers). In those cases where HCFA experiments with competitive procurement, HCFA will also need to maintain enough viable providers and suppliers to assure an effective procurement process in future years, given the substantial purchasing role Medicare plays in the health care marketplace.

Recommendation 4: Congress should require the Secretary of Health and Human Services to report annually on how HCFA has used its authority to innovate and with what results for quality, costs, and access. Congress should designate an advisory body to respond to this report and advise Congress about potential improvements.

In return for granting higher discretion to HCFA in managing FFS Medicare, Congress should hold HCFA to a greater standard of accountability for cost and quality outcomes than it has previously. In an annual report to Congress, the Secretary of Health and Human Services would review HCFA's overall innovation management plan, actual projects undertaken, and evidence of how well HCFA is fulfilling Congress's mandate to transform FFS Medicare from a bill-paying program to one accountable for the quality and costs of services it covers. The Study Panel further recommends that Congress require the Medicare Payment Advisory Commission (MPAC) review the Secretary's report each year, comment on it, and recommend any changes in the waiver authority it believes appropriate.

Recommendation 5: To help Congress hold HCFA accountable to the public for the discretion described in Recommendation #3, HCFA should require that each experiment obtain evaluation data in order to learn quickly from the initiative.

Assessment of experiments is necessary in order to learn and for effective legislative oversight. FFS Medicare's current demonstration authority recognizes this necessity in its requirements for complete, rigorous evaluations of each demonstration project, but such studies can be a time-consuming process. The Study Panel believes FFS Medicare needs the capacity to develop valid data more quickly so that policymakers can make timely decisions about whether to replicate, abandon, or alter each experiment. The Panel recommends that HCFA require the designers of each experiment to identify indicators that will allow for prompt, but valid information about how well each experiment is operating.

Conclusion

The BBA of 1997 increased Medicare beneficiaries' opportunities to receive their Medicare benefits through privately run health plans. Because these new choices will not be appropriate for all beneficiaries, beneficiaries also deserve a viable FFS option. Yet, managing FFS Medicare represents a significant challenge for the federal government, and for HCFA in particular. In order to advance the quality of care for FFS Medicare's beneficiaries and to assure the taxpayers' money is well spent, HCFA must have modern management tools at its disposal. In managing FFS Medicare, HCFA should have the capacity to apply new knowledge from research and the private sector about how best to manage health benefits for older Americans and those with disabilities, especially as the number of beneficiaries living with chronic conditions continues to grow. The changes needed to bring about this capacity will require strong leadership and bipartisan consensus among our elected officials. In order to prepare HCFA for the next generation of beneficiaries, we need to develop that consensus today.

Mr. Chairman, I thank you for the opportunity to present our work this morning. We are happy to answer any questions you or the other members of the Committee may have.

Attachment A

NASI Study Panel on Fee-For-Service Medicare

Paul Ginsburg, *Chair (from February 1997)**
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Washington, DC

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*Paul Ginsburg assumed the duties of Study Panel Chair when Janet Shikles left the U.S. General Accounting Office and took her current position in February 1997.
**Formerly a private consultant and full Panel member, Judith Moore became an *ex-officio* member when she took her current position in August 1996.

Chairman THOMAS. Thank you, Dr. Ginsburg.

Ms. Lewin.

STATEMENT OF MARION E. LEWIN, M.A., STUDY DIRECTOR, COMMITTEE ON CHOICE AND MANAGED CARE, INSTITUTE OF MEDICINE

Ms. LEWIN. Mr. Chairman, Mr. Stark, and members of the committee, I'm very pleased to be here today, on behalf of the IOM Committee on Choice and Managed Care, and my remarks are based on their report. The list of the members of that committee and their recommendations are attached to the testimony.

Before I provide my few comments on this very important topic of today's discussion, I want to provide some important clarifying information. One is that the report that we did came out in August 1996, before the passage of the Balanced Budget Act of 1997. Second, the committee was mandated to look primarily at how to make the Medicare Choice system more accountable, and to improve informed purchasing by and on behalf of beneficiaries. It was not given a specific mandate to look at the organization of HCFA, but clearly as we went through our work, the organization of HCFA and the role of HCFA did become an important topic. But only one of the study's seven recommendations pertains to HCFA, and regarding that recommendation the committee made the following points.

It said that, if we want to make the Medicare market more accountable, trustworthy, and assuring for Medicare beneficiaries, there were some concerns about HCFA; that administration of a market-oriented multiple choice program and the management of the traditional Medicare program involved very different corporate culture and missions; that the two functions require different types of management, staff expertise, orientation, and knowledge. And the committee spoke to the benefit of HCFA recruiting staff and senior managers with extensive experience in managing the various aspects of multiple choice in the private sector. Then also that a flexible response mode to changing conditions and opportunities is required for the effective management of a multiple choice market in order to provide the best options for beneficiaries. Such responsiveness may be hard to achieve with the regulatory constraints of HCFA.

As part of its recommendation, the committee suggested an entity for study, which we call the Medicare Market Board, which has taken on a life of its own. As the committee was envisioning this Medicare Market Board, they looked at a model at something like the Federal Reserve Board. The committee didn't investigate it further. We didn't have specific experts on the committee on public administration and organizational management. But they felt that a Medicare Market Board should have the stature, leadership and resources to hold plans accountable, and to be a dispassionate developer of the rules of the game.

Since the publication of our report, I think the committee believes and the committee is now doing some continuing activities, that HCFA has made some impressive strides to more capably and effectively administer this complex and challenging world of choice. The committee is especially heartened by HCFA's new center for

beneficiary services because they are undertaking or implementing many of the other recommendations we made in the report, and is also applauding the establishment of the Center for Health Plans and Providers, which does include many, if not all of the elements and responsibilities that we have envisioned under the Medicare Market Board.

I think that the major difference is that as some of the other witnesses have said, that the committee felt that there really needs to be a fire wall between the choice plans and the fee-for-service. Even on our committee, we had representatives from the fee-for-service world and representatives from the new managed care world. There was a tension. The people from the managed care world really didn't want fee-for-service to succeed. They didn't really want it to be improved because it would compete with them.

So I think there is a feeling that if in a large self insurance plan, which you could really think of as Medicare, you do need a fire wall between people who are managing and administering the competitive choice plan and the ones that are managing the fee-for-service.

As part of our committee's work, we heard a lot of testimony from model purchasers, the people that we feel are doing it right, that are the leaders in this arena. I do want to share with you that certain themes and cautions from these purchasers, from these plans, from these States, from these organizations, were heard again and again, both in the commission papers and in our hearings. That is, that doing it right requires a real commitment of staff, talent, time, technology, and resources in order for these kind of strategies to have a real payoff. It can not be done on the cheap. I think the lack of resources is a real detriment and a problem for HCFA as it has been given these major, major new responsibilities.

Why don't I end here so that we can allow time for discussion. Thank you.

[The prepared statement follows:]

INSTITUTE OF MEDICINE
NATIONAL ACADEMY OF SCIENCES
2101 CONSTITUTION AVENUE, N.W. WASHINGTON, DC 20418

United States House of Representatives
Committee on Ways and Means
Subcommittee on Health

Preparing the Heath Care Financing Administration (HCFA) for the 21st Century
Thursday, January 29, 1998

WRITTEN STATEMENT

Marion Ein Lewin, M.A.
Study Director, Committee on Choice and Managed Care: Assuring Public Accountability and Information for Informed Purchasing by and on Behalf of Medicare Beneficiaries
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and

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On behalf of the Institute of Medicine's Committee on Choice and Managed Care, I am pleased to be here today to participate in an important and timely hearing on "Preparing the Health Care Financing Administration (HCFA) for the 21st Century." My testimony is based on the findings and recommendations of a 1996 report that the IOM Committee issued on *Improving the Medicare Market: Adding Choice and Protections.* The list of members who served on the Committee and developed the recommendations is attached to my testimony.

Before I provide specific comments on the topic of today's discussion, I want to provide some clarifying background information. As mentioned previously, the report on which these remarks are based was issued in August, 1996, before the passage of the Balanced Budget Act of 1997 and a major reorganization of HCFA . The major focus and purpose of the IOM report was not to look at the mission and organization of HCFA, but to provide guidance to policy makers and decision makers on ensuring public accountability, promoting informed purchasing, and installing the necessary protections to help Medicare beneficiaries operate effectively, safely, and confidently in a new environment of greater health plan choice and managed care. Only one of the study's seven recommendations pertains to HCFA. The bulk of the recommendations relate to: how the government should evaluate and approve health plans; what role the traditional Medicare program should play; how to help the elderly understand and fairly compare their options; and, how to develop the necessary guidelines regarding enrollment, marketing, and grievance procedures.

The IOM was asked to conduct this study by a number of private foundations in the aftermath of proposals in the 104th Congress to restructure the Medicare program. I served as the study director for this effort.

Regarding HCFA, the Committee expressed a number of concerns as part of their deliberations on how to make the Medicare market more accountable, trustworthy, and assuring for Medicare beneficiaries. Among the concerns were the following:

- Administration of a market-oriented, multiple choice program and the management of the traditional Medicare program involve very different missions and orientations. Managing these two programs — one a stable traditional public indemnity insurance program, the other a purchaser, customer-oriented program — requires very different organizational structures.
- The two functions require different types of management, staff expertise, orientation, and knowledge. The committee spoke to the benefit of HCFA recruiting staff and senior managers with extensive experience in managing various aspects of multiple choice in the private sector.
- A faster, more flexible response mode to changing conditions and opportunities is required for the effective management of a multiple choice market in order to provide the best options for beneficiaries. Such responsiveness may be hard to achieve with the regulatory constraints of HCFA.

- The committee believed strongly that strengthened leadership and new responsibilities for managing the choice paradigm had to be supported by adequate organizational, financial, and staffing resources.

As part of its recommendations, the IOM Committee suggested that a study be commissioned to assess the pros and cons of establishing, either within or independent of HCFA, an entity along the lines of a Medicare Market Board. Such a board would have the stature, leadership and resources to hold plans accountable; to develop standards of competition based on quality and performance to: collect and publish essential data; develop and implement an effective and responsive beneficiary information structure; continually review issues related to benefits, quality, and fair payment to health plans; and, be responsible for the ongoing evaluation and improvement of the multiple choice market for Medicare beneficiaries.

Since the publication of the report, HCFA has made impressive strides to more capably and effectively administer the complex and challenging world of choice, managed care, and multiple services delivery arrangements. HCFA has established the Center for Health Plans and Providers with many of the elements and responsibilities that the Committee envisioned for the Medicare Market Board. HCFA's new Center for Beneficiary Services has set an ambitious agenda for trying to expand consumer choice and informed purchasing by focusing on critical information needs and looking at beneficiaries as their primary customers. The Agency also is taking important strides in establishing on-line help for beneficiaries to assist them in the ability to compare health plan offerings on the basis of benefits, costs, and quality in a way that is meaningful and understandable.

According to what the committee envisioned in its report, the above are substantial steps in the right direction. Nevertheless, HCFA still has a daunting, if not an overwhelming agenda to fulfill in responding to the mandates of the Balanced Budget Act (BBA). The BBA contains a number of requirements to improve the information available to beneficiaries, to standardize some of the enrollment activities, and to gradually move Medicare to an open enrollment model. During its work, the committee commissioned a number of papers and solicited expert testimony from major purchasers in the public and private sector to garner their experience and lessons learned about developing and implementing strategies for promoting informed and accountable health plan choice by beneficiaries. The committee heard certain themes and cautions again and again: Doing it "right" requires a real commitment of staff, talent, time, technology, and resources in order for these strategies to have a real payoff. It cannot be done on the cheap.

As it undertakes its formidable short- and long-term agenda, another major challenge for HCFA will be to deal fairly and progressively with the new world of health plan choice in the face of a 30-year investment and understandable attachment to traditional Medicare. During our IOM study there was some concern expressed over the inherent ability of an Agency with a long-term investment in one program to at the same time have the responsibility of developing a framework and infrastructure to compete against it.

To update you on the IOM Committee's work, we will be conducting a major workshop in early March on "Developing an Information Infrastructure for Medicare Beneficiaries in an Environment of Choice." In planning this workshop, HCFA has been especially helpful in sharing with us the issues that they believe are most relevant and important to their current work in implementing the requirements of the BBA. Much of the workshop's agenda will be devoted to these themes and issues.

Thank you for giving us this opportunity to testify. I would be happy to answer any questions.

Institute of Medicine, National Academy of Sciences

Choice and Managed Care: Assuring Public Accountability and Information for Informed Purchasing By and on Behalf of Medicare Beneficiaries

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Excerpted from *Improving the Medicare Market: Adding Choice and Protections*
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Findings and Recommendations

RECOMMENDATION 1

All Medicare choices[1] that meet the standard conditions of participation and that are available in a local market should be offered to Medicare beneficiaries to increase the likelihood that beneficiaries can find a plan of value. Traditional Medicare should be maintained as an option and as an acceptable "safe harbor" for beneficiaries, especially those who are physically or mentally frail.

Number and Type of Health Plans to Be Offered

Findings

Medicare beneficiaries are currently offered traditional Medicare, Medigap policies, and, in many areas of the country, a growing number of alternative health plans. New initiatives in Medicare and proposed reforms of the Medicare program would broaden the number and range of alternative health plans offered.

For most Medicare beneficiaries the range of options and the responsibility for choosing among those options are likely to be significantly greater than those currently available to a large percentage of the working population. Unlike private employers, which have the power to limit the number and types of plans offered, current Medicare practice and proposed reforms would allow any plan that meets specified conditions of participation to sell coverage to Medicare beneficiaries.

Although the committee was cautioned that a large number of choices may increase the confusion for Medicare beneficiaries, it may also increase the ability of Medicare beneficiaries to find a plan that they like, for example, a plan that includes their chosen doctor, that offers valued additional coverage, or that provides convenient access to services. The fear of not being able to continue to see a chosen caregiver has been shown to be a major reason why elderly individuals are reluctant to move into managed care arrangements. Competition among a larger number of health plans will likely produce more innovation on the part of health plans to find ways to be more responsive to the wants and needs of beneficiaries.

The committee also was concerned that limiting the numbers of plans, beyond requiring them

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[1] For the purpose of this chapter, the term Medicare choices is an umbrella term for traditional Medicare, Medigap insurance, and alternative health plans (including managed care).

to meet benchmark[2] conditions of participation, would raise policy and political issues, given the size of the Medicare program and the proportion of total U.S. health care revenues that it represents. Setting limits would have a vast impact on competitors and the market as a whole.

Subrecommendations

The committee recommends that all *Medicare choices* that meet the benchmark conditions of participation be offered to beneficiaries. Conditions of participation should be carefully constructed to bear the burden of assuring informed choice by beneficiaries and accountability by health plans for access to quality systems of care. All *Medicare choices* should have to meet common conditions of participation.

This policy may result in the marketing of plans with limited appeal and small numbers of Medicare beneficiary enrollees over time. The committee recommends that these kinds of plans be tracked over time and evaluated for their potential impacts on risk selection[3] and administrative costs and the extent to which they cause confusion among beneficiaries.

The Traditional Medicare Program

Findings

Given how little is known about ensuring informed choice and holding health plans accountable for providing quality care to Medicare beneficiaries and given the consequent risks for the beneficiaries, the committee believes that traditional Medicare must remain an option and a safe harbor for beneficiaries.[4] This option should be at least as good as the existing Medicare program in terms of benefits, beneficiary cost-sharing, choice of providers, geographic access, and other factors.

The committee believes that maintaining traditional Medicare as a choice is critical for allowing large numbers and a wide range of plans to be offered to Medicare beneficiaries. Without the ability to retain the traditional Medicare program as an option and safe harbor, particularly for beneficiaries who are physically and mentally frail, the committee would not recommend widening the Medicare marketplace to the extent that is advocated in this report.

The committee is aware that traditional indemnity plans are becoming a relic for the market under age 65; many fee-for-service plans have been discontinued because of their high premiums, their noncompetitive benefits, and adverse risk selection. Within this environment, special challenges exist for the future viability of the traditional Medicare program. Constraints on Medicare spending are adding new urgency to managing the costs of care delivered in the traditional Medicare program. Maintaining traditional Medicare as an option is likely to be difficult and could require additional costs to government.

The committee was not able, within the time frame and scope of its task, to make the difficult estimates of these potential costs to government or their wider social implications. The committee is mindful, however, of efforts by the National Academy of Social Insurance, the Prospective Payment

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[2] Benchmark is defined as a floor, with the expectation that participating plans would exceed this level.

[3] As in other sections of the report, the committee understands the inadequacy and limitations of current risk adjustment methods and recommends that further research be supported in this critical area. In the meantime, however, practical requirements necessitate that available techniques be used to make best-judgment decisions.

[4] The committee defines *safe harbor* as a program that is financially stable and that remains an option for the foreseeable future.

Assessment Commission (ProPAC), PPRC, and others to explore ways in which Medicare's fee-for-service program can be shaped in the future to make it more efficient and to improve its management and delivery of care.

Subrecommendations

In the framework of the findings presented above, the committee recommends that HCFA, under its demonstration authorities, accelerate its efforts to identify private-sector purchasing and management techniques that can be adopted appropriately for use by the traditional Medicare program as an alternative to price reductions and, when possible, to offer additional benefits to maintain the program's value. HCFA's current development of "centers of excellence" for high-technology procedures seems an example of such an adaptation.

As indicated elsewhere, it is also critical that risk selection measurement and adjustment technologies be improved for use by traditional Medicare and health plans. As improved technology for measuring risk selection is developed, HCFA should study the traditional Medicare program's risk pool relative to those of other health plans and assess whether program funding fairly reflects Medicare's risk profile to enable it to offer a product of competitive value to beneficiaries. The federal government should also study and pilot test ways to pay health plans more fairly for chronically ill beneficiaries to encourage health plans to invest in and market to those beneficiaries.

Risk Selection

Findings

It was beyond the scope of the present study to address problems of risk selection among the multiple *Medicare choices* and to recommend steps to correct for those problems. During its deliberations, however, the committee found that mechanisms to prevent or correct for risk selection are critical to the ultimate success of any system offering multiple health plan choices and that the existing Medicare AAPCC cannot be relied on to achieve success in this area.

The number and range of health plan choices being proposed for Medicare beneficiaries and variations in benefits, premiums, and marketing are likely to greatly increase the potential for risk selection among those offering the various *Medicare choices*. Since risk selection can seriously undermine the viabilities of the traditional Medicare program and individual plans, it is important that this problem be addressed and controlled.

Ultimately, the committee is concerned about incentives and the capability of physicians with a direct financial interest in a plan to recruit (or avoid) subscribers on the basis of whether that individual is a high- or low-level user of health services.

RECOMMENDATION 2

Enrollment and disenrollment guidelines, appeals and grievance procedures, and marketing rules should reflect Medicare beneficiaries' vulnerability and lack of understanding of traditional Medicare and Medigap insurance and their current lack of trust in important aspects of alternative health plans.

Beneficiary Enrollment and Disenrollment

Findings

The committee found that numerous factors make it critical to facilitate the Medicare enrollment and disenrollment process in an environment of market competition and broader choice:

- Medicare beneficiaries are apprehensive about managed care, the concept of risk, the choice

process, and lock-in provisions that would prevent beneficiaries from leaving a plan with which they become dissatisfied after enrollment.

- Many Medicare beneficiaries are poorly informed about traditional health insurance in general and are even more poorly informed about their *Medicare choices* and the choice process. A considerable amount of beneficiary dissatisfaction, especially among those beneficiaries who are new to managed care, appears to be related to misunderstandings of the basic structure, payment and care practices, and the choice process.
- Some beneficiaries unknowingly lose their Medigap insurance coverage or face a premium increase if they join a managed care plan and later return to Medicare.
- Managed care uses practice protocols and definitions of what constitutes medical necessity and appropriate care that vary from those used by the traditional Medicare program. These differences can result in various types and levels of service for specific illnesses and conditions. It is often difficult for beneficiaries to understand these protocols and their implications for the specific services offered by various plans before enrolling in a plan.
- Many Medicare beneficiaries are disadvantaged in the choice process by physical or mental frailty or by poor vision or hearing.
- Some Medicare beneficiaries who receive their care from HMOs now must enroll in and disenroll from plans as they move between summer and winter residences. The portability of a managed care plan may be further hindered by annual open enrollment policies and lock-in provisions.
- Beneficiaries can be negatively affected by health plan changes beyond their control, such as when their provider ceases to contract with the plan.
- Beneficiaries who make misinformed choices can be hurt financially or clinically, or both. The committee is most concerned with minimizing adverse clinical outcomes, but would err on the side of greater leniency in allowing beneficiaries to leave a plan with which they are dissatisfied.

Subrecommendations

Given the findings presented above, the committee recommends a transition period of 2 years from the time that legislation is implemented during which the federal government would continue the current option of permitting monthly changes of enrollment by Medicare beneficiaries. After this transition period, enrollees should be locked into the plan that they have selected for 1 year, with the following exceptions. All enrollees will have 90 days from the time of enrollment in a health plan to disenroll and enroll in traditional Medicare, and newly entitled beneficiaries and beneficiaries who have never before chosen a health plan (i.e., those who have been enrolled in the traditional Medicare program) should have the prerogative of changing plans or rejoining the traditional Medicare program within 90 days. There is a prevailing sentiment among committee members that the federal government should set limits on the number of times that new health plans' members can change plans. Beneficiaries should be allowed to return to their previous Medigap policy with no additional premium costs and with no restrictions placed on preexisting conditions if they disenroll from a health plan within 90 days and return to the traditional Medicare program.

The committee would like to see the federal government encourage plans to offer adequate out-of-area coverage for their enrollees who reside out of the plan's service area for more than 3 months. This can be achieved through interplan reciprocity or point-of-service options.

Grievance and Appeals Procedures

Findings

The current Medicare appeals process has been shown to be slow and not adequately advertised by HCFA or health plans. Furthermore, the current appeals process is tailored more to

reviewing whether a service should be reimbursed by Medicare or a health plan and less on the important issue of whether a needed service was denied.

In a competitive environment, to attain better risk selection, health plans have the incentive to encourage healthier people to enroll in the plan and to discourage from enrollment those who need more services. This could prompt plans to be less responsive to the grievances of sicker Medicare enrollees.

Subrecommendations

The committee recommends that the existing appeals process be strengthened, streamlined, and better publicized.

Furthermore, the committee recommends that the federal government make available an expedited review and resolution process for *Medicare choices* (by an agency independent of the health plan and the traditional Medicare program) to review emergency conditions, such as the following: (1) when a situation is life-threatening, (2) when the time involved to review the appeal under the usual process would result in a loss of function or a significant worsening of a condition or would render the treatment ineffective, or (3) when advanced directives or end-of-life preferences are involved.

The federal government should carry out this expedited review through an independent private nonprofit agency in each area of the country. The agency should review any negative findings with the health plan involved and report to the federal government any recommended changes to improve the plan's performance. The cost of this independent, expedited review process should be covered by the Informed Choice Fund. The federal government should be able to assess the costs of these reviews on the health plans when the number of such reviews and negative findings becomes excessive.

Health Plan, Medigap Insurance, and Traditional Medicare Marketing Practices

Findings

Past experience with Medigap policy sales has demonstrated the potential for widespread abuse. Federal and state regulatory mechanisms have been put into place to deal with these abuses. However, greater incentives for abuse exist with the sale of alternative health plans. The commission on a single sale can be a significant portion of an agent's compensation.

Health insurance is also complex, and it is difficult for beneficiaries to compare the benefits offered by competing health plans. It will likely remain so for most Medicare consumers. Many Medicare beneficiaries are particularly vulnerable in their need and desire for adequate health care coverage and have been found to have low levels of understanding of *Medicare choices*.

All of these factors that make elderly beneficiaries especially susceptible to improper marketing practices are underscored by the fact that elderly people have a preference for and rely on one-to-one interactions as a way of learning about their health plan options.

Subrecommendations

To promote comparable levels of accountability, the committee recommends that serious consideration be given to having a new entity approve in advance the public information and marketing materials used by health plans and by the traditional Medicare program. Additionally, the federal government should work with state governments to oversee the marketing of Medigap policies to individuals in the framework of the new requirement for a single open season and conditions of participation.

The committee recommends that the agents and marketers of health plans and Medigap policies be required to inform Medicare beneficiaries up front of their commission for the sale of the policy. Unsolicited door-to-door marketing and outbound telephone marketing should be prohibited.

Rigorous marketing rules of conduct should be required to protect beneficiaries. For example,

- lock-in requirements should be made more lenient for beneficiaries who enroll via door-to-door or telephone marketing,
- retroactive disenrollment should be permitted if enrollment takes place as a result of misleading marketing, and
- compensation to marketing agents should be tied to retention of the enrollee in the health plan, and
- retention rates should be reported to potential enrollees by the health plan and by agents.

The committee recommends that the federal government define the basic requirements of any marketing presentation by a health plan or Medigap insurance provider, including such items as providing a copy of a brochure or pamphlet that clearly compared standard health plans, a description of the lock-in provision and a discussion of the availability of the beneficiaries' providers under the plan, and marketing materials in the primary language of the buyer. The federal government should also collaborate with states to ensure consistency in these requirements and should be able to effectively sanction health plans and Medigap insurance providers that break the marketing rules.

RECOMMENDATION 3

The committee recommends that special and major efforts be directed to building the needed consumer-oriented information infrastructure for Medicare beneficiaries. This resource should be developed at the national, state, and local levels, with an emphasis on coordination and partnerships. Information and customer service techniques and protocols developed in the private sector should be used to guide this effort, and the best technologies currently available or projected to be available in the near term should be used.

Beneficiary Information Needs for Informed Choice

Findings

Many Medicare beneficiaries do not understand the *Medicare choices*. Many are fearful of any change in Medicare and distrust the new choices of health plans. A wide range of unbiased information about *Medicare choices* may increase the level of trust. The committee has found that Medicare beneficiaries want and need standardized, unbiased, clearly understandable information, including the following:

- how the different *Medicare choices* actually work;
- the out-of-pocket costs of the various plans;
- the experiences of people similar to themselves (e.g., people of the same age, health, sex, ethnicity and cultural background) seeking care under the various *Medicare choices*;
- how patients have access to and are treated by their doctors (both primary care and specialist physicians) under the various options;
- the accessibility of the services that they are likely to need, especially hospital and ancillary services, as well as the accessibility to cutting-edge care and where it is provided;
- an indication that the information is accurate, timely, reliable, and trustworthy (beneficiaries are savvy in discerning the quality and inherent biases of the information); and
- how participating physicians are paid.

Some groups of beneficiaries, especially those with chronic conditions, desire more specific information, such as protocols for treatment or whether a particular prescription drug is provided in

their *Medicare choice*.

Medicare beneficiaries appear to be active users of media of all types, older adults are particularly oriented toward one-to-one communications with another individual. Furthermore, the committee is pleased with the progress being made by private credentialing organizations like NCQA and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) to develop data sets that can be used to certify plans and inform consumers, such as HEDIS.

Subrecommendations

In efforts to communicate the information in the box "Medicare Choices Information for Beneficiaries" to Medicare beneficiaries, a broad range of mass media and other forms of communication should be used. Emphasis should be placed on providing beneficiaries with easy telephone access to individuals who can guide them on the use of the materials providing comparisons of health plans and who can provide additional clarification and information on plans and providers. To the degree possible, health plans will be asked to submit information in a format that will allow beneficiaries or their families to access the information via the Internet.

To establish trust, a private, nonprofit organization should validate and publish summaries of performance data and make more technical backup data available to beneficiaries and others who have a reasonable right to know. Beneficiary surveys should be standardized across plans, they should be audited, they should include a representative sample of those who are covered (including by ethnicity), and they should oversample beneficiaries with chronic or disabling conditions. Materials should be adapted for use by those with special physical limitations, such as poor vision and hearing.

To keep its information as complete and current as possible, this organization should obtain expert advice from national quality and service accreditation organizations in the continuing development of data needs, comparative reports, and surveys for the purposes described above.

Medicare Customer Service and Enrollment Center

Findings

There exists a critical need to increase understanding of and trust in the restructured Medicare program by the public. Medicare beneficiaries and the general public need to be provided with a broad and objective education about the coverages, costs, and purposes of Medicare and the new health plan choices.

Objective and responsive information on all aspects of *Medicare choices* is also needed to hold the health system and plans accountable. An increase in the amount of this type of information will augment Medicare beneficiaries' trust in the Medicare program and the choice process.

The committee finds that the private sector's information and communication technologies for assembling, cataloging, and making available information on various health plan features to consumers have advanced well beyond those currently being used to serve Medicare beneficiaries. An example cited frequently at the symposium and in the commissioned papers is the notion of customer service centers that allow telephone access to representatives with on-line support. The central availability of the federal government's access to standard data from participating health plans, the traditional Medicare program, and Medigap insurance offers an opportunity to use this technology to better ensure informed choice by beneficiaries and accountability by health plans.

Furthermore, regional and local variations in health plans and health care, coupled with the strong desire among beneficiaries for one-to-one communication, suggest that additional information and service activities be carried out by ombudspersons or agencies at the regional and area levels. Models for such activities exist in information, counseling, and assistance (ICA) programs, which are funded primarily by HCFA.

BOX 3-1

Medicare Choices: Information for Beneficiaries

To provide the necessary information for informed purchasing, the committee recommends that the federal government make available to beneficiaries, directly or through health plans, the following types of information on *Medicare choices:*

1. The enrollment and disenrollment rules, the choice process, and the range of services available from the health plans.
2. How traditional Medicare and Medigap insurance, in comparison with alternative health plans, pay and contract with providers, for example, choice of providers and portability.
3. Comparative benefits, including
   - emergency and out-of-plan urgent care;
   - hospital services (including access to centers of excellence);
   - nursing home, home health, and hospice services;
   - prescription benefits;
   - physician services, including the availability of specialists;
   - foot care, dental care, and mental health care; and
   - services of alternative providers such as chiropractors.
4. Comparative costs, including premiums, cost-sharing, and balance billing, with examples of comparative costs for different classes of beneficiaries, for example, the well elderly; disabled, institutionalized, and chronically ill people; and individuals with major illness episodes while on Medicare. Medigap insurance premiums should be shown to be in addition to the Part B premium.
5. Comparative performance on clinical, structural, and satisfaction benchmarks:
   - scientifically valid process and outcome measures in a form salient and relevant to beneficiaries, including the
     - —percentage of beneficiaries with diabetes who receive an annual eye examination,
     - —percentage of female Medicare beneficiaries who receive an annual or biannual mammogram and Pap smear,
     - —percentage of males who receive a prostate examination,
     - —percentage of beneficiaries who receive preventive services, such as hypertension screening and influenza and pneumococcal vaccinations, and
     - —recidivism rate for various diagnoses;
   - access measures, including
     - —the percentage of referrals denied or unavailable,
     - —the average waiting time to obtain a referral,
     - —average times to obtain an appointment once a referral has been made,
     - —ease of phone access and average waiting times in a physician's office, and
     - —physician turnover rates; and
   - satisfaction measures (specifying those with chronic conditions or disabilities), including
     - —disenrollment information, including the percentage of persons who disenroll within 3 months of enrollment,
     - —appeals and grievance information, including the numbers, reasons, and resolutions of grievances and appeals per *Medicare choices* organization,
     - —access and quality findings from HCFA monitoring surveys and relevant state regulatory reports, and
     - —findings from surveys commissioned by the organization on satisfaction with physicians and hospital care, access to specialists, and other factors found to be important to beneficiaries.
6. A clear description of the details of each plan and the Medigap policy, including
   - in- and out-of-network access and costs;
   - how referrals are made (e.g., who makes the referral decisions and on what basis);
   - appeals and grievance systems;
   - up-to-date listings of all providers by type and specialty, credentials, and whether an individual provider is accepting new patients from the plan;
   - financial and contractual arrangements between plans and providers that may influence their decisions regarding services in the judgment of the federal government;
   - financial and solvency status; and
   - use of out-of-area specialty centers.

On request, policies or protocols for covering or providing specific services (such as a prescription drug) or services for specific conditions (such as chronic obstructive pulmonary disease, congestive heart failure, diabetes, and joint replacement) should be provided.

Subrecommendations

To further these objectives, the committee recommends that the federal government contract with and oversee a private, nonprofit agency to develop a state-of-the-art *Medicare Customer Service and Enrollment Center* that would (1) administer a Medicare customer services answer center; (2) develop, collect, and distribute open enrollment materials and enrollment data; (3) reconcile enrollment data and payments to plans, including monthly changes and related transactions; (4) provide an evaluation component for the purpose of continual improvement and plan feedback; and (5) contract for regular customer service satisfaction surveys.

The Center would strive to offer Medicare beneficiaries national and regional or local access to the types of services provided by the benefits departments of the nation's large employers, building on the regional-area work of organizations such as ICA programs.

The Center will provide education, counseling, and legal assistance and will process complaints, grievances, and appeals from plan members through regional and local agents such as ICA programs. It will install a tracking system to report all complaints, grievances, and appeals, and will report this information to beneficiaries annually and to health plan chief executive officers monthly.

In carrying out this effort, the Center will take advantage of the most effective and efficient methods of electronic communication, including toll-free telephone communication, on-line communications, town meetings, newsletters, and multimedia techniques, to provide information about plans and the process of choice that is as detailed as possible.

The Center's national, regional, and area activities would be funded by the federal government through the Informed Choice Fund.

Choice Facilitating Organizations

Findings

The committee finds that many independent private organizations that already exist or that might well develop can assist beneficiaries with making informed choices among the options available through the Medicare program. These facilitating or mediating organizations offer services ranging from providing objective additional information on plans and choices beyond what the Center offers, to evaluating plans by additional objective criteria, to prescreening and selecting plans that the organization's customers or members might choose, to bargaining for better value from the plans. In fact, many employers are offering such services to their Medicare-eligible retirees, making Medicare HMOs or Medigap policies, or both, available to them during their annual open seasons.

These Choice Facilitating Organizations do raise some concerns. Insurance brokers or other parties with financial interests may misuse these opportunities to market products rather than provide objective advice. Also, even well-functioning organizations could divert feedback on the services offered by a plan from the Center and its regional agents and dilute the effectiveness of the Center's national reporting. The committee leans toward limiting the establishment of these organizations to groups that do not have a vested financial interest in the choices that consumers make or, at a minimum, requiring such organizations to adequately disclose their sources of funding and potential biases that might result from these financial interests.

Subrecommendations

The committee recommends that nothing in law or regulation should inhibit the development of private organizations whose major purpose is to facilitate choice for Medicare beneficiaries, including groups that offer preselected panels of health plans. Although the committee believes that such organizations should be limited to groups that do not have a vested financial interest in the choices that are made, at a minimum, these organizations should be required to fully disclose their sources of funding and potential biases that might result from these financial arrangements.

To help make the Choice Facilitating Organizations as useful to beneficiaries as possible, the

federal government should require health plans and the traditional Medicare program to make available appropriate information to such organizations that have a legitimate interest in that information, such as the data behind quality or accreditation scores.

The committee advocates that public and private entities experiment with such organizations, including providing funding from the Informed Choice Fund to those that meet the criteria of independence and objectivity to augment the work of the Medicare Customer Service and Enrollment Center. Choice Facilitating Organizations may be particularly useful during the early phase of Medicare choice development.

The Informed Choice Fund

Findings

The provision of information on *Medicare choices* to Medicare consumers is in its infancy stage. Most of the information about quality and performance that has been developed and collected has been for large purchasers, plan administrators, or clinicians, not as part of an effort to educate and inform individual consumers.

Subrecommendations

The committee recommends that an *Informed Choice Fund* be developed for use by the federal government for the purpose of strengthening the infrastructure used to inform Medicare beneficiaries of their health plan choices. The Informed Choice Fund would be used to fund the operations of the Medicare Customer Service and Enrollment Center. Demonstration grants to Choice Facilitating Organizations could be made from this Fund, as desired by the federal government, after the operations of the Medicare Customer Service and Enrollment Center are funded.

The Informed Choice Fund would derive its income from a predictable revenue source, such as a fixed amount from each Medicare beneficiary or a flat amount or a percentage of the monthly Medicare premiums. One demonstration project might be to allow beneficiaries to designate all or a portion of their share of these funds to the Choice Facilitating Organization of their choice.

RECOMMENDATION 4

The federal government should require all *Medicare choices* to be marketed during the same open season to promote comparability and to enable beneficiaries to adequately assess and compare the benefits and prices of the various options.

Coordination of Traditional Medicare, Medigap Insurance and Health Plans: *Medicare Choices*

Findings

Comparing the prices and benefits of the various *Medicare choices* is difficult at present because they are not marketed at the same time or under the same ground rules. For example, the beneficiary may not see the high cost (frequently $1,000 or more) of the traditional Medicare program with Medigap insurance relative to the cost of a managed care plan. In addition, beneficiaries who leave Medicare and their Medigap policy for a managed care plan may find that they cannot repurchase their Medigap policy because of a preexisting condition.

The committee finds that the division of responsibility for enforcing the rules of participation in and compliance with these programs between state and federal government complicates the process of informed choice, grievance and complaint resolution, and plan accountability and fragments the offering of health plans across state lines.

Subrecommendations

It is within this context that the committee recommends that the selection of *Medicare choices* be coordinated. All three types of plans should be offered during open enrollment periods and under the same conditions of participation.[5]

The federal government should work with state governments to coordinate the federal requirements surrounding *Medicare choices* with existing state regulations for Medigap insurance and private insurance. The U.S. Congress should consider what policy-making and enforcement activities are most appropriately and effectively conducted by the federal government and which can be delegated to state governments to ensure consistency and economy.

Standardized Packaging, Pricing, and Marketing of Benefits

Findings

Through the course of its deliberations, the committee found that although standardized benefits might simplify the choice process for elderly individuals, standardization is likely to dampen innovation and responsiveness to a broader range of consumer desires and preferences. However, the committee also appreciates the advantage for the beneficiary of the current standard benefit categories under Medigap insurance, which facilitate comparisons of the benefits and costs of different benefit options and comparisons of different insurers providing the same option. The committee acknowledges that many employers and private organizations have developed formats that allow the benefits of competing health plans to be clearly displayed and compared. It would be relatively simple for Medicare to do the same.

Terminology relating to the benefits offered by health plans varies greatly and makes it difficult to make clear comparisons among health plans. More research is needed on the types of information that beneficiaries want and need to exercise informed choice and how best to present that information.

Subrecommendations

The committee wants to preserve the general approach taken by the law governing Medigap insurance without restricting choice to the same extent. It believes that health plans should be moved toward standardized packaging, pricing, and marketing of selected benefit packages to allow beneficiaries to more easily compare the benefits offered by different plans. The committee recommends all plans be required to offer and price a basic benefit package (current Medicare Part A and Part B services) and have the option of offering and pricing two other popular benefit packages defined by the federal government and included in basic comparisons promulgated by the federal government. These popular benefit packages should include added benefits shown by market sales and surveys to be of special interest to the elderly (services such as pharmacy, eye care, and foot care) and ones that are popular given the cost. Health plans would be free to offer and price benefit packages other than these two that add to the basic benefit, but these other packages must be clearly identified as nonstandard, must offer substantial differences from the basic benefit package, and would not be included in the Medicare Customer Service and Enrollment Center's standard published comparisons. The federal government should commission the Medicare Customer Service and Enrollment Center to develop and use formats that allow beneficiaries to make easy and clear comparisons of benefits and other information on *Medicare choices*, drawing on the best practices used by employers and private and public organizations. The federal government should also suggest questions that Medicare beneficiaries should ask about nonstandard packages.

To make this process even easier, the federal government should promulgate common terminology related to benefits. All *Medicare choices* should use this terminology to describe the benefits of each of their offerings.

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[5] The Physician Payment Review Commission's 1996 Annual Report to Congress provides a worthwhile discussion of the pros and cons of annual versus continuous open enrollment seasons.

The federal government should coordinate its activities with those of state governments to ensure consistency between these benefit packages and those of Medigap insurance.

RECOMMENDATION 5

The committee is concerned about the increasing restrictions on physicians (and the potential conflict of interest of physicians) when they act in their professional role as advocates for their patients and carry out their contractual responsibilities and receive economic incentives as health plan providers. The committee favors the abolition of payment incentives or other practices that may motivate providers to evade their ethical responsibility to provide complete information to their patients about their illness, treatment options, and plan coverages. So-called anticriticism clauses or gag rules should be prohibited as a condition of plan participation.

Physicians and Professionalism

Findings

The committee recognizes that physicians' advice to beneficiaries is a quintessential part of ensuring informed choice. Because of the inherently personal nature of the physician-patient relationship and its special importance to elderly patients, the committee is concerned about the increasing restrictions on physicians (and the potential conflict of interest of physicians) when they act in their professional role as advocates for their patients and carry out their contractual responsibilities and receive economic incentives as health plan providers. The committee is particularly concerned about reported contractual restrictions (such as anticriticism clauses) on physicians acting in their professional role as a source of advice to their patients. Physicians must maintain their freedom to talk to their patients with full honesty about the clinical aspects of their care and treatment options.

Subrecommendations

The committee recommends that neither the *Medicare choices*' payment incentives nor their coverage and treatment protocol policies motivate providers to evade their ethical responsibility to provide patients with complete information about their illness and treatment options (such as referrals to a specialist), what to the best of the provider's knowledge the patient's plan covers, and which health plans in the provider's experience provide the broadest range of services to the patient in question.

Competition among *Medicare choices* is likely to restrict the definitions of *inappropriate services* by refining the definitions of *medical necessity* and *appropriate services* to contain costs and ensure quality. The committee finds that it is important for beneficiaries to have access to the unbiased judgments of their practicing physicians regarding their health needs in the context of plan procedures and protocols so that they, as patients, can make informed choices and thereby shape this new understanding of "appropriate."

Within the scope of its responsibilities, the federal government should identify practices that inhibit open communication between a provider and a patient in any setting and either prohibit them as conditions of participation of plans or require the plan to disclose such practices to potential enrollees. The committee recommends that the federal government require plans to disclose to plan enrollees how physicians get paid, whether they are rewarded for withholding referrals, and any other restrictions affecting how physicians can inform or treat plan enrollees. Similarly, educational materials should make clear the incentives in traditional Medicare and Medigap insurance to provide unnecessary care and the risks of these incentives.

RECOMMENDATION 6

The federal government should hold *Medicare choices* accountable by requiring them to meet comparable conditions of participation as a Medicare option and by monitoring and reporting on their compliance with these conditions.

Conditions of Participation for *Medicare Choices*

Findings

Some private and public employers have administered choice programs for many years and have developed and are continuing to improve the conditions of participation of health plans for ensuring that beneficiaries can make informed choices and for ensuring accountability on the part of the health plans. The very nature of accountability for Medicare health plans suggests that minimum standards should be established for health plans in areas where beneficiaries cannot reasonably be expected to make informed choices or where they might be easily confused or misled. This process of informed choice should be facilitated so that plans compete to exceed those minimum standards.

The committee finds that managed care plans not only pay for the services of providers but that they also use contractual arrangements to establish incentives for and place controls on providers' services. Thus, a beneficiary's choice of health plan can affect not only whether services are covered but also how they are provided. To further the responsiveness of plan management and providers to the special needs and demands of Medicare beneficiaries, the committee suggests that plans actively and meaningfully include beneficiaries in their governance and board activities and otherwise integrate the consumer voice into the plan's management and decision-making structure.

This said, the committee acknowledges that performance and disclosure requirements cannot compensate for limits on monetary resources for coverage. No amount or type of oversight and regulation can offset the intrinsic limitations on quality and access that necessarily follow from low levels of funding by the political process or the inability or unwillingness of beneficiaries to pay additional fees for health services.

Subrecommendations

The committee recommends that the federal government be given the flexibility to adjust the conditions of participation to take into account the evolution of higher standards and new systems and structures for ensuring informed choice and public accountability of *Medicare choices*.

Quality Assurance and Outcomes

Findings

The availability of *Medicare choices* introduces a potential for competition among plans on the basis of improvements in quality of care. To capitalize on this potential, the quality of service provided by health plans must be measurable and must be communicated to beneficiaries in a way that is relevant to them so that quality can be taken into account and so that a beneficiary can make an informed choice. Choice in health care, as in any environment, also introduces incentives to restrict the provision of or payment for services to remain competitive. This can produce effective and needed economies by reducing inappropriate or noncovered services. It may also, however, reduce the amount of appropriate care provided. Quality measures, monitoring, and meaningful ways of disclosing and communicating findings are needed so that the federal government and beneficiaries can hold plans accountable for reaching an appropriate balance between restricting inappropriate care and providing appropriate care.

The committee finds that quality measurement and communication are still in the early stages of development, especially quality measurements based on outcomes. Important initial efforts are under way by private credentialing agencies, such as NCQA's HEDIS, JCAHO, the Foundation for Accountability,

BOX 3-2
Conditions of Participation

The committee recommends that all *Medicare choices* meet the following minimum standards:

- participate in the annual open season and sell policies to Medicare beneficiaries during that open season or on certain other occasions, such as when a beneficiary first becomes eligible;
- offer open enrollment, guaranteed renewal, and no clauses precluding enrollment because of a preexisting condition for newly eligible beneficiaries and for beneficiaries changing plans;
- offer Part A and B benefits (except for Medigap policies) and meet other Medicare benefits requirements;
- provide information specified by the federal government to ensure informed choice by beneficiaries;
- meet quality certification requirements comparable to those already in use and in development by recognized national private accrediting entities and require appropriate progress and improvement against such standards over time;
- have resources, including appropriate mixes of specialists and referral resources, to provide benefits throughout service areas to a reasonable degree defined by the federal government so as not to divide metropolitan areas or counties except when natural barriers or other conditions divide service areas;
- provide a user-friendly, well-communicated, and responsive appeals and grievance process and allow retroactive disenrollment of beneficiaries who are determined by a fair and appropriate process to have misunderstood the implications of their choice and who have suffered serious financial or other consequences;
- meet fair marketing standards;
- meet specified fiscal solvency and financial disclosure requirements, allow compliance audits of financial and quality assurance operations, agree to use federal government-promulgated terms for describing coverages, and agree to accept enrollees without prejudice in all circumstances and particularly when the beneficiary has been enrolled in a plan that has gone out of business or become insolvent within the prior 60 days;
- not discourage providers from advising patients regarding their treatment options and plan coverages;
- provide such data to the federal government as required for it to test the plan's performance and compliance; and
- provide such information as it may require to the Medicare Customer Service and Enrollment Center.

and others, to develop reporting systems and measures of health plan quality. These efforts, however, reduce but do not eliminate the risk of poor quality.

Subrecommendations

To best ensure quality, all *Medicare choices* should be subjected to comparable state-of-the-art standards and monitoring for quality. The federal government should use the best of the currently available technology to set standards and monitor the quality of health plans. When the standards and processes of private credentialing agencies meet or exceed those of the federal government, private organizations should be used to reduce duplication in the market. The federal government might well foster competition and innovation among private credentialing agencies for different aspects of this function.

Communication with beneficiaries about the quality of a health plan and traditional Medicare plans should be done by the Medicare Customer Service and Enrollment Center by using the latest information available from credentialing processes and the latest techniques for communicating plan performance. In this vein the federal government should give priority to research and demonstrations on communicating quality performance information to beneficiaries.

The committee recommends the development of common definitions for reporting quality for use by individual plans and for auditing plans against their own published reports to the federal government.

Managed Care and Underserved Populations

Findings

The committee is concerned about ensuring access to health plans and their services for all beneficiaries, including those in vulnerable populations and underserved areas. Although the average Medicare beneficiary has been shown to have good access to care, certain groups who have been identified as vulnerable in traditional Medicare may be at risk for access problems in Medicare managed care. These groups have been identified by PPRC to include African-American beneficiaries and those who live in Health Professional Shortage Areas or urban and rural poverty areas. Evidence indicates that managed care arrangements have been slow to include underserved populations, especially those in rural areas (Institute of Medicine, 1996).

At the workshop and through the commissioned papers the committee was made aware of the special value that elderly individuals place on having easy access to their physicians, and the importance that they place on being treated by their providers in a respectful and a socially and culturally sensitive way. The committee heard again and again that elderly individuals place key importance on their ability to have access to "their" traditional providers with whom they have developed a personal relationship.

The importance of considering the effect of personal and cultural factors on access is heightened by the changing demographics of the U.S. population. The committee heard that certain Medicare beneficiaries (particularly low-income and minority groups) may be at significantly higher risk of not being able to continue to be seen by their traditional network of providers in an environment of managed care. Because of the lower socioeconomic status of many individuals who are members of minority groups, a managed care plan may be the only delivery option that is affordable.

As managed care plans continue to develop they will have an increased responsibility to improve access for underserved populations. The committee believes that health plans should be held responsible for serving their entire service area without compromising access or quality of care. The committee found that some providers who have served their communities for many years or who are part of essential community provider networks, have not obtained the credentials required by some managed care organizations either because of institutional racism or common practice within their specialty to forego board certification. It is important that health plans develop several measures of clinical competence that are sensitive, valid, and reliable in their ability to assess clinical competence through both outcome and process indicators. The committee heard testimony that managed care plans often do not disclose their

credentialing standards and policies. At the very least, such disclosure should be required. The committee lauds the efforts under way in HCFA, PPRC, a number of health foundations and other groups to track and address key issues that could arise in monitoring access to care under a restructured Medicare program.

Subrecommendations

Broad access for Medicare beneficiaries is key. The committee recommends that the federal government ensure that there is adequate access and choice of plans for individuals in all socioeconomic, cultural, and language groups and for underserved areas and populations. Elderly beneficiaries particularly value care that is respectful, personalized, and culturally sensitive. When warranted and documented (i.e., when access is demonstrably inadequate), the federal government should require the plans in an area to improve their contracting with community-based providers who meet quality-of-care standards as a condition of participation.

RECOMMENDATION 7

Serious consideration should be given and a study should be commissioned for establishing a new function along the lines of a Medicare Market Board, Commission, or Council to administer the *Medicare choices* process and hold all *Medicare choices* accountable. The proposed entity would include an advisory committee composed of key stakeholders, including purchasers, providers, and consumers.

Medicare Market Board and HCFA

Findings

Bearing in mind the recommendations that the committee has made regarding ensuring public accountability and informed purchasing for beneficiaries in an environment of choice, the committee had a number of concerns as it relates to the choice management capabilities of HCFA, as it is currently structured, to effectively manage *Medicare choices*. The committee spent considerable time discussing the challenges and complexities of effectively managing two very different and potentially competing programs. For example:

- The administration of the multiple choice program and the management of the traditional Medicare programs involve very different missions and orientations.
- The two functions require different types of management, staff expertise, backgrounds, and knowledge. The committee is concerned that staff and senior managers with extensive experience in managing various aspects of multiple choice in the private sector be recruited and employed for this effort.
- The functions call for different organizational and corporate cultures, one operating a stable traditional public indemnity insurance program and the other a purchaser- and customer-oriented program that is required to be responsive to a diverse group of private programs in a rapidly changing and dynamic marketplace.
- A faster response to changing market conditions and opportunities is required for the effective management of competing plans to provide the best options for beneficiaries. Such responsiveness may be hard to achieve with the regulatory constraints of HCFA.
- The committee believes that these strengthened and new responsibilities for managing the choice of plans must be supported by adequate organizational, financial, and staffing resources, which are needed to effectively and efficiently accomplish the mission described here.

Subrecommendations

The committee believes that these growing choice management functions would benefit from an organizational identity with the stature to facilitate recruitment of the needed leadership and staff and to build public trust. For that reason the committee recommends that serious consideration be given to establishing a new function along the lines of a Medicare Market Board, Commission, or Council that would include an advisory committee with key stakeholders (i.e., purchasers, providers, and consumers).

The committee was not able to research adequately the question of where this function should be located in government. The committee is aware of current initiatives to simplify and streamline government regulations as well as the efforts being made by HCFA to address some of the committee's concerns. The committee's discussions included the option of incorporating the new Medicare Market Board entity within HCFA, but with dedicated management and resources; establishing a Federal Reserve Board type of agency that has greater flexibility in rule making; establishing a PPRC- or ProPAC-type entity reporting to the Congress; as well as other possibilities.

With that in mind and given the potential impact of the proposed new entity on the health care economy and the well-being of 37 million beneficiaries, the committee recommends that the U.S. Congress commission a study on what functions should be included in any new entity and what functions should stay with the present organizational structure, the roles and experience of federal agencies with a comparable mix of functions, the rationale for their structure, their organizational placement (including their relationship to the U.S. Congress and the executive branch) to better assess the advantages and potential shortcomings of moving in this direction.

In recommending the consideration of a new function such as a Medicare Market Board, the committee was cognizant of the fact that even a new entity will be limited or circumscribed by the realities of the political and fiscal environments in which it must operate and be accountable.

The committee envisions any proposed entity to have general responsibilities in the following areas:

- *Data collection, data publication, consumer education, and support*

  Contract with a Customer Service and Enrollment Center for these functions and augment the Center's services by using Choice Facilitating Organizations.

- *Health plan standards*

  Consult experts and conduct research and demonstrations to refine the conditions of participation by health plans on an ongoing basis to reflect the service and quality that the government expects for Medicare beneficiaries, regardless of the plan that they choose. The conditions would be set on a national basis and would be measurable and subject to an annual evaluation of compliance. To the greatest extent possible they would be consistent with standards used by the private sector to minimize duplication.

  Invoke specific sanctions in the event that the standards of a plan fall below the set standards.

- *Benefits, quality, and fair payment to health plans*

  Continually review clinical developments and services pertaining to what constitutes quality or appropriate care and refine the definitions of benefits under Medicare Part A and Part B.

  Review developments in the health insurance marketplace and refine the standard benefit description, pricing, and marketing requirements.

  Review risk selection in the traditional Medicare program and health plans and develop procedures or recommendations to the U.S. Congress for controlling or adjusting for adverse and favorable selection.

- *Evaluation and improvement of multiple choice in Medicare*

  Review the workings of the multiple choice market for Medicare beneficiaries and report to the U.S. Congress on the extent to which beneficiaries are able to make informed choices, the extent to which government and beneficiaries are succeeding in holding plans accountable for ensuring quality of care and containing costs, and ways to improve the system's performance.

  Review traditional Medicare and health plan costs and performance to determine whether the amount and form of the federal government's contribution to costs (e.g., premium payment) yields the government and its beneficiaries both containment of costs and assurance of quality.

  Report and recommend changes to the U.S. Congress to better hold plans accountable to these ends.

  In conducting each of its responsibilities, it would adhere to rigorous conflict-of-interest standards.

Chairman THOMAS. Thank you very much, Ms. Lewin. I understand that your study and book came out prior to the BBA being passed, but HCFA reorganized itself prior to the BBA passing as well. I read with note on page 107 of your book, and you indicated in your testimony, that the "administration of multiple choice programs and the management of the traditional Medicare programs evolved very different missions and orientations." But in your testimony, you indicated that you believe HCFA has made impressive strides to deal with this.

Was the reorganization of HCFA, notwithstanding it occurred prior to the BBA, the direction that you think they should be going? Or should it be more in the direction of I think probably to use Butler's position as a kind of a guidepost, that in fact bringing the two together, the fee-for-service and managed care, may not be the right direction. You indicated they clearly deal with things differently. Where are you on the fire wall? I don't think you contradict yourself, but I am a little concerned about your praise of HCFA and the point you made in the book.

Ms. LEWIN. Okay. Let me try to clarify that. First of all, in terms of HCFA's reorganization, we do feel that the Center for Beneficiary Services is certainly a step in the right direction. Our other recommendations about how to develop an infrastructure for information for Medicare beneficiaries and what is needed, many of these are now the priorities for the Center for Beneficiary Services, whether they can truly implement that ambitious agenda with limited resources of course——

Chairman THOMAS. But we were very concerned about that. We are going to monitor the resources. But that is more of an informational, relational. I am concerned about the structural change of in essence taking the whole managed care program that was outside the house or maybe in the garage, and bringing it, integrating it into the overall structure. Not the end work product of some areas that are beginning to understand belatedly the beneficiary is a customer and they need information.

Ms. LEWIN. Well, let me just say that the Medicare Market Board, we were clear that we felt that there should be a dispassionate group that would set the rules for the game for both managed care and fee-for-service. Then the second level is how you actually contract with plans. We felt that it even could be under the Medicare Market Board, but at some level, there had to be a fire wall between the people who administer the one part of Medicare and the other. The committee stopped short in terms of making a final recommendation, because we really didn't feel that we had the expertise and the time, this was a very short-term report, to actually develop the details of how that should be done.

There is a potential of a Medicare Market Board building some kind of a fire wall even in one organization. I mean it certainly has been done. But we are not able to supply the details.

Chairman THOMAS. Stuart, obviously your approach is that with your number of analogies, that you really shouldn't be doing two in the same shop. What is your assessment of the reorganization that HCFA carried out, a help or hindrance to moving in the direction that——

Mr. BUTLER. Well, as Marion Lewin pointed out, some of the functions that would have to be under some kind of marketing board have been developed. There is an intent at HCFA to try to do this. However, no reorganization within the current structure can achieve what you really want to achieve because it's an issue of a culture. It's an issue of the skills that are involved. It is also an issue of keeping people apart from each other. Keep the umpires away from the players. This is absolutely crucial for Medicare to be successful. As Ms. Lewin pointed out, within her committee, the whole world can be divided into fee-for-service people and managed care people, as far as I can see. There is this dichotomy. So I think that ultimately there must be a revision of the HCFA reorganization to separate these functions out, if we are going to see Medicare work effectively for everybody.

Chairman THOMAS. One of my concerns is that I think in fact failure to innovate was reinforced by the fact that the fee-for-service was structured as the way to operate. One of the reasons we are lagging behind now is that it's the Government's structure and not a flexible one that can change with the marketplace. I think maybe skilled nursing facilities were invented by Government payment structures. My very real concern is that what we are talking about a fire wall between fee-for-service and managed care, and we are beginning to think that there's this bifurcated world or that this is the way things are, I am worried that we are going to stifle innovation in that regard and that we have got to create the maximum opportunity for innovation. Those were the various programs we had. To the degree that bureaucracy locks itself into a certain pattern now, it inhibits the change that I think needs to take place. So I am very much concerned about anybody saying that there is this bipolar world in terms of an approach. I am trying to figure out a way to deal with it in multiple ways.

The other concern I have, both in terms of Dr. Ginsburg and I'm sorry to say, Dr. Butler, you as well, if we are going to run a defined benefits world, I can assure you, we ain't going to let those folk make the decisions in the general sense or for Congress to judge on a pass/fail basis an overall program.

Now, if you want to talk about shifting to a defined contribution, where Congress' obligation is to pony-up "X" number of dollars, then I am more willing to talk about letting the professionals manage the packaging and delivery of those dollars to maximize the benefit both to the beneficiaries, and get the maximum distance out of your dollars. Now that is a different approach to the way that you have offered it.

So what is your reaction to moving to a defined contribution which would maximize HCFA's ability to package and reorganize and create a comfort level on the part of Congress, because that is what they are supposed to be doing? We are doing what we're doing. But in a defined benefits world, there is no way you are going to.

Mr. BUTLER. I agree, as you know, about moving towards a defined contributions system. I think that is ultimately the way to go. But even if you don't complete that task, I would just make two observations about the point you made.

First, I would totally agree that we need to have increased flexibility in the way in which the fee-for-service in the system operates. But second, I think you would also accept that there is clearly a dilemma in the process we have of trying to set benefits within a defined benefits system. Because in reality, all kinds of political pressures come to bear on Congress regarding what services are provided. Provider organizations are highly influential and pressing their cases. One of the problems we have with the Medicare system is that effect.

Somehow we have got to find a midway position between allowing orderly evolution and yet also having effective Congressional control over the benefit structure. That's really what I was getting at. I don't have a simple answer to it. I just think that somehow we have got to get away from either complete control by a bureaucracy over benefits or by a political process constantly trying to determine how long people should be in hospital and what services they should be provided in their every circumstance.

Chairman THOMAS. My concern is that to the degree you would move to your halfway house of an all-or-nothing approach still dealing with defined benefits, the way in which Congress would express itself unfortunately, Ms. Lewin, would be back to cutting funding for the support of, the administration of, and then you kind of create a built-in guaranteed failure of the halfway house, because the only way you can get at it is to control the mechanism of delivery or of review or the rest.

So at some point we have to engage in a fairly fundamental debate about more fundamental changes, not just in the management, but in the program itself. We have to be aware of one clearly affects the other, and not think that we can just play with the management structure inside HCFA and solve a lot of problems. I guess what I am saying is this is an ongoing changing process. We have only begun. Some people think we have finished. I know you do not. But we will be looking to people like you to give us some models. I especially have difficulty with a quality group of folk coming together who could provide answers and then say well, we have decided we can't come up with something. Somebody has got to walk the plank. I don't think it's Congress that should walk the plank on coming up with specific changed suggestions. We need you folk as well. But I appreciate what you have done.

The gentleman from California?

Mr. STARK. Thank you, Mr. Chairman.

Dr. Butler, on page 3, you talk about the separation of the management of the market from the management of any plan. I mentioned that in my opening statement. You can't have somebody promoting a product and regulating it. It's like the problems with the FAA who promote airline travel and at the same time tell airlines how to operate. It's an inherent conflict of interest.

I would like to bring up another issue. I think you make a strong case for a problem that I have complained about for some time. That problem is the National Committee for Quality Assurance and the Joint Accreditation Committee for Hospitals. Both of those groups have their boards stacked with people who either operate or own the very entities that these people are supposed to investigate on behalf of the Federal Government. My sense has been

that we have got to separate that. We cannot have the fox in the hen house. Does that comport with your concerns? If we are going to contract with outside groups, basically private groups, to do quality investigations for us, there should just be an absolute prohibition between any contact with that company and the people that are investigating.

Mr. BUTLER. I'm not an authority on the structure NCQA, so I would hesitate to talk in detail about that. I would say that your general principle is one I would agree with as a general matter, namely that for those who set the rules of the game that will affect any particular player should, at the very least, any involvement should be very explicit and clear and taken into account. Ideally, the people involved should not have a direct interest in the outcome of any of those decisions, I think as a general principle.

Now there is also of course the issue of an advisory role. It makes a lot of sense to have people who are practical players in a field to give advice and to make recommendations and so on. But that can be separated from the ultimate authority of who makes the decision.

Mr. STARK. Thank you. I, by the way, just as a sidebar, like your idea of a board to manage the Medicare managed care plan. I would love to discuss that with you further at some other time. I think we have to do something in that area.

Either Dr. Gluck, or Paul Ginsburg, could respond to this. We now reimburse virtually any hospital that wants to conduct a transplant operation, even though common wisdom would suggest that those centers which do many more procedures have far better outcomes.

Would you all support giving HCFA the authority to narrow the number of facilities for certain complex procedures so that we concentrate experience? I hate to use the words "centers of excellence", because I'm not sure how you define that. But, these centers that have more experience, would we not be doing a service by giving HCFA the authority to direct patients to them?

Mr. GLUCK. The study panel spent a fair amount of time looking at the examples from private health insurance, in which patients are steered toward those providers that do better in cost and quality outcomes. The panel was struck by that, and it certainly informs their recommendations. They didn't get into a lot of the specifics about exactly how that would be done.

Mr. GINSBURG. Clearly, one of the innovations that we can imagine would be HCFA identifying for beneficiaries the best transplant providers and we're contracting with them. We did not discuss whether the ones that do not make that cut should not be in the program or they shall just hold non-preferred status. But it clearly is in the program's interest to steer beneficiaries toward more effective providers.

Mr. STARK. You also talk about the practice patterns that are identified in the Dartmouth Atlas. Somebody recently indicated—I think it was Uwe Reinhardt in his Christmas card—that a procedure that costs $8,000 fees in Miami is only $3,000 in Minneapolis. Now I have a plan to contract with Northwest Airlines. We could do a lot of flying people back and forth from Miami to Minneapolis and save a lot of money, it seems to me, in between. But all I have

been able to find is that these huge differences in the cost of care—where the outcomes don't reflect—the cost, is tradition. These differences are habit. They are a whole host of things which I'm not sure Congress can control.

But I would hope that you could help us in finding some way that we could begin to move toward some national standards. With two and a half and three times a difference for the same procedures with equally highly qualified and well-trained providers, we are going to have a problem that is just going to intensify if we can't figure out a way to—level that out.

Mr. GINSBURG. Yes, these variations demonstrate the potential for saving money and improving quality by moving beneficiaries towards where the best care is delivered. A number of implications for the Pand's ideas come up. One is that if a certain procedure costs $8,000 in Miami and $3,000 in Minneapolis, we should concentrate our efforts improving its delivery in Miami, but not in Minneapolis, because I wouldn't rule out a Medicare program to provide an option for beneficiaries to travel to a facility that has a contract with HCFA to provide these services on the basis of its quality and cost.

Mr. STARK. The airlines will be after us. Thank you, Mr. Chairman.

Chairman THOMAS. Just briefly along that line, I think it's fairly easy to talk about the best move to quality and the rest. The difficulty I have is coming up with a really objective way to measure some of that. The best way I know is to collect the data statistically, create outcomes, compare outcomes for dollar spent, and begin to structure it in a way that allows you to at least define quality in a relative sense. Especially to determine what you get for your dollar. And then create some positive guidelines.

I have a very real concern, this is slightly off the mark, but clearly an issue we have to deal with is the ability to gather that information, the question of confidentiality, the ability to produce with clear protections for folk where it's appropriate, the material necessary to produce the outcomes research to provide the positive guidelines given the potential of some legislation which will limit us. Minnesota has been mentioned several times. Over the break, I spent some time at the Mayo Clinic talking with them. Their real concern, for example, the new Minnesota State law in the ability to collect information. The whole question of information collection as a matrix for making decisions, both of cost effective and of "quality" will be absolutely critical to us to be able to do the kinds of things you have been discussing. It's an area that all of us have to deal with because a very simple bill passing will eliminate our ability to move in a number of directions that would produce quality medical care at a reasonable cost to taxpayers.

The gentleman from Louisiana?

Mr. MCCRERY. Thank you, Mr. Chairman. Actually, you asked most of the questions that I was going to ask.

Dr. Butler, if the title of this hearing had been preparing Medicare for the 21st century rather than preparing HCFA for the 21st century, would you have submitted different testimony?

Mr. BUTLER. Well, I would have commented probably on the defined contribution issue, as I have done before. But I think the

structural changes I suggested, whether or not one goes further in terms of Medicare reform as a whole, are still sound organizational principles for where we are in the structure of Medicare, which has been to move from a kind of a one type of benefit structure and operation to a much wider choice. When you have a range of choices and people have to evaluate them, and plans are in competition with each other, it forces I think you to look at a structure that makes sure that people have information; and it's honest and dispassionate information, which is not possible under the present arrangement.

Mr. MCCRERY. I thought Mr. Thomas' criticism of your proposal was a little unfair, given the constraints of the topic of the hearing. I wanted to make sure you had the opportunity to say that if you prepared testimony on the future of Medicare, it might be different from the 21st century for HCFA.

I happen to agree with the criticisms that Mr. Thomas leveled at your proposals, as well as some of the others. Even though we could have a dispassionate board, if that's possible, I don't think by any stretch of the imagination that Congress, as long as we have a defined benefit program, is going to hand over to some dispassionate board the power to describe and define the benefits. Even if it's on an up or down vote, any time you start taking away benefits from people, we are going to vote down. That's just the nature of this beast. Now if you want to add benefits, we'll vote up.

So I just don't think your proposal is practical from a political standpoint. I understand where you are trying to go. You are trying to form some kind of midway stop along the way from where we are now to a defined contribution. I hope that's what you have in mind. But I don't think we can do that. I think we have finally faced the question of whether we have a defined benefit program or a defined contribution program. We can't go halfway. We have tried. I mean we have done these little piddling things with choice and Medicare Plus and all this stuff. It's going to fail, in my view. We are going to continue to have costs go through the roof and we're going to continue to be the arbiters of what benefits those managed care plans must provide. So I just don't think that your proposal is going to get us to where we need to go.

We really ought to just face the question and debate it honestly and have it out. Then maybe we'll win and get a defined contribution system and let the market work. Maybe we should just fold Medicare into the private healthcare marketplace all together, do away with Medicare as it exists today and have some sort of Government assistance to everybody for healthcare, from children all the way up to the most elderly, but let the market be the manager of the system and not the Government.

Mr. BUTLER. I don't fundamentally disagree with that characterization of where we need to go.

Mr. MCCRERY. I would hope not.

Mr. BUTLER. I am doing my best today to look at the current situation of how to improve it. I think you would agree, I suspect, that a large group of legislators trying to figure out a comprehensive package of benefits and to make sure that it's improved every year on the basis of best knowledge is not a very good way of doing it.

Mr. MCCRERY. It's nuts.

Mr. BUTLER. It may be the only way right now. However, I would suggest that you look at one of the short-term proposals I made, which was simply to say let us set up at least an advisory body of some kind to suggest to Congress.

Mr. MCCRERY. I think that's a swell idea. I hope we do it, but I don't have high hopes for solving the problems with it.

Does anybody else want to comment?

Ms. LEWIN. I guess I did want to comment in this discussion between a defined contribution or a defined benefit. I mean that is a whole different debate. But when this committee did its work, I think one of the underlying issues, and I know it's been overplayed, is trust in the system. There is now a lack of trust on behalf of beneficiaries because they feel that the information they get is inadequate, it's not trustworthy, it's not understandable. When we looked at best practices, like CalPERS, or Pacific Business Group on Health, and some of the large corporations, when consumers or patients trust the information and feel that their employer is on their side but also is interested in providing more cost effective appropriate healthcare, then you can move to a more value-based system. But I think when you tell the elderly we're going to go to a defined-contribution without that inherent trust, I think that is a problem.

Mr. MCCRERY [presiding]. That's a good point. Obviously if we went to a defined contribution system, we would have to have some Government-imposed information availability program so that seniors and everybody else in the healthcare system could make good choices. Thank you.

I guess I'll assume the chair and call on Mr. Houghton.

Mr. HOUGHTON. I guess I'm next. Thank you very much, Mr. Chairman.

Thank you very much for being our last panel. You have been very patient. I really would like to ask sort of a broader question about responsibility here. One of the problems which exists here in Congress is that we have responsibility and we're clearly interested. There is an enormous amount of money involved. Yet we sort of dabble in the organizational bit rather than being sort of the board of directors. One of the questions I would like to ask you, do you think that the management of HCFA really understands what we are asking them to do?

Mr. GINSBURG. I can comment on the board of directors' role versus getting into details. I saw this firsthand in my experience with Medicare physician payment reform, which was very detailed and technical—for example, setting relative values and geographic factors. Congress, as far as I am aware, never engaged in that level of detail. They set up the overall principle, and HCFA implemented it and reported how they did it. I believe that Congress didn't get into the details because the leaders knew if one relative value wa changed, the members would hear from lobbyists forever to change the relative value that affects their group. The down side of getting involved in the details was very clear to them. I think it's not as clear with things like the benefit structure of Medicare.

I can envision Congress learning from the experienceof dealing with detailsconcluding that there are certain areas that it just

should not get into because of the consequences. The Congress should act more like a board of directors and delegate more to HCFA. Over the years that I have watched HCFA, it has been very responsive to the Congress. Some of the biggest problems have come with interest groups that are narrow focused. They tend to do do better in Congress than they do in approaching the Executive Branch. This has caused a lot of the turmoil.

Mr. HOUGHTON. Does anybody else have any comments on that? Because I think the thrust of my question is really this is an organizational issue. Obviously, you want to look over the next hill and see whether HCFA is prepared for some of the dynamics of the next century. However, the question is, will they really understand what Congress wants. If they don't, we should tell them. If they do, I don't know why we have a board of directors, advisory commissions, and things like that. That is up to them. They ought to decide that. I don't know how you feel about this. Maybe Dr. Butler or Ms. Lewin?

Ms. LEWIN. I think part of it is this whole new world is challenging for all organizations. When I even think of being employed at the Institute of Medicine, how many things have changed for us. I mean the whole world is more market oriented and competitive, et cetera, et cetera. I think that HCFA is trying very valiantly to respond, and very responsibly. I mean when you go there, you really do have a sense that people are working very very hard. I mean clearly this is a whole different orientation. I think it is a challenge. I think that is why hearings like this are very good because you put people on notice that you are watching.

Just to divert a little bit, but I think it's relevant, and actually I'm now kind of going in a different direction to what we were discussing earlier between fee-for-service and managed care. But we had a lecture at the Institute of Medicine last night which I thought was very telling, by someone by the name of Arnie Millstein, on purchasing quality on behalf of purchasers. He cautioned the audience in saying you know, we have gotten too much in this polarization of fee-for-service versus managed care. What we really should be looking at is the average American healthcare and the best healthcare that America has to offer. Whether it's fee-for-service or managed care, that should be our goal.

My feeling is that sometimes we're looking at this as fee-for-service versus managed care. Whereas both sides, that really should be their goal, to purchase the best care that America has available.

Mr. BUTLER. Congressman, I think it's not only a question of giving clear direction to an agency and making sure that its senior management understand that. I think as many of us have said in different circumstances, that there is a culture of an agency to consider too. It is very difficult to take an agency or a group of people in the private sector, let alone the public sector, who are very used to seeing their role in one way and being trained in that way, to then try to get them to do something else. Divorce lawyers don't tend to make very good marriage counselors. There are reasons for that.

Mr. HOUGHTON. I understand that. I'll just interrupt a minute, and then I'll cut off, Mr. Chairman. But I mean I think sure, conditions change, market changes, demands change, the money

changes. That's to keep a monitoring eye on it, not to direct whether to establish this board or that board or have advisory committees. I mean that's the operations that have got to do that. Thank you.

Chairman THOMAS. [presiding] Just let me say, very briefly, because I know we want to move on, this business about best I just think has to always be qualified. That is, we are dealing with a program that at least in the Part B portion is 75 cents subsidized by the taxpayers. Given the advances of medical science, you have got to somehow reconcile the public treasury with the medicine available. People will consume—and this is my friend from Louisiana's statement that I've stolen a long time ago, I figure another six months and I'll just quit giving you attribution unless you are here—People will consume as much healthcare as the people are willing to pay for. The reason I like moving more toward a defined contribution, and frankly, discussing as a matter of public policy, not just for Medicare but a number of other areas, how much we should be putting in there is that that is what Congress should be doing, setting the policy and the overall structure. The professionals ought to be determining how we maximize the return on that dollar in healthcare we should provide them with the tools to be able to measure between them far better than we do now. It is a legitimate and appropriate role for Government, including the education of the consumer, woefully ignorant now, about their options and what they have available.

But the innovation, the specifics and the way in which that product is delivered should only remain in the private sector because that is where you get the rapid innovation and the turnaround and the change. That kind of a blend I think ultimately will bring some folk who now apparently are on opposite sides but don't realize that there is an area of common ground.

Obviously, there are a lot of vested interests and sacred cows that were just shot or slaughtered by that statement that we have to overcome to go forward, but it's something I think we have to do.

The gentleman from Louisiana for a final question?

Mr. COOKSEY. I am looking here at an earlier edition of National Journal. There are four Presidents with big ideas and four Presidents with small ideas. I just happened to be in Washington the summer when I was in medical school, the summer that Medicare was signed into the law. Lyndon Johnson is not on either side.

My question is, can we step back and look at the big picture? Can we come up with a plan that is a defined contribution and consider three categories, the people that get their payment from the Government, the indigent, the Medicare or the Medicaid, the old veterans like me when I get a little older. Then the people that get their insurance or their health insurance from their employers. The third group are individuals who are not in either category, but are out there maybe as small business women, men, individuals that don't have any real tie, but have to pay for their insurance. Can we step back and look at a plan that would be defined contribution, let the Government pay where they are going to pay, and then let all the others have full deductibility for their health insurance, and the employer get out of the health insurance business, and the em-

ployer have no deductibility? Would that be feasible? Do you think that can be done? Then this would put us back in the marketplace. I deal with these veterans on my Veterans Affairs Health Subcommittee. He would have a card and he would go in and pay for it, but he has got a defined contribution.

Mr. BUTLER. I strongly feel it can be done. I am more than happy to share with you some of the material that we prepared in the past suggesting exactly that. You are talking about a combination of things. First looking at Medicare, at defined contributions to people. And second, you are looking at changing the way the tax system operates to do two things, to enable people to obtain the means they need through some kind of refundable credit, and ending this bias in the current system towards one type of organization for healthcare for the working population, which is through the place of employment. This also means looking at the role of other intermediaries to help to pool people together so that you don't have to go through the employment system. I think that a number of ideas along these lines should be looked at. It is a continuum.

I think it's very important that we have a healthcare system in this country which is a continuum, whether one is elderly, working population, or unemployed.

Mr. COOKSEY. Dr. Ginsburg, do you have an opinion?

Mr. GINSBURG. Yes. The major contribution that employers have made in their provision of health insurance is forming a group in which everyone or almost everyone is going to be buying insurance. Of course our tax system has distorted things because there's an additional incentive to get insurance through employers.

I could see a lot of advantages over the long-term to phasing employers out of the health insurance area. But what we need to replace them with is a strong mechanism to create and govern the health insurance market. I wouldn't want to have a situation where everyone bought their health insurance in the individual market with tax credits because that market has long failed. It has not well served people who can't get insurance through employers.

So I think that there is an important need, whether you call it a purchasing coalition or a purchasing cooperative, to have another entity that people go with their tax credits to find out what qualified plans are available, what the choices are, and what it costs. I think that would work, but if we don't set that up, then we could lose a great deal.

Mr. COOKSEY. Ms. Lewin, I liked your term "fire wall." I understand that analogy. Do you think it can be done?

Ms. LEWIN. I agree with Paul. First of all, I think everything is possible. I think a key thing with the defined contribution is of course where do you set the contribution. If people feel that they can seek valuable and essential healthcare services, it's going to be more politically acceptable. But I think the problem with the voucher idea is first of all, at what rate do you set the voucher. But then also, what is the purchasing capability of people with that chit. I mean there are some people that will be much more disadvantaged.

So I do agree with Paul. I think if you set in and develop also at the same time an infrastructure, where people can be well-informed about their options and also that they can join various

groups that will help them purchase more effectively, I mean I think clearly we're moving in that direction, even if we don't say it. Many of the employers now basically give a defined contribution. They say this is the rate to buy our standard managed care package. If you want to buy something else, it's out of pocket. So that I think that defined contribution is a trend that we're seeing more and more. Whether we can make it the major way that we pay for healthcare services, I think remains an open question.

Mr. GINSBURG. We very much are going toward the defined contribution. In the employer market it's getting to that point where a lot of employees have confidence in their employer that their defined contribution will be enough to enroll in a plan that is adequate. The challenge for making a Medicare-defined contribution acceptable is to convince the beneficiaries that the contribution will be set high enough so that a plan that is called acceptable, whatever that means, will be available, as opposed to allowing it to shrivel over time so that more and more personal resources are going to have to be used to getting a "adequate" plan.

Mr. BUTLER. If I could just add too, however, that that issue with the defined contribution is real, but it's not unique to the defined contribution approach. It's also true of a defined benefit. If you say we're going to give you all these benefits, but then you say we're not actually going to pay physicians and hospitals adequately to provide them, you are in fact reducing the value of the benefit.

So while I agree with that point about the defined contribution, it's not unique to the defined contribution.

Chairman THOMAS. The fundamental problem has been that we started out with a program rooted in the historical structure of the cost plus defined benefits. It never ever had the built-in flexibility to make the kinds of adjustments because your argument is that people are going to worry about whether or not the plan can adequately cover the benefits that were presented. Had it had enough flexibility for changing management delivery structures, you could have maintained a number of benefits at a savings. So it's just a big chicken and egg problem that we have begun to address.

I think, Stuart, you are absolutely right. We can ratchet down payments to doctors and hospitals and say we have maintained a defined benefit program. It's just that we have a hollow shell for benefits and the rest of it.

The concern to me goes back to the basics, how can the taxpayer get maximum value for the dollar? To me it is in setting a structure which gets us more out of it, more into a policy, and create a degree of flexibility that whatever it is that we are able to deliver, it's the best that we can deliver for the dollar amounts, rather than talking about everybody in the U.S. gets the best medicine available. Frankly, there are not enough bucks in the system to deliver that in terms of what the private sector can do for people who have open-ended dollar amounts. That may be the subject of another hearing.

I appreciate all of you coming. Without any further questions, the Subcommittee stands adjourned.

[Whereupon, at 1:13 p.m., the hearing was adjourned subject to the call of the Chair.]

[Submissions for the record follow:]

Statement of
Dwight S. Cenac
Chairman of the Board
Home Care Association of America (HCAA)
9570 Regency Square Blvd., Jacksonville, Fl 32225

Submitted to the
Health Subcommittee of the
Committee on Ways and Means
U.S. House of Representatives

Preparing the Health Care Financing Administration
for the
21st Century

Thursday, January 29, 1998

Mr. Chairman and members of the committee, on behalf of Home Care Association of America (HCAA), I am honored to share our views concerning the critical issues related to Medicare policies for post-acute services, especially home health care. HCAA represents over 350 freestanding home health agencies across the United States.

This submittal is divided into four sections:

I - The Home Health Surety Bond

II- The Interim Payment System (IPS)

III- Operation Restore Trust (ORT)

IV- Hospital Self-Referrals

I hereby request that, if the full committee or the Health Subcommittee considers holding hearings pertaining to home health care, that I be invited to offer verbal testimony before the committee on behalf of freestanding agencies which represent 49 percent of the industry. I would also request that representatives of the National Association for Home Care, the American Federation of Home Health Agencies, the Home Health Staffing and Services Association, and the two largest state associations, California Association for Health Services at Home and the Texas Association for Home Care also be invited to provide verbal testimony to this committee on the key issues of the Balanced Budget Act of 1997 that affect homebound patients across the nation. All of these organizations are strongly united on the critical issues of Surety Bonds, the IPS and Operation Restore Trust.

Section I- The Home Health Surety Bond

In the January 5, 1998 Federal Register, HCFA issued a **Final Rule** pertaining to the Surety Bond for home health care agencies (with comment period ending after the deadline for purchasing a Surety Bond). **HCFA's rules will force many honorable home health agencies out of business and HCFA has clearly overstepped the intent of Congress** (found in Section 4312 of the Balanced Budget Act) with these regulations. **Since release of the Surety Bond regulations, 99% of all surety companies on the Treasury's approved list have refused to write the bond.** The remaining 1% of these companies are fearful of approving this bond in its current form. Most companies have refused to issue these bonds because of HCFA's extreme regulation (cumulative liability limits, open-ended obligation, and broad attachment conditions).

In the January 23, 1998 issue of USA Today newspaper, reporter Peter Eisler reported, ***"Surety officials say only a fraction of the 10,000 or so home care providers needing a bond will get one."*** **Another quote from the report states,** ***"The only (home care providers) who would be able to get these bonds would be the very biggest, says Martin Huber of the National Association of Surety Bond Producers. As the rules are written, 'the surety doesn't know the limits of its liability. It's too risky.' Among bonders' concerns: Capitalization: To reduce risk, many bond writers want home care agencies to put up unusually high collateral. Small and medium sized agencies generally don't have the assets, nor do nonprofits. Process: The government can make claims on a home care agency's bond without going to court. Bond writers don't like the lack of appeal avenues."***

The OIG and HCFA have given very misleading reports and have therefore, created pressure on Congress to drive so-called "fraudulent" home health agencies out of business. It seems clear that HCFA is a government bureaucracy that lives on expanding its power and driving honorable home health agencies out of business, while the OIG has "apologized" to home health agencies who were wrongly placed on a list of "problem agencies". None-the-less, the OIG is continuing in standing by the results of this misleading report to Congress. HCFA (and its fiscal intermediaries) are identical to the Internal Revenue Service in attempting to collect as much money as possible (wrongly or rightly) so that they can report to Congress and the media the benefits of their actions. HCAA shares Congress' concern about true fraud and abuse, however, by making the regulations so extreme that only very large publicly-held chain agencies, including hospitals-owned agencies are the only agencies wealthy enough to purchase a bond, Congress is inadvertently creating a home health monopoly and rewarding those type of companies who have been the main perpetrators of fraud. Freedom of choice of provider and competition will be nonexistent. **Also, do not be fooled that Provider Service Organizations and "Medicare-Choice" plans will fill in the gap.** The government will have to spend millions of dollars (as it has done to attract Medicare beneficiaries to HMOs that have ended up costing the government far more money than traditional fee-for-service Medicare) to persuade beneficiaries to join these untried and risky health care plans.

This extreme Surety Bond **final** regulation is proof that HCFA's hidden agenda is to drive primarily honorable freestanding home health agencies (who cost far less to provide care than hospital-owned home health agencies) out of business by issuing regulations that cannot be complied with. Under the guise of Operation Restore Trust, (ORT - more details about ORT can be found in this testimony) and the Wedge Survey, HCFA is again showing that it seems to be their intent to force primarily freestanding agencies (many who have been in business for many years) out of business without due process.

The following paragraph comes from a letter dated January 19, 1998 by Leigh Anne Cedeno, AAI, CIC, Director of Royal Benefits Planning of Jacksonville, Florida to the Health Care Financing Administration in response to commenting on the final Surety Bond regulation. I believe this paragraph will give the committee insight pertaining to HCFA and the Surety Bond Regulation:

"Before HCFA issued the final Surety Bond regulation, I telephoned Mr. Ralph Goldberg at HCFA and he advised that HCFA utilized the expertise of the National Association of Surety Bond 'Producers' (NASBP) when drafting the bond specifications. Unfortunately, since talking with Mr. Goldberg my research has shown that NASBP is an association mostly comprised of commission earning insurance agents, not surety underwriters. NASBP president Mr. Darrell C. Dodson, wrote that this bond 'is great news for our industry' because I believe NASBP members saw big dollars signs if they could get the bond issued. It appears HCFA did not contact the surety companies that would be at risk for these bonds. If HCFA had contacted the surety companies opposed to NASBP (the people who would profit from this mandate), HCFA would have known that this bond (under HCFA's current specifications) is uninsurable."

HCAA is also concerned that HCFA has chosen to establish a "flat rate to determine the amount of the bond that will be used in combination with a $50,000 minimum bond." We are concerned that 15% of HHAs Medicare payments is far too large of a percentage to base the amount of the bond on. The January 5, 1998 Federal Register states, "In 1993, Medicare overpayments were 4 percent of total Medicare payments made to all HHAs. In 1996, Medicare overpayments had grown to 7 percent of total Medicare payments made to HHAs." **Why then would HCFA overstep the intent of Congress by including a 15% penalty in the final Surety Bond regulation?**

HCAA requests that HCFA makes the following changes to the regulation:

1) HCFA should take into account that fiscal intermediaries already "withhold" payments to HHAs using the audit adjustment factor, so the 15% requirement should be stricken from the regulation.

2) The limit of liability should be for one year only, not cumulative and not infinite.

3) The conditions for accessing the bond should be for fraud and bankruptcy only.

4) HCFA should be directed to change the February 27, 1998 deadline to June 6, 1998 (60 days after the comment period) to take into account comments from the Federal Register and make changes from those comments to the regulation. The current deadline of February 27, 1998 is without question, **reckless and irresponsible** (to home health providers and more importantly, to home health care patients across the United States) on the part of HCFA, given that the comment period to the rules ends on March 6, 1998 (after the Februrary 27, 1998 deadline requiring that a home health agency have a Surety Bond in place).

5) The rule should not be retroactive to January 1, 1998. HCFA officials have informed HCAA staff that the regulation stands as is (unless directed otherwise by senior HCFA officials), and that home health agencies that continue to provide care will not be reimbursed for services rendered from January 1, 1998 to February 27, 1998 if they are unable to purchase a bond.

Section II- The Interim Payment System for Home Care

HCAA is very concerned that the Interim Payment System (IPS) for home health care (Section 4602 of the Balanced Budget Act) will force many patients who are under a physicians plan of treatment of home care into more expensive nursing homes and hospitals. Already across the United States, due to the projected "per-beneficiary cap", home health agencies (who are under the IPS caps) are being "forced" (due to unreasonable IPS per-beneficiary caps) into discharging patients who desperately require home care services. The reality of the matter is that if the "national" cap is four thousand dollars per patient (in the aggregate), home health agencies cannot treat patients who require more intensive care.

The life-threatening flaws of the IPS include:

1) IPS improperly returns home health care cost and care levels to fiscal 1994. This FY 94 level is not adequate considering that hospitals were not discharging patients as quickly and in such a deteriorated condition as they are in 1998 and considering that wages (which represent over 70% of home care costs) were significantly lower in 1994 (as they were for all American employees).

2) The IPS creates "unfair competition" and improperly pits home health agencies against each other to treat patients. Some agencies are under IPS's inappropriate caps while others are not - clearly an improper and unfair regulation. In my own hometown of Jacksonville Florida, our agency with a cost-report fiscal year of December 31 has already taken steps to comply with our "lower" IPS payments, while other agencies which have a cost-report fiscal year end of June 30 are not affected by the Interim Payment System and they are offering our employees and our patients increased salaries and home care services. This is causing confusion among home health beneficiaries because agencies not currently affected by IPS are informing patients that they can receive "More Care" from them versus an agency currently under IPS.

3) The current IPS plan requires an agency to use the "unduplicated census count of patients". Unfortunately, many agencies may have inaccurate data due to "flu-shots" being given to the public. The problem is that there is no "case-mix adjustment" to properly reflect "changing" patient care needs and/or "changing" patient care populations.

4) Lastly, HCFA's is currently unable to "prorate" the per-beneficiary limitations between home health agencies treating the same patient in the same year. HCAA believes (and at least one of Medicare's intermediaries have confirmed) that HCFA will be unable to determine (a pro-rated beneficiary cap) in a reasonable timeframe, for patients receiving home care from more than one home health agency. This will mirror the problem currently in the HMO industry where a patient signs up for an HMO without telling the home health agency currently treating the patient, with the impression that the patient is in the traditional fee-for-service Medicare program. The home health agency continues providing services, only to learn that neither Medicare, nor the HMO will reimburse the home health agency for services rendered while the patient was enrolled in the Medicare HMO.

HCAA recommends the following solutions to the Interim Payment System:

1) Change the "base year" of the per-beneficiary cap to 1996 cost data, versus 1993, to more adequately reflect adequate and necessary care and cost levels.

2) Ensure that a "regional" average is used versus a "national" average. Care levels are different in different areas of the country, i.e. more managed care is found in California while in Louisiana and Texas, fewer Medicare beneficiaries are choosing managed care plans.

3) Implement IPS "uniformly" to "all" agencies at the same time - i.e. "all" agencies should be subject to the "per-beneficiary caps" on the same date, <u>not</u> based on their fiscal year end.

4) A "case-mix adjustor" in the "per-beneficiary caps" should be made to account for low visit volume patients in the base year.

5) Immediately call for hearings on the Interim Payment System and ask home care industry representatives to testify about the damaging effects of this legislation and to offer solid alternatives to this flawed plan.

6) Recommend that HCFA postpone implementation of the Interim Payment System. HCFA has been charged to develop a prospective payment system for home health care by October 1, 1999. HCFA is already overwhelmed by Congressional mandates, so HCAA believes that the Interim Payment System will force HCFA to concentrate on IPS versus developing a good PPS plan.

Section III - Operation Restore Trust

Another critical issue to the survival of the freestanding home health agencies is Operation Restore Trust.

Do not be deceived by reports from HCFA that this program is taking in $10.00 for every $1.00 spent. This committee **(and the media)** must ask HCFA these questions:

1. How many cases, that ORT has brought forward, have been OVERTURNED by an Administrative Law Judge and by other branches of the judiciary?

2. How many freestanding agencies have been targeted by ORT, and how are they targeted?

3. How many agencies targeted by ORT are MINORITY-OWNED?

4. How many agencies who have been penalized under ORT were done so simply because they were not afforded judicial relief or simply did not have the funds to fight because they are small businesses. HCAA asks that hearings be held on this issue and HCAA will provide agency owners and staff to testify on how their agency has been improperly punished by ORT (and Wedge surveys) and hence denied their rights of due processs under the law.

5. How many hospital-based/owned agencies have been targeted by ORT?

On behalf of the over 350 members of HCAA, I applaud efforts by the federal government to root out fraud and abuse. I offer my services as, Chairman of the Board of HCAA, to work hand-in-hand with the government, in any way, to ensure that when Medicare funds are spent, they are well spent. It is critical that we get what we pay for. However, in the past ORT and HCFA have been not only reluctant, but adamant about **NOT ALLOWING** cooperation between the industry and the government, pertaining to ORT. Are we asking for leaders in the industry to be directly involved when considering possible fraud cases? No. **Are we asking for a cooperative, ongoing effort to work with Linda Ruiz of HCFA, on possible issues pertaining to fraud and abuse? Absolutely, yes.**

In addition, a Providers' Bill of Rights must be adopted to ensure that providers are free from strong-arm tactics sometimes used by ORT (and Wedge Surveyors). In the case of CSM Health Services in California, HCFA stripped the home health provider of their provider number before the administrative process was allowed to work. An Administrative Law Judge overturned HCFA and ORT, and even The Honorable John G. Davies (Case No. CV 96-4651-JGD), United States District Court-Central District of California stated, **"I think the surveyors--I think CSM has a case. The evidence that is before me that I have perused, read, considered, leads me to those conclusions. The Surveyors, I had the impression, were not reticent to wear their power on their cuff and to manifest it and exercise it in ways that are undesirable in today's society. The bureaucracy overreacted once again."**

We ask the committee to urge HCFA to respect freestanding agency owners and order HCFA to cease and desist using strong-arm tactics in Operation Restore Trust.

Also, the committee should ask HCFA to honor the favorable and correct decision in the CSM case in California.

We ask the committee to urge HCFA to expand Operation Restore Trust to hospital-owned/based agencies and large chains. We also request that a Providers' Bill of Rights be developed, with input from HCAA and other trade associations.

In conclusion, let me be clear. I believe that HCFA is using ORT to circumvent due process of freestanding home health agencies. With the enormous influx of funds from Kennedy-Kassebaum, HCFA will be given a green light to force freestanding home health agencies out of business. I urge the committee to ask HCFA for detailed reports on their fraud and abuse activities, not limited to funds recovered, but cases appealed and overturned in favor of freestanding agencies and hold public and open hearings to discuss ORT (and Wedge survey) "auditor" abuses.

Section IV- Hospital Self-Referrals

One of the most critical issues to freestanding, entrepreneurial home health care agency owners is the issue of hospital self-referrals. The key words that we have heard over the last three years of the Republican-controlled Congress are "competition" and the "free-market." If this committee and this Congress truly believes in these principles, then we ask that freestanding home health agencies be allowed to compete on a level playing field with hospital-owned/based agencies. In addition, this committee should review the December 9, 1997 OIG report entitled, "Medicare Hospital Discharge Planning" (OEI-02-94-00320). This report confirms what HCAA has been telling Congress for over 3 years. Two quotes from this report states, "***Hospital ownership does seem to have influence on which home health agencies patients are referred to"*** *and* ***"Hospital ownership also influences the duration of home health agency services." (emphasis added).***

Currently, 42 CFR 424.22 entitled, "Requirements for home health services" states:

(d) Limitations on the performance of certification and plan of treatment functions.- (1) Basic rule. Beginning November 26, 1982, and except as provided in paragraph (e) of this section, need for home health services to be provided by an HHA may not be certified or recertified, and a plan of treatment may not be established and reviewed by any physician who has a significant ownership interest in, or a significant financial or contractual relationship with, that HHA.

Section (e) states: Exception to limitations- (1)Exceptions for governmental entities. The limitations of paragraph (d) of this section do not apply to an HHA that is operated by a Federal, State, or local governmental authority.

In addition, 42 CFR 424.22 section (3) clearly states:

Significant financial or contractual relationship. Beginning November 26, 1982, a physician is considered to have a significant financial or contractual relationship with an HHA if he or she-

(i) Receives any compensation as an officer or director of the HHA; or

(ii) has direct or indirect business transactions with the HHA that, in any fiscal year, amount to more that $25,000 or 5 percent of the agency's total operating expenses, whichever is less. Business transactions means contracts, agreements, purchase orders, or leases to obtain services, supplies, equipment, and space and, after August 29, 1986, salaried employment.

History

HCAA has always believed that this regulation is crystal clear. Hospitals are prohibited from having doctors certify or recertify plans of treatment to hospital based/owned agencies if the doctor is employed by the hospital, and that doctor receives compensation over $25,000. Opponents of this regulation say that new health care systems developed over the past several years have made this regulation outdated and obsolete. The American Hospital Association (AHA) has lobbied hard to have Secretary Shalala declare a "moratorium" on enforcing this regulation until Stark II legislation is finalized. **HCAA believes that improper hospital self-referrals drive up costs, eliminate competition and denies patient choice.**

I recently read a quote from Representative Thomas Bliley of Virginia pertaining to competition. Representative Bliley stated, **"Last Congress, we broke up one of the biggest monopolies still standing, giving consumers a choice in local telephone service. It's time we did the same thing with electricity." Also he said, "no economist can quarrel with" the notion that "competition lowers prices, competition improves productivity, and monopolies are always inefficient and expensive -- always. That's not opinion, it's fact. You know it, I know it, ... and history proves it."**

Chairman Bliley is correct in his comments. **Competition is the key to lower prices, higher quality and patient satisfaction.** When telephone companies, airlines, cable television operators and fast food restaurants are allowed to compete fairly, prices go down and quality goes up. However, that doesn't mean that safeguards are done away with. It is imperative that regulations remain in place to ensure companies do not sacrifice quality in favor of profit. Federal agencies, like the FDA are necessary to ensure that food is safe to eat. In the same way, the Department of Justice, OIG and FTC should ensure that, in the health care sector of our economy, patients have the freedom to choose their own health care provider, especially home health care.

Consider that the hospital has a "captive patient." The patient has received services while in the hospital and then when the patient is discharged to home health care, it is logical that the hospital would want to have that patient remain in the hospital system. The excuse a hospital may use is, "we want to ensure that you are given continuity of care." Eventhough freestanding, Medicare-certified home health agencies are in the community, the hospital may be reluctant to lose the Medicare dollars associated with that patient. Then, if the patient returns to the hospital, the hospital may be able to receive that patient under a new DRG and again drive up health care costs.

The main issue you should consider is **PATIENT CHOICE**. In many instances throughout the country, we have heard from freestanding home health agency owners that patients they have been treating, when readmitted into the hospital, are in some cases discharged to the **HOSPITAL-OWNED/BASED HOME HEALTH AGENCY.** Hospitals must honor patient choice and put aside profit. It is imperative that the patient is allowed, without coercion or manipulation, **the freedom to choose his post-acute provider, and the choice must be honored by the hospital.**

The freedom to compete for providing health care services is also a concern. HMOs and hospitals have the financial resources to place **FULL PAGE ADS** in newspapers and have **LARGE ADVERTISING BILLBOARDS** to lure patients into their care. Freestanding home health agencies do not have the resources to compete with this type of advertising. Certainly, Medicare provides reimbursement for limited types of education, but HCFA is reluctant to pay for any advertising except in the case of recruitment.

We urge the committee to ask HCFA to maintain and vigorously enforce the "Hoyer Commentary" pertaining to 42 CFR 424.22 and ensure that hospitals allow freedom of choice to patients.

Testimony of

The National Association of Health Underwriters

for

Committee on Ways & Means
Subcommittee on Health

January 29, 1998

Mr. Chairman and Members of the health subcommittee, my name is Thomas P. Bruderle. I am the Director of Congressional Affairs with the National Association on Health Underwriters (NAHU) We are pleased to offer comments on "Preparing the Health Care Financing Administration (HCFA) for the 21st Century," the subject of the health subcommittee's hearing of January 29, 1998. NAHU's more than 14,500 members are insurance professionals involved in the sales and service of insurance and related products for more than 100 million Americans.

Our comments are directed toward that portion of the Balanced Budget Act (BBA) directing HCFA to provide beneficiaries with a nationwide Medicare+Choice Information Fair in 1998.

The passage of the statute last year marks the first time that older Americans will have the same opportunity to select from among health insurance options available to those younger. In fact, beneficiaries were able to choose components found in the Medicare+Choice program through their employers when they were in the workforce. The BBA has allowed beneficiaries to "catch-up" to where they were at an earlier time. As we will explain, the experiences seniors have had with health insurance professionals may prove especially helpful to HCFA in providing information on their new Medicare+Choice options.

For many older Americans, their new health care choices could be a confusing array of printed materials comparing plan options, benefits, requirements and premiums. For example, HCFA brochures might show an HMO option with a choice of multiple provider networks, but might be unclear on the requirement that primary and specialty care be secured through the same provider network. Preferred provider networks might be listed with health maintenance organizations. On the surface, these might look the same but they are, in fact, very different plans.

To meet the mandate of the Balanced Budget Act, HCFA proposes to make available the Medicare+Choice options through the Internet, an 800 toll-free number and community-based organizations. We question the wisdom of relying on these sketchy, unproved techniques, not user-friendly to older Americans, while failing to take advantage of the expertise of the insurance professional with which many seniors are already familiar..

Any reliance on the Internet for transmitting complex, highly interactive information seems to us a risky venture. We believe seniors would not be as comfortable with the Internet as they would be with direct, face-to-face communications, an experience many, if not all, have had while in the workforce. Furthermore, the cost of purchasing, installing and using the hard- and software would be prohibitive for many beneficiaries.

At first glance, a toll-free telephone number would seem a more appropriate tool since far greater numbers of older Americans have a telephone. However, the unseen information specialist on the other end of the 800 number may have to respond to hundred of detailed Medicare inquiries, and not merely read general information. Again, the telephone fails to capture the dynamics of personal communication at which the insurance professional would excel for this audience. Community-based senior organizations, that provide other information and services, would also seem to miss the mark in both providing an adequate explanation of the Medicare+Choice options and, in confidence, responding to personal questions.

In sum, HCFA has the challenging task of organizing data on competing health plans and providing information for beneficiaries to make wise choices for their future health. As it is now funded and staffed, we believe the agency lacks the financial resources and personnel to undertake this responsibility. It would be short-sighted and unwise to rely exclusively on the largely untested, ill-designed information sources the agency has identified to meet the critical information needs of millions of older Americans.

We believe it would be in the best interests of HCFA, and the population it serves, to call on a time-tested, experienced, efficient, and over-looked resource: the insurance

professional. Throughout their working lives, many beneficiaries have relied upon the counsel and understanding of insurance agents in their communities to sort through the maze of health plan and benefit choices for them, their families or their employees. Older Americans have come to trust and expect the more knowledgeable, personal services offered by their insurance advisors.

With an understanding of the senior market, an insurance agent can direct a senior on a limited budget to the HMO plan that offers a prescription drug benefit; or the ease of a PPO plan to the senior unlikely to adjust well to seeing a primary care physician for referral to a specialist.

Professional advice and information are only the "front" end of the service the agent or broker would provide the beneficiary. Once choices have been made, it is the agent who would serve as the important intermediary between the beneficiary and the Medicare+Choice option answering technical questions, working with physicians, hospitals, and helping with the paper-work.

Insurance agents, of course, must be licensed by the state where they reside and practice, and annually they must complete rigorous continuing education requirements to retain their licenses. Furthermore, agents are used extensively by the insurance industry to market health insurance and related products. There are several good reasons for this preference.

First, the use of agents is cost effective for insurance carriers. Agents are contractors of insurance carriers, not employees, which means that carriers do not have the associated costs of an employee such as benefits, expense reimbursement and the employer FICA match. Instead, they have only the cost of the agent's commission which is the same percentage paid monthly, provided the coverage remains in force. Successful agents in the health insurance market develop a clientele over time, building new relationships while renewing others.

This latter point explains a second reason for the private sector's use of agents: consumers like them and many develop satisfactory relationships spanning a working career. Different from the salaried employee of a carrier, the agent or broker represents the best interests of the consumer, not the insurance company. The health insurance professional can offer a variety of products from several carriers and explain the differences among them, all to the benefit of the consumer.

A third reason is the agent's independence. Responsible to the consumer, it is in the agent's best interest to identify closely with the needs and concerns of the consumer.

To provide fair compensation for the services of the health insurance professional, on the one hand, while encouraging policies, plans, and programs which will provide for the most cost effective use of government resources, on the other (while also ensuring quality), we propose a new "safe harbor" similar to that used in the Medicare supplement market.

First, those who would sell the Medicare+Choice options must be licensed in the state where they do business.

In addition to licensure, insurance professionals must complete continuing education requirements annually to retain this designation. Licensure and renewal are the surest incentives for avoiding illegal behavior.

Second, those who sell Medicare+Choice options must be required to complete successfully Medicare+Choice Training Program.

In addition to insurance agents representing consumers, all who sell in the Medicare market, including employees of insurance carriers and health maintenance organizations, should be knowledgeable in ALL of the choices available to seniors, at least to respond to basic questions of available choices.

Third, commissions for the sale of a Medicare+Choice product should be level and paid monthly.

To avoid moving beneficiaries from one plan to another, a process called churning, and realizing a commission for each "sale," there should be no finder's fees or higher first year commissions. Instead, level commissions paid over the life of a contract would eliminate the incentive for churning.

Fourth, contracts between insurance carriers and agents should contain a clause stating that commissions for existing Medicare+Choice plans would continue in the event of relationship between the carrier and the agent terminates, provided the agent remains licensed.

When they enter a new geographic area, some insurance carriers contract with many agents to sell their products as a way of quickly gaining market share. Once they have it, they may decide to limit their continuing contracts to a handful of "top producers." To prevent an incentive to move the case to another plan by either a "top producer" or the carrier, the agent (if still licensed) who initially sold the Medicare+Choice plan to the beneficiary would continue to receive the monthly commission previously established. This, again, addresses the government's concern about churning.

NAHU is convinced that the insurance agent is the best medium to help disseminate information about the new Medicare+Choices. A dynamic partnership with the insurance professional means that HCFA will be able to address more effectively the other demands imposed on it by Congress. Meaningful education that serves the best interests of the consumer will have a dramatic effect on seniors as they move to a Medicare system designed to respond to their individual needs. With this greater understanding and sense of control, seniors will be more willing to enroll, and continue that enrollment, in the same kinds of managed care plans that have been so successful in the private sector.

Thank you for the opportunity to provide our comments on this important issue

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WRITTEN TESTIMONY SUBMITTED TO THE SUBCOMMITTEE ON HEALTH OF THE WAYS AND MEANS COMMITTEE FOR THE JANUARY 29, 1998 HEARING ON PREPARING THE HEALTH CARE FINANCING ADMINISTRATION FOR THE 21ST CENTURY

By Karen Rogers
President-Elect
Oklahoma Association for Home Care

Congress made more than $115 billion in cut from the Medicare program to help preserve the solvency of the program through the Balanced Budget Act of 1997, signed into law by the President on August 5, 1997. Although most of these cuts were labeled as reimbursement reform for providers of health care services, the reality is that they represent a significant loss of benefits to Medicare beneficiaries. Particularly affected by these cuts will be the 3.6 million Medicare home care patients.

It is not hard to follow the logic for reform of Medicare home care payment; home care is not only the fastest growing portion of the Medicare budget, allegations of fraud and abuse in the industry have been widespread, albeit often misrepresented. The home care industry, as represented by the National Association of Home Care (NAHC) and the Oklahoma Association for Home Care (OAHC), supports a Prospective Pay System scheduled to go into effect in October 1999. We also support measures to prevent and control fraud and abuse. The industry is quite concerned, however, about serious hardships and inequities imposed, and potentially imposed, upon the industry and individual agencies by the provisions in the BBA. Of particular impact to home care agencies, and consequently to patients, are the following provisions:

SURETY BOND REQUIREMENTS. The final rules for home health surety bonds were published in the Federal Register on January 5, 1998; Agencies have until February 27, 1998 to produce evidence of bonding to HCFA retroactive to January 1. The rules for bonding are so restrictive that most surety bond companies have declined to write these bonds. Predictions are that more than eighty percent of all nongovernment-owned agencies, which are normally exempt, will not qualify for bonding under the current rules.
(Additional comments on surety provisions- p. 2)

INTERIM PAYMENT SYSTEM. IPS is meant to bridge from the old, retrospective home care reimbursement payment system to the new Prospective Pay System to be effective October 1, 1999. IPS reduces costs through two mechanism. First, a new formula is used to calculate per visit cost limits, effectively reducing these limits by approximately 15% industry-wide. Second, per-patient, per-year payment is capped (aggregate beneficiary limit) to each agency using a formula based on that agency's prior costs. The formulas will result in wide variations in the aggregate beneficiary limit. One agency may be limited to $4000 per patient, whereas a neighboring agency may receive upwards of $10,000 per patient. This example is just one in a myriad of inequities and hardships imposed by IPS under the current law. ***(Additional comments on IPS provisions- p. 3).***

VENIPUNCTURE EXCLUSION. Effective February 5, 1998, the need for venipuncture (blood drawing) is excluded as a qualifying skill for the Medicare home care benefit. For those homebound patients whose only skilled need is for venipuncture services to monitor medication therapy or disease states, Medicare home care is no longer an option. ***(Additional comments on exclusion provisions- p.4).***

In summary, these home care provisions in the Balanced Budget Act of 1997 will, in reality, reduce the care that home care agencies will be able to provide for the homebound elderly and disabled under the Medicare program. Compounding the problem of reduced care are inherent inequities created by the Act, which will result in competitive advantages and disadvantages for different agencies.

SURETY BOND:

The Balanced Budget Act required a home health agency to have a surety bond in the amount of at least $50,000 by January 1, 1998, to participate in the Medicare program. The final regulations for home health agency surety bonds were not published in the Federal Register until January 5, 1998 so agencies were given until February 27, 1998, to show evidence they had the required bond. However, the bond requirements were so onerous that most surety companies declined to write the bonds for Oklahoma home care agencies.

We were disturbed to learn that the Health Care Financing Administration took it upon itself to go beyond the mandate of Congress and require the bond to be a minimum of $50,000 or 15%, whichever is greater, of the agency's Medicare payment for the prior year and with no cap. This creates an incredible hardship on home care agencies. A typical medium size home care agency in Oklahoma receiving $1 million in Medicare reimbursements would be required to have a $150,000 bond. Home care agencies are required to hold a surety bond regardless of their good standing with the Medicare program.

The bond amount requirement is a vast overreaction to the problem. HCFA's own data shows that only two-tenths of 1% of all Medicare home care payments are unrecouped overpayments.

Those very few surety companies who have expressed any interest in writing the bonds are demanding that home care agencies, or their owners, have a net worth three to four times the value of the bond. That presents an additional problem. Medicare reimburses home health care agencies for costs only, allowing no accumulation of equity in the business. If Congress and HCFA wishes the mandate that home health agencies obtain a surety bond, then the cost of that surety bond should be a reimbursable expense.

We are concerned that the bond amount is based on an agency's Medicare reimbursement, not overpayments made to the agency during the prior year. This defeats the intended purpose of HCFA to protect itself from uncollectable overpayments.

A major concern with the surety bond regulations published on January 5, 1998, is the cumulative liability. Home health agencies are, under current regulations, required to have a series of one-year bonds. Since HCFA has an indefinite period of time in which it may come back and file a claim against the bond, home health care agencies must purchase a new bond each year, thereby "stacking" the liability for the bonding company. Even if HCFA does modify this requirement, the assets requirement which are likely to be imposed by bonding companies may still make surety bonds unavailable to many home care agencies.

HCFA also requires home care agencies to hold separate bonds for the Medicare and Medicaid programs which duplicates their expenses.

INTERIM PAYMENT SYSTEM

The previous reimbursement home care payment system paid a home health agency the *lowest* of three ways:

The agency's billed charges;
The agency's per visit cost limit multiplied by the number of visits made; or
The agency's actual costs as reported in its annual cost report.

The Interim Payment System adds a fourth component:

The agency-specific per-beneficiary aggregate limit multiplied by the agency's unduplicated census.

The per-beneficiary aggregate limit is calculated in the following manner:

75%- The agency's 1993-94 reasonable costs (per cost report) divided by the agency's reported unduplicated census;
25%- The standardized regional average per patient costs for the agency's census division;
The 75/ 25% blend is multiplied by 0.98, for a 2% reduction overall.

If the agency was opened after 1993 and has no cost reporting period ending during fiscal 1994, its per-beneficiary annual limit will be calculated on the basis of the national median of the blended limits.

The hardships and inequities imposed by this system include the following:

1. **Home care services will be reimbursed at rates that reflect 1993 utilization rates of home care use.** From 1993 to 1997 higher-cost patients have chosen home care over nursing homes or extended hospital stays; advances in technology and home care professionalism have made this possible.

2. **The calculation of the per-beneficiary aggregate limit:**
   Rewards those agencies that had high costs and utilization in 1993;
   Penalizes lost cost, low utilization agencies;
   Further penalizes newer agencies, particularly those in geographic regions of higher utilization;
   Uses unduplicated census in the calculation- an irrelevant and often misreported figure in cost reports, thereby skewing results

3. **No exceptions to the per-beneficiary limit are made for the long-term, chronically ill patient in the home.** These patients are covered under the Medicare home care benefit, but the agency that cares for these types of patients may commit financial suicide.

4. **The per beneficiary aggregate limit is to be "prorated" between agencies when more than one agency provides care to the same patient within the year, but no system has been developed to address proration problems.** The system will have to deal with situations in which the agencies have different fiscal years, different per beneficiary limits, and/or different fiscal intermediaries; nor is there a method to address utilization needs of the patient, varying discipline mixes, and tracking of the cap.

5. **HCFA does not anticipate publishing the per-beneficiary aggregate limit until April 1998, even though many agencies have been operating under the limits in increasing numbers since October 31, 1997.** These agencies are operating "in the dark".

VENIPUNCTURE EXCLUSION

The bill revises the definition of skilled home health services, effective February 5, 1998, to specifically exclude venipuncture (blood drawing) as a qualifying service for the Medicare home care benefit.

The rationale behind this exclusion is twofold: patients requiring venipuncture services generally need this service on an ongoing, long-term basis to monitor the effects of medication therapy where a too high or too low blood level is potentially dangerous or life-threatening, or to monitor chronic health conditions where medication adjustment is frequently necessary. HCFA views the long-term nature of this service as outside the

intended scope of the Medicare home health benefit.

Secondly, home health agencies have often provided frequent, sometimes daily or twice daily, home care aide services to these long-term venipuncture patients. Medicare regulations require that daily skilled nursing services have an "end in sight", but do not require that there be an end in sight for daily home care aide services. HCFA's viewpoint is that agencies provide unnecessary venipuncture services in order to be able to provide frequent, therefore costly, home care aide services, thus abusing the program.

The venipuncture exclusion can therefore be seen as "throwing the baby out with the bath water" in that ALL patients will be denied this necessary benefit because of concerns of potential abuse. Of particular concern is the large number of patients that require venipuncture services to monitor the effects of Coumadin therapy, a "blood thinner" used for patients with stroke, heart conditions and other vascular diseases. Coumadin has a very narrow window of effectiveness. If the level is too low, the patient risks dangerous clotting. If the level is too high, stroke or other potentially fatal bleeding can occur. While some laboratories in urban areas may offer phlebotomy services in the home, homebound patients living in rural areas and areas without these services have no good options for this very necessary blood monitoring.

HCFA's concern about overuse of home care aide services has some validity; home care aide services have been an area of overutilization in home care. However, normative standards for home care services do not exist at this time, so agencies have no guidelines for appropriate utilization other than the Medicare benefit itself, which allows for these services. Providers have typically been paid, without question, for these services provided and billed through the fiscal intermediary. Could it be that the venipuncture exclusion is a smoke screen for the true objective, which is to limit home care aide services. If so, why not simply revise the Medicare home care benefit to limit home care aide services? This would place the potential political ramifications of cutting a Medicare benefit on squarely on the shoulders of HCFA. Currently that burden is being carried by the home care agencies that are forced to reduce patient care in order to survive.

Retired Public Employees Association, Inc.

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Statement to the House Committee on Ways and Means
Subcommittee on Health

Congressman Bill Thomas, Chairman
Mr Chairman:

I am writing as President of the Retired Public Employees Association, which represents more than 70,000 of New York's state and local government retirees and their spouses. Many of our members are Medicare beneficiaries and in order to reduce the confusion and fear that they often experience when there are major changes in programs, it is important for the Health Care Financing Administration to provide the standards, reviews and approvals needed to implement Medicare+Choices in a timely fashion .

To assist HCFA in managing these additional obligations, we recommend the elimination of tasks relating to the administration of peripheral activities, such as the use of private contracts by Medicare beneficiaries. Specifically, we propose that Congress repeal Section 4507 of the Balanced Budget Act of 1997 which institutes direct contracts between practitioners and patients and we urge Congress to reject the Kyl-Archer Amendments (H.R.2497 and S.1194), now in committee. Repealing the former would eliminate the need for HCFA to track affidavits and to develop data-bases relating specifically to out-of-pocket costs due to direct contracts; rejecting the latter would eliminate an administrative burden that is expected to impair HCFA's ability to "screen inappropriate and fraudulent claims " and thereby "compromise the agency's effort to combat fraud and abuse".