

STATEMENT

**BEFORE THE
SENATE COMMITTEE ON FINANCE**

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Chairman Baucus, Senator Grassley, distinguished members of the Committee, it's a pleasure to be with you. I appreciate the Committee's excellent work on so many issues important to our economy and to the lives of people across our country. And I welcome the opportunity of appearing before you to talk about what we're doing at the Department of Health and Human Services to make our department more capable of fulfilling the mission our name describes – service to people who need help.

Today, I'm going to discuss changes we're bringing to the Centers for Medicare and Medicaid Services, or CMS - formerly known as the Health Care Financing Administration, or HCFA. But I want to set my remarks about the Centers in a broader context. The transformation of the Centers is part of a larger effort to renew my Department, to make it more efficient so that it can be more effective.

We are taking aggressive steps toward bringing a culture of responsiveness to H-H-S. This culture, this spirit, is rooted in a commitment to compassion and a call to responsibility. We intend to reinvigorate the entire department with a spirit of responsiveness to our constituents – to you, members of Congress; to our colleagues in government, here in Washington and throughout the nation; and to those who really are our most important constituents, the men and women and children we serve. And we intend to answer our call to serve our constituents with a deepened sense of responsibility and a heightened sense of mission.

Too often, we've had to deal with an attitude that says, "This is the way it's always been. It's the best we can do." I reject that attitude completely. H-H-S is a wonderful department staffed by thousands of dedicated public servants. Yet it's human nature to accept the status quo. So, I've sent a clear message - accepting mediocrity runs counter to our duty as servants of the public's interests and the public's trust. Our constituents, the American people, deserve better. Under the new spirit we're bringing to H-H-S, they will have better.

One of the first things we've done is to demand a renewed dedication to answering people when they need help. When physicians call us, when ordinary people write us, when other agencies ask for help and when people like you in the Senate or the House have questions and concerns, we need to respond quickly, thoroughly and accurately. The days of long delays, unintelligible answers and inadequate assistance are over.

To that end, we've established a new protocol for responding to requests for help and information. As a first step, the HHS Executive Secretariat has been charged with clearing away all backlogged correspondence by July 1.

I've directed that an answer to any letter for my signature must be on my desk within 15 business days of the time it arrives in my office. Frankly, I think even that's too long. But at least it sets a deadline for accountability.

We are also moving toward a paperless system to speed up our response time. And I've insisted that all written material be expressed in plain, understandable English. If we can perform cross-continental surgery using satellite technology and electronic data transfer, we can write a simple English sentence that anyone can understand.

Responsiveness must extend to states, as well. As all of you know, I was a governor for 14 years. From my own experience, I know the frustration of trying to get help from Washington. Let me emphasize that the difficulty lies not with any one group of individuals but with a system that sometimes seems to put nicely filled-out forms ahead of pressing human needs.

Of course, there is a genuine need for some rules. But rules should exist to help, not hinder, our efforts to assist hurting people. When regulations, mandates and paperwork obscure or even thwart the help we are called to provide, those rules need to be changed.

In the past four months, I've approved more than 600 Medicaid and SCHIP waivers and State Plan Amendments. I have authorized these changes because people with immediate needs cannot wait for a rumbling bureaucracy to plod along. They need help when they need it – and in most cases, that means not at some distant point in the future, but now.

We must give states the flexibility to develop Medicaid and SCHIP programs that suit their needs and we must speed approval of their innovative ideas and solutions. As is indicated by the number of waivers and State Plan Amendments I have approved, we

have already made significant progress in this area, but we know there is much more to be done. Since I became Secretary, we have reengineered the Medicaid waiver process with a focus on “getting to yes.” We are working with states to be more responsive and timely in our decision-making on waivers and amendments, to encourage innovation by the states and to grant speedy approval for “look-alike” waivers. We are also cleaning-up the backlog of State Plan Amendments, now have a new database in place to track the status of state waiver requests and are fostering a new culture at CMS of giving states an answer - period. Of course, we would like the answer to be “Yes,” but whatever the answer, we must foster a culture of deciding and of answering even if the answer is “No.”

In addition, we’re forming a new regulatory reform group that will look for regulations that prevent physicians and other health care providers from helping people in the most effective way possible. This group will determine what rules need to be better explained, what rules need to be streamlined and what rules need to be cut altogether.

Within H-H-S, we must solve our own technology problems. For example, HHS currently is home to nearly 1,200 different computer systems, most of which can’t talk to one another. There are 981 toll free numbers, hundreds of computer rooms and many of individual agency support services, such as help desks. In one department office, we have five financial management systems, 13 grants management systems, six acquisition management systems, six personnel systems and 13 email systems. As one might guess, they have difficulty communicating with one another since there is no common infrastructure. When I arrived at HHS and learned about this, it seemed to me that this

was very much like a city in which every block had its own power plant and its own telephone company.

In the short time I've been in HHS, I've taken a number of steps to start making sense of all of this. First, I am determined that HHS Information Technology will be managed on an enterprise basis—with a common infrastructure, rather than by many separate agencies. I will establish the HHS Chief Information Officer with authority over HHS information technology resources with the charge to implement a “One Department,” one-enterprise approach to information technology. I've recently decided that HHS will have one financial management system for CMS. It's called HIGLAS, and I will describe it in a moment. There will be another management system for the rest of the department. And I have decided that HHS will have one personnel system.

So, the transformation of the Department of Health and Human Services has begun. It will take time and will demand some expenditure. But it can be done, and it will be done.

There is no place where that transformation is more critical than in the agency that administers Medicare, Medicaid, and the State Children's Health Insurance Program (SCHIP). Administrator Tom Scully and I are committed to ensuring these programs are more responsive to our provider partners, the States, and the millions of Americans who depend on them. We intend to work with this Committee and with Congress in a bipartisan fashion to accomplish our objectives, so that these critical programs are prepared to meet not only today's needs, but also tomorrow's challenges.

BACKGROUND

CMS is the nation's largest health insurer, providing coverage to more than 70 million Americans. This year alone the Medicare, Medicaid, and SCHIP programs will pay an estimated \$476 billion in benefits. CMS has one of the largest budgets of any federal agency or Department. Each year Medicare alone processes nearly one billion claims from over one million physicians and other health care providers.

The Medicare and Medicaid programs have been the center of our society's commitment to protect the low-income and ensure that all of our seniors enjoy a healthy and secure retirement. Honoring this commitment means making sure that the Medicare program is financially prepared for new beneficiaries, and ensuring that current beneficiaries have access to the highest quality care. And it means ensuring that States are afforded flexibility to meet the needs of their citizens. It also means changing the way the CMS does business, improving its relationship with its business partners, and taking bold action to modernize its programs for the future. As Tom Scully and I announced last week, we have made several important management improvements to CMS. I will discuss these and other changes in greater detail in my testimony today and also highlight future objectives that I hope we can accomplish together during this Congress.

NEW AGENCY NAME AND STRUCTURE

Last week, we announced our plans to rename the Health Care Financing Administration and call it the Centers for Medicare and Medicaid Services. The department asked a variety of sources for suggestions and reactions to the proposed names, including seniors, the Agency’s provider partners, State Health Insurance Assistance Programs, and State Medicaid Directors. We conducted extensive focus group testing. We even set up a contest for our employees to offer suggestions. This change is more than cosmetic. It represents a new openness and a new atmosphere at CMS. It also better reflects the Agency’s mission to serve Medicare and Medicaid beneficiaries and it makes it clear to the Americans, who rely on these programs, that the CMS is responsible for administering these programs. All the focus groups said, “What is HCFA?” and “Medicare and Medicaid should be in the name.” So, we did what they suggested.

In addition to the name-change, several constructive organizational changes were also announced. The Agency has been reorganized and simplified around three centers that better represent the Agency’s major lines of business. These core centers will give beneficiaries, States, physicians and other providers a clear and direct point of contact within the Agency for information on policies and programmatic changes that impact them. The three core centers are as follows:

- ***The Center for Beneficiary Choices*** will focus on educating beneficiaries about their health care choices. From traditional fee-for-service and Medigap, to Medicare Select and Medicare+Choice, beneficiaries too often do not understand their options and we are determined to change that. The Center

also will be responsible for managing the Medicare+Choice plans, conducting consumer research and demonstration programs, providing beneficiary education, as well as overseeing beneficiary grievance and appeals processes.

- *The Center for Medicare Management* will be responsible for managing the traditional fee-for-service Medicare program. The center will develop and oversee the Agency's fee-for-service payment policies and manage the Medicare fee-for-service contractors. These functions are over 85 percent of Medicare program operations and represent CMS's largest functions.
- *The Center for Medicaid and State Operations* will be primarily responsible for programs administered by the States. The center will work in partnership with the States in administering the Medicaid and SCHIP programs, as well as overseeing insurance regulatory activities, survey and certification, and clinical laboratories. The profile of the center will be raised, so will its responsiveness to States.

IMPROVING AND EXPANDING EDUCATION

In the next few months, we also will launch an aggressive new education campaign to ensure that all Medicare beneficiaries understand the program, their coverage options, and the costs associated with the health care decisions they may make. We know from our polling and focus groups that far too many Medicare beneficiaries have a limited understanding of the Medicare program in general, as well as their Medigap, Medicare

Select, and Medicare+Choice options. We firmly believe that CMS must improve and enhance its existing outreach and education efforts so that beneficiaries understand their health care options. In addition, CMS will tailor its educational information so that it more accurately reflects the health care delivery systems and choices available in beneficiaries' local areas. We know that educating beneficiaries and providing them more information is vital to improving health care and patient outcomes.

With that goal in mind and in an effort to ensure that Medicare beneficiaries are active and informed participants in their health care decisions, the CMS will expand and improve the existing *Medicare & You* educational campaign. For example, CMS is:

- ***Initiating a Multimedia Education Campaign*** to raise awareness among Medicare beneficiaries of their health care options. The Agency will use major television, print, and other media to reach out and share information and educational resources to all Americans who rely on Medicare, their families, and their caregivers.
- ***Increasing the Capacity of Medicare's Toll-Free Lines*** so that the new wave of callers to 1-800-MEDICARE generated by the advertising campaign receives comprehensive information about the health plan options that are available in their specific area. By October 2001, the operating hours of the toll-free lines will be expanded and made available to beneficiaries, their families, and caregivers 24 hours a day, seven days a week. The information

available by phone also will be significantly enhanced, so that specific information about the health plan choices available to beneficiaries in their state, county, city, or town can be obtained and questions about specific options, as well as costs associated with those options, can be answered. Call center representatives will be able to help callers walk-through their health plan choices step-by-step and obtain immediate information about the choices that best meet the beneficiary's needs.

For example, a caller from Bozeman, Montana could call 1-800-MEDICARE and discuss specific Medigap options in Montana. Likewise, a caller from Des Moines, Iowa or Dallas, Texas could call and get options and costs for Medigap or Medicare+Choice alternatives. If requested, the call centers will follow-up by mailing a copy of the information discussed after the call.

- ***Improving Internet Access to Comparative Information*** and providing new decision making support tools on the Agency's excellent website, www.medicare.gov. These enhanced electronic learning tools will allow visitors, including seniors, family members, and caregivers to compare benefits, costs, options, and provider quality information. This expanded information is similar to comparative information already available, such as *Nursing Home Compare* and *ESRD Compare* websites. With these new tools, beneficiaries will be able to narrow down by zip code the Medicare+Choice plan options that are available in their area based on characteristics that are

most important to them, such as out-of-pocket costs, whether beneficiaries can go out of network, and extra benefits. They also will be able to compare the direct out-of-pocket costs between all their health insurance options and get more detailed information on the plans that most appropriately fit their needs. In addition, the Agency will provide similar State-based comparative information on Medigap options and costs.

CREATING A CULTURE OF RESPONSIVENESS

One of my top priorities, as Secretary and I know one of Tom Scully's top priorities, is to improve the CMS's responsiveness. The concerns and interests of beneficiaries and the Agency's provider, plan, State, and Congressional partners clearly deserve greater attention and focus. And we are committed to addressing this head-on and fostering a new culture at CMS. The Agency is:

- ***Eliminating Regulatory Red Tape*** for the plans, providers, and other stakeholders who provide services to Medicare beneficiaries. Far too many of our partners have raised concerns about the extent of the Medicare program's regulatory burden and the cost of doing business with Medicare. I am committed to taking swift action to reduce unnecessary burden and complexity. We need to streamline Medicare's requirements, bring openness

and responsiveness into the process, and ensure that regulatory changes are sensible and predictable.

- ***Establishing Key Contacts for the States*** at the regional and central office level. These staff will work directly with the States to help eliminate Agency obstacles in obtaining answers, feedback, and guidance. Each State will have one Medicaid staff assigned to them in the regions and another in Baltimore, who will be accountable for their specific issues. I have attached a list of these contacts to my testimony.
- ***Creating Primary Contacts*** for beneficiary groups, plans, physicians, providers, and suppliers to strengthen communication and information sharing between stakeholders and the Agency. CMS will designate a senior-level staff member as the principal point-of-contact for each specific provider group, such as hospitals, physicians, nursing homes, and health plans. These designees will work with the industry groups to facilitate information sharing and enhance communication between the Agency and its business partners. The designees will help ensure that industry groups' voices are heard within CMS.
- ***Enhancing Outreach and Education*** to providers, plans, and practitioners by building on the current educational system with a renewed spirit of openness, mutual information sharing, and partnership. The Agency will provide

improved training on new program requirements and payment system changes, increase the number of satellite broadcasts available to industry groups, and make greater use of web-based information and learning systems.

- ***Responding More Rapidly and Appropriately to Congress and External Partners*** by promptly responding to Congressional inquiries. The Agency also is exploring ways to make data, information, and trend analyses more readily available to the Agency's partners and the public in a timely manner. In addition, the Agency will make explicit and widely publicize the requirements for obtaining data and analyses from the Agency, including protecting the confidentiality of the data. I have attached to my testimony a copy of a detailed response to a letter from Representatives Nancy Johnson and Pete Stark, which posed a series of questions I know many of you have asked of Tom Scully and me. I think this response, which was completed within two weeks of Tom's arrival, is indicative of this new culture at the Department and CMS. We are committed to responding promptly to Congressional inquiries.

ADMINISTRATIVE REFORM

CONTRACTING REFORM

Since 1965, when Medicare was created, the government has relied on private health insurance company contractors to process claims and perform related administrative services. Today, CMS relies on 49 contractors to provide these services. In May, I

moved my office to CMS headquarters in Baltimore to get a firsthand look at the employees, operations, and programs administered by CMS. Of the extensive technical briefings I received from the Agency staff that week, none was more eye opening than the briefing on the Agency's fee-for-service contractors. I was stunned at the way these contractor arrangements work – it is one of the worst remnants of Medicare's original 1965 design. I came away from that meeting convinced that we must take bold action to reform the current contracting system and I want to work with this Committee to achieve this important objective.

In order to manage the Medicare program efficiently and effectively, we must change the Centers for Medicare and Medicaid Services' relationship with the Medicare fee-for-service contractors. I firmly believe that this work should be awarded competitively to the best-qualified entities using performance-based service contracts that include appropriate payment methodologies that result in contracts receiving payment when they deliver something of value and profit only when they perform at or above the satisfactory level. We must be able to maximize economies of scale and improve the level of service to our beneficiaries and providers. We would like to work cooperatively with our existing contractors to get to this goal – but the changes will require legislative action.

Today, the fee-for-service contractors are governed by Medicare laws that impose outdated requirements and diverge from general federal acquisition laws in several respects. The Medicare statute restricts the Secretary as to the types of entities that may administer Medicare claims. On the Part A side, providers nominate the entity that

processes their claims. For Part B, the program must use health insurers to process claims. We intend to forward legislation to address these differences and we want to work with this Committee and Congress on a viable, sensible solution.

Through these changes, the CMS hopes to accomplish the following:

- Provide flexibility to CMS and its contractors to better Adapt t changes in the Medicare Program.
- Promote competition, leading to more efficiency and accountability.
- Establish better coordination and communication between CMS, its Contractors and providers.
- Promote CMS' ability to negotiate incentives for Medicare contractors to perform well.

These changes will enhance the Agency's ability to more effectively manage claims processing for the Medicare program in the future and ensure that the future changes to the Medicare program's operating structure are free from unnecessary constraints.

FINANCIAL MANAGEMENT REFORM

On a related topic, CMS currently lacks a dual entry financial management system that fully integrates the Agency's accounting systems with those of its Medicare contractors. Today, many Medicare contractors rely on PC-based spreadsheets and a series of fragmented and overlapping systems to maintain their accounts receivable. Most contractors do not use double entry accounting methods or have claims processing systems with general ledger capabilities. As a result, the accuracy of reported activities

must be verified manually, which increases the risk of administrative and operational errors and misstatements. Despite these difficulties, I am proud that CMS has maintained clean audit opinions in recent years.

A major component of the Department's Chief Financial Officer's (CFO) audit comprehensive plan is to replace these systems with a state-of-the-art, integrated accounting system, which will include our Medicare contractors' activities and ensure the Medicare Trust Funds and the Agency's financial operations are protected from needless waste and errors.

CONCLUSION

I want to assure you that Tom Scully and I are committed to working with this Committee and Congress on a bipartisan basis to strengthen the programs administered by the CMS. We already have taken the first steps towards improving CMS's management and changing the culture and attitude of the Agency. We are committed to strengthening beneficiary understanding of the Agency's programs, enhancing education and outreach to the Agency's provider and State partners, and reforming fee-for-service contracting so that the Agency's programs are prepared for the future. Thank you again for the opportunity to be here today. I appreciate your interest and commitment and I am happy to answer any questions.

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