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

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

**BACKGROUND**

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

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

## IMPROVING AGENCY RESPONSIVENESS

As I mentioned, we are taking aggressive steps to bring a culture of responsiveness to CMS. This culture, this spirit, is rooted in a commitment to compassion and responsibility to beneficiaries and the physicians and providers who serve them. We intend to reinvigorate the entire Agency with a spirit of responsiveness to our constituents - to you, members of Congress; to our colleagues in government here in Washington, and throughout the nation; and to the men, women, and children our programs protect. To promote responsiveness, the Agency is:

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

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

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

• ***Responding More Rapidly and Appropriately to Congress and External Partners*** by promptly responding to their inquiries. We are developing an intra-Agency correspondence routing system, and timeliness standards, to respond more efficiently and promptly to congressional inquiries. We also are also exploring ways to make data, information, and trend analyses, more readily available to our partners and the public in a timely manner. In addition, CMS will make explicit, and widely publicize, the requirements for obtaining data and analyses from us, including protecting the confidentiality of the data.

## REGULATORY REFORM

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

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

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

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

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

In no way will we diminish our interest in fighting waste, fraud and error in the Medicare program. Most

physicians, and other providers, are honest and want only to be fairly reimbursed for the high-quality care they provide; but for the small percentage of people who take advantage of the system, we will continue our aggressive efforts to protect the funds that taxpayers have entrusted to our use.

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

**STREAMLINING THE REGULATORY PROCESS**

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

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

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

**IMPROVING PHYSICIAN AND PROVIDER EDUCATION**

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

We recognize that the decentralized nature of this system has, in the past, led to inconsistency in the contractors' communications with physicians and providers, and we have recently taken a number of steps to improve the educational process. For example, we have centralized our educational efforts in our Division of Provider Education and Training, whose primary purpose is to educate and train the contractors and the provider community regarding Medicare policies. We are also providing contractors with in-person instruction and a standardized training manual for them to use in educating physicians and other providers. These programs provide consistency and ensure that our contractors speak with one voice on national issues. For example, in coordination with the Blue Cross/Blue Shield Association, we developed train-the-trainer sessions for implementing both the Hospital Outpatient and Home Health Prospective Payment System regulations, which included a satellite broadcast that was rebroadcast several times prior to the effective date of the regulation. Following these sessions, we held weekly conference calls with regional offices and fiscal intermediaries to enable us to monitor progress in implementing these changes. We are continuing to refine our training on an on-going basis by monitoring the training sessions conducted by our contractors, and we will continue to work collaboratively to find new ways of communicating with and getting feedback from physicians and providers.

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

· ***Expanding our Medicare provider education website.*** We provide a variety of resources online at the Medicare Learning Network homepage, www.hcfa.gov/MedLearn. MedLearn provides timely, accurate, and relevant information about Medicare coverage and payment policies, and serves as an efficient, convenient provider education tool. The MedLearn website averages over 100,000 hits per month, with the Reference Guides, Frequently Asked Questions and Computer-Based Training pages having the greatest activity. I would encourage you to take a look at the website and share this resource with your physician and provider constituents. We want to hear feedback from them on its usefulness so we can strengthen its value.

· ***Providing free computer and web-based training courses.*** Doctors, providers, practice staff, and other interested individuals can access a growing number of web-based training courses designed to improve their understanding of Medicare. Some courses focus on important administrative and coding issues, such as how to check-in new Medicare patients or correctly complete Medicare claims forms, while others explain Medicare's coverage for home health care, women's health services, and other benefits.

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

implemented, we will move to organize similar web navigation tools for other Medicare providers.

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

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

· ***Developing Call Center Profiles***. Earlier this year, we visited eight of our largest Medicare contractors to collect information on their operations, their use of technology, their performance data, their most frequently asked provider questions, and their training needs. We are now collecting similar information from all of the remaining Medicare call centers via an online profile. The profiles will be completed by early August, and we will analyze them to identify additional training needs and other improvements we can make at our contractors.

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

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

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

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

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

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

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

**IMPROVING AND EXPANDING BENEFICIARY EDUCATION**

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

With that goal in mind and in an effort to ensure that Medicare beneficiaries are active and informed participants in their health care decisions, we will expand and improve the existing *Medicare & You* educational efforts with a new advertising campaign. We will launch a multimedia campaign using television, print, and other media, to reach out and share information and educational resources to all Americans who rely on Medicare, their families, and their caregivers. We are also:

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

· ***Improving Internet Access to Comparative Information*** and providing a new decision making tool on the Agency's award winning website, **www.medicare.gov**. These enhanced electronic learning tools will allow visitors, including seniors, family members, and caregivers, to compare benefits, costs, options,

and provider quality information. This expanded information is similar to comparative information already available, such as *Nursing Home Compare* and *ESRD Compare* websites. With these new tools, beneficiaries will be able to narrow down by zip code the Medicare+Choice plan options that are available in their area based on characteristics that are most important to them, such as out-of-pocket costs, whether beneficiaries can go out of network, and extra benefits. They also will be able to compare the direct out-of-pocket costs between all their health insurance options and get more detailed information on the plans that most appropriately fit their needs. In addition, the Agency will provide similar State-based comparative information on Medigap options and costs.

**CONCLUSION**

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