AGENCY OVERSIGHT HEARING ON HHS: THE MISSION OF HHS

HEARINGS

BEFORE THE

SUBCOMMITTEE ON HUMAN RESOURCES AND INTERGOVERNMENTAL RELATIONS

OF THE

COMMITTEE ON GOVERNMENT REFORM AND OVERSIGHT HOUSE OF REPRESENTATIVES

ONE HUNDRED FOURTH CONGRESS

FIRST SESSION

MARCH 1 AND 22, 1995

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AGENCY OVERSIGHT HEARING ON HHS: THE MISSION OF HHS

WEDNESDAY, MARCH 1, 1995

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HUMAN RESOURCES AND
INTERGOVERNMENTAL RELATIONS,
COMMITTEE ON GOVERNMENT REFORM AND OVERSIGHT,
Washington, DC.

The committee met, pursuant to notice, at 10:04 a.m., in room 2247, Rayburn House Office Building, Hon. Christopher Shays (chairman of the subcommittee) presiding.

Members present: Representatives Shays, Souder, Chrysler, Martini, Sanford, Towns, Lantos, Barrett, Green, and Fattah.

Staff present: Lawrence Halloran, staff director and counsel; Doris Jacobs, associate counsel; Kate Hickey, professional staff; Robert Newman, professional staff; Thomas Costa, clerk; Cheryl Phelps, minority professional staff; and Elisabeth Campbell, minority clerk.

Mr. SHAYS. I would like to call this hearing to order and to welcome our very distinguished Secretary of HHS and our Deputy Secretary Walter Broadnax—nice to have you here as well—and say I feel it is a very special time to have you. You are a distinguished public servant. Our paths crossed in 1975 when you were hired by the Finance Committee of the Connecticut General Assembly to redo how we finance public education, and we are still using the system that you helped us devise in 1975, and I think we have been blessed by that system.

So, Madam Secretary, I welcome you, and, as we do with all witnesses who appear before us, we will swear both of you in, but I view this as a very informal discussion about what the Department is doing, where you have your challenges, where you have your successes, and how we can be helpful in making this a more successful government. But if you will both rise I will swear you in.

[Witnesses sworn.]

Mr. SHAYS. Just to reiterate, the hearing is to discuss the challenges that are before HHS, areas of success, areas where you feel you need to do a better job; also if we could touch on—and I think your statement does that—how the Department might look to change and be better organized. I know you have an ongoing process in that way.

So I would welcome you to this hearing, and I would just say that any statement that you have or your Deputy Secretary or any of the Members have will be included in the record. I would ask unanimous consent that that would be the case, and I will call on

the ranking member and also welcome the former chairman of a committee that I served on that included some of our jurisdiction.

It is wonderful to have you here, Mr. Lantos, as well.

[The prepared statement of Hon. Christopher Shays follows:]

PREPARED STATEMENT OF HON. CHRISTOPHER SHAYS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CONNECTICUT

This oversight hearing by the Subcommittee on Human Resources and Intergovernmental Relations on the Department of Health and Human Services is its first hearing with this agency in the 104th Congress and we are pleased to have as our first witness the Secretary of the Department, Donna E. Shalala. Today we start our oversight process by discussing the mission of HHS in order to begin to identify major opportunities for cost savings, improved efficiency, and reform.

The HHS budget request for FY96 is $716 billion, a 7.5% increase or approximately $55 billion over the FY95 budget. Their budget request includes $37 billion for discretionary programs, an increase of 4% or $1.5 billion. While HHS has made progress by consolidating some activities, reducing funding for selected programs, and reducing the rate of growth in health-related entitlements, we hope that much more can be done.

HHS is a vast, complex organization and this Subcommittee will be spending a great deal of time examining its management systems and controls as well as its plans, programs and problems. In future hearings we will seek the views, criticisms and recommendations of a variety of organizations and individuals such as the General Accounting Office, Congressional Budget Office, Inspectors General and others from the public and private sectors who are familiar with HHS.

As we conduct all hearings, our position continues to be that we want to know what the departments and agencies under our jurisdiction are doing right in addition to what they might be doing wrong.

We look forward to the Secretary's testimony and very much appreciate her time and views to assist us as we begin our deliberations on HHS. Her testimony will be valuable in helping the Subcommittee meet its oversight and reform responsibilities.

Mr. SHAYS. Mr. Towns.

Mr. TOWNS. Thank you very much, Mr. Chairman, first for holding this hearing.

Let me say that I have tremendous respect for the chairman to the point where, if they asked me to pick somebody in the Republican Party that is a member to rank under, I am certain that I would select you, there is no question about it, because of my admiration, because of my respect for you.

But I must say that I am concerned about the fact that, as we meet, as we talk, and as we discuss, at the same time there seems to be a bigger agenda, a higher agenda by the leadership, wherein we had the Secretary of HUD in, and I thought we had an excellent discussion, and I felt there were some things there that we could begin to work with and to do to be able to strengthen HUD and, at the same time, provide the kind of services that need to be provided, but the next day I read in the paper that HUD was being cut $7 billion. So it comes to mind, what are we really talking about? Are we going to be serious about this? And I hope we are because this is a very serious kind of matter that we are dealing with, and inasmuch as I have great respect for the Secretary and I know her commitment and dedication, but Houdini can't do but so much without having the kind of resources to be able to meet the needs of people out there, and, as you know, the needs are really great. So I am sort of wondering in terms of how this is going to really play out over the next few weeks.

We will have before us, I know, other Secretaries who operate agencies which come under our jurisdiction. How can we, on the

one hand, ask them to define and defend their mission and operations and programs, activities, and give us their reinvention plans while, on the other hand, we plot to raid their agencies without any warning whatsoever, let alone consultation? Maybe it is our mission that needs to probably go under review. Maybe that is what we need to do.

I know you are on the Budget Committee. Maybe you can at some point shed some light on some of this, and I know your commitment, and I know your dedication. I don't question it one iota. I know of your concern about providing quality care, and I would never question that because I know in terms of many discussions that I have had with you, but I must say to you that I am troubled over the fact of how we are dealing with this issue, these many issues, not only in terms of this particular agency but other agencies.

So here again, as much as I am very excited about the format and I think that you are on the right track, but I am not sure whether or not there is a bigger agenda that makes what we are doing almost irrelevant.

I yield back.

[The prepared statement of Hon. Edolphus Towns follows:]

PREPARED STATEMENT OF HON. EDOLPHUS TOWNS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK

Mr. Chairman, I commend your leadership in convening this hearing and what I understand will be subsequent meetings regarding the Department of Health and Human Services and its future operations. You have worked hard to create a constructive and bipartisan atmosphere for us to consider this important issue; as you did during the past two HUD hearings, and as we can surely expect for later hearings.

However, I am deeply concerned that these hearings may be, for all intents and purposes, fundamentally immaterial. That in light of the "Contract With America" and the underlying goals set out by the Republican leadership, the future of these agencies is a foregone conclusion.

How can we have a HUD hearing with Secretary Cisneros one day—a hearing with the GAO and HUD IG a week later—and then sit back and watch as HUD's current budget is slashed by $7 billion the very next day?

And while I find it very hard to believe that this legislative body can act responsibly within a 24 hour timeframe, I certainly don't believe we can do so retroactively, as we propose to attempt today.

Today we will ask the Secretary of the Department of Health and Human Services to present and defend her 1996 budget and efforts to improve the performance of this critical agency in the face of:

- A rescissions bill that guts existing and operational HHS programs;
- A welfare reform bill that undermines work requirements already set out in current law and punishes children for mistakes their parents make; and
- A child welfare bill that repeals the provision in the child care and development block grant that provides resources for early childhood, before-school and after-school programs, and deprives poor children of possibly the one nutritious meal they might eat in a day.

If, as it certainly appears, this Congress has opted to legislate through the appropriations process, then the oversight activities of this committee are a moot point.

Over the next two weeks, we will have before us three other cabinet officials whose agency operations fall within our jurisdiction. How can we, on the one hand, ask them to define and defend their mission, operations, program activities, and reinvention plans, while on the other hand, we plot to raid their agencies without warning, let alone consultation? Maybe it's our mission that needs to undergo a review.

Mr. Chairman, like you, I take my committee responsibilities very seriously and therefore welcome today's hearing as an important first opportunity to consider the administrations's strategy for restructuring and revitalizing HHS.

Madame Secretary, I appreciate your hard work and look forward to your views on the future of your agency and the population you serve, both as you have

planned, and possibly as a casualty of some more draconian agenda. And, although I am anxious to learn in the fullest detail of your agency's reinvention strategy, I understand that you may be precluded from sharing aspects with us that have not yet been formally presented to the Vice President.

Mr. Chairman, I would urge that we leave the record open to allow the Secretary to submit additional testimony regarding Phase II of the Department's reinvention initative when it becomes available later this month.

Mr. SHAYS. Thank you. I thank the gentleman.

Representative Lantos, would you have a statement?

Mr. LANTOS. I don't have a statement, Mr. Chairman, but I would like to make a couple of very brief remarks.

First, let me say that I want to congratulate you for assuming the chairmanship of this very important subcommittee. There is no Member of the Republican Party for whom I have more respect than you, and there is no Member for whom I have a greater degree of personal friendship than I feel toward you. I know you will discharge your responsibility with fairness and an enormous degree of conscientiousness and distinction.

I am equally pleased to have my good friend, Representative Towns, as the ranking member who will do equally well.

I just want to say a word about our distinguished witness who has brought to government a degree of intelligence and compassion and understanding and a commitment to public service that we are all immensely proud of.

I do find the whole thrust of what we are doing in this field nothing short of nauseating. The New York Times ran a chart last Sunday, which I hope all of you saw, that demonstrates that, of all the western industrial powers, our tax burden is by far and dramatically the lowest. This chart I would like to ask be part of this record because what this chart shows is the attempt at brain washing that is permeating this country.

[The information referred to follows:]

WESTERN EUROPE'S TAX BURDEN

TAXES IN WESTERN EUROPE ARE HIGH . . .

Government Tax Revenues as a Percent of Gross Domestic Product in 1994

Country	Percentage
Denmark	58.6
Sweden	56.2
Norway	55.2
Finland	54.0
Netherlands	51.2
Belgium	50.0
France	49.6
Austria	48.0
Italy	46.3
Germany	46.1
Spain	39.5
Britain	36.4
United States	31.6
Western Europe	45.5

Source: Organization for Economic Cooperation and Development.

. . . AND MANY COUNTRIES PLAN NEW TAXES IN 1995

Britain—4 percent rise in excise on alcohol. Small rise in gasoline and diesel taxes.

Germany—7.5 percent income tax surcharge for rebuilding of East Germany. Doubling of wealth tax to 1 percent. 25 percent jump in tax on insurance policies. 1 percent tax to pay for elderly care.

France—Increase on gasoline taxes push prices up 5 percent. New taxes expected later in the year to combat big budget deficit.

Italy—Large tax increase expected later in year to reduce growing budget deficit.

Spain—Value added tax jumps to 16 percent, from 15 percent. 2.5 percent rise in transporation taxes. 3.5 percent increase in alcohol taxes. Gasoline, electricity, tobacco and mail taxes all increase.

Sweden—Top tax bracket rises to 56 percent, from 51 percent. 2 percent payroll tax to pay for pension and health insurance. V.A.T. increases for postage and restaurants.

Switzerland—6.5 percent V.A.T. on wide range of goods introduced, replacing narrower 6.3 percent sales tax.

Mr. LANTOS. The message that you get is that the long suffering, ultra-rich need relief. And Herblock's cartoon in this morning's paper showing children and women going first as they are pushed off the gangplank into the turbulent waters of life adequately summarizes what we are doing.

The problem with this country is not that the poor are getting too much money, the problem in this country is not that too many people are being inoculated or too many pregnant women are getting some help, the problem in this country certainly lies elsewhere. It lies in the 1980's, during the course of which mind boggling fortunes were made not by production but by the shuffling of papers and the development of a mentality of greed and selfishness and a total disregard for the common weal.

When I came to this country, Mr. Chairman, in 1947 as a penniless immigrant on an academic scholarship, the single thing that impressed me most was that this society was moving increasingly toward less and less class division and the doors of opportunity were gradually being opened wider and wider, which enabled a penniless immigrant from Central Europe to get an education, build a family, and, near the end of his career, begin public service in the Congress of the United States.

I see all the trends running in the opposite direction, and as one who is as passionately patriotic as only people who are Americans by choice typically are, I cry for this trend. Everything which we have built over decades is in the process of being destroyed on the phony grounds that there have been excesses, as there obviously have been, inefficiencies, bureaucratic mistakes, you name it. I wonder whether General Motors or General Electric or IBM or any of the other giants are flawless in their activities. They don't seem to be.

One of the largest British banks just in the last 2 days went bankrupt. It went bankrupt. A paragon of private enterprise, because of its failure of adequate oversight, has now found itself facing almost a billion-dollar loss because of the activities of a single individual. We crucify the CIA when, among its tens of thousands of operatives, you find a skunk. We destroy agencies where an occasional individual makes a mistake as if all of us would be that perfect.

I don't need to remind the chair that whatever problems we have are surely bipartisan. The indictment against James Watt, former

Secretary of the Interior, and an indictment that you and I worked so hard on in our investigation, just came down. So I think the self-righteous and arrogant conceit that permeates so many of our new colleagues is nothing short of nauseating, as if they had discovered virtue in government and are now determined to inculcate it into the rest of us.

Let me also say, Mr. Chairman, in conclusion, that I want to pay tribute to you personally and to another colleague who is no longer with us, Congressman Dick Swett of New Hampshire, who are coauthors of the Congressional Accountability Act which passed this body by a vote of 427–4 last August, and it was Republican shenanigans in the Senate that prevented it from becoming law in the 103d session.

I find it amusing but also disgusting that every time I hear the recitation of the great achievements of the 104th Congress the only Act that anybody can point to, because it is the only piece of legislation that passed, is the Congressional Accountability Act, which was the product of a bipartisan effort led by you and Congressman Swett, and it is now the piece de resistance of those who are trying to wreck everything that we built in this society.

I was on a television program——

Mr. SHAYS. If you could just try to wrap it up.

Mr. LANTOS. I will wrap it up.

I was on a television program sponsored by the chamber of commerce the other day, and one of the freshmen very proudly claimed credit for this new era which was able to pass this legislation. He didn't have a clue that we did this last time and we did it on a bipartisan basis.

So I hope as we listen to the Secretary and deal with these issues we return to a balanced and bipartisan approach and finally get beyond this shrill, phony crusade which has discovered virtue and efficiency in the last few weeks.

I thank the chair.

Mr. SHAYS. I thank the gentleman for his comments, and before calling on the Secretary, I would say for the record that this is a committee that oversees waste, fraud, and abuse in the Departments of HUD, HHS, Labor, Education, and Veterans' Affairs, and also has the responsibility for all reorganization as well.

Our job is not to create programs but to look at programs to make sure that they are being run well. We have responsibility for all reorganization. We also have responsibility for intergovernmental relations, the whole concept of federalism, and one of the things we will be focused on is a dollar appropriated, how much does it really mean, how much actually gets down to the person on the street.

There are other comments that both my colleagues feel very strongly about that I would be happy to address. I certainly think that the Senate showed bipartisan cooperation in killing the congressional accountability bill last year. So as it passed by bipartisan support, it also died with it as well, and I would say to the Secretary that this is intended to be your opportunity to present your feelings and convictions about your Department, and we don't think that it is going to be required that we will have to ask you to come before the committee again. You are opening it up, and

then we intend to call on your Assistant Secretaries and other people who ably serve the Department. So we know that this is, I think, the eighth committee you have spoken to since the start of the year and appreciate you being here and happy to see a smile on your face.

STATEMENT OF DONNA SHALALA, SECRETARY, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, ACCOMPANIED BY WALTER BROADNAX, DEPUTY SECRETARY

Ms. SHALALA. Thank you very much, Mr. Chairman.

I am very pleased to be here. I have not testified before this committee before. It is my eighth testimony in 2 months. I think that was the total of my testimony for all of last year actually. It is very nice to see you again.

I should point out I was hired by the Republicans in the State legislature in Connecticut early in my academic career to go with my graduate students and work on a very important school finance issue.

I am also pleased to be here with my colleague, Walter Broadnax. He and I have never testified at the same time, so this will be fun for us.

Let me race through my testimony just to give you some feel for what I have in my text.

Mr. SHAYS. No, you do not need to race through it. Feel free to give it any way you would like, and we will get you out of here before 12.

Ms. SHALALA. All right.

Let me say that we look forward to working with the committee. My Assistant Secretaries are available to come before you. We will be talking to you about some reorganization as we work through REGO II with the Vice President, and I think you will receive most of those proposals very favorably.

We believe that government must focus on the everyday needs of the American people. We believe that local communities have to participate in identifying their problems and should play a guiding role in solving them. We believe that some jobs now done by the Federal Government should be turned back to the States. But we also believe that some issues cross State boundaries and require leadership at the Federal level.

By its very definition, the mission of the Department of Health and Human Services promotes the health and the well-being of every single American. Our mission includes everything from ground-breaking research at the National Institutes of Health, to ensuring the safety of Americas' food and drugs, to providing a Head Start for our children, to enhancing the Medicare program for America's seniors. These are crucial duties, Mr. Chairman, and they demand world-class performance. That is our responsibility to the American people. We must be tough, we must be disciplined, and we must be responsive to the American public. We must learn to do more with less.

Before I continue though, I would like to talk for a few minutes about the impact on the Department of the rescissions bill that the Labor-HHS Appropriations Subcommittee reported out last week. I am here today to discuss with you how to make the Department

more efficient and effective, and I see this process continuing as a thoughtful dialog between the Department and Congress.

Unfortunately, the rescissions package is a step in the opposite direction. It is not a thoughtful approach to making government more efficient. In fact, I believe the appropriators wielded a hatchet, hitting the most vulnerable Americans. One example of this is the historic toll-free 24-hour domestic violence hotline to offer advice and, most importantly, referrals to battered women and their children. It was a central part of last year's crime bill. It was the part of the prevention proposals in the crime bill that had bipartisan support. It was funded at just $1 million under last year's crime bill, and was eliminated in the rescissions bill. I believe that this cut is a giant step backward in the fight against domestic violence.

The rescissions bill also cuts the Ryan White Program by $13 million, which represents about 25 percent of the funding increase from 1994 to 1995. This program provides crucial services to people with AIDS or who are HIV positive, including a special demonstration program for pediatric patients. AIDS is now the leading cause of death for all Americans between the ages of 25 and 44, and every dollar of funding for this program is vital.

Mr. Chairman, I realize that we all have tough choices to make, but these choices have to be made in a coordinated and thoughtful manner to protect all Americans, particularly children. We are ready to do our part. The Reinventing Government Initiative led by Vice President Al Gore is part of our effort to make government more responsive, more efficient, and effective.

We are just now beginning the second phase of reinventing government. We are reexamining everything we do with a view toward answering the fundamental questions that the President asked every Department and agency to address. First: Are our programs or functions critical to the agency's mission and based on customer input? Second: Can the program or the function be done as well or better at the State or local level? Third: Is there a way to cut cost or improve performance by introducing competition? And fourth: Can the program be improved by putting customers first, cutting red tape, and empowering employees?

I have directed my senior staff to develop an aggressive plan to address these questions. We are working collaboratively with the administration's National Performance Review team which includes representatives from OMB and the Domestic Policy Council.

Led by the Deputy Secretary, a number of our senior staff have worked around the clock to ensure that each of our Reinventing Government II proposals not only achieve substantial gains in effectiveness and efficiency but also serve our customers better. These proposals will be presented to the Vice President later this month. Although we have not reached the end of the second phase, I can talk about our successes on our ongoing initiatives and the challenges we see ahead.

First, we have accomplished a great deal in reducing the size of the Department. Every Department and agency was required to develop a streamlining plan to achieve its share of the Government-wide reduction of 272,000 full-time employees by 1999. Our plan

will realize our target by reducing our work force by more than 12,000 employees.

Legislation passed last year removes the Social Security Administration from the Department and establishes it as an independent agency in the executive branch effective March 31 of this year. I am very pleased with the leadership of my senior officials, especially Social Security Commissioner Shirley Chater, who have worked effectively to create what history will record as a resounding success. The GAO agrees with this assessment.

At the same time we are streamlining our operations, we are also taking on major new national initiatives and strengthening existing programs. For example, we are improving the Head Start Program. With bipartisan support, last year we passed the most comprehensive Head Start agenda in history. We worked hard to improve the quality of services at Head Start centers, and now over 90 percent of Head Start grantees meet our quality performance standards. We have given grantees more flexibility to respond to local needs, and we have made the program more responsive to the special needs of working families.

We have made big gains in breast cancer research and prevention and treatment, including landmark implementation of the National Action Plan on Breast Cancer. We recently learned that from 1989 to 1992, breast cancer mortality rates declined 5 percent among all women and by 18 percent since 1987 among women in their thirties. Breast cancer screening rates are at their highest rates in history due in part to increased funding for the CDC National Breast and Cervical Cancer Program and the National Cancer Institute's education and outreach efforts. One reason for these accomplishments is that we are committed to thinking about all of our programs and services from our customers' perspective.

Let me tell you about just a few of the strong measures that we have taken to put the American people first. We are attacking waste, fraud, and abuse. In 1994 our inspector general helped recover and save $5.4 billion in Medicare and Medicaid, and across the entire Department we recovered and saved more than $8 billion. That is the largest amount ever saved by the Department in 1 year.

We are also working to promote efficiency and consolidate services and doing more with less. We believe firmly in the concept of performance partnerships with the States. In the President's 1996 budget proposal we consolidated 108 Public Health Service activities in 16 performance partnerships to give States and other grantees increased flexibility in exchange for increased accountability for results.

We are working on innovative approaches for getting our work done faster, smarter, and better. One example of that is the Health Care Financing Administration's overhauling of its claims processing system for Medicare. When it becomes operational beginning in 1997, the Medicare Transaction System should enable us to answer beneficiary questions more quickly and accurately. We will also reduce regional inconsistencies in the acceptance and denial of claims. Once this project is completed, we will provide more effective service and we will cut administrative costs.

We are working to change the way Medicare and Medicaid work to improve quality and promote efficiency, to lower costs, and to give the American people more health choices. More and more States are taking advantage of new opportunities to offer managed care programs under Medicaid, and more and more health plans and individuals are choosing the managed care option under Medicare.

Last year Medicaid had a 63 percent increase in the number of Americans enrolled in managed care plans. We moved from 4.8 million people in 1993 to 7.8 million in 1994. The number of seniors choosing managed care through the Medicare program grew by 16 percent, from about 2.7 million people in 1993 to more than 3.1 million in 1994, and we expect this rate of growth to continue.

Viewing the Department's activities from the customer's perspective has been fundamental in planning the White House Conference on Aging. In preparation for this event, we asked seniors and others from across the country to contribute ideas about the major themes for the conference. We intend to use the White House conference to develop the network of public and private partnerships necessary to drive aging policy as we prepare for the 21st century.

We are also demanding more leadership and creative thinking from our employees. At HHS we have established a continuous improvement program that involves the entire Department in the process of change.

Mr. Chairman, now I would like to say some things about the challenges before us. One is to respond to the charge given us by the President in the second phase of Reinventing Government to rethink all we do at HHS. That is an enormous task, but it is also easier in some ways than the other challenge I see ahead because it is fairly well defined.

In my view, the more formidable challenge is to create a culture of continuous improvement in government, and not just in the Federal Government. The essence of that change is to move government away from the traditional bureaucratic mode of operation; that is, working from the top down to manage the activities of field staff and other levels of government and the public as well. Rather, government must operate in a manner that fits with the information age. It must work from the bottom up through staff who deal with customers and who understand what they want. It must listen and respond rather than direct and control. We must work in partnership with other levels of government, especially the States, the private sector, and local communities, to help communities meet their own needs. We do no not have any choice on whether or not we will move in this direction, Mr. Chairman.

As Vice President Gore said when he spoke to Government executives a few weeks ago about the Reinventing Government Initiative, "If America is to regain trust in her government, America's government must reinvent itself based on trust. That is what the government of the future is all about, trust and opportunity."

I appreciate being asked to appear before you today, and I will be happy to answer any questions you may have.

[The prepared statement of Ms. Shalala follows:]

PREPARED STATEMENT OF DONNA E. SHALALA, SECRETARY, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Good morning, Mr. Chairman, members of the subcommittee: I am very pleased to be here, Mr. Chairman, and participate in your subcommittee's effort to make government more effective and efficient.

We believe that one of the keys is working together—and we look forward to doing just that with you and your colleagues on the Committee.

We believe that government must focus on the everyday needs of the American People.

We believe that local communities must participate in identifying their problems and should play a guiding role in solving them.

We believe that some jobs now done by the Federal government should be turned back to the states.

But we also believe some issues cross state boundaries and require leadership at the federal level.

By its very definition, the mission of the Department of Health and Human Services promotes the health and well-being of every single American.

Our mission includes everything from ground-breaking research at NIH, to assuring the safety of Americans' food and drugs, to providing a Head Start for our children, to enhancing the Medicare program for America's seniors.

These are crucial duties, Mr. Chairman, and they demand world-class performance. That is our responsibility to the American people.

We must be tough, disciplined and responsive to the American public. We must learn to do more with less.

Before I continue, Mr. Chairman, I would like to talk for a few moments about the impact on HHS of the rescissions bill that the Labor-HHS Appropriations Subcommittee reported out last week. I am here today to discuss with you how to make the Department more efficient and effective, and I see this process continuing as a thoughtful dialogue between the Department and the Congress.

Unfortunately, the rescissions package is a step in the opposite direction. This is not a thoughtful approach to making the government more efficient; in fact, I believe the appropriators wielded a hatchet, hitting the most vulnerable Americans.

An example of this is the historic toll-free, 24-hour domestic violence hotline to offer advice and referrals to battered women and their children. It was funded at just 1 million dollars under last year's crime bill—and eliminated by the rescissions bill. This cut is a giant step backward in the fight against domestic violence.

Mr. Chairman, I realize that we all have tough choices to make. But these choices have to be made in a coordinated and thoughtful manner to protect all Americans, especially children.

We are at the ready to do our part. The Reinventing Government initiative, led by Vice President Al Gore, is part of our effort to make government more responsive, efficient and effective. We are just now beginning the second phase of Reinventing Government.

We are reexamining everything we do with a view toward answering the fundamental questions that President Clinton and Vice President Gore asked every Department and agency to address:

Are our programs or functions critical to the agency's mission based on "customer" input?

Can the program or function be done as well or better at the State or local level?

Is there a way to cut cost or improve performance by introducing competition?

Can the program be improved by putting customers first, cutting red tape and empowering employees?

I have directed my senior staff to develop an aggressive plan to address these questions. We are working collaboratively with the Administration's National Performance Review team, which includes representatives from OMB and the Domestic Policy Council.

A number of our senior staff have worked around the clock to ensure that each of our Reinventing Government II proposals not only achieves substantial gains in effectiveness and efficiency, but also serves our customers better. These proposals will be presented to Vice President Gore later this month.

Although we have not reached the end of the second phase, I can talk about our successes, our on-going initiatives, and the challenges we see ahead.

First, we have accomplished a great deal in reducing the size of the Department.

Every Department and agency was required to develop a streamlining plan to achieve its share of the government-wide reduction of 272,000 full-time employees

by 1999. Our plan will realize our target by reducing our workforce by more than 12,000 employees.

Legislation passed last year removes the Social Security Administration from the Department and establishes it as an independent agency in the Executive Branch, effective March 31 of this year.

I am very pleased with the leadership of my senior officials—especially Social Security Commissioner Shirley Chater—who have worked effectively to create what history will record as a resounding success. The GAO agrees with this assessment.

At the same time that we are streamlining our operations, we are also taking on major new national initiatives and strengthening existing programs.

For example, we're improving the Head Start program. With bipartisan support, last year we passed the most comprehensive Head Start agenda in history.

We've worked hard to improve the quality of services at Head Start centers, and now over 90 percent of Head Start grantees meet our quality performance standards. We've given grantees more flexibility to respond to local needs. And we have made the program more responsive to the special needs of working families.

We have made big gains in breast cancer research, prevention, and treatment—including the landmark implementation of the National Action Plan on Breast Cancer.

And recently, we learned that, from 1989 to 1992, breast cancer mortality rates declined 5 percent among all women—and by 18 percent since 1987 among women in their thirties.

Breast cancer screening rates are at their highest levels in history, due, in part, to increased funding for the CDC National Breast and Cervical Cancer Program and the National Cancer Institute's education and outreach efforts.

One reason for these accomplishments is that we are committed to thinking about all of our programs and services from our customers' perspective.

Let me tell you about just a few of the strong measures that we have taken to put the American people first:

We are attacking waste, fraud, and abuse. In 1994, our Inspector General helped recover and save 5.4 billion dollars in Medicare and Medicaid. And, across the entire Department, we recovered and saved more than 8 billion dollars—that's the largest amount ever by HHS in one year!

We are also working to promote efficiency and consolidate services, and doing more with less.

We believe firmly in the concept of "performance partnerships" with the States. In the President's 1996 budget proposal, we consolidated 108 Public Health Service activities in 16 Performance Partnerships to give states and other grantees increased flexibility in exchange for increased accountability for results.

We are working on innovative approaches for getting our work done faster, smarter, and better. One example of that is the Health Care Financing Administration's overhauling of its claims processing system for Medicare.

When it becomes operational beginning in 1997, the Medicare Transaction System should enable us to answer beneficiary questions more quickly and accurately, and will reduce regional inconsistencies in the acceptance and denial of claims.

Once this project is completed, we will provide more effective service—and we will cut administrative costs.

We are working to change the way Medicare and Medicaid work, to improve quality, promote efficiency, lower costs, and give the American people more health choices.

More and more states are taking advantage of new opportunities to offer managed care programs under Medicaid. And, more and more health plans and individuals are choosing the managed care option under Medicare.

Last year, Medicaid had a 63 percent increase in the number of Americans enrolled in managed care plans—from 4.8 million in 1993 to 7.8 million in 1994.

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Viewing the Department's activities from the customer's perspective has been fundamental in planning the White House Conference on Aging. In preparation for this event, we asked seniors and others from across the country to contribute idea about the major themes for the conference.

We intend to use the conference to develop the network of public and private partnerships necessary to drive aging policy as we prepare for the 21st century.

We are also demanding more leadership and creative thinking from our employees. At HHS, we established a Continuous Improvement Program that involves the entire Department in the process of change.

Mr. Chairman, I would now like to speak about the challenges before us.

One is to respond to the charge given us by President Clinton and Vice President Gore in the second phase of the Reinventing Government initiative to re-think all that we do in HHS.

That is an enormous task—but it is also easier in some ways than the other challenge I see ahead, because it is fairly well-defined.

In my view, the more formidable challenge is to create a culture of continuous improvement in government—and not just the Federal government.

The essence of that change is to move government away from the traditional, bureaucratic mode of operation—that is, working from the top-down to manage the activities of field staff, other levels of government and the public as well.

Rather, government must operate in a manner that fits with the information-age: It must work from the bottom-up through staff who deal with customers and understand what they want. It must listen and respond rather than direct and control.

We must work in partnership with other levels of government—especially the States, the private sector, and local communities to help communities meet their own needs.

We do not have any choice in whether or not we will move in this direction, Mr. Chairman.

As Vice President Gore said when he spoke to government executives a few weeks ago about the Reinventing Government initiative, "If America is to regain trust in her government, America's government must reinvent itself based on trust. That is what the government of the future is all about: trust and opportunity."

I appreciate being asked to appear before you today, and I will be happy to answer any questions you may have.

EXECUTIVE SUMMARY

A JOURNEY OF CONTINUOUS IMPROVEMENT

In the spring of 1993, after Vice President Gore initiated the National Performance Review (NPR), Secretary Donna E. Shalala established a Continuous Improvement Program (CIP) at the Department of Health and Human Services (HHS). The Secretary stated that "this is not a race, but a start of a continuous journey to improve the services of this Department."

Two events in July of 1993 energized the CIP. In a Town Hall meeting held in the Hubert H. Humphrey building, the Vice President and the Secretary discussed with HHS employees all over the country opportunities for change. Then, Secretary Shalala convened the senior leadership of the Department to define four themes that should drive HHS for future years:

Preventing Problems
Improving Customer Services
Independence through Empowerment
Applying Modern Management Approaches

The CIP involves HHS employees in an ongoing process of creating a more customer-oriented, efficient government. A Steering Committee composed of the Department's senior executives and chaired by the Deputy Secretary provides oversight to the CIP, and an Advisory Group works closely with the many volunteers who participate in work groups.

These work groups are working to implement the recommendations of the NPR. They are identifying opportunities for further change to make HHS operations more cost-effective and meaningful for customers, the American people, and our partners in service delivery.

While just celebrating its first birthday, the CIP has already changed the culture of the Department. Applying the concepts underlying the NPR, the CIP now has many success stories to tell. Change is coming from all directions—from the work groups and teams of the CIP, the staff offices in the Office of the Secretary (OS), the Operating Divisions (OPDIVS), and, most important, from our customer and partnership outreach. This Executive Summary highlights those early successes; the rest of the report provides the details.

THINKING STRATEGICALLY

HHS has been referred to as a confederation of independent affiliates, each with its own cluster of goals, constituencies and methods of attaining support. Quite frankly, that is no way to strategically administer the cabinet agency responsible for meeting the health and well-being of all Americans. In the past, the problem was that strategic integrated planning had never been established successfully as a strategic management tool in HHS. Today, that has changed.

A first-ever department-wide strategic planning process has been designed and is being implemented and integrated with the budget process. The plan is structured around the Secretary's major initiatives as described in her Performance Agreement with the President, her Themes, and her Legacy statement.

In addition, agencies are taking new approaches to their individual strategic plans, building employees and customers into the process, e.g.:

The Health Care Financing Administration (HCFA) presented its first strategic plan in over 17 years to each of 4200 employees. Over 5200 employee comments were used in revising the draft plan.

The Administration on Aging (AoA) is widely distributing its strategic plan to staff and to the Aging Network.

Administration for Children and Families's (ACF) draft vision statement and strategic goals are being reviewed and debated by ACF's entire staff, with the aid of facilitators selected by their interim labor/management partnership council.

DELEGATING AND DELAYERING

In the last year, progress has been made in gaining more authority from central agencies and delegating that and other authorities to managers and employees. Other efforts are eliminating or loosening controls and streamlining processes.

Workgroups coordinated with the General Services Administration (GSA) to receive increased dollar limits on emergency motor vehicle repair for workers in the field. They have successfully worked with the Office of Management and Budget (OMB) to obtain more HHS authority for generic customer surveys.

Senior policy officials in the OS have delegated full authority (received from GSA) for acquisition of federal information processing resources to the OPDIVS. They have also delegated authorities in finance, information resources management (IRM) planning: personnel and workplace decisions (e.g., alternative work schedules).

OPDIVS themselves are passing on authorities received from the OS to their program managers. And they are sharing more of their own authorities. For example, the ACF has issued new administrative and personnel delegations to lower levels of the organization. A draft set of program delegations will move many of ACF's programmatic authorities (e.g., approval of grants awards and state plans) down to those ACF offices who more frequently communicate with the organizations ACF serves.

A major CIP workgroup proposal is now under review by the CIP Steering Committee that would significantly reduce the time needed to produce a regulation. It proposes broader delegation of authorities and early involvement in the development stage by customers and internal/external stakeholders.

The 51 processing sites for personnel and payroll processes for HHS employees will move to 3 hubs.

A special study team, which received guidance from a panel of the National Academy of Public Administration (NAPA), has completed a proposal (now under review) that offers paradigms for headquarters and field functions and for administrative and support services, designed to reduce costs and improve services.

CUTTING PAPERWORK AND CONTROLS

HHS is deeply committed to cutting paperwork and controls. A CIP Workgroup is reviewing all internal controls (approval requirements, detailed guidance or reporting requirements), with a goal of reducing them by 50% by 1996. They are working in partnership with the Office of Inspector General to learn from HHS employees which of these requirements are burdensome or of little value. However, rather than waiting for the final analysis of the workgroup and IG, many organizations are cutting burdens right now:

In the Office of the Secretary, 18 personnel instructions were abolished, and 75% less narrative and fewer schedules are now required for budget justifications.

In the agencies, change is also on-going: for example, the Centers for Disease Control and Prevention (CDC) has terminated 130 unnecessary internal issuances.

ACF has met its goal of reducing internal IRM policies and procedures by 50%.

Timesheets and timecards are now eliminated in some parts of the Department, with full implementation scheduled for all HHS organizations by December, 1995.

The Department's grants policy manual is being replaced with simplified guidance and fewer controls.

Travel management is being automated; and written orders for 120,000 "small purchases" will be replaced with the use of purchase cards or other oral purchasing methods (estimated $5.7 annual savings).

INFORMATION TECHNOLOGY (IT)

Some of the most innovative changes stem from new applications of information technology. Applications of information technology to simplify work processes and service delivery is critical to meeting the NPR challenge to "work better and cost less." It is also key to communicating better among ourselves and with our partners and customers.

An ACF, SSA and Department of Agriculture task force is working with states in the southeast to deliver benefits (AFDC, food stamps and social security payments) electronically by 1996. This effort serves as the prototype for the nationwide Electronic Benefits Transfer (EBT) program.

HHS is riding the information superhighway. The Department's new home page on Internet is http://www.os.dhhs.gov. Now employees, partners, and the public can electronically access a wide range of information about HHS and its programs (e.g., evaluation, study abstracts, medical research information, and grant and program information).

OPDIVS are employing information technology to improve operations and services: HCFA's new Medicare Transaction System will process more than one billion claims a year, totally overhauling the process for paying health care providers and bringing with it a new era of customer service. The Indian Health Services (IHS) is increasing third party collections from Medicare, Medicaid and private insurers, using patient business office automated billing.

RESPONDING TO OUR PARTNERS AND CUSTOMERS

In early September, 1994 HHS published customer service standards for the customers we serve directly in Social Security, Medicare and Indian Health programs. In addition, the Secretary established and published standards for how we will work with HHS partners in service delivery. Our goal is to involve the customer and our partners in everything we do, from strategic planning to program and administrative improvements. These are just a few of our achievements:

During HCFA's "Seniors Week" more than 30 senior staff met with older citizens and other beneficiaries in hospitals, nursing homes, senior centers, and counseling programs. HCFA managers are expected to continue this kind of outreach.

SSA held focus groups of a cross-section of beneficiaries and the general public, and mailed 22,000 comment cards to obtain feedback from customers.

Intradepartmental groups are identifying innovative service integration projects at state and local levels.

The Maternal and Child Health Bureau (MCHB) of the Public Health Service (PHS) streamlined its annual grants management cycle (with customer input) and now announces grant competition opportunities three months earlier in the cycle.

A CIP workgroup on customer services is preparing a proposal for how states and communities can apply for a range of distinct discretionary grant programs with one cluster application, moving HHS closer to the Vice President's call for a "seamless" government.

To develop program approaches for a new Head Start initiative, ACF supplemented the work of an Advisory Committee by conducting more than 30 focus groups with a mix of parents, practioners, researchers, advocates and others.

ACF also used focus groups of family support and preservation program directors, practioners and experts in implementing the Family Preservation and Support Services Program.

WORKING COOPERATIVELY

Realizing that the successes to date and expectations for tomorrow depend on the work and innovative thinking of HHS employees, HHS leadership is committed to on-going employee involvement in continuous improvement efforts. Much credit belongs to our employees for the successes and innovations this report highlights:

More than 400 volunteers staff the CIP. They form and serve on workgroups and workteams in addition to performing their normal job duties, and they chose their own leaders. Geography is no barrier to team membership. Employees in the field are electronically linked into group meetings. The ten Regional

Directors and their staffs participate in the weekly Advisory Group meetings through telephone hook-up. Many of the OPDIVS have followed this same model and have their own internal continuous improvement efforts.

SSA is reengineering its disability processing to reduce the time for decisions on initial claims from 155 days to less than 60 and reduce the time to receive an appealed decision from 550 days to about 7 months.

More than 3,500 employees responded to the Secretary's call for ideas for improvement. Those employees who provided an address received an acknowledgement, and all ideas were referred to workgroups and programs for use in formulating change. And the ideas keep coming.

A CIP workgroup is improving communications capabilities with employees, through e-mail technology, the Internet, and a quarterly newsletter (2 issues to date).

A critical link to employee buy-in to CIP is working in partnership with the unions. Some Organizations have formed partnership councils (NIH, SSA, regions), while others are working with unions to do so (HCFA, ACF, CDC).

In May, 1994, the union and management leadership held a retreat to define the nature and role of a departmental HHS Partnership Council.

We know that labor/management partnership will be a new concept for many, requiring new skills and ways of thinking and working together. Therefore, training is occurring and being developed in interest-based bargaining, alternative dispute resolutions, managing conflict, and basic mediation skills. Some organizations (HCFA and the regions) are already employing interest-based rather than traditional "proposal/counter proposal" bargaining.

TAKING RISKS AND EXPERIMENTING

Last year the Secretary responded to the Vice President's request for laboratories for reinvention by establishing three laboratories. Since that time, the number of CIP labs has grown to eleven (full descriptions of these laboratories are on page 19:

Two Indian Health Service Medical Centers in Alaska and Phoenix are looking to improve customer service and satisfaction.

The Peer Review System at the National Institutes of Health (NIH) is being redesigned to streamline its grant review process.

HCFA is testing new methods of developing and issuing regulations.

The Office of the Assistant Secretary for Personnel Administration (ASPER) has set up a lab with ACF to test new ways of managing human resources.

The National Library of Medicine (NLM) is taking steps to move from outmoded computer systems to more user-friendly hardware and software products.

The International Cancer Information Center (ICIC) is developing a model program for innovative, flexible, and responsive information dissemination.

The Denver regional office is working in conjunction with the Office for Civil Rights on a Workplace Resolution Activities Center.

HHS is a prominent participant in the interdepartmental Georgia Common Access lab to look for ways to make the application and eligibility determination processes of federal and state aid more user-friendly.

Regional offices are testing programs to franchise personnel services and new methods of conflict resolution.

A CIP workgroup has created a lab to develop an HHS "corporate" presence on the Internet.

STREAMLINING

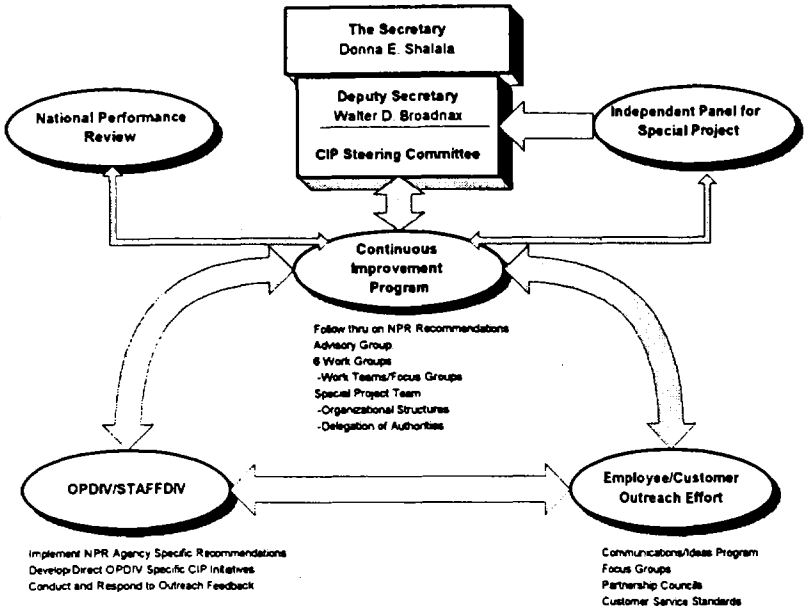
This Department is deeply committed to the goals and objectives articulated in the NPR. We plan to meet or exceed the streamlining goals in virtually all categories. The activities summarized in this report support our streamlining efforts to make the Department more efficient, effective, and responsive to our customers and partners.

CONCLUSION

When HHS employees first started forming the CIP groups and teams they asked, "Please do not hamper the volunteers with extensive reporting requirements." In other words, they did not want the CIP program itself to become a burdensome internal control and reporting process. Because this request made sense, retreats, newsletters, the meetings of the Advisory Group and Steering Committee, and the Secretary's leadership conferences are used for exchanging ideas, collecting information, and giving guidance from the HHS leadership.

The purpose of this report is to document some of our many triumphs and to encourage all employees to keep up the good work. Of course, we could not capture

THE HHS CONTINUOUS IMPROVEMENT PROCESS



every one of our achievements this time around. Since the time that this report went to press, there have been more victories for the Department and the American people. Accolades to all—but remember, our work has only just begun.

CONTINUOUS IMPROVEMENT PROGRAM—INNOVATION IN EVERY COMPONENT

The Continuous Improvement Program is not confined simply to the activities of the cross-cutting work groups. Within each Operating Division and the larger Staff Divisions, efforts are underway to streamline internal operations consistent with the recommendations of the INPR and reengineer or reinvent program operations unique to the OPDIV/STAFFDIV. What follows are reports outlining these initiatives.

ADMINISTRATION FOR CHILDREN AND FAMILIES

ACF began its continuous improvement process a year ago when the Assistant Secretary challenged the ACF executive staff to identify cross-cutting management problems that, if corrected, were most likely to improve ACF-wide operations and that could be addressed through teams composed of a wide array and diversity of ACF staff. After identifying the following issue areas—program monitoring; communications; delegations of authority; staff development and training; and performance measurement—volunteers were solicited from across the agency, both in headquarters and regional offices, to serve on the teams. Each was chartered to develop recommendations to "reinvent" the way ACF does business in these broad areas and each received training in quality management and team concepts.

At the same time a Quality Management Design Team was formed to determine how quality management principles and concepts could help ACF improve its program performance and internal management, and to design a long-term strategy for making those concepts a real and integral part of ACF's organizational culture and way of doing business. In another area, ACF launched a business reengineering project designed to dramatically change the way ACF awards monitors and accounts for the billions of dollars in grant and entitlement funds given to states and other grantees every year under 60 different programs.

All ACF employees were invited to submit ideas for improvement directly to the Immediate Office of the Assistant Secretary. The ideas received in response to this invitation, along with those received in response to the Secretary's Employee Outreach initiative under the CIP are being reviewed and responded to by program and administrative staff throughout ACF. Several have been adopted and implemented.

Project Team Activities

A brief review demonstrates the success of these efforts.

In response to recommendations made by the Delegations of Authority Team, new administrative and personnel delegations have been issued that move decision making to much lower levels of the organization. The team has also completed a draft set of program delegations that poses many programmatic authorities (e.g., approval of grant awards state plans down to management levels that are closer to the organizations ACF serves. A new team has developed a training strategy that will help managers assume their responsibilities under these new authorities. A new LAN based system has been created that provides access to administrative policies and guidelines through personal computers.

The Program Monitoring Team (which includes two members from state agencies) has developed a new monitoring strategy that moves away from the compliance monitoring paradigm of the past towards a technical assistance and partnership model which is supported by both ACF staff and the grantee community.

The Performance Measurement Team, as part of its charge to help move ACF towards measuring outcomes and preparing to meet the requirements of GPRA played a key role in establishing Child Support Enforcement programs as a pilot under GPRA. This experience will provide a model for ACF and others in the Department in developing performance measurement systems and improved strategic planning processes that measure results and have the support of our State and grantee partners. Additionally ACF was the first OPDIV to receive generic approval of partner satisfaction surveys from OMB.

One of the suggestions that came from the Communications Team was to provide minutes of the weekly Executive Staff Meetings to all ACF staff via e-mail. This is being done on an on-going basis and the response of staff has been extremely positive. Many staff see this as a significant step towards improving communication and building trust within ACF. The Communications Team also recommended that the Assistant Secretary meet with all support staff. Two

meetings were held and resulted in launching a newsletter designed especially for ACF support staff.

Using information gained through a series of focus groups at headquarters and in the Regional Offices, the Staff Development and Training Team is developing an ACF-wide training strategy that will focus on improving manager skills needed to meet the demands of working in a quality management environment building careers and skills necessary to achieve ACF's vision, and creating a new emphasis on training as a priority.

New Approaches

Seeing some of the early successes and benefits of addressing problems through a team approach, several managers have created teams to address other issues. One is developing a new performance appraisal system for managers and supervisors, while another is reinventing ACF's FMFIA program.

The Child Care Bureau within ACF will consolidate all child care functions. This initiative represents a major collaboration within ACF and will result in more streamlined seamless child care services.

The Grants Administration Business Reengineering Project has developed a detailed set of recommendations and action plans which will create an entirely new system of supporting grant programs through customer-focused more automated approaches of awarding and managing grant funds for all ACF programs.

Overlaying and setting the tone for all of these specific activities and related management initiatives is a new partnership that is being built among ACF executive staff through a series of management conferences and a substantially changed format for weekly staff meetings. The executive staff now comes together as a team to discuss and resolve agency-wide issues in a way that focuses on the outcomes to be achieved as an organization, not as individual program and staff offices. This partnership approach has also resulted in the sponsorship of an interim Labor/Management Partnership Council and reflects the values and vision that were created together to guide the agency's actions.

ADMINISTRATION ON AGING

The Administration on Aging began its continuous improvement process at a propitious time. AoA was still organizing itself as the newest and smallest OPDIV in the Department, and the position of the Commissioner on Aging had recently been elevated to that of Assistant Secretary for Aging. In light of the new expectations these changes created in the field among the Aging Network. CIP was also an opportunity to reinvigorate an agency that in recent years had experienced a steady decline in funding levels and staffing resources.

Vision Statement/Strategic Plan

The process began with a management retreat to begin to establish a vision and create an atmosphere that supported employee empowerment to benefit AoA's customers—seniors. Immediately following the management retreat, the Assistant Secretary formed a "Change Management Team" to review AoA's organization procedures and culture. This team made vital contributions to the development of a vision statement and a strategic plan documents that are a cornerstone of AoA CIP commitment.

AoA's vision is that all older Americans (present and future) have the right to an independent productive healthy and secure life. The plan presents such goals as "Providing Leadership for an Aging Society" and "Making the Administration on Aging a Premier Model Government Agency." The vision statement and strategic plan have been widely distributed to staff and to the Aging Network and are a basis by which AoA is pursuing priority initiatives in such areas as home and community based long term care developing a blueprint for an aging society meeting the needs of older women, combatting hunger and promoting healthy nutrition among older americans, and reducing crime and violence against seniors.

Management Improvements

AoA has made great strides in continuous improvements in such areas as:

Correspondence and Assignment Control: AoA procedures formerly mandated the signature of the Commissioner on Aging for virtually every document. Managers are now empowered with signature authority to dispose of issues and paperwork at the most appropriate level.

Information Resources Management: An ambitious multi-year effort called the Rightsizing Initiative is being undertaken, to develop and implement the automated systems that support AoA's administrative responsibilities. The agency is replacing old mainframe computer applications with new ones based on our

Local Area Network of personal computers, which eliminates unnecessary duplication and takes advantage of the most economical and efficient hardware and software now available.

Federal Managers Financial Integrity Act: Management control areas have been assessed to assure that appropriate controls are firmly in place. The analysis of AoA business processes undertaken as part of its IRNI Rightsizing Initiative supports this. Some management control reviews have been canceled due to elimination of obsolete requirements.

Grants Management: A Departmental review of its grants management operations produced an overall high rating for the agency. During that review, however the team recommended an agency grants manual. A draft manual was developed and is being reviewed in light of continuous improvement principles.

Customer Services

AoA has developed customer service standards to document its commitment to a higher level of support for the State Tribal and Area Agencies on Aging—and the service providers—who are our partners in delivering services to older Americans and their families. Although Executive Order 12862 mandated publication of customer service standards only for federal agencies that directly serve sizable portions of the public AoA deemed the importance of its relationship with the Aging Network sufficient to make this additional effort more than worth while.

The document spells out the standards we have set for ourselves in providing the Aging Network the support it needs to do its job well. These commitments range from giving prompt responses to telephone calls to providing the detailed technical information and assistance the people in the network tell us they need. Because the Aging Network has the crucial responsibilities for delivering services to older Americans and their families improving our service to the network is good for AoA good for the network and good for the public. The standards signed by both the Secretary and the Assistant Secretary for Aging, are being sent to the agencies that comprise the network.

HEALTH CARE FINANCING ADMINISTRATION

The Health Care Financing Administration has committed itself to creating a quality environment that embraces strategic thinking as a means to assuring continuous quality improvement in all activities. HCFA's continuous improvement program is centered around a strong commitment by the Administrator and senior agency staff to a total quality environment (TQE), made operational through a strategic plan. During the last year, HCFA's senior staff, along with union representatives worked through an Executive Steering Committee (ESC) to develop the agency's first strategic plan in its 17-year history.

HCFA's Strategic Plan

The Strategic Plan was originally drafted by ESC in a 6-month period of intensive work marked by consensus decision-making on all items. The draft plan was presented by ESC members to each of HCFA's 4200 employees in small groups of 30–50 employees. Extensive employee comments (over 5200) were used in revising the draft plan. HCFA sought comments from customers, states, partners, and others with an interest in the agency's activities.

The final plan defines HCFA's mission—assuring health security for beneficiaries. The plan also articulates the agency's vision for the future—guaranteed equal access to the best health care. To implement the strategic plan seven goals 28 objectives and 94 strategies were defined (unified by several underlying, recurring themes). They are investing in employees improved service to beneficiaries building partnerships and teamwork improved communications, and more efficient utilization of resources.

The plan is being implemented by volunteer teams working throughout the agency. In addition the plan will be used to guide budget and resource decisions.

Customer Focus

During the past year HCFA has dedicated itself to serving its customers—both directly and through partnerships with contractors, states, and the SSA field offices. In order to guide Medicare and Medicaid service improvements focus groups have been convened and surveys undertaken. Under the newly designated Associate Administrator for Customer Relations and Communication a revitalized Office of Beneficiary Services has taken the lead for expanded and extended beneficiary activities. A first-ever HCFA Beneficiary Awards Ceremony in May 1994 honored HCFA's partners from all over the U.S. for providing extraordinary service to the Medicare and Medicaid customers.

In order to provide more opportunities for first-hand beneficiary interaction, managers and senior staff have been encouraged to visit customers for person-to-person contact. During "Senior Week," more than 30 senior staff met with older citizens and other beneficiaries in hospitals, nursing homes, senior centers and counseling programs. Managers are expected to seek out such opportunities for regular communication with beneficiaries and providers outside of the office.

TQE, Employee Empowerment and Team Building

HCFA leadership has committed itself to providing a total quality environment in which to accomplish its work, with emphasis on employee empowerment and working in teams. A union partnership was forged when senior staff and representative of HCFA's two unions (AFGE and NTEU) formed the previously discussed ESC. The ESC chartered itself to implement TQE throughout the agency and also guided the development of the agency's strategic plan.

Other labor-management cooperation is evidenced by interest-based negotiation currently nearing completion between AFGE and HCFA at Baltimore headquarters. Consolidation and realignment of regional activities have been undertaken in collaboration with NTEU, and recent realignment in the regional staffing of the Peer Review Organization program was announced only after notice and agreement with NTEU union leadership.

Diversity

An important subcomponent of TQE and team building is HCFA's commitment to valuing and celebrating diversity, particularly within the workforce, but also as applied to beneficiaries. Some 500 HCFA managers, led by the Administrator, attended a kick-off diversity training course in February, 1994. Managers will be participating in additional training during the year.

A national conference, "Valuing Diversity in Ourselves and Our Beneficiaries," was held on June 1, 1994. Participants included the Secretary, the Administrator, 500 HCFA managers, HCFA contractors, state representatives, and Peer Review Organization staff.

Procurement

In its most important administrative initiative, HCFA is moving to implement a Medicare Transaction System (MTS), that use the most advanced computer technology to process more than a billion Medicare claims a year by the turn of the century. To accomplish this enormous undertaking, HCFA worked with GSA and used their "Trail-Boss" procurement program enabling HCFA to expedite this ADP procurement and eliminate time-consuming sequential approvals. This successful joint HCFA–GSA reinvention of the procurement process will facilitate the more rapid development of MTS, allowing a new era of customer service and convenience for Medicare beneficiaries and providing a total overhaul of Medicare's process for paying health care providers.

Reorganization and Streamlining

A major reorganization was completed to streamline HCFA's organizational structure and improve its efficiency consistent with reinventing government initiatives. Functions were consolidated using existing resources. Continued streamlining and organizational activities are underway aimed at putting TQE into practice by valuing employees and empowering them to define their own work and reinvent the most efficient ways to accomplish that work. The aim is to empower middle managers and employees by reducing unnecessary layering, controls and roadblocks.

Additional Activities

A number of additional activities are underway including reinventing HCFA's relationship with the states based on a realization that mutual respect and interdependence are critical. Negotiated rulemaking or "reg-neg," is being used to work with those customers and partners affected by our regulations before drafting federal rules (see Reinvention Labs). In addition policy is being developed in collaboration with customers providers contractors and states in areas which need change and review such as home health care.

HCFA has begun to significantly change its organizational culture and is reinventing itself. Employees are encouraged to think beyond their own job their own part of the agency and even beyond HCFA itself to reinvent everything related to how the business of health care financing is accomplished. This is truly a continuous improvement process.

THE PUBLIC HEALTH SERVICE

Since the Vice President began the National Performance Review and Secretary Shalala initiated the CIP, the PHS has actively engaged in efforts to reinvent and streamline. The PHS streamlining effort is linked to its strategic plan that provides the framework for identifying priorities and developing a shared vision across the various programs for future years. The planning process will be used to identify cross-cutting issues that require all PHS agencies to contribute to a joint action plan.

The mission of the Public Health Service (PHS) is to protect and improve the health of the American people and to close the gaps in the health status of disadvantaged populations, through health policy development, service delivery prevention, regulation, research, information, and education. PHS includes an enormously wide range of health related activities: direct patient care and public health services at Indian Health Service (IHS) facilities; epidemiological studies and research in the prevention of illness and the promotion of health at the Centers for Disease Control and Prevention (CDC) in Atlanta; promoting new advances in biomedicine through extramural research grants to universities and hospitals and intramural research in the nation's most advanced laboratories and clinical facilities at the National Institutes of Health (NIH) in Bethesda; research testing and inspection of the nation's food and drugs at the Food and Drug Administration (FDA); support for health services and health professions development and training including assistance for State and local organizations providing health care to underserved populations at the Health Resources and Services Administration (HRSA); development and dissemination of scientific and policy-relevant information about the quality medical-effectiveness, and appropriateness of health care practices by the Agency for Health Care Policy and Research (AHCPR); and national leadership provided by the Substance Abuse and Mental Health Services Administration (SAMHSA) to ensure that knowledge is effectively used for the prevention and treatment of addictive and mental disorders. It is this complexity of program purposes and structures that the PHS continuous improvement process must recognize as it moves forward.

PHS Reinvention Process

The Assistant Secretary for Health established a Reinvention Team to lead the PHS reinvention effort and ensure that it achieves improved performance and customer service. The team is headed by a senior official from the Office of the Assistant Secretary for Health (OASH) and includes representation from all PHS agencies. The Reinvention Team will work to assure that agency-specific streamlining plans are developed and cross-agency mechanisms are in place to permit full sharing of information and innovative approaches. Work teams will undertake projects to improve support systems that cut across agency lines.

Technology and Automation Improvements

PHS is implementing various initiatives to enhance program management by using the latest computer and communication technology.

The Grants Information and Tracking (GIAnT) system was designed to coordinate and standardize the data for AHCPR's grants and contract activities. GIAnT will automate the review, award, and closeout of grants, using a state-of-the-art client-server system. This project will be linked to the reengineering of the research grants process being undertaken by NIH's extramural research reinvention laboratory.

CDC has implemented Imaging Technology in the Budget Branch to store budget files for the current fiscal year. This technology permits budget information to be found quickly no matter how long the report, provides simultaneous access to current and archived reports, and eliminates the paper and printing costs associated with computer-generated reports. SAMHSA is in the process of implementing a unified grant application and information management system beginning in fiscal year 1995. Data that were entered into multiple systems previously will need to be entered only once improving the accuracy and completeness of extramural grant information.

CDC has automated many activities related to purchasing. An Integrated Voice Response (IVR) system allows vendors to use their touchtone telephone to learn the status of invoices billed to CDC and to obtain payment information. The system handles hundreds of calls each month from vendors that in the past would have required the attention of personnel at the financial management help desk. A pilot Electronic Data Interchange (EDI) project issues delivery orders and receives invoices for CDC's contractors for technology and services as well as issuing small purchases and receiving invoices from selected large vendors. Benefits include reduced costs and errors, less paper and record storage, better fiscal management, and improved customer service.

CDC is implementing the Payments Expedited Paperlessly (PEP) System to automate the pay process for invoices with small dollar amounts ($2,500 or less) for a single line item. These invoices currently require almost as much time to process as million dollar items. Using sampling and other quality control techniques to manage the process will improve customer service, free staff resources for the big dollar items, and focus agency attention on significant dollar amounts. CDC is also installing an automated system that allows all Federal Express invoices to be transmitted electronically to the agency and then forwarded to the appropriate office for approval. The automated payment method has saved time by consolidating the billing approval process and eliminating paper handling and mailing between Federal Express and the agency.

FDA has initiated the Administrative Systems Automation Project (ASAP) to provide a centralized, automated set of integrated agency-wide information systems to improve the day-to-day administrative services required to support FDA programs. This system will also provide an easy-to-use interface to access the system and will be available to FDA employees at anytime from any location.

Two Centers in FDA are working to establish a project management system in the pre-market application review process to plan and coordinate the activities of application review teams. Also at FDA, a cross-agency work group has developed a proposed "Omnibus" rule for electronic signature. The proposed rule permits the use of electronic records/signatures for records required to be maintained by the regulated entity except where paper record/handwritten signatures are specifically required by regulation.

The FDA, working closely with the U.S. Customs service, is automating procedures for regulating imports. The current manual process for handling its import operations has been burdened with frequent processing delays and backlogs, especially at busier ports. Currently 1.6 million entries of FDA-regulated products are processed annually and that number is expected to increase to 2 million by the year 2000. On October 1, 1993, FDA Commissioner Kessler and Customs Commissioner Weiss committed to implementing the Electronic Entry Processing System (EEPS) in 18 locations nationwide in 1994. These 18 locations handle about 80% of the total number of entries of FDA-regulated products. The electronic entry processing system enables brokers to submit data electronically to FDA, and to receive back the FDA determinations. About 60% of the imports are entered electronically; of those, approximately 50% receive a determination electronically that they may proceed.

IHS is implementing an automated Administrative Resource Management System (ARMS) to electronically manage budget, travel, and procurement documents for increased efficiency. HRSA is considering ways to reorganize its Fiscal Services organization to take advantage of new technology, management techniques, and modified reporting and monitoring requirements.

Through its Telecommunications Improvement Project, OASH is evaluating the use of Integrated Services Digital Network (ISDN) to enhance employee and customer access to state-of-the-art technologies. An ISDN telephone connects parties digitally and with greater efficiency than traditional analog lines. Although voice communication is improved in the digital environment, the main advantage is the increased speed of data transmission. For example, PHS is now exploring ISDN for video to the desktop, telecommuting teleradiology remote LAN access, and connectivity to databases for intelligent electronic forms.

Improving Customer Services

The following initiatives are aimed at enhancing the way PHS provides services to customers. In many instances, technology is used to improve responsiveness to customer needs by allowing them easier and more efficient access to information.

The Indian Health Service has published preliminary customer service standards for its clinical facilities serving American Indians and Alaska Natives. These standards will be refined in response to customer surveys, consultation with Indian Tribes and organizations, and staff initiatives to improve service quality.

The Agency for Health Care Policy and Research (AHCPR) is working with the National Library of Medicine's National Information Center on Health Services Research and Health Care Technology to improve the dissemination of the results of health services research including clinical practice guidelines and technology assessments. The new system to access this information is called HSTAT (Health Services and Technology Assessment Text). It is a free online system accessible through the Internet and other electronic communication services. The full text of clinical practice guidelines the quick reference guide for clinicians and the consumer brochure can be downloaded. By the end of 1994, AHCPR's technology assessments will also be available.

AHCPR has also installed an InstantFAX system to give consumers researchers and clinicians a quick way to get the agency's publications. This is a fax-on-demand service available 24 hours a day 7 days a week to anyone with a touchtone operated fax machine. InstantFAX has already responded to 9,000 calls with 67,000 pages of information and saved $20,000 in dissemination costs.

The Project Management Development and Implementation Team in FDA's Center for Drug Evaluation and Research has made changes in the new drug application review process which helped the agency achieve the performance goals in the Prescription Drug User Fee Act a year ahead of schedule.

CDC is implementing the Public Health Laboratory Information System (PHLIS) a PC-based electronic reporting system, to allow laboratories of state public health departments to report data concerning laboratory isolates to CDC. The system provides quicker access to information for local (intra-state) analysis and reporting as well as national data for CDC. PHLIS operates in 50 states, Washington, D.C., and Guam, and supports laboratory reporting for five pathogens. The quality of data has substantially improved through PHLIS because validity checks are now performed at the state before the data are sent to CDC.

CDC is implementing the Laboratory Information Tracking System (LITS), a PC-network (LAN) based system. that will allow laboratory personnel to dial into CDC laboratories to obtain results on the specimens they have sent in. LITS will also provide a mechanism for CDC staff to respond in a timely manner and with minimum difficulty, to inquiries from local hospitals and state national and international health officials who have sent specimens for analysis.

The Bureau of Health Resources Development (BHRD) in HRSA is conducting HIV clinical audio/teleconference calls to disseminate information to the international community. This activity is garnering active participation from other Public Health Service agencies including NIH, CDC, and the Indian Health Service as well as from the Departments of Defense and Veterans Affairs. Since information regarding HIV care is ever-changing these live audio teleconferences are far more cost-efficient than videotapes often costing $60,000 to produce only to become outdated. The average cost of each audio teleconference which reaches thousands of primary care providers is approximately $6,000.

The Bureau of Primary Health Care (BPHC) has implemented BPHC ACCESS (ACcelerated Communication Electronic Service System) a national electronic bulletin board that makes information about BPHC programs available to anyone with a computer and a modem. BPHC ACCESS also provides a forum for users to discuss current issues and allows users to send a message to BPHC leadership and receive a response within six business days.

SAMHA's National Clearinghouse for Alcohol and Drug Information has established PREVline (PREVention Online) an electronic network dedicated to exchanging ideas and information concerning alcohol, tobacco, and other drug problem prevention PREVline provides users with an on-line library of research data, scientific studies, and other prevention information; approximately 1,000 downloadable files; access to information specialists who will reply to the user within 24 hours; and a public forum in which users can post questions and comments.

The Substance Abuse and Mental Health Administration (SAMHSA) established a Customer Service Committee to find ways of improving agency responsiveness to the needs of the grantee and applicant community. The Committee has asked a number of grantees, prospective applicants, state mental health and substance abuse directors, and professional and advocacy organizations for feedback on agency performance. Detailed, thoughtful responses have been received. The Committee will pursue the many excellent suggestions for improving services.

SAMHSA's Center for Substance Abuse Prevention (CSAP) announced the availability of funds which will enable six of its Community Partnership grantees to assume the lead role of substance abuse prevention services in collaboration with six Department of Justice funded Weed and Seed projects. The Weed and Seed projects are being selected as sites to support DoJ's Reinvention Laboratory on anti-crime and social service delivery strategies. A criterion for selection of the sites is the existence of a CSAP grant in the community.

FDA has implemented a Good Review Practices Initiative. This initiative is a participative effort involving individuals from all levels of the product application review process collaborating to develop guidelines for statistical and clinical reviews.

Streamlining Internal Processes and Operations

There are many initiatives in PHS to improve and streamline management operations. For example, small grants programs in AHCPR are being analyzed to determine if the existing process represents the most efficient use of resources. CDC reviewed all existing internal issuances to determine whether they should be updated

or canceled. Out of 350 reviewed, 130 were considered unnecessary and have been terminated.

Among process improvements currently underway in HRSA, the Bureau of Primary Health Care (BPHC) has established the goal of developing a single application format and set of instructions for all of the Bureau's grant applications. The "single application" will apply initially to the Bureau's service delivery programs including: Community Health Centers, Migrant Health Centers, Health Care for the Homeless, Public Housing Primary Care, Comprehensive Perinatal Care, Special Infant Mortality Reduction Initiative Projects, and HIV Early Intervention Services.

A HRSA work group has been established to examine appropriate headquarters and field relationships in the context of changed delegations, continuing streamlining initiatives, and changed program and state relations as a result of health care reform. This work group is composed of representatives of each bureau, the Regional Health Administrator, and State Health officers.

The Maternal and Child Health Bureau (MCHB) in HRSA has continuously streamlined its annual grants management cycle since FY 1992. Customer (grantee) input is obtained, and their interests considered. One result is that Federal Register notices announcing competition opportunities are now made three months earlier in the cycle than in previous years, permitting prospective applicants additional time to plan and submit their responses.

HRSA is planning to reorganize the Hansen's Disease Program to adjust to changing program needs and to restructure the Federal Occupational Health program to streamline and improve services.

HRSA's Office of the Administrator (OA) has developed a "Quality Idea" process whereby any HRSA employee may submit a proposal for an improvement and be assured of an acknowledgment within 24 hours and, after due consideration, a written reply from senior agency management. Since June 1992, approximately 20 proposals have been adopted.

NIH has initiated a review of its intramural research program which will include examining the role, size, and cost of the program and developing a system for allocating resources to and among its intramural programs. This is a two-phase review process that began in July, 1993 and includes: a trans-NIH Intramural Program fact-finding effort by an internal committee and an Intramural Program evaluation carried out by a group of external advisors.

As part of an overall initiative to promote diversity in the work force. NIH has developed a new and enhanced recruitment and retention policy for scientific and program staff to bring minority students into the NIH intramural laboratories. A contract with Alexander and Associates to develop an affirmative action plan for NIH has been signed.

NIH is also updating its Administrative Data Base by reengineering the internal management systems it supports and then applying the latest technology to make their operation as efficient as possible. Teams of NIH and outside experts will review and analyze the processes to remove unnecessary steps and take advantage of planned improvements in the agency's communications infrastructure.

IHS is developing a restructuring plan with Tribal consultation to streamline the Headquarters and Area offices. The emphasis of the plan is on reducing the management and administrative costs. IHS has moved to increase third party collections from Medicare, Medicaid, and private insurance through a Patient Business Office Automated Billing Package. All IHS facilities will have complete patient business office automated systems in place by the end of FY 1995.

A SAMHSA work group is looking at alternative arrangements for peer review of grants and contracts to improve communication between review and program staff on substantive issues. Another work group is reviewing and reassessing SAMSHA's 25 collaborative efforts with other Federal agencies to identify areas potentially requiring new or enhanced collaborations and to weed out those of marginal value. Steps to implement the recommendations of these work groups are pending within the Agency.

CDC has implemented the purchase card program to streamline payment procedures and reduce administrative costs for the acquisition of supplies and services. This initiative demonstrates the benefit of the CIP Support Services Work Group proposal that the Department expand the use of credit cards throughout the Department for purchases under $2,500.

FDAs Reinventing Administrative Management Project (RAMP) is focused on improving a broad array of administrative processes including: time and attendance recruiting, barcoding property, imprest funds, small purchases, correspondence tracking, Federal Register document tracking, headquarters and field facilities management, and training. The initiatives seek to improve internal business processes

and internal customer service and shift resources from administrative to program areas.

To improve financial management FDA is replacing most of its cash imprest funds with third party drafts. At present the third party draft system has been installed in five of FDA's 22 field District Offices and efforts are under way to install it in five more District offices before the end of the calendar year. FDA is also installing a software system that will fully automate the audit and payment of Federal Express and cellular telephone bills which should result in savings and increased efficiency. FDA's accounts payable system is also being modified so that all invoices are registered on the date they are received rather than when they are ready for payment. This will strengthen internal controls over invoices and will increase the ability to manage workload and to respond to program and vendor inquiries. The new system should be in place by the end of FY 94.

FDA proposes to use an alternate financial reporting form for Special Government Employees (SGEs), particularly those who serve on Advisory Committees. The proposed form, which is intended to reduce the burden of reporting by gathering only meeting/task-specific financial information, has been developed and tested with selected SGEs and has been distributed to top Agency management officials for review and approval. Eighty percent of the responding SGEs see this proposed new reporting form as a significant improvement over previous reporting requirements.

SOCIAL SECURITY ADMINISTRATION

The Social Security Administration (SSA) has been a leader in many of the most crucial elements of the National Performance Review and the Continuous Improvement Program. Since the mid 1980's. SSA has focused on measuring customer satisfaction with SSA's services through customer surveys. In addition, to insure the integrity of those measures of satisfaction, SSA asked the Inspector General to conduct annual surveys. Therefore, as other federal departments and agencies have moved to establish customer service measures and processes, SSA has been able to provide technical assistance in such matters as survey design.

SSA has also been a leader in another key area—strategic planning—having had an agency-wide strategic plan in place since 1991. SSA is now moving to reassess that plan, updating it as necessary and ensuring that it properly reflects customer and stakeholder views of service priorities. This year, SSA's performance has been so noteworthy that Vice President Gore visited the agency in June 1994 and presented the agency with his "Hammer" award for its accomplishments in three major initiatives. A description of these efforts are as follows:

Providing World Class Service

In addition to its ongoing surveys of customers, SSA developed a wide-ranging program to get the views of both its customers and its employees about world-class service—one of the Commissioner's three primary goals. To get the views of its customers, SSA conducted meetings with 12 focus groups consisting of a cross-section of current beneficiaries and the general public and is planning several more, mailed 22,000 comment cards, and completed 4,000 additional comment cards by phone to obtain feedback from customers. SSA is also discussing world-class services with individuals and organizations that are interested in the services SSA provides to its customers.

SSA sent a questionnaire to all SSA employees, seeking their perspectives on what barriers prevent them from providing the best service possible. Over 17,000 employees responded. SSA also conducted in-depth discussions on this subject with over 2,000 of its employees.

SSA is analyzing this information, which it will then fold into its strategic, budget and resource planning.

Disability Process Reengineering

Despite the best efforts of its employees, SSA continues to have difficulty providing an acceptable level of service to customers applying for disability. In fiscal year 1995, incoming initial claims regarding disability determinations are expected to increase 69% and appeals workloads to increase 75% over 1990 levels. After first contacting the SSA, the claimant now waits about 155 days on average to finally receive a decision notice regarding an initial claim. If the claim is denied and appealed through the hearing level, it takes over 550 days from the claimant's first contact until a final notice is issued.

For these reasons, SSA indicated an effort in the fall of 1993 to reengineer the disability process. A team composed of 18 federal and state employees conducted by personal interviews with front-line employees, managers, and executives as well a

representatives from the medical community, legal aid, advocates and special interest groups.

Following the release of a preliminary report in March, 1994, the team sought public comment and presented a final report to the Commissioner incorporating those comments. On September 7, 1994, the Commissioner announced the final plan for a new, user-friendly and cost-effective disabibity application process. The new process will be made streamlined, flexible, and customer focused, with emphasis on the use of technology, teamwork and director customer participation in the process. The process will merge several job functions from the current process into an empowered new position, and reduce the number of steps involved in disability decisionmaking. When fully implemented, the time a claimant waits for a decision on an initial claim will be reduced to no more than 60 days. The time to receive a decision appealed through the hearing level will be reduced to about seven months. SSA expects to begin implementation of the plan in October, 1994, although many aspects of the plan such as automation, regulatory and legislative changes may take longer. Full implementation will take time.

Georgia Common Access Application

SSA placed an important role on the Georgia Common Access Team. The team was able to streamline the application process for six different types of aid by reducing a total of 64 pages to 8 pages and still meet the filing requirements of each of the individual agencies. A six-month pilot program began in March 1994 in the Atlanta area. (For more detail, see Reinvention Labs.)

OFFICE OF THE SECRETARY

The Office of the Assistant Secretary for Management and Budget

The Office of the Assistant Secretary for Management and Budget has been actively engaged in the continuous improvement process for the past year. Many of the areas of opportunity for moving from "red tape to results" encompass functions for which ASMB has institutional responsibility within HHS, such as procurement, finance, budget, information management and support services. ASMB staff have taken advantage of this opportunity for change and working closely with OPDIV counterparts as well as with peers from other federal agencies is developing strategies and plans to introduce new ways of doing business.

ASMB has adopted an approach to continuous improvement that says that, whenever appropriate, authorities will be delegated to the lowest level permitted by central management agencies such as the Office of Personnel Management (OPM), OMB, the General Services Administration (GSA), and Treasury. Many of the remaining delegations have until now been controlled by the central management agencies. ASMB staff are working closely with central management staff on several interagency task forces as well as informally to develop implementation plans which will empower agency line managers in these functional areas. Accomplishments todate are described below.

Delegations of Authority

The ASMB increased the delegation of procurement authority to OPDIVs for acquisition of federal information processing resources consistent with the new course being set by GSA and supported by the National Performance Review. This is the maximum authority that can be delegated to the OPDIVs at present under current GSA regulation. The ASMB, as the administrative head of OS, also re-delegated to STAFFDIV heads authority for several personnel-related decisions, such as alternative work schedule and alternative work site requests.

Reducing Administrative Burden

The ASMB Division of Acquisition Policy and Oversight (DAPO) expressed a concern to the Office of Federal Procurement Policy (OFPP) about the burdensome requirements of the OFPP policy on management oversight of service contracting. As a result of the DAPO efforts, a supplemental policy was published in February, 1994, which relaxed some of the requirements. ASMB is working through the Management Oversight Council to find ways to reduce the burden of the internal control processes relative to FMFIA and Audit Follow-up. OPDIVs have been enthusiastic about ASMB proposals to simplify reporting requirements in FMFIA and Audit Follow-up activities and to eliminate non-essential or duplicative control activities.

In addition based on a revised OMB Circular A–127 which eliminates the specific government-wide review requirements ASMB's Office of Finance issued a directive which implements a revised approach for meeting the requirements of Section 4 of the FMFIA. Under the new approach, OPDIVs will have the flexibility and are encouraged to use a number of on-going activities (i.e. CFO audits, Office of the In-

spector General (OIG) reviews) to provide annual assurance to the Secretary on whether or not their financial management systems are in conformance with government-wide requirements. This new approach eliminates the need for separate and burdensome reporting.

Reengineering

ASMB is a participant on behalf of the Department in a government-wide initiative to address and study the role of business process reengineering. One of the case studies to be used in the study will be the Public Health Service National Practitioner Data Bank which is reengineering its processes from manual, paper, and labor-intensive to automated and paperless systems. Additionally an ASMB quality improvement project was completed which reengineered the grants policy process. As a result the grants policy manual is being replaced by simplified guidance—thereby reducing the number of controls and empowering the OPDIVs. ASMB staff collaborated with OPDIV staff to produce this continuous improvement success.

Performance Measurement

ASMB is responsible for the implementation of the Government Performance and Results Act. Many of the SPR recommendations and CIP activities will require measurement of performance or results to ensure accountability. ASMB is approaching the implementation by providing maximum latitude to the OPDIVs to develop strategic plans and performance plans and measures which fit their individual cultures. ASMB is using a pilot program approach within HHS as well as participating in the OMB pilot program. Policies and procedures will flow from pilot results and central mandates will be kept to an absolute minimum.

Empowerment

ASMB has initiated the expansion of the use of purchase cards for acquisition of small purchases. ASMB, the OPDIVs and the Office of Federal Procurement Policy have signed a pledge that commits these organizations to creating and implementing simplified methods of procurement. This agreement supports and encourages the expanded use of purchase cards in the Department, thereby empowering card users to obtain needed goods quickly and with far less administrative burden, while retaining essential accountability.

The Office of the Assistant Secretary for Personnel Administration

The Office of the Assistant Secretary for Personnel Administration established the ASPER Continuous Improvement Program (ACIP) in August 1993. ACIP's task is to identify plan and oversee the implementation of improvement strategies that help respond effectively to major change and to meet streamlining goals while maintaining and improving the quality of our products and services. The ACIP process has broken new ground in identifying our customers and in proposing innovative ways of providing customer-focused HRM services. The following are examples of ACIP initiatives.

HHS Regional Hub Project

The Hub project consolidates and redirects the processing of certain types of personnel and payroll transactions creating the possibility of decreasing from 51 processing sites to 3 or 4. Advantages of this consolidation are: economy of scale; greater accountability; improved accuracy, timeliness and customer service; and the development of a "critical mass" of expertise. This project is only possible through the greater use of automation and telecommunications. For example, analysis indicates that if there is an automated current file of employees and a way to attain historical information for each employee very few transactions require the use of an Official Personnel Folder. This consolidation increases the cost-effectiveness of alternatives such as contracting out the folder maintenance.

The initial analysis and planning for consolidation have been completed. Work has now started to achieve further economies through reengineering the processes done at the Hubs. The first Hub site went operational as a pilot on June 27, 1994.

Multi-Regional Interest Based Negotiation

HHS has used interest based negotiations (IBN) as a significant departure from the traditional, position based process in a successful experiment with NTEU and the Multi-Regional Bargaining Unit which represents 4,226 employees in the ten HHS regional offices throughout the country. This process, which builds upon group participation, consensual decision-making techniques, and facilitation, has been gaining considerable appeal and momentum among management and labor particularly with the emphasis placed on developing more cooperative union-management relationships and building partnerships as envisioned in Executive Order 12871.

Initially, Union and Management decided to test the process by negotiating two contract articles. They used a process which included joint training using the DOL/FMCS model as a general guide but with the addition of experienced facilitators. Because of the positive reactions of all negotiation team members both parties unanimously agreed to continue the use of the IBN process in their renegotiation of the term contract.

To allow others to build on their experience the parties are in the process of developing an Interest-Based Negotiation Experiment Case Study and a Process Model to serve as a practical how-to guide for teams and/or facilitators. (The case study features a series of "Lessons Learned.") An evaluation project that assesses the IBN process, the administration of the new Negotiated Agreement, and the effect of the use of the IBN process on the ongoing relationship of the parties are also being developed.

Employee Express Interagency Task Force

ASPER leads a ten federal agency Employee Express Interagency Task Force chartered under the OPM/Agency Personnel Automation Council. The Task Force, which began its work in January, 1994, was formed to define the technology, cost-benefits and options available to provide current employees with immediate access to information about their own personnel/payroll records as well as the ability to directly process those actions which are at their discretion. Such actions would include choosing health benefits and Federal Employee Retirement System/Thrift options during open season, specifying tax withholding and bond purchases, and changing home addresses. Use of touchscreen kiosks and touch-tone phones with 800 numbers to allow employees to make these personal choices from their homes as well as the office is possible. New employees could also use the system to easily enter the information needed for the myriad enter on duty (EOD) paperwork which would then be complete and ready for signature on the first day of work.

The immediate goal is jointly to develop and implement a pilot Employee Express system by January, 1995 to include federal and state tax withholding direct deposit of paychecks, direct deposit of other voluntary allotments, and home/check mailing address changes. Thus, the Employee Express system will empower employees at all levels, reduce processing time and effort, and remove a layer of personnel office activities that add no value.

Office for Civil Rights

Continuous improvement efforts in the Office for Civil Rights have focused on redefining the mission of the agency and developing a strategic plan for the future. The Director of the Office for Civil Rights co-chaired a review team composed of staff from various OPDIVS and STAFFDIVS to identify ways to enhance the civil rights operations in the Department. The team examined every aspect of OCR's operations and issued a report with several recommendations.

Among the recommendations was that OCR needed to develop a strategic plan to focus the work of the office and to improve the functioning and structure of the office. OCR is in the process of developing this strategic plan under the leadership of the OCR Deputy Director. During the initial phase of the strategic planning process, nine draft goals were identified which would close the gap between where OCR is today and where it should be by 1999. Strategic planning is also being coordinated with OCR's efforts to streamline operations.

The Office of Inspector General

The Inspectors General, through the President's Council on Integrity and Efficiency (PCIE), developed a common vision and statements on mission, authority and reinvention principles that meet NPR's goal to change the culture of government, while, at the same time maintaining the independence of Inspectors General. The HHS Inspector General wanted to be the first to follow the PCIE principles she had a lead role in developing. First, OIG held focus groups with the OPDIVs and STAFFDIVs to get customer feedback on OIG activities, to determine how to improve relationships, and how program staff could input to the OIG workplanning process. OIG has determined to eliminate the old "gotcha" reputation and replace it with a professional, helpful but nonetheless independent image. Secondly, OIG developed a coordinated workplanning system which has involved meetings with program staff at the plan development stage and comments on draft workplan documents.

Concurrent with the above, OIG established a senior working group to develop an OIG Strategic plan. The mission, vision and values statements are complete and the goals, objectives and performance measures will be presented to staff to reach consensus. Early in this endeavor, an employee survey was conducted and action plans

set up to assure that staff have the resources and skills they need to meet the goals and objectives.

Over the past year OIG has taken bold new steps to do more with less, and has been able to assist states and other bodies do their work more efficiently and effectively. Examples follow:

IG Coordination with States and Local Audit Groups

The OIG has shared its experiences concerning Medicaid audits with State auditors to develop partnerships that will enhance improvements and provide mutually beneficial results. This is a shift from the traditional emphasis on retrospective compliance type reviews to cost savers that will benefit both the State and federal governments.

Preaward Audit Pilot Project

Preaward audits of bid proposals from contractors provides the Department a substantial return on audit investment. To do this more efficiently without any sacrifice in quality, OIG is piloting a new approach for certain contract proposals submitted by HCFA. The pilot audits using the "Proposed Guidance Book" far-out perform the conventional audits.

The pilot audits required an average of about 34 staff days to complete versus the 102 staff days required by conventional audits.

The average cost to complete the pilot audits was $14,443 versus $43,583 for the conventional audits—savings of $23,140 per audit.

The pilot audits resulted in attributable cost savings of 17.6 percent of proposed costs as compared to 20.1 percent for conventional audits.

The pilot audits achieved a return on audit investment of $170 to $1 compared to $90 to $1 for conventional audits.

Fraud Task-Force

The OIG has worked with the Department of Justice to establish an Executive Level Health Care Fraud Policy Group. The Group includes representatives of the Attorney General's office, the Civil and Criminal Divisions, the FBI and OIG. The group has been working to identify new methods of proceeding against health fraud, identifying priority areas for increased enforcement, and breaking down red tape barriers.

Office of Intergovernmental Affairs

Establishment of Regional Health Care Reform Teams

In order to support one of the President and Secretary's top priorities for this Department, Health Care Reform, the Office of Intergovernmental Affairs established Regional Health Care Teams (RTs) in each of the ten HHS Regional Offices to ensure information relating to health reform is disseminated to state and local officials, other interested organizations, groups and individuals in a timely manner and to facilitate the flow of information regarding health care reform from the regional offices to headquarters.

The RTs have been organized in each regional office under the leadership of the Regional Directors with representatives from HCFA, PHS, AoA, and other HHS Operating and Staff Divisions as needed. Given the complexities of health reform issues plus the varied interests of diverse groups, organizations and individuals and the multiple HHS components associated with health care programs (Medicare, Medicaid, etc.), coordination by HHS at the state and local level is critical. The RTs, which meet weekly, ensure that the flow of information downward is as smooth and effective as possible, and that the flow of information (issues, concerns) back to headquarters' policy makers is timely and meaningful.

Regions

The continuous improvement program is not limited to headquarters; it flourishes in regional offices as well. Every Thursday morning the regional offices join the Advisory Group via conference call. In addition, regional office staff use the phone lines to participate in numerous work group meetings. Many reinvention labs are located in regional and in field offices where staff directly interact with customers.

In Chicago, SSA established a Field Office Support Unit (FOSU) at the Great Lakes Program Service Center to support processing in SSA's region V field offices. Under this innovative approach, the centralized staff of 24 technicians is fully trained to process all Supplemental Security Income workloads, tasks that generally fall to SSA's field offices to perform. The FOSU also has the ability to process and other workload from SSA field offices that does not require face to face contacts. With this resource available to help out and overburdened field office, SSA can ensure timely and effective service when large increases in workload and/or staffing

shortages occur anywhere in the region. Through the first 7 months of operation, the FOSU has processed over 12,000 actions for field offices.

As noted elsewhere in this report, the multi-region bargaining unit provides a model for union partnerships. The use of alternative dispute resolution techniques for the past five years has meant no litigation. The Labor Management Relations Committee has successfully used interest-based bargaining to negotiate two contract articles and are now using it to complete bargaining for 15 more.

A number of regions have begun to explore and implement ideas endorsed in the NPR report. For example, the region X RASC has begun a customer feedback program that includes meetings with customers and follow-up telephone inquires and is developing an automated process for producing lists of applicants for vacant positions which has been distributed to all RPOs and has been selected for OPM's program to share successful automation projects with other agencies.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. CONSTANCE A. MORELLA TO DONNA E. SHALALA

Question. I have heard from some constituents who are particularly concerned with the impact of FTE reductions on the National Institutes of Health. Several issues have been raised, including:

NIH has been disproportionately affected by the FTE reductions, having to sustain a 15 percent FTE reduction—while the rest of the Department has had to shoulder an 11 percent reduction.

The NIH has more than met its FTE reductions, mainly through a hiring freeze in force since 1993. I have heard that in some cases, this hiring freeze has had serious consequences for some specialized positions.

Promotions of employees have slowed significantly, particularly at upper levels. The cumulative result over five more years could result in the departure of talented scientists.

More flexibility is essential in restructuring if NIH is to continue its current mission.

I would appreciate it if you could respond to these concerns. Can any action be taken to address these issues?

Answer. Within the context of necessary FTE reductions, careful choices have been made which require all HHS agencies to share in the burden of reductions. Because of an expanding population requiring health services and the opening of fourteen new or expanded facilities funded by Congress between FY 1994 and FY 1999, FTE needs for the Indian Health Service are particularly acute. Departmental FTE targets are also affected by the need to furnish user-fee support for many of the Food and Drug Administration's FTEs.

Every agency of the Department has convened work teams to develop innovative approaches and creative recommendations for improving the way it does business. One such groups is the NIH Resource Allocation Group, which has recommended a series of initiatives and efficiencies. In allocating FTE targets to individual Institutes, a model was constructed that accorded high priority to scientific rather than administrative positions. However, at the same time, it is not possible to absorb reductions of 15 percent in total NIH employment by reducing "control" and "headquarters" personnel, as direct in the National Performance Review. Therefore, NIH had to set a target reduction of 15 percent for units designated as "control." Positions for doctoral scientists were assigned a target reduction of 5 percent. After that, all other positions were reduced accordingly to achieve the required reductions.

The PHS agency-wide hiring freeze was lifted in February 1995, allowing agencies to being hiring within their established FTE targets.

Question. I am concerned with the future of the HIV prevention community planning process—will this process be protected under the proposed CDC block grant? The local community planning process is very consistent wit the trend toward local control, and it should be allowed to continue under any block grant proposal.

Answer. Among the goals of the HIV/STD/TB Performance Partnership Grant proposed by the Administration is "to encourage community involvement in HIV, STD, and TB which would include active participation in setting priorities and determining how funds will be spent."

The new HIV/STD/TB Grant would build upon the model established during the past year of the HIV/AIDS prevention program. The new grant program would use the same model, but would add funds to support TB and STDs. Because well-developed community groups are not available for consultation on STD and TB, CDC proposes a three-year phase-in for full flexibility.

Question. Will the Office of Women's Health continue to play a prominent role as it has over the past two years? Will the Office continue to have direct line authority to you?

Answer. The important role of the Office of Women's Health will certainly continue and should be even more effective as a result of the increase in resources available to the office. The Director of the Office of Women's Health reports to me through the Principle Deputy Assistant Secretary for Health, Jo Ivey Boufford. However, I am well informed regarding the activities of the OWH, and meet regularly with the Director.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. WILLIAM J. MARTINI TO DONNA E. SHALALA

Question. Secretary Shalala, later this year Congress is expected to look at the issue of FDA reform. In light of this, is the Administration working on its own plan to reform FDA? And if so, could you share any details of this plan with the Committee:

Answer. As you know, the President has asked all Federal agencies to examine their organization, procedures, regulatory requirements, and other elements and consider what can be eliminated, streamlined, privatized devolved to the States or otherwise reformed. Regulatory agencies were particularly asked to focus on whether their regulatory burdens on the private sector could be reduced. On March 16, the President announced the first five of a number of anticipated reforms in FDA's regulatory requirements.

Additional reforms will be announced in April via a report on regulation of drugs and devices. More reforms, including food and veterinary medicine, will follow. By June, the FDA is to report to the President on their findings resulting from his directions to all regulatory agencies to review their regulations for continuing appropriateness, to hold public meetings around the country hearing the concerns of regulated industry, and to identify regulations that can be converted to negotiated rulemaking.

Question. Madame Secretary, there are two issues that are important to the pharmaceutical companies in my state. I would like to know the Administration's position on renewal of the orphan drug tax credit. The tax credit was not included in the President's FY 1996 budget. Additionally, I am equally concerned about the R&D tax credit which will expire in June. Could you please share the Administration's views on these important concerns with the Committee?

Answer. The tax credit for "orphan drug" clinical testing expense, which provided a credit equal to 50 percent of qualified clinical testing expenses paid or incurred in the testing of certain drugs for rare diseases, expired with respect to expenses incurred after December 31, 1994. The research and experimentation tax credit, which allows a credit for 20 percent of qualified research and experimentation expenditures in excess of a base amount, is due to expire with respect to expenses incurred after June 30, 1995.

The Administration supports these and other expiring tax provisions, and would be glad to work with the Congress to find suitable revenue offsets or spending reductions with which to pay for them.

Question. My final question is in the area of government reform. It seems that Vice President Gore's National Performance Review is requiring that HHS only cut 150 positions in FY 95. I am aware that the FY 1996 figure is higher. Given that HHS employs over 127,000 people, how far beyond the 150 slots can HHS be downsized. Additionally could you please share any comments regarding specific HHS programs that in your opinion can be either downsized, eliminated, or combined?

Answer. In FY 1995 HHS, including SSA, is planning to reduce 1,766 FTE and in FY 1996 our reduction is targeted at 1,368 FTE. Between the FY 1993 base and FY 1999 HHS will reduce more than 12,500 FTE or 10 percent.

At the same time FTE are being reduced, HHS is implementing streamlining and continuous improvement initiatives that will result in a smaller and more efficient Department in the future. A principal focus of our efforts is to reduce the size and cost of administrative structures and shift resources from overhead and control functions to service delivery areas. This will mean fewer supervisory and headquarters staff and fewer staff in control areas such as accounting, personnel, budget, procurement, public affairs and legislation.

One example of administrative cost reduction is the restructuring of our regional organization. We are eliminating positions in our regional offices and transferring administrative functions to service delivery organizations. Another example is a pro-

posal in our FY 1996 budget which calls for the consolidation of 107 program activities into 16 performance partnerships. This consolidation is expected to produce significant savings in staffing and administrative costs in FY 1996 and beyond.

We are presently in the second phase of Reinventing Government and we are confronting additional challenges relating to consolidation of activities and realignment and restructuring in order to improve service delivery and reduce administrative costs. We expect to unveil the results of this effort within the next 30 to 60 days.

Mr. SHAYS. Madam Secretary, I appreciate your comments, and we will feel free to ask both you and your deputy any questions.

Walter, did you have any comments you wanted to make?

Mr. BROADNAX. No.

Mr. SHAYS. OK.

I would be interested to have you just focus in on, from an operational standpoint, where you think you have made your biggest successes and where you think, from an operational standpoint, you have your biggest challenges.

Ms. SHALALA. Well, I think I would say—and Walter may want to add to this—that our biggest successes are going to be on the big programs, the remanaging of HCFA, and, in particular, HCFA's strategies along with some helpful congressional legislation to bring down the rate of increase in both Medicare and Medicaid. You see the first results this year that have built up over the last year or so, and that is that the base line for Medicare and Medicaid is down $200 billion.

Mr. SHAYS. Over a 5-year period?

Ms. SHALALA. It will be down $200 billion over a 5-year period. The rate of growth is now moving into single digits. That is a major breakthrough.

I can talk about our prevention programs and some of the impact we are having on specific strategies. I think the first thing is that while the Department could focus on some categorical programs, we need to get some discipline into the rate of growth.

Now some of that came down because, obviously, the economy picked up. Bringing down the deficit helped. Some of it came down because we finally got control and stopped the creative financing that the States were doing in terms of the use of provider donations and taxes. Some of it came down because of the maturity of the system and the ability of managed care in some cases to bring down costs.

For example, 75 percent of all the recipients of Medicare now can choose managed care if they want to. We expect that 20 to 25 percent of Medicare recipients will be in managed care at the beginning of next year. That is how quickly people are moving into managed care. They are particularly moving in areas where there is deep managed care penetration.

I personally believe that moving more beneficiaries into managed care is really a generational issue, because we have a generation used to fee for service. As they live in areas in which they and their families have experienced managed care, and if that is what they see as the most efficient way, particularly for the elderly, to get their care, we will see more people choosing managed care. The Governors are clearly moving and you can see it in our waivers, to move more of the Medicaid population into managed care. We still have big challenges there in relationship to the Medicaid population.

In addition to that, we have refocused the public health part of the Department on prevention while maintaining the brilliant biomedical research at the National Institutes of Health. The CDC and the Public Health Service are clearly now focused on major public health issues: smoking cessation, illegal drug use, and issues like breast cancer and AIDS.

We went to the AIDS communities and rather than giving them top-down direction, we said, community by community, you develop the strategies for AIDS. We will fund those strategies, but you develop the strategies. So it is a bottom up approach with the community buying in, using private money, State money, local money, as well as the Federal money, using it in a way that I would describe in some cases as glue money. That is a very different way of thinking. We did the same thing on breast cancer.

So that gives you some feel for the kinds of issues we are working on.

I could go into the new computer systems in HCFA, getting rid of the differential between regions, getting more discipline, bringing in modern technology, but I think I'll end there and let some other people——

Mr. SHAYS. I gave a pretty broad question.

What is the impact of Social Security being removed from HHS? It constituted obviously in terms of total dollars a good chunk of your budget.

Ms. SHALALA. It basically splits the Department into two, and what it does is force us to think about our field operation, and one of the things that——

Mr. SHAYS. Do you have any jurisdiction after March on Social Security?

Ms. SHALALA. Yes, because I am a member of the Trust Fund Board, so I will.

We will continue to work with Social Security because what the split does is split the disability programs, and that is one area where we continue to work. We also will continue to work on aging policy with Social Security. But we will work with it as we work with the Department of Education and the Department of Labor in that regard.

Mr. SHAYS. In your comments about managed care, I am making an assumption that we need to go into managed care in both Medicare and Medicaid. What is the more difficult one for us?

Which will be more difficult, do you think, for us? Is Medicaid going to move more quickly into managed care, or is Medicare?

Ms. SHALALA. Medicaid will, because the Governors can make that decision. They have to have waivers in most cases.

We have committed ourselves as a country to giving the senior citizens greater choice of the plans that they go into. I believe it is both a generational and a geographic problem. I have lived most recently in a community in Wisconsin in which 97 percent of the population are in managed care. For the senior citizens in Madison, WI, managed care is not a new concept; it has long traditions both in rural and urban areas in Wisconsin. However, you get to a place like New York where you don't have a long tradition, some old managed care organizations like HIP, and let me just give you a sense of the difference.

For example, if we go to Florida, where the managed care companies have access to the elderly population, they can choose managed care, they offer Medicare beneficiaries everything but the kitchen sink: free drugs, no copayments—a very attractive incentive package, and yet they don't have big numbers of elderly moving into managed care in Florida.

However, if you go to Portland, OR, where there is a longer tradition of managed care, they are not offering all those things. Yet the elderly are disabled—mostly elderly, are moving in. That is No. 1.

No. 2, is that there clearly is some real selection going on. Managed care companies are going to places such as square dances, for example, where they will find the healthy elderly.

I have been accused of paying too much to managed care entities. Our studies actually show we are paying about 5 percent too much, but that is only because many managed care organizations take a very healthy group from the elderly population. What happens when they begin to enroll sucker elderly beneficiaries? Will our reimbursement rates have to adjust? We don't know a lot about pricing managed care for a high-risk population.

I think we are moving smartly into the managed care business. We have had the biggest movement into managed care in this administration than any previous administration. I think we have to be careful to preserve choice for senior citizens, and to make sure quality is there, and to make sure that we get our pricing straight, because the managed care agencies themselves aren't so sure how we reimburse. Our biggest challenges will be the disabled, where there is very little managed care experience. There is not a lot of experience with the elderly in managed care, but there is almost no experience dealing with the disabled, and, as you know, there are large numbers of people both in Medicare and Medicaid who are disabled.

Mr. SHAYS. If I could, I have just two areas as it relates to this, and I just want to touch on those. I am putting on my budget hat. I agree with you that Medicare and Medicaid are getting down into that single digit, 9 point something, from 10, but our sense is that we don't get a handle on this budget unless we get the Medicare increases to about 5 to 6 percent a year, and one of the positive outgrowths in the debate on health care was that we really forced the private sector to really rethink what they are—I mean a major savings took place just during the debate by the private sector responding, and that is a positive response to what the President has done.

My question to you is, shouldn't we be having a far more proactive effort? I mean I don't think HCFA, for instance, is really—it has got a lot of challenges, so I know it has got a lot on its plate, but I don't see it being very proactive in trying to promote managed care in Medicare.

Ms. SHALALA. You know, it is interesting, if you talk to the fee-for-service people, they will tell you that we are very aggressive. The rates of increase in managed care are rapid, it is a little over 1 percent a month now.

Mr. SHAYS. But we are working on such a small base.

Ms. SHALALA. We are at a 9-percent base and we are moving up.

What I am saying to you is that it is tricky, Congressman, because you can start off putting the healthy elderly into managed care. The managed care companies wouldn't have the capacity if we moved too quickly. We would end up repeating the horror stories of the Medicare mills and the Medicaid mills, so we have to be careful about not shoving everybody in.

Second, we have a commitment to preserving choice; and, third, we need to know more about how we price and how we do capitation for a high-risk population. One of the things we could end up doing is increasing enrollment in managed care and underpaying managed care companies, and by shoving large numbers of very risky people into their pools. I would say that we are moving quite quickly into managed care. Will we move more quickly? The answer is yes, because the Governors will start to move their Medicaid populations in. But even they will start slowing down because they then have to maintain high quality Medicaid HMO's.

We have tried to move our people into HMO's that aren't set up just for Medicare to ensure that you continue to have a mix of enrollees. Finally, the big issue in managed care is home care, where costs have soared.

Mr. SHAYS. Probably because of no copayments, don't you think?

Ms. SHALALA. Well, it may be that, or it may be that it is a tough thing to administer and to manage when you are sending an individual into someone's home as opposed to having oversight on an institution like a nursing home. Most of the costs in Medicaid are, in fact, long-term care costs. I mean about two-thirds of the costs there.

Mr. SHAYS. Before calling on my ranking member, or the ranking member, Mr. Towns, I wanted to just acknowledge the presence of three new Members, Mike Souder from Indiana, and Chaka Fattah from Pennsylvania. Philadelphia?

Mr. FATTAH. Philadelphia.

Mr. SHAYS. My grandparents' home.

And as well Dick Chrysler from Michigan, and then Mark Sanford from South Carolina. I welcome all of the gentlemen here.

Mr. Towns, you have 10 minutes, and we will just roll the clock twice.

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

Let me begin by saying, Madam Secretary, I have really been impressed with some of the things you have been able to do in spite of all the kinds of problems that we have had and the mixed signals that you receive from time to time coming from this side in terms of the House in particular.

Ms. SHALALA. It is easier than running a university, Congressman.

Mr. TOWNS. If you can run one in New York, you can run one anywhere, no question about it.

Let me just say that I know that many waivers exist out there. Some States have come in and have gotten waivers. As we move to reorganize and to reinvent, what will happen with these waivers that have already been given? What will take place?

Ms. SHALALA. The waivers are, in fact, contracts usually for 5 years, so the waivers basically are a 5-year contract between the Federal Government and the States. In every case we have written

language into the waivers that says that if the program is fundamentally changed then that will change the waivers, and the Governors knew that.

In welfare reform, for example, we indicated very clearly that if there was a fundamental change in the welfare system, that the waivers would have to change and we would go through that process.

Mr. TOWNS. As I look at what we are doing here in terms of reinvention and all the kind of changes that we are making, suppose we find out that one of those Governors out there really has a solution to one of these major problems that we have been dealing with, these many years, what can we do at that point?

Ms. SHALALA. If I found out that a Governor out there had a solution to a significant problem, I would be up here in 2 seconds with a piece of legislation to change the Government program.

Mr. TOWNS. Do you think we would be able to change it? Because we are so focused now on downsizing, eliminating, and not listening to a great degree, because we have sort of figured out this is the way we want to go regardless of whatever signs or indications might pop up.

Ms. SHALALA. Well, it depends on what the Federal Government's oversight role is. Some of the proposals that are before Congress essentially give the money to the States. In some of the first drafts I saw, for instance, of the Ways and Means welfare reform bill, the Secretary was actually taken out of it. You could not haul me up and say what's happening in this State versus this State because I would have no authority to actually go and collect the money.

Some of that has been changed in new drafts, but I think one of the important points here is that even as we talk about the different relationship between the Federal Government and the State government, it is still people paying their taxes to the Federal Government. We favor an oversight function even as we devolve responsibility so that we can, in fact, tell you whether there has been a breakthrough on a waiver, or so we can help you to take responsibility.

Mr. TOWNS. So you can't tell us, you are saying? You can't tell us?

Ms. SHALALA. There are some drafts in some legislation that actually say that the Secretary does not have the oversight authority, over the programs. The block grant is for the States to do what they want with the money and that the Secretary may not have the authority or the resources to do proper oversight. It makes the accountability issue more complex, and one of my great concerns is that if it is Federal taxpayers' money, I need to be able to help the members of the congressional committees that I report to understand what is going on out there. We ought to be very careful in the process of devolving power to make sure that we have oversight responsibility so that we can say to Federal taxpayers this is the way your money has been spent.

One of the great problems of some of the block granting in the past is that we didn't have a clue what was going on out there. As a result the programs got cut way back because there were lots of crazy stories of things that were being done with the money. I

would suggest that we have built, for example, Congressman Towns, evaluations into every waiver.

One of the things I have argued with the States about, because they don't necessarily want to spend the time, is that waivers are for demonstrations, and are to be evaluated. We give waivers because we want to learn something, and therefore we have been firm about both identifying what we wanted to learn and making sure that the State had in place a good evaluation system.

Mr. TOWNS. Well, you know, I must admit that I am happy to hear that you do have some concerns along the lines that I have concerns. The fact that inasmuch as we begin to push all these things back to the States, I think it was Tip O'Neill, who was a very popular Speaker here, said that all politics is local, and I am thinking about the fact that there is a strong possibility that people who are really needy, because of the fact that they are not in the political kind of mix or do not have the political kind of support base, will be left out, and if we are not careful, if this is not structured properly, there would be nothing that you would be able to do to make certain that those folks receive service in a timely fashion.

Ms. SHALALA. There are two authorities that I need. One is data collection. We need a data base so we know what is going on, so it is not just a snapshot view of an individual State. This committee will want to know what the effects of a major reorganization had on all the States and then individual States so we can compare them. Second, I need genuine oversight responsibility so that taxpayers and Members of Congress will know from our inspector general as well as from the evaluations the Department conducts whether the goals that they hope to achieve have in fact been achieved.

I would argue it is possible to devolve more flexibility, more authority, but to simultaneously hold the States accountable for what they do with the Federal dollars that they are being given. Finding that balance is much of what the debate is about and ought to be about.

Mr. TOWNS. Let me just say, Mr. Chairman, I know you made a commitment, but I think that you didn't expect the turnout that you have, so I understand the fact that you have to have the Secretary out by a certain time. I am just going to ask this last question.

Ms. SHALALA. I am fine.

Mr. SHAYS. We have an hour, so you are doing all right.

Mr. TOWNS. I am doing OK? I mean I don't want to sort of hog it up and then all of a sudden the Secretary has to leave and a new Member is saying that, "He is just like the rest of the old members."

Mr. BARRETT. We already said that.

Mr. TOWNS. You already said that. I don't want that to happen. You already said that.

A final question then. One area of efficiency that we continue to hear: That the Department can do more about its review and approval process at FDA. Can you briefly describe the advances FDA has made in streamlining approvals for medical devices, and are

there changes that HHS would be willing to propose to streamline FDA's export policy for medical products that we develop here?

And let me just go a little further. Have you had the opportunity to receive the report commissioned by the CDC which evaluated New York State's childhood vaccine delivery system, and, if so, do you think that New York can serve as a good example for an alternative distribution strategy?

Ms. SHALALA. On the last question, my view is that the distribution strategies are very much determined by the States. Different States have different needs, and I think that although we originally had done it at the request of the States, we have moved away a great deal from a more centralized distribution strategy for vaccines to the States developing their own distribution strategies for vaccines.

The point here is that, no matter what the delivery system is, what we are trying to do is to move from being a Third World country in the number of our children who have been vaccinated properly to a 90 percent goal in the next—in the next couple of years.

On the device review times, we have submitted as part of our fiscal year 1996 budget a user charge. It is part of our overall streamlining of the review process of medical devices. I have a chart here that gives you a sense of what our goal is, and that is to move from 27 months, which is the average review time for new devices, to 12, and on devices similar to marketed devices, to actually move it down to 3 months. We have made a significant impact on drug review times by using user charges, and working with the industry. We are also reviewing the possibility of exempting certain device changes altogether to try to get the system streamlined.

[The information referred to follows:]

Drug Review Times

	Months
New Applications:	
1992	27
1994	19
Supplements:	
1992	12
1997	6

Device Review Times—In Months

	Current	Proposed
New Devices	27	12
Devices Similar to Marketed Devices	20	3

Ms. SHALALA. I think that this Government ought not to be putting in place and ought not to scrimp on resources, whether it is a combination of user charges or the Federal Government's own taxpayer money, to restrict American companies from getting their products to market and from being able to get their products overseas. We have a big commitment to get those times down and we are working with the industry to do that.

Mr. TOWNS. Thank you very much, Madam Secretary.

Mr. SHAYS. I thank the gentleman, and I am going to take the gentleman's advice in this way. We do have a number of new Members who have come. We are still going to allow the new Members to have the 10 minutes, but what I am going to do is rotate 5 and them come back and bypass the chairman and ranking member, so in case some of you have to leave a little earlier.

Let me just welcome Gene Green from Texas, Tom Barrett from Wisconsin, and Bill Martini from New Jersey.

And, Mark, you have the floor.

Mr. SOUDER. Thank you.

I had a question, and I am sorry if it is somewhere in our documentation and I missed it. Right now I am having, in this first 100 days, trouble remembering what State I'm from, let alone all the details. The 12,000 employees that you reduced or plan to reduce, will that include the Social Security transfer?

Ms. SHALALA. The answer is yes.

Mr. SOUDER. How many employees is that approximately?

Ms. SHALALA. Walter is in charge of——

Mr. BROADNAX. About 5,000 of that number is Social Security, and 7,000 is the balance of HHS.

Ms. SHALALA. HHS is going down at a rate faster than Social Security in part because we needed to invest in Social Security to reduce the time of disability reviews and to put in some new technology.

Mr. SOUDER. And what is the total number of employees at HHS now?

Ms. SHALALA. I think that is on a 128,000 base.

Mr. SOUDER. And the Social Security, will it be reduced, or are the 5,000 just being transferred?

Ms. SHALALA. We are trying to do everything with vacancies, so Social Security will be going down by that number.

Mr. SOUDER. And in the 128,000 figure, how many of those were Social Security?

Ms. SHALALA. About half.

Mr. BROADNAX. Yes, about half.

Mr. SOUDER. So it is 66, and you are reducing approximately proportionately.

You have had a statement about the breast cancer rates—the screen rates are going up. Do you have any idea what percentage of that is because of the Government programs directly as opposed to private sector awareness?

Ms. SHALALA. I assume all the time that it is a combination of public and private. In fact, as part of our Breast Cancer Action Plan we brought together private sector people, the advocacy groups, and the nonprofits. We don't think that we can get prevention done in this country without a public-private-nonprofit effort. So I would never identify something with just a Government investment. We may be the catalyst, we may on occasion be the leader and bring focus, but it is always going to be a public-private effort.

Mr. SOUDER. One of the debates that we are internally having and has been discussed for years: Do you see any reason why, in the holistic approach to families and children problems, the WIC and food stamp programs aren't under HHS?

Ms. SHALALA. I just am not authorized to talk about transferring programs from one Government agency to another.

Let me say that at the State level and local level, we are involved in getting those programs to work together with the AFDC program and with the Medicaid program. In Oregon, for example, we have a major effort with the county, the city, and the State to increase flexibility to get those programs to work more carefully together, and that is our goal in every community.

Mr. SOUDER. There is a lot of concern, and I think it is also Head Start being in HHS, and one of the things a lot of us will be pushing for is more logical realignments and more holistic approaches. That is partly why we are burning up a lot of dollars by spending time coordinating and trying to deliver. For anybody who has ever been out in any urban or rural area, it is so hard for them to figure out where to go for money. It is almost a full-time job to figure out how to get your supplemental income.

Ms. SHALALA. You know, I should say that neatness may not necessarily achieve that, particularly if it means that you bring down the amount of money that is available. There is not that much overhead at the Federal level in these programs.

For example, to make Head Start a seamless program, there is a zero to three initiative which Congress approved last year that allows the States to fit their early childhood and prenatal care programs right into the Head Start Program. We have worked with the Department of Education to fit the Head Start Program into the school system program so you go right from Head Start into kindergarten, into the first grade. For instance, we will have no new Head Start buildings that aren't located close to schools.

The Head Start Program is an example of a program that started with a fundamentally different philosophy than the schools program did, which is one of the reasons that it was put in the Department. That philosophy is to involve parents from the very beginning and to fit them together with other Government programs.

While I don't like fragmentation and think small categorical programs ought to be merged, which we have done a great deal of, I personally don't think that the problem is as much the fragmentation of programs as other factors. We can do some things with flexibility to make sure programs fit closer together. We must make quality investments, and make sure that communities can fit the programs together seamlessly. I would be careful about too much centralization because many times the dynamic nature of the programs are the result of their separate identity.

Mr. SOUDER. Thank you.

Can I make one brief comment, and that is that I understand your point in Head Start, but you made a terribly insightful declaration against education when you said Head Start involves parents and it is unlike a school system in education.

Ms. SHALALA. But Head Start was actually first developed because of great anger by low-income parents about school systems that did not deeply involve parents.

The emergency education system has changed dramatically, in particular, the investments in early childhood in the early years, in our understanding that all the successful programs we know have involved parents, and it was Head Start that helped, I would

argue, some of that revolution in early childhood education, and our understanding of the role of parents as opposed to keeping them out of—out of both the schools as well as early programs.

Mr. SHAYS. One of the fortunate things in this committee is, because we have combined two of the subcommittees, we are able to look at Education, Labor, HHS, HUD, as well at the bigger picture that goes beyond the Department.

Ms. SHALALA. Congressman, I would urge you to have Mary Jo Bane, the Assistant Secretary for children and families, who has Head Start under her, and is also an expert in education, come and talk to the committee if you are particularly interested in how programs fit together.

Mr. SHAYS. We will be delighted to do that.

I thank the gentleman for his questions.

Mr. Fattah.

Mr. FATTAH. Thank you, Mr. Chairman.

Let me both welcome the Secretary and her Deputy, whom I spent some time with at the Kennedy School at Harvard.

Ms. SHALALA. Is it true he was your professor?

Mr. FATTAH. This is true.

Mr. SHAYS. And what kind of grades did he give? [Laughter.]

Mr. BROADNAX. He was an A student, Congressman.

Mr. SHAYS. Do you wish you had given him A's now?

Mr. BROADNAX. I was smart enough to do it then.

Mr. FATTAH. It is good to see both of you.

I'll take my few minutes and try to ask a couple of questions all wrapped up in one. One is if you could give some quick comment on some of the proposed cuts and their impacts, for instance, on the Ryan White AIDS Program and also on the domestic abuse hotline, if you didn't cover that in your opening statement, but moreover and more locally related, the Healthy Start Initiative and in my district has had a tremendous impact, and I was wondering whether you could make some comment about that program and where the Department is nationally with that effort.

Ms. SHALALA. Let me say a couple of things. I did talk a little about the hotline program, my disappointment that it is included in the rescissions when it had bipartisan support. In fact, everybody marched up and said the one thing they liked in prevention was what we had done about domestic violence.

Mr. SHAYS. I wonder if the gentlelady would just suspend for a second because of your statement. I checked that out with Representative Porter, and I think you will be happy to know that they are going to insert that back in. They took it out of the crime bill not intending to take that portion out. In other words, there may be a lot of areas where you have criticism, but that is going to be put back in the budget, and I thought you would be happy to know that.

Ms. SHALALA. I'm ecstatic.

Mr. GREEN. Can we add some other things to that?

Ms. SHALALA. On the Ryan White Program, my concern there is that AIDS is now the leading killer of people between 25 and 44 and we need every dollar we can get for that investment. The Ryan White money is community-based money that goes out to the communities; they decide how to use it. It is focused specifically on

areas that have very high percentages of HIV–AIDS. It is a very important part of this Government's commitment, and the President has made an enormous commitment on AIDS in particular.

On Healthy Start, I know the Philadelphia program has been phased out. It was originally set up as a national demonstration. We had hoped to follow it up and have been searching for a way to be able to continue some of the Healthy Start programs, but I am afraid that it just got cut and caught in the downsizing and the budget cuts. I think it is one example of a program that works and that we are just having a struggle in trying to maintain.

Mr. FATTAH. Thank you.

I yield back the remainder of my time, Mr. Chairman.

Mr. SHAYS. Thank you. I thank the gentleman.

Mr. Chrysler.

Mr. CHRYSLER. Thank you, Mr. Chairman.

Madam Secretary, what are your views on the block grants that are going on right now with the concept of block granting a lot of the welfare stuff back to the States?

Ms. SHALALA. I do not intrinsically have a problem with block grants as long as we have built into them, in the case of some of our public health block grants where the issue is welfare reform. However, my reading of the Ways and Means Committee bill is that it is not welfare reform, but that in fact it removes welfare from being an entitlement. This is an entitlement for working families, because they are the ones who get laid off in Michigan for short periods of time.

We have removed in that bill the economic stabilizing effect, a very important role for the Federal Government. The Ways and Means Committee takes less money and sends it back to the States with very few rules. Particularly, it misses the point about welfare reform that I believe both parties have been talking about, which is moving people from welfare to work. The work requirements in the subcommittee bill were less stringent than the current work requirements. Even as raised, they are weaker than Ronald Reagan's successful 1988 welfare reform bill.

Second, it is unrealistic in that it cuts out large amounts of child care moneys for folks when they move from welfare to work. It is unrealistic to expect a young single mother with a child to move into the work force without any child care, without health care. We must not simply create incentives to push people out, but we also have to be realistic about families' needs. It also reduced, from what the President wanted, the availability of child care for working folks.

It seems to me that low-income working people in this country ought to be able to not worry about their children and the incentives and the availability of programs ought to be for those that play by the rules, and I just don't see it in that bill.

Finally, we must hold both parents responsible. We apparently will have child care support enforcement, but making sure that both parents are responsible for taking care of that child must be a very important part.

I am concerned about how teenagers are treated in the bill. If you are 19 and you have a child you are treated differently than if you are 15 and you have a child. I don't like the idea of not mak-

ing cash assistance available to the parents of teenagers. We suggested that the check go to the parents of that teenager. The Ways and Means bill gave that check to the bureaucracy to provide services. Our preference is to strengthen the family.

Strengthening the family, holding both parents responsible, having very tough work requirements, but making sure support payments are there—you can do all of that within the context of more flexibility for the States. The States can work out the education and training programs, but you have to give them the resources to do it and some performance expectation, and I would argue the central expectations ought to be on work and responsibility.

Mr. CHRYSLER. Why can't they do that for themselves? And also you mentioned when a person is temporarily unemployed. Usually when a person is temporarily unemployed, they have unemployment insurance to take them through that period.

Ms. SHALALA. Many low-income people don't because of the nature of their jobs. Let's use your State for example. If there is an economic downturn and a low-income marginal worker gets laid off, what they do now, and because the State is going into recession, one way of pulling the State out of a recession is some investment by the Federal Government in some automatic programs such as food stamps, AFDC—and often the child care programs kick in, so that that family can use the welfare system and the social programs the way we want them to work; that is temporarily, to get them back on their feet to be able to feed their families. In fact, I would argue that moving to block grants from the current arrangements remove the safety net for working families. It doesn't necessarily remove the safety net for the poorest of the poor, depending on how much money you give, but it removes it for working families who need these programs temporarily, that need to be able to bounce into a program temporarily to make the transition, and that is my only point.

For the State it becomes even more problematic. If the State has an economic downturn, the recession goes deeper and broader if it doesn't have some money coming in for its workers. It is harder for businesses to tax under that situation, I would argue. It is harder for the State to pull itself out of a recession if you don't have some resources coming in for laid-off workers, and I would simply urge all of you to think about the economic consequences of moving away from a strong Federal role.

In Gary, IN, those programs were very important. That community went through a very useful economic transition, but it would have never been able to pull itself out unless there were programs that came in, and, again, temporarily; workers use these programs temporarily when they are laid off.

I believe the people that play by the rules in this country, that get up in the morning and go to work, that, through no fault of their own, get laid off, ought to be able to feed their families and their States ought not to have more difficulty getting out of those recessions. In the most difficult times for the States to help those people, we the Federal Government, ought to provide assistance that is automatic.

Mr. SHAYS. I thank the gentleman.

Gene Green from Texas.

Mr. GREEN. Thank you, Mr. Chairman, and I want thank the Secretary. Two weeks ago she was in Houston and spoke at our DeBakey lecture series at the Texas Medical Center, and a great attendance by both the business community and our medical community.

In fact, we had three Members of Congress there to enjoy your remarks.

I have some questions, but I know the frustration in the States because we created a pre-K program in Texas in 1984 in response to the lack of expansion or even the cutbacks in Head Start in the early eighties, and I know what happened. At the same time, we also required parental involvement, and we do have—in fact, I was at the school Monday morning in Houston. It had a 3-year-old program at that elementary school, and so some of the States are taking on that program because, again, I have a district and we could use a number of more Head Start centers, but the State has taken up that, so we are using that experience from Head Start and the success from Head Start in some of our State programs.

One question, and hopefully we can—I know the effort on the medical side on moving or encouraging seniors particularly to become managed care under Medicare, and if you could just briefly tell us where we are at on Medicaid for managed care and moving more toward that effort as an alternative.

Ms. SHALALA. Medicaid has had a 63 percent increase over the last year in moving to managed care, almost three—I think it is 3 million people; in my testimony, have moved into managed care from Medicaid. The Governors are moving very rapidly. We are trying to make certain that they are looking at quality, that they are phasing it in as part of our waiver process. I have a number of waivers on my desk from a number of States who want to move into managed care, and we will over time surely be approving more of these waivers.

Our concerns are about the capacity of the industry itself, and the ability of the States to do oversight. We don't want to repeat the terrible waste and fraud that we had in the 1980's, so we want to be very careful as we move into this. We are obviously not stopping the flow and we certainly don't want to stop the Governors from looking for good alternatives, but the alternatives have to be not only for fiscal discipline but also for quality. We want to maintain quality.

Mr. GREEN. OK.

In my other Committee on Education and Economic Opportunities we have passed part of the welfare reform bill, and I know you addressed it in the block grants from my colleague, Mr. Chrysler, and talked about your concern about the block grants and the school lunch program, and what I would like to ask is, doesn't the Federal care result in a possibility, for example, of an unfunded mandate if we require the States and we limit their administrative costs to less than it is now?

For example, whether it be the WIC program or the nutrition program, that is, it is costing 8.5 percent on the average and we are limiting them to 5. Do you see any flexibility in that? Because, again, it goes back to the individual legislators now to say, OK,

maybe we can cut some administrative costs, maybe we can't, out of that.

Ms. SHALALA. As I indicated earlier, I don't see this movement toward block grants with no performance measures really as reform at all. It may be seen as the ultimate flexibility, but you don't have a lot of flexibility when you are not given the money that you need. In fact, what you are doing is mandating the States to pick up the difference, which will be very difficult for most of the States because their whole systems are built around an assumption that there is going to be a reasonable amount of increase in these programs. So I couldn't agree with you more about the difficulties being created.

But again, back to my earlier point, to simply throw money out there without some expectation is a fundamental debate, as you well know, Congressman Green. It is a debate about whether the Government has a responsibility to make certain that a child born in one part of the country doesn't starve because they happened to be born in a part of the country where there may be a different philosophy. I assume that we bring some basic values to the operations of the national government, and one of the fundamental ones ought to be basic opportunity, and that includes having enough to eat and having shoes for American kids.

Mr. GREEN. OK. Thank you very much.

It looks like I just ran out of time.

Mr. SHAYS. You will have another chance if you would like, if you want to wait.

Mr. GREEN. OK.

Mr. SHAYS. I thank the gentleman.

The gentleman from New Jersey, Mr. Martini.

Mr. MARTINI. Thank you, Mr. Chairman, and good morning, Madam Secretary, and I apologize for not having been here during most of your testimony. We were in a markup.

I apologize to you, Mr. Chairman. I was in a markup in another committee and had to be there, and, at risk of repeating what you may have already testified to, I guess one of the concerns that I have had for a long time, and I think reflective of my State being a State with a lot of pharmaceutical industries and manufacturers, is the inordinate time for approval of new drugs and medical devices, and I think I heard the tail end of one of your comments here, and it is probably too lengthy now for you to get into the whole recommendations, but I would hope that there are recommendations to speed that up.

But one of the concerns is, in talking about increasing of application fees, I have had feedback already that they may just be a further delay or just add an additional cost to the process of speeding it up, and maybe you can comment on that.

Ms. SHALALA. I have a chart here that shows you, from 1992 to 1994 what we have been able to do and how much further we expect to come down on drug review times.

We have worked with the industry. They work with us on the user fees, as you know, and we have been able to demonstrate that putting in those additional resources and streamlining the process has actually brought down the review times. We intend to bring them down even further in fact. We have cleaned up a lot of the

backlog, and we are going to do the same thing on medical devices, where we have asked for user fees.

I think the industry will be very pleased with some of the other changes that we are going to make in the FDA, as a part of Reinventing Government II, which will report in June.

Mr. MARTINI. Just one or two other questions in this area. Very shortly, I guess in the next week or two, Congress will be taking up a tort reform bill, and part of that bill I believe will have a provision that if a drug manufacturer has gotten FDA approval before leasing the drug and then some years later there is a lawsuit alleging products liability—a cause of action in products liability against the drug, the manufacturer will be able to utilize the fact that they got FDA approval as a defense of that suit, subject, of course, to the extent, I understand, if there were some new information provided to the manufacturer from the time of the initial release of the drug to the time of the filing of the suit which the manufacturer withheld, then the defense would not be available to the manufacturer.

Do you have any thoughts on that?

Ms. SHALALA. I think I would have to look at the specific legislation, the tort reform legislation, before I expressed a view and check and see what our position is. I am not sure that we have reviewed the legislation in the Department, but I would be happy, if we do have a position, to provide it in writing to you.

Mr. MARTINI. Thank you.

And just two other items of interest in this FDA area and particularly with respect to the President's proposed budget. One is the orphan drug tax credit and research and development tax credit which expires in June, and I guess we are concerned as to what the administration's position is with respect to either or both of those.

Ms. SHALALA. I'm not sure I have that. Why don't I provide it for the record.

Mr. MARTINI. If you would. Thank you.

Just in closing if I have another minute or two, just picking up from the last conversation you were having about welfare reform block grants, et cetera, we have had some statistics made available to all of us, I'm sure as well as other Members of Congress, of new initiatives that have been made in States like Wisconsin, Michigan, Massachusetts, et cetera, and I'm sure before those initiatives were undertaken there were a number of people out there expressing similar concerns that we all have about what are we doing, and are these things going to be helpful or not, and yet some of the statistics, as far as we are hearing, would indicate that these are improvements in the system, that it is becoming a more effective system and it is also ending a pattern of dependency.

How, in the face of those types of situations where we see States having the willingness and the courage to go forth and try some new things, should we not consider those things which in many respects what we are considering now, I think, mirror some of the things they have implemented?

Ms. SHALALA. Congressman, we have been—first of all, we have approved those waivers, and that is that the States laid out for us, in fact, working with us in most cases, what it was they were try-

ing to achieve, what the goals were, how they were going to use their resources, what the protections they were building in place, et cetera. Those States have been able to go to test those ideas in a joint partnership with the Federal Government.

The President has long believed in welfare reform and was one of the leaders in 1988 in the bipartisan effort to reform the country's welfare laws. In addition to that, he strongly believes that the States ought to have more flexibility. His own bill reflected what we had learned from the States.

All we are saying is, we do not believe in simply throwing that money out there. Not only is there not enough money so it doesn't have any child care, doesn't have any education and training, doesn't have any expectations in terms of work requirements for the States, doesn't necessarily have the level of parental responsibility that we think ought to be in place, but there ought to be some principles built into the welfare reform legislation that protect the Federal taxpayer, protect children at the same time, and make sure it is real welfare reform.

Simply sending out a check to the States doesn't necessarily get welfare reform in all States. If we want welfare reform in this country there ought to be some expectations and some genuine resource investments, though in our case our proposal was budget neutral.

Mr. MARTINI. Thank you very much.

Thank you, Mr. Chairman.

Mr. SHAYS. I thank the gentleman.

Representative Barrett from Wisconsin.

Mr. BARRETT. Thank you, Chairman Shays.

First of all, I like your seating structure here, the informality of it. I think it is helpful. And, Secretary, it is nice to see you. I watched the men's Badger Basketball Team last night, so I'm not in a very good mood this morning. They didn't play that well against Minnesota, but that's the way it goes.

Ms. SHALALA. I'm sure we are going to get a response about the University of Connecticut's——

Mr. BARRETT. Yes, Connecticut can talk this year; that's for sure.

I think, to go back, if we could, to the food stamp program, and maybe even before we touch on the food stamp program I want to spend a little time on the school lunch program and your analysis of what is going on there and what type of impact that will have. There has been a lot of back and forth discussion about whether there is going to be cuts things like that. Just your views on that.

Ms. SHALALA. Well, as you know, Congressman, I don't have responsibility for food stamps, it is in USDA. When it looked like we were going to block grant food stamps, however, our concerns were that it was the most basic protection that we had for American children and families. But it looks now that it will be continued to be an entitlement.

My concern about the school lunch programs and the other kinds of categorical or entitlement programs that are to be put into block grants is that one of the things we have been able to do in this country is establish nutrition standards. We have been raising those nutrition standards to make certain that the food that the taxpayers were paying for was good, nutritious food.

If we cut back on things like school lunch where there may not be enough money to cover every child, I think that it affects the children whose parents are not in the food stamp program.

Carol Browner, my colleague from EPA, was telling me that a high percentage of the kids in her child's school get subsidized school lunches, but many of the children don't. What happens to her child in the classroom with a child that hasn't been able to have breakfast or lunch?

So I think that we have to be careful about these fundamental programs. Again, not much different than what I would call the work requirements, that if people send in their taxes to the Federal Government, they expect you and me to set some standards for how that money is spent. You would suggest that it is possible to give the States more flexibility to fit the programs together, but at the same time we ought to have some high standards and we must make sure that the resources are there so that no child gets up in the morning, goes to school, and is hungry for that day.

Mr. BARRETT. We do hear a lot from the States about too much control in Washington and that they can make the decisions better than we can, and I think that the intensity of those concerns varies from program to program.

With respect to the school lunch program, what has been your experience? Have you heard a lot of complaints from the States that the Federal Government has been overbearing in this?

Ms. SHALALA. There's a culture saying that we have been overbearing. I often get calls from Governors saying, "Why did you do this? Why did you do that?" It turns out that we haven't done it at all, that it is written into their State law or into their State legislation.

I would hope that the States are going through the same kind of review we are. I will not justify crazy rules. I mean there just is no reason for that. I think we should be more flexible with the States. The President feels very strongly. He was running a State government before obviously. I have spent most of my career working with States, so you won't find a greater advocate than me to give them more flexibility. But at the same time the reason we got into these programs was not because the Federal Government wanted to meddle. They were conservatives like Robert Taft of Ohio that believed very strongly that there were some fundamentals to what it means to be an American, that we ought to even out some of the differences between poor States and rich States, and that one of those things ought to be about what our children have available to them, whether they grow up hungry.

We have found that delivering the meals in schools are among the best ways to provide some support, that combined with some food stamps. So there is a national role here. There ought to be more flexibility for the Governors and the States, but I think we could find that balance.

Mr. BARRETT. Of the complaints that you have heard with the school lunch program, what are the most glaring complaints you have heard from the States?

Ms. SHALALA. I have never heard a complaint about the school lunch program. I have heard some complaints about the AFDC programs and Medicare programs.

Mr. SHAYS. Talk to the students. [Laughter.]

Ms. SHALALA. Well, actually I went out to eat with some students. I went with Ellen Haas, the Assistant Secretary of Agriculture who is in charge of the programs when we raised the nutrition standards. I was asking the kids about the food because they had been eating under these new nutrition standards, and they said the food was great. They also said, "But we don't get treated like this very often." I said, "You mean they changed the food when we showed up?" and they said no, that this was the first time that they had tablecloths. [Laughter.]

Mr. BARRETT. Thank you.

Mr. SHAYS. We can go around to the four gentlemen for another 5 minutes. We have had our 10, and I would give the floor to Mr. Souder.

Mr. SOUDER. I wanted to come back to the managed care question. You said that there were differences in age or appeared to be, that younger people were tapping into that more than people who weren't as familiar with managed care, and you used an example of Maine and Florida where there was a tradition. What other type of demographic difference do you see? Do you see any by male or female, race, ethnicity, income, rural, urban?

Ms. SHALALA. Certainly there isn't a lot of managed care in rural America. In Wisconsin there is. There just happens to be two big rural care HMO's which are 100 years old in both cases. However, my sister lives in North Dakota on a wheat farm and I think there are one or two HMO's in all of North Dakota.

So as we develop these programs we have to be awfully careful that we are not moving people into something that is not available and is not going to be available. Fee-for-service is probably going to continue to be the primary vehicle in rural America.

I don't know of any gender splits. In many cases the States are basically putting all of their Medicaid recipients, like Tennessee, into managed care. In the case of Medicare, it really is whether the area has had a high penetration of HMO's for the whole population. So a Portland that has lots of HMO participation will attract more of its elderly into HMO's because they know people have been in HMO's. Where as in Florida which has had a long tradition in Medicare of fee for service, the elderly are particularly concerned about keeping their doctors, with whom they have developed a relationship. The older you are, the more fearful about your health. So it is that that seems to make the difference.

What I have suggested is that, as we have more and more generations of people—the penetration for HMO's in this country is about 30 percent—have had experience with HMO's, they probably will want to stay with their HMO's as they reach 65. We will have to learn how to do that transition for them, and that is the only point I'm making.

I am also making the point that we have moved aggressively to increase the number of approved HMO's for senior citizens. We now have 75 percent of all the senior citizens in this country are in areas where they have HMO's available to them so if they wanted to choose an HMO they could.

Mr. SOUDER. Are you seeing any income or education differences?

Ms. SHALALA. Eighty percent of those on Medicare have incomes under $25,000 a year, so you are talking about a population that doesn't have a lot of income. Apparently it depends on the penetration, not whether they offer a lot of different kinds of things.

In Boston, for example, the HMO's are offering the elderly health clubs as part of their package. Remember this rapid movement has been since the beginning of this administration, so the HMO's are learning, as we are, what kind of marketing will attract people to HMO's.

The Governors have made a decision to try HMO's for part of their Medicaid population, and in other cases for their entire Medicaid population, as the State of Tennessee did, and we have approved those waivers.

Mr. SOUDER. I wanted to also talk about the block grant question, at the risk of sounding like a self-righteous freshman.

One of the things that I find really ironic when we get into the donor State question is also related to your earlier comment about the unemployment percent, that the donor States are often the ones which have the highest rate of urban poverty and high risk areas. A lot of the States that are gaining in these formulas are rural and have the lowest unemployment rates in the country. That seems a little ironic given when we look at the south, which is where many of the add-ons occur, like it was 30 years ago rather than the south of today. I'm not sure that the argument of donor States is a valid argument in today's environment.

Ms. SHALALA. I'm not sure I made the donor State argument. The programs work in a way so that a State like Texas that has relatively high, though under Ann Richards higher, cash payments under AFDC got more food stamps. Really, these programs work on where poverty is located for the most part, though they work in tandem where the cash income is taken into account. So the south, you will see a higher use of food stamps than you will cash assistance.

Mr. SOUDER. When I was Republican staff director at the Children Family Committee on the Republican side when Mr. Miller was there and Ann Rosewater from your Department and Alan Stone, we had a big battle over this very question. The poverty level often shows rural communities are in poverty when in fact they have all kinds of supplemental incomes and their cost of living is substantially different. What a committee study showed is Wayne County in Detroit, New York City, Philadelphia, Cook County, and Los Angeles County were in better shape than a lot of rural areas, including several Amish areas in Indiana, based on the coverage, and there is some kind of formula problem.

What I would argue is that the States understand those differences. There are some prejudices against the urban areas which we also have to watch. I am not wholly against the Federal Government putting some standards on the block grants, and I am concerned about the money coming in here and transferring to us obligations without control. But at the same time I don't think all wisdom lies here. I think the Governors, the legislators, the cities, and the mayors know in their States a lot of these differences that, in the past, we kind of glossed over. And when you actually look at

a lot of these programs at the grassroots level we have made some bad errors.

Ms. SHALALA. I hope I haven't sent you a message that I think we have all the answers. The writing of formulas, if you move from an entitlement to a block grant will be actually quite dicey, as you will find out. Depending on what kind of poverty measures you take into account, and the formulas that are currently being written do not necessarily favor rural States or southern States, as opposed to when people need it.

You see these programs, as we do, as transitional programs, as temporary programs, and what you want to do is to make sure they are in place, they have firm rules, so that if someone gets laid off they can feed their family, and that they have firm rules about how long people can stay on the programs and what kind of help they get when they move in transition off the programs, and those were the points I was making about this.

Mr. SHAYS. Thank you, Mr. Souder.

Representative Green, you have 5 minutes if you like.

Mr. GREEN. Thank you, Mr. Chairman. I hope to yield back some of the time.

To the Secretary, one question I wanted to ask earlier was on the welfare reform, and I know—and in my other committee we actually put in a definition of work as the bill came out of committee, but the current proposal—and you may because you see it on a daily basis, and I know Ways and Means is still doing their work on it—what would be the requirements under the current proposal that is coming through the House as compared to the administration's proposal on the work issue, the work requirement?

Ms. SHALALA. There is actually a substantial difference. The last draft I saw has a 4 percent requirement. The current requirement in current law is 1 percent. I mean that is a big difference. We had about 50 percent of the eligible population moving by the end—over the next 5 years moving into work requirements.

The important thing is that the States, no matter what number you pick, ought to be doing more than what we are currently doing. We want to move people off welfare, particularly if we are putting enough resources in. But what we want is to get everyone who is able bodied off of the welfare rolls into a 2-year time limit, as quickly as we possibly can. A 2-percent requirement, which was the original bill, a 4-percent requirement, which was the last draft that I saw, are simply not welfare reform. I mean it's just not welfare reform.

Mr. GREEN. In following up on that, but also the purview of the committee more is the coordination, and I know the welfare reform bill and the job training programs that HHS participates in along with the Department of Labor, and what job training programs do you expect we would see? Because we are going to have Secretary Reich, I believe, in early March—next week—on consolidating with the Department of Labor so we don't have that duplication in providing particularly under umbrella welfare reform.

Ms. SHALALA. Under the President's bill, we intended to use the Department of Labor programs and leave it to the Governor to designate what the jobs agency was in the State, who would have the lead on job placement and job development.

We did retain in the President's welfare reform bill the cultural change in the welfare office so that from the moment someone walked in they were getting ready for work. The individual's education and training component of the plan was retained by the social service office in the State and so that there was some management of that process, but the design of it was left to the States.

The important thing is to make an up front investment, to make sure child care is there, to make sure that there is some health care there as part of the transition, but to time limit it so it is real welfare reform and so that you can measure some goals for the State of what you intend for the outcomes to be.

Mr. GREEN. In my final minute, Mr. Chairman—and I am not on the committee that deals with tort reform, but I think it is ingenious, the idea of saying if you have FDA approval then you are not responsible unless there is new information that comes up, and, again, having served 20 years in the legislature, I guess we could apply that to driver's licensing, that if the State licenses you, then you must be OK, and that is why our roads are so safe.

Thank you, Mr. Chairman.

Ms. SHALALA. I think I'll let that one go.

Mr. TOWNS. I think his team lost too. [Laughter.]

Mr. SHAYS. Mr. Towns.

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

Let me sort of raise a question in terms of, you had a proposal, as I remember, which was somewhat different from the Goodling proposal which was, I think, H.R. 999, with regard to shifting Federal responsibilities to the States, talking about the lunch programs. You know, I just sort of looked at that. At some point won't this become an unfunded mandate, the fact that you are pushing it to the States, that if the need is greater than what we are actually giving in terms of the grant——

Ms. SHALALA. Well, I think that the Governors are beginning to realize that the cumulative effect of all these cutbacks are going to be tremendous on the State if what they want to do is maintain their program investments. It is not just school lunch, it is the welfare programs, it is the child care programs, it is the whole range.

If Medicaid is block granted, it will have a tremendous effect on the health industry in the States and on the quality of life in those States, so we are in fact, by cutting back on the programs and sending less money to the States, imposing what will eventually be huge financial burdens. Certainly the States are going to have to go through some radical changes in their own organization as a result of it.

Mr. TOWNS. Let me ask you another question. I know that there are meetings going on now in terms of the second phase of the reinvention in terms of the proposal, and I know there are some things you might not be able to answer, and I understand that and respect that and want you to know before I even start dealing with this particular issue.

There has been a lot of discussion about the merging of the Surgeon General's Office with the Assistant Secretary of Health. Is this more than just a heavy rumor, or is it something that is moving toward fact? Could you comment on it?

Ms. SHALALA. I can't reveal what our discussions are, but the President is sending up or has sent up a candidate for Surgeon General, and we made the decision in this administration to keep the position separate.

The assistant secretary of health has his hands full with a hundred programs or so that are being consolidated, and the Surgeon General has been the prevention public health spokesperson for the Department, and at this time we think keeping those jobs separate is appropriate. But there is no rumor of anything we are doing on our side.

Mr. TOWNS. OK. You know how you sort of—I guess coming from New York, you even get more rumors than you get from other places, but I just wanted to let you know I heard that.

Ms. SHALALA. No. There were, in fact, some recommendations from some Republican Members of Congress that the jobs be combined. They were combined in the Carter administration.

Mr. TOWNS. Right.

Mr. Chairman, before I yield back let me ask unanimous consent to include Mrs. Collins' statement in the record. The ranking member of the full committee, who could not be here, asked me to convey that to the Secretary, and she would like to put a statement in the record.

Mr. SHAYS. Without objection, that will be done, and the ranking member of the committee as well as the full chairman are always welcome in these hearings to participate.

[The prepared statement of Hon. Cardiss Collins follows:]

PREPARED STATEMENT OF HON. CARDISS COLLINS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ILLINOIS

Mr. Chairman, I am pleased to join you and the ranking Member of this Subcommittee in welcoming the Secretary of the Department of Health and Human Services. Given the enormous size of this agency, and the magnitude of its reach, its mission, and its budget authority, the reinvention of government as it pertains to HHS will touch the lives of every American. Clearly, the Committee's oversight of this initiative, as well as any other HHS reform initiatives is critical to the social, economic and fiscal well-being of this country.

I thank you, Chairman Shays, for scheduling this hearing which I hope will be the beginning of a careful, compassionate, and balanced review of HHS operations and meaningful discussion of its future. However, I too, am alarmed by the Republican leadership's headlong rush to carry out the "Contract with America" with so little regard for our poorest and most vulnerable citizens, let alone any regard for the normal legislative process: holding hearings to gather information; developing, considering and passing legislation in Committee, then final deliberation on the Floor.

I have to tell you that I too have noted that the pace with which we are examining the operations of Federal agencies in this Committee is more than matched by the vigor with which programs are cut and budgets slashed on the Floor of the House.

As a result the legislative process is now turned on its head, and I question our ability to have a meaningful discourse on the possible achievements Secretary Shalala might reach under the Administration's reinvention strategy, or even what progress she anticipates for fiscal year 1995. For example, why are we considering the Secretary's plan to improve the child welfare system, when a legislative proposal repealing the Abandoned Infants Assistance Act, the Child Abuse Prevention and Treatment Act, the Adoption Opportunities Program, the Crisis Nurseries Act, the Missing Children's Assistance Act, and the Family Support Centers program under the Stewart B. McKinney Homeless Assistance Act is already on the Floor.

When you get right down to it, Mr. Chairman, that ship has sailed and we were left standing on the dock.

We have a role, a responsibility, and an authority in this 104th Congress that I refuse to see marginalized. Mr. Chairman, I want to work cooperatively with you

to assure that both the legislative process and our jurisdictional interests within that process are preserved. The agencies under review by this Subcommittee are those that impact the most basic aspects of American life: home, health, work, education, economic security. We cannot afford to stand aside when our input is so critical.

Mr. SHAYS. I want to thank you, Madam Secretary.

Before I ask my remaining 5 minutes of questions, I think you have been a very informative witness, and this is a helpful process for us to begin to decide how we allocate our time. This committee could spend full time just on HHS, and you know the recommendations——

Ms. SHALALA. We hope you don't. [Laughter.]

Mr. SHAYS. No, you need not fear. Less likely with your presence here, I might add. With FDA and HCFA and all the other incredible responsibilities you have, and welfare reform, it is just a tremendous area of responsibility.

Mr. Broadnax, am I pronouncing your name correctly?

Mr. BROADNAX. That is correct.

Mr. SHAYS. I anticipate you will probably come before the committee again as the deputy involved in operations and so on, and I just wanted to provide you this opportunity just to make an observation, not necessarily to have to respond to any questions, but if you would like to just make an observation, and, again, I want to welcome you to the committee.

Mr. BROADNAX. The one observation I would make goes back to an earlier part of the question and answers where the Secretary was talking about, and someone had asked her about, directions. I think that a lot of our energies on the operational side are quite compatible with the conversations that are going on, certainly within this committee, in terms of, we are spending a lot of energy in the Department in terms of focusing and refocusing our programs, in terms of tightening programs and working on the issues of fraud and abuse, and as I have listened to the conversation this morning it has been very educational for me because it reassures me that the directions that the Secretary has set for us on the operations and management side seem to be very compatible with the interests and directions I have heard articulated in this committee this morning.

Mr. SHAYS. Thank you.

We will have a responsibility to reorganize, and I am one of a number of people on our side of the aisle that have said, where a Secretary is willing to weigh in on this, that we are going to accomplish more by trying to work with the Secretaries in reorganization than just trying to reinvent our own version of what the Department should be, and so I really extend a very sincere hand of cooperation in this effort. It has got to be in the President's advantage to reorganize in a constructive way, and Congress's, as well as the American people.

One of the things that I have also promised that I would do is not put demands on Departments for lots of information that won't be used, and so in that spirit I also would make this request, and it is a fairly limited one in that I am not going to make a lot of requests, but in your statement, Madam Secretary, you said that some jobs now done by the Federal Government should be turned

back to the States, and I would love an idea of those kinds of jobs that you think could be turned back to the States.

I also agree, I will say parenthetically, with your concept that basic block grants should have some kind of guidelines. It is, in fact, Federal dollars, and we do want some effort to have not total uniformity, because we want the creativity that States provide, but we do want some basic minimum standards. But I do believe that in this Congress and with the support of many people we will see block granting happen. So I find it encouraging that you want to try to help us find a way to do that as successfully as possible, so you are not just saying you are against block grants. I would make this kind of final point. I believe that we started this hearing a little contentiously in terms of not you, Madam Secretary, but just some strong feelings about what is happening, what is the Appropriations Committee doing, and so on.

It is my intention that this committee do what we are supposed to do and do it fairly and openly and honestly and have a dialog, and I hope that that will be the case in other committees, but we can't determine what Appropriations is going to do or what an authorizing committee is going to do as well.

But I do have to tell you that what unites the majority is real effort to try to get our financial house in order more quickly than I think the White House wants to, and we may have honest disagreements on how we do it. We have a recision bill, for instance, and I am not eager to do some of the recisions, and some I won't, but I am also not inclined to want to fund the California plan the way it has been suggested. I mean we are talking about billions of dollars being sent to California, and so we have debates there.

It might have been helpful to avoid some of the criticism on the cuts, and I would be happy to have my colleague respond not just to get the last word here, but it would have been helpful to have some idea of where we would fund the supplemental, the emergency supplemental, and it might have steered us away from some of the cuts that are being suggested.

But I mean this is a dialog that is going to take place on the floor of the House and it is going to take place in committees. It will be very open, and my hope is that we will do the right thing. But I acknowledge to you, Madam Secretary, that you are doing basic services to people truly in need.

I question the whole concept of welfare, as it being temporary, and I buy into basically as a general philosophy that is going to guide me in the next 2 years, the difference between a caring society and a care-taking society. As a moderate Republican, I found some solace in that I voted for programs, but if I am really being open and direct with myself, some of what I have done is perpetuate something I don't like to see, families, particularly minority families, broken up, incentives for there not to be a father and mother, and so on.

So we are going to be debating some very difficult issues, and hopefully we can do it as often as possibly together.

I am about to adjourn the meeting. I don't know if the gentleman is prepared to have me adjourn.

Mr. TOWNS. I just want to make a couple of points.

Mr. SHAYS. Sure.

Mr. TOWNS. First of all, I would like to ask that we keep the record open for, I don't know how many days—I think we need to try to get some information in on phase two. I think we would love to put some of that in the record. So 5 days?

Mr. SHAYS. If we could, if we could keep the record open for 3 days, without objection. We will be having hearings on a number of the different issues that you are going to be presenting. I am not expecting that you provide us this information in the next 3 days if that is right, but we will have the record open for 3 days.

We will be having other hearings to address specific issues, and we will be happy to insert any information you want into any records and committee hearings that we have. So without objection, we will do that for three legislative days, and I thank you both for coming, and we adjourn—excuse me, before adjourning.

Yes, sir.

Mr. TOWNS. Let me just respond.

Let me just say this to my friend—and, believe me, we are actually friends—who I respect and I think is a great legislator and one that is compassionate and easy to work with. You know, however, what I am really saying—and he is referring to my opening statement—is that I just do not want to see Secretaries and their staff do a lot of work planning and preparing and sort of coming in with what we consider very reasonable kind of proposals that will basically get us to where we want to go, and I know you don't control the Appropriations Committee, I know you don't control the Budget Committee, I know that you don't control all these things, but I want you to know that I am going to say this everywhere, I am going to say this on the floor, off the floor, between the floors, I am going to say this everywhere I go, because I think if they are going to do the work I think that we need to give them support in that regard, and that is all I'm saying, and we should not ignore what they are doing and then come up with our own ideas. I think that is a mistake. That's all.

Mr. SHAYS. Thank you. I thank the gentleman.

We look forward to working with you and your entire Department and thank you sincerely for being here today.

Ms. SHALALA. Thank you.

Mr. BROADNAX. Thank you.

Mr. SHAYS. This hearing is adjourned.

[Whereupon, at 11:50 a.m., the subcommittee was adjourned.]

[Additional material submitted for the record follows:

PREPARED STATEMENT OF HON. GENE GREEN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Thank you, Mr. Chairman. Today we continue our examination of the mission and operations of another federal agency under our jurisdiction: the Department of Health and Human Services. While HHS lacks some of the glaring management problems that afflict other federal agencies, it's large yearly budget and important social programs demand our attention.

Programs that HHS administers will likely be cut or block granted this year. Also large cuts in Medicare and Medicaid will also be forthcoming. I would certainly enjoy hearing the Secretary's response to these impending changes. Particularly, I would like her to respond to some of the appropriations cuts in child nutrition programs and describe, as she interprets it, how much federal oversight will remain with those programs.

Finally, with respect to reforms within HHS, I would like you to describe some of your past successes, and some of the actions taken to reduce abuse of the SSI program.

Thank you, Mr. Chairman. I look forward to hearing the testimony of the distinguished Secretary.

PREPARED STATEMENT OF HON. BERNARD SANDERS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF VERMONT

Mr. Chairman, I am pleased that Secretary Shalala has joined us today to discuss the Department's new plans for the second stage of reinventing government. I have just a few points of concern that I would like the Department to consider as it moves it plan forward to Congress.

In October 1992, Public Law 102–515, the Cancer Registries Amendment Act, was signed into law. The Cancer Registries Amendment Act created a foundation for a nationwide cancer surveillance system, National Program of Cancer Registries (NPCR), which would allow this country to monitor national and local disease trends, target scarce intervention resources, and evaluate our cancer control efforts. Fiscal year 1994 (FY 1994) marked the first year of appropriations for this important program, which is guided by the Center for Disease Control and Prevention (CDC). As the author of that legislation with Senator Patrick Leahy, also of Vermont, we have been most pleased with the initial progress that has been made in implementing this critical control infrastructure component.

We are as committed to this program today as we were in 1992 and encourage the Administration to insure the continued viability of this national effort. This is especially important as the Congress and the Administration pursue opportunities to consolidate grants and provide state decision-makers with increased flexibility over the expenditure of federal resources. If the NPCR is folded into a consolidated grant program then this country will lose the ability to insure that we have an accurate national picture of the extent of the cancer problem across the U.S. It will also place severe limitations on the sharing of data information within states and between states. We strongly support the continuation of this surveillance program, and all other surveillance systems, as categorically-funded efforts.

Madame Secretary, when one in three of us will get cancer at some point in our lives and one in four of us will die of this dreaded disease, we cannot take a step backward on our ability to control and prevent this disease, As you may know, the Chief of Orthopedic Surgery at Memorial Sloan-Kettering Cancer Center called cancer registries, "The Cancer Weapon America Needs Most."

We owe it to our family and friends that have suffered from this terrible disease; we owe it to the health of our nation and the future health of our pocketbooks to prevent and control cancer. The cancer registries are our most potent weapon against this disease, and I urge you to fight to preserve this program.

On another note, I want to encourage the Department to fight to preserve the Low-Income Home Energy Assistance Program (LIHEAP). In my home state, LIHEAP provides approximately 24,000 Vermonters with subsidies to heat their homes. This money goes to the poorest individuals in our country. Fuel assistance recipients have an annual income of less than 150 percent of poverty, and more than 70 percent of these households had incomes of less than $8,000.

Many Americans, including the disabled, the working poor, and low income senior citizens in desperate need of funding for LIHEAP and without it these vulnerable Americans will be forced to chose between heating their homes and feeding their families.

As you know, recently a House Appropriations subcommittee passed out a rescission package that would slash $4.28 billion from health, labor and education programs between now and the end of fiscal year 1997. Including in that package of cuts was the absolute elimination of the Low-Income Home Energy Assistance Program (LIHEAP).

What kind of family values are contained in the Republican "Contract with America" that wants to provide billions in tax cuts to wealthy Americans, billions in increased defense spending, and at the same time cuts back on programs for the weakest and most vulnerable people in our society.

Clearly, you are familiar with some of the other damaging cuts that the Republican rescission bill has in store for health, education, and labor programs. The Balance Budget amendment will only make these savage cuts go far deeper. And the announcement by Senator Packwood that $400 BILLION in cuts are in the work for Medicare and Medicaid tells us where these cuts are going to come from—the most vulnerable members in our society.

And while I trust you will join me in fighting these cuts in programs assisting children, seniors, veterans and other vulnerable Americans, I know you have the task of "reinventing" your Department. I would encourage you to insist on clear standards in block grants to states—and no reduction in the total funds in these programs. Let's not let the block grants be a disguise for massive cuts in funding to help needy Americans. We should not only guarantee that the needs of our children, veterans, seniors and working families are met and not ignored, We should reward states that do better for their populations and not punish them. We should give incentives to states that increase the minimum wage, reduce childhood poverty and promote policies that make work pay.

In close, let me thank you for the tremendous work you have done to try to provide every American with affordable and comprehensive health care. And while times are certain to be difficult over the next two years, I trust we can continue to work together to protect the lives of middle and low-income working Americans and fight to protect the programs helping individuals who are often unable to stand up for themselves.

PREPARED STATEMENT OF THOMAS J. KENNEDY, M.D., PRESIDENT, NIH ALUMNI ASSOCIATION

The Alumni of the NIH may not be aware that, for the last 24 months, what I believe could become a tragedy of major significance to science and to the health hopes and prospects of the American people has been unfolding, quietly and largely unnoticed except in Bethesda. The "direct operations" of the NIH—intramural research and the federal management of extramural research—are under severe and, unless modulated, perhaps ultimately ruinous retrenchment orders. Here's the story.

DOWNSIZING GOVERNMENT

Shortly after his inauguration, President Clinton announced that he intended to reform federal government operations and that Vice President Gore had been named to lead a "National Performance Review" effort to "Reinvent Government". Pursuant to this proposal, three Executive Orders (E.O.s 12837–12839), having the force of law, were issued on February 10, 1993.

The first requires each federal agency to identify the level of "administrative expenses" in the FY 1993 Appropriation; and thereafter, in its next four budget submissions, to, seriatim, reduce these expenses, adjusted for inflation, to the levels of 3%, 6%, 9%, and 14% below the FY 1993 level.

The second mandates termination of 1/3 of all existing Federal Advisory Committees and sharply constrains the chartering of new Advisory Committees.

The third orders agencies to eliminate 4% of their full time equivalent (FTE) positions (for an aggregate reduction of 100,000), with 25% of the target being reached by the end of FY 1993 (Sept. 30, 1993), 62.5% by the end of FY 1994, and 100% by the end of FY 1995. In making these reductions in workforce, 10% of the positions eliminated must be in the highest grades (GS 14 or above in the Civil Service system and the equivalent in other personnel systems).

Subsequent directives from the OMB made clear that all NIH "direct operations" were to be categorized as "administrative expenses" and that the 14% reduction in these expenses must be in addition to the savings accruing from the elimination of FTE positions in the workforce. Thus, the jargon of "reinvention" transformed every penny spent on scientists working at the laboratory bench or at the bedside of research patients or on administrators of extramural grants and contracts into "administrative expenses"!

In September,1993, the President accepted the recommendations of Vice President Gore's National Performance Review, under which the required reduction in the federal workforce was raised from 4% to 12% (or from 100,000 to 252,000 FTE positions) and ordered the agencies to each submit an implementing "streamlining plan" to the OMB within less than 90 days. These plans were: to address how the agency proposed, within 5 years, to halve the current ratio of managers and supervisors to other personnel; to be "characterized by delegation of authority, decentralization, empowerment of employees to make decisions, and mechanisms to hold managers and employees accountable for their performance"; to propose ways to reduce "red tape"-generating and efficiency-hampering overcontrol and micromanagement, and to simplify the internal organization and administrative processes of the agency; and to seek to realize cost savings, improve the quality of government services, and raise morale and productivity.

Personnel ceilings established by the Presidential Executive Orders and their implementing directives from the OMB were subsequently enacted into law by the Congress in the Federal Workforce Restructuring Act of 1994 (P.L. 103–226) with a further increase in the mandated reduction in the number of FTE positions to 272,000; the savings attendant to these personnel reductions were dedicated, in the 1994 Violent Crime Control and Law Enforcement Act (P.L. 103–322), to the expansion of police forces, to the enlargement of the nations prison capacity and to the financing of social programs directed at the prevention of crime.

Additional requirements to reduce the size of the federal workforce and of the Senior Executive Service, issuing from either the Administration or the 104th Congress, are likely fall-outs from forces set in motion by the elections of November, 1994.

DOWNSIZING THE NIH

Information on the impact that this national policy is having on the NIH is not easy to secure and informants are both hard to find and cautious about discussing these matters. But here are what I choose to think are some of the "facts".

In the proration of the workforce reductions, the NIH took a disproportionately heavy "hit". While the DHHS share of the reduction in FTE positions was 11%—the overall government average requirement was 12%—the Public Health Service (PHS) imposed, for reasons unknown, a 15% downsizing on the NIH. Additional cutbacks may be necessitated, unless some resolution acceptable to the Administration of a complex and politically sensitive personnel ceiling problem in the Indian Health Service can be negotiated.

The NIH has been working valiantly to comply with the mandates imposed upon it. One notably vigorous effort has been spearheaded by "The NIH Resource Allocation Group" (RAG) and its Working Group, that transmitted a lengthy set of recommendations to the Director, NIH, on May 23, 1994. But despite the energy and ingenuity manifest in the NIH's planning to meet White House goals, reaching the prescribed personnel ceiling targets (a 15% reduction by the end of FY 1999) will still require surgery that I believe can only be called draconian.

That the NIH has so far managed to more than meet its FTE reduction target ceilings is largely accounted for by a hiring freeze on FTE appointments, in force since December, 1993; the price: serious discrepancies between personnel needs and availability, especially with respect to specialized skills.

Since about the same time, promotion of employees from the level of GS 13 (or equivalent) to GS 14 has been virtually impossible. The queue of productive scientists waiting for hard earned and increasingly overdue promotions is steadily lengthening; and even when vacancies at the upper levels open, only a trickle of promotions will be possible. Less obvious but probably just as significant, in the many instances in which promotion is coupled to the award of tenure, delay and uncertainty about the latter matter enhances frustration and depresses morale.

From the point of view of intramural scientists, the specter of five more years of steady, progressive, inexorable, grinding truncation of resources, both personnel and materiel, coupled with very limited opportunities for new FTE hires and promotions, only to be followed, after FY 1999, by stabilization—until a new steady state of personnel turnover is reached—at a downsized level that permits new FTE recruitment and promotions only to the extent that vacancies are created by retirements or resignations, clearly does not constitute an incentive to remain in federal service. The cumulative result of the process now underway, should it not be halted and reversed, will likely be that many of the NIH's best intramural scientists will elect to leave, thereby not only initiating deterioration of a world class biomedical research institution, but also leveraging it's rate.

The unfolding of this doomsday scenario could not be happening at a more inopportune time for the nation. The NIH is at the peak of its powers (vide infra for an assessment of it's stature); it is blessed with a superb staff, visionary leadership, generally good and improving facilities and with extraordinary control over the quality of it's staff, especially through authority on tenure appointments that is unique and unprecedented throughout the whole federal government. In short. it is poised as never before to tackle effectively the plethora of unbelievably promising scientific opportunities at hand to advance human health and well being.

The Presidential initiative to "reinvent" government is intended to make the federal government less costly as well as more efficient and responsive. It was designed to correct, wherever they existed in the vast bureaucracy, practices that subverted efforts to achieve the President's objective, such as excessive staffing and dispropor-

tionately large numbers of employees in higher salaried positions, leading to a top heavy and overly pyramidal hierarchial organizational structure that is widely believed to cause the suppression of the creativity and the disempowerment of rank and file personnel. Whether or not the White House's diagnosis and prescribed therapy—including the overtones of Deming's "Total Quality Management" to which so much of Japan's economic growth and development has been attributed—are generally appropriate for the nation's federal bureaucracy as a whole is not an issue on which I have an opinion or on which my opinion should carry any weight whatsoever. But I do think that I possess the bona fides to comment credibly on the applicability of the program to the NIH's intramural research program.

The size of the intramural research program on the Bethesda campus has evolved as the outcome of a long series of Legislative and Executive Branch decisions, extending over almost a half a century. True, the size of this program is discretionary—as also is that of the extramural research program—and could be reduced at any time, by Legislative or Executive Branch action, to any level deemed to be appropriate to the prevailing circumstances. But a rational and defensible policy decision to shrink the intramural program should be argued, one would think, specifically on the merits of the case for redetermining the proper scale of a singularly outstanding federal research enterprise, and not simply be the non-specific outcome of a uniform, across-the-board, "one-size-fits-all" formula to streamline the federal government.

The total expenditures of intramural research are surely misidentified as a federal government "administrative expense", a category whose curtailment was a major objective of the "National Performance Review", "Reinventing Government" and the "streamlining" plans. Intramural research expenses are undeniably programmatic, the cost of performing research, not administrative.

The intramural research operation is not bloated, top heavy, inefficient, overstaffed, etc.,—the principal charges against the federal bureaucracy as a whole to which "reinvention" is addressed.

Flattening an overly vertical personnel pyramid, because the ratio of supervisors to other personnel is too high may make sense in some situations. But it is not a rational policy for a scientific research operation and it's imposition can only indicate a misunderstanding of the characteristics of the scientific research process. The civil service (or equivalent) grade levels of scientists in intramural research—as well as in other federal science agencies such as the US Geological Survey—reflect the scientific expertise of, and the "market" for, that talent, rather than the managerial or supervisory responsibilities the incumbents shoulder. The relationship of scientists, inside or outside government, to lower grade level employees differs essentially from that in conventional workplace settings, of high level managers and supervisors to lower grade level employees. Typically, a scientist, of whatever eminence or distinction, collaborates with, rather than manages or supervises, a colleague or two, mentors one or two pre- or post-doctoral students and, perhaps, directs the work of a technical assistant or so. Compliance with the "reinvention" canons would require either extending the span of control of scientists or reducing their grades—either a recipe for disaster.

The emphasis placed thus far in this letter on the unfortunate impact of "reinvention" on NIH intramural research is not intended to ignore or minimize the baleful effect of the process on the staff entrusted with the scientific administration of the NIH's extramural research activities. In this arena, the most detrimental consequences are to be felt in the "reinvention" specifications that target higher graded employees and the ratio of supervisors to other personnel. The grade levels of extramural scientist-administrators are based on the talent and expertise they embody. Many were only recently distinguished research scientists or renowned academic scholars. The NIH relies on them, not to "manage" or "supervise" a large array of lesser bureaucrats, but for their knowledge of and good judgement about the science, the scientific priorities, and the science community at the cutting edge of the fields of science that fall within their portfolio of responsibility. The elimination of individuals of this calibre would surely impair the quality of the extramural programs over which they exercise administrative responsibility and, in the end, impair the totality of the nation's biomedical research program.

The fundamental reality is that the conditions that reinvention of government was crafted to correct do not generally exist at the NIH. While several of the recommendations of the NIH's internal study committee, the Resource Allocation Group (RAG), make evident that slimming and streamlining of the management of several relatively small extramural and intramural research administrative functions (e.g., personnel management, procurement, etc.,) is possible, the whole exercise

seems otherwise to be the application of a drastic solution to an almost non-existent problem. As a result, an exceptionally fine research endeavor is in process of being seriously compromised, apparently almost mindlessly, capriciously and incidentally, as a result of having become entrapped in an irresistible set of forces and dicta designed to correct problems that do not characterize intramural research or the scientific administration of extramural research

In my view, the overarching concepts within which the problems raised for the NIH by "reinvention" must be framed are that:

> A vast array of difficult to intractable problems, inimicable to human health—some known, others waiting in ambush—will, in the normal course of events, continue to take a tragic toll on existing populations and on future generations.
>
> The only way to ameliorate these fateful inevitabilities is research, a process that is difficult, intellectually demanding, often slow in achieving results, replete with enticing lures that end in blind alleys, and costly. Unfortunately, it is also the only imaginable and historically proven route to the improvement of human health.

The times and circumstances may argue that the rate of growth of research investments be slowed, but it should never be cut, as is now happening now! Worse, the best is being cut first. My message, as you must surely have guessed by now, is to urge you not to sit idly by but to protest—to your Congressional Delegation, to the President and the Vice President, to the Secretary, DHHS, to the Directors of the OMB (Dr. Alice Rivlin) and of the OSTP (Dr. John H. Gibbons). Encourage the leadership of your institutions and the officers of your scientific societies to join in protest to the wanton and senseless destruction of a magnificent biomedical research institution.

Wherever well informed people may stand on the political spectrum, whether they be true believers in the power of government to solve societal problems or confirmed skeptics committed to severe limitation on the role of government in human affairs, whether they be conservative Republicans or liberal Democrats, whether they base their views on scientific knowledge and experience or on the educated judgements of enlightened citizens, there is one conviction from which there is virtually no dissent: the NIH, intramurally and extramurally is one creation of government in which every American can take immense pride.

Intramural NIH Science: A Quality Enterprise

My assertion that intramural NIH is top notch is not just the chauvinism of a superannuated alumnus; it is a reality beyond cavil or dispute. Let me cite only two lines of evidence based on as objective measures of quality as are available: membership in the most prestigious and selective society that honors scientific achievement in the United States, the National Academy of Sciences (NAS); and bibliometric data, reflecting the acknowledgement that scientists accord predecessor scientists by citing earlier publications of their predecessors as the groundwork which facilitated the discovery of the advances they themselves are currently reporting in new publications.

First, the distribution of NAS memberships among universities, government agencies, industrial organizations and other entities.

> As of July 1, 1994, 1702 of the Academy's members were active, 82 were emeritus and 298 were foreign associates. Membership is overwhelmingly academic, with very modest representation from independent research institutes, government science agencies and industry. The NIH with 51 members ranks 7th in the whole country, trailing only Harvard (142, if the Harvard-Smithsonian Center for Astrophysics is included), the Univ. of California at Berkeley (110), Stanford (106), MIT (99), the California Institute of Technology (60) and Yale (56). The NIH, of course, is a biomedical research institution; there are many fields of physical, mathematical, agricultural, social and political science that are almost entirely outside its ambit of concern, mission and responsibility, and which are not represented on it's staff, except incidentally and to a minuscule degree. Table 1[1] shows that in the subset of sciences central to the NIH's mission, it's rank order is considerably better than 7th. The edge enjoyed by the NIH over most of the very distinguished academic institutions ranking below it in total membership—the Univ. of California at San Diego and the Univ. of Chicago (45), Princeton (43), Cornell (38), the Univ. of Wisconsin (35), the Univ. of Pennsylvania (33), the Univ. of Washington (31), the Univ. of Illinois (28),

[1]The distribution of members, by section, from the several institutions in this table was obtained by a tedious hand-sort, comparing two divisions of the NAS's Members Directory. In a few instances, the totals for an institution differ from the actual totals by 1 or 2. These tabulating errors, in my opinion, do not invalidate the conclusions.

Columbia Univ. and the Univ. of California at Los Angeles (27), the Rockefeller Univ. and the Bell Laboratories,(24), Johns Hopkins Univ.(19), the Univ. of Michigan (17), the Univ. of Minnesota (16), Duke Univ. and the Univ. of California at San Francisco (15), New York Univ. and Washington Univ. (14), and the Univ. of Texas, Southwestern (11)—would be even more impressive, were the comparison to be based solely on the number of members from the biological and medical sciences.

The number of staff members elected to the NAS from the NIH exceeds the total (20) from all other federal agencies:[2] the Dept. of Veterans Affairs, 3; the NIST, 2; the Naval Research Laboratory, 4; the USDA, 2; the US Geological Survey, 4; US Naval Postgraduate School, the NOAA, the DHHS, the Council of Economic Advisors and the U.S. Forest Service, 1 each. In fairness, it should be noted that there are 45 members of the National Academy of Engineering (NAE) from the federal agencies:[3] Agriculture, 3; Commerce, including NIST, 7; Defense, 1; Army, 5; Air Force, 2; Navy, 5; Educ., 1; Energy, 5; Interior, 2; EPA, 1; OSTP, 1; and NASA, 12.

The NIH has had, for the most part, to home-grow its NAS members. By the time outsiders have attained the distinction that warrants election to the Academy, they are usually well beyond the NIH's price range for salary, benefits and "perks". The NIH has only infrequently been able to recruit mid-career and senior scientists of NAS calibre from the outside; notable recent examples are Francis Collins and Harold Varmus. On the other hand, many outstanding young, mid-career and senior NIH scientists, who either have been, or are about to be, elected to the Academy, have been recruited to academic institutions or industry and are liberally represented in the latter's delegations of NAS members.

Over the last thirty years, the value of bibliometric evidence for measuring the quality of science has become well established, its limitations recognized and defined and the high degree of correlation between it and peer judgement demonstrated. What does it have to say about intramural NIH?

The most recent sophisticated study, commissioned—and substantially incorporated into it's final Report—by the Institute of Medicine *Committee to Study Strategies to Strengthen the Scientific Excellence of the National Institutes of Health Intramural Research Program,* chaired by Harold Shapiro, the President of Princeton Univ., was prepared by Dr. Helen H. Gee in 1988. The Gee study included papers published from 1973 to 1984 in a set of basic and clinical science journals, recognized to be central to biomedical research by the Science Citation Index, the NLM, the NIH and the NSF and authored either by the sector of intramural scientists or by the sector of authors who indicated a university or a medical school as their base of operations. Her analysis compared trends, over the epoch, in measures such as the total number of publications, the "presence" of each sector of authors in the arena under consideration, the number of citations per paper, the average influence per paper—a weighting adjustment reflecting citation patterns and practices in specific fields—and the percentage of papers from the sector that appeared in the docile of most frequently cited papers. Comparisons were made for: two large aggregate fields, clinical medicine and biomedical research; 44 subfields; and a broad class, "general biomedical research", defined as papers of the ilk traditionally published in journals such as Science, Nature, PNAS, etc. Gee outlines the patterns of change—growth or stability or decline in publications, citations or influence, by field—that have occurred over the epoch. Despite the ups and downs described in the Gee analysis, the IOM Committee—relying mostly on this data—concluded that "the intramural program, overall, demonstrated a high level of performance when compared to the general academic community".

But to me, the startling observation was that, in the three periods of time studied, for the broad fields and for almost every subfield, the comparisons of the average influence of intramural vs. academic papers, and/or of the number of citations per intramural vs. per academic paper, and/or of the percentage of intramural vs. academic papers in the top decile indicated that the intramural sector consistently exceeded academic by a 40–90% margin (Table II).

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[2]The 21 NAS members from FFRDCs (Federally Funded Research and Development Centers)—Argonne, Brookhaven, Fermilab, Jet Propulsion, Lawrence-Livermore, Lincoln, Oak Ridge, National Radio Astronomy and Sandia—have been excluded from this enumeration, since they are not federal employees.

[3]Again, the 30 members of the NAE from the FFRDCs have been excluded, for reasons I believe proper.

Can it be argued that the NIH superiority in this data set is due to the fact that the universe to which it is compared is so large and heterogeneous as to obscure the stature of distinguished academic institutions? I think not. For research to be conducted and published: it must first be funded; most academic biomedical research is funded—after rigorous peer review in a federally competitive atmosphere—by NIH extramural programs; and most NIH money ends up in a relatively small number of research-intensive universities and medical schools. Thus, the Gee study has compared intramural research principally with the best of academic research and shown that intramural generally stood head and shoulders over it's competitors through 1984. As of that date, intramural NIH was not just good. It was, arguably, the best.

What has the record been since 1984. Nothing as elegant as the Gee study has been published but occasional reports out of the Institute for Scientific Information's Science Watch have appeared. The March, 1994, issue reported that:

From 1981 to 1993, the 5-year average ratio of actual to expected citations for NIH papers, for all institutes in the aggregate, fluctuated from 29.69% above world average for the period 1981–85, to 31.05% (1984–88), 30.99% (1985–89), 30.12% (1986–90), 29.83% (1987–91), 25.89% (1988–92), and 26.09 (1989–93);

over the same epoch, the citation impact of NIH papers, relative to the U.S. biomedicine baseline, rose from 85.22% above the baseline to 88.05% above in 1985–89, and then fell to 75.00% above in 1989–93;

intramural papers, though they make up only 2–3% of the total, constituted about 15% of the 300 most frequently cited papers, worldwide, each year from 1983–87 and about 10% from 1988–93 (in a much larger pool);

of the 30 papers most frequently cited each year from 1981 to 1993 from the world literature, an average of 5 (range: 2–10) were from intramural research:

of the 10 most frequently cited, an average of 1.6 (range: 0–3) were from intramural research.

Why Science Watch emphasizes that the NIH intramural is "slipping" is puzzling, in the face of the fact that the changes in the degree of dominance over the epoch examined are not consistently unidirectional and the sheer increase in the denominator of research establishments, industrial and foreign, tend inevitably reduce the relative dominance of the intramural effort. It still looks like "The Champ" to me.

On these two lines of evidence alone—NAS membership and bibliometrics—and without recourse to scads of additional supporting data—on Nobel, Lasker and other awards, on leadership positions held and discharged with distinction in hundreds of scientific societies, on the outstanding contributions made by NIH-trained postdoctoral students as well as by former NIH employed scientists to the intellectual life of the nation's scientific community through service on faculties of top notch academic institutions and on staffs of leading industrial organizations—I rest my assertion that the NIH is the finest biomedical research organization the world has ever seen. If some think this be hyperbole, let them present the data to support their assertion.

Creative Management: the Hallmark of the NIH

Perhaps the most extraordinary achievement—managerial, not scientific—of intramural NIH is to have been able, for almost a half a century, to systematically and continuously overcome barriers to the attainment of excellence, barriers that are virtually nonexistent in private, non-government organizations and institutions but inescapably associated with in-house government operations. Government salaries and fringes are as a rule significantly below those in academic settings for comparable positions; the highest possible annual salary the NIH can pay—and that to only a very, very few, with many years of service—is under $150,000. Government personnel systems were designed to serve traditional government functions and to prevent politicalization of public sector employment, not for recruiting, promoting, and retaining scientists. For example, permanent civil service status, embodying extraordinary assurances against dismissal, comes automatically and early, usually after one year of satisfactory service; postponing it, to permit more confident assessments of the creativity of candidate scientists, does violence to the most sacred canons of civil service personnel policy. The authority possessed by the NIH for many years to designate selected young scientists as in "tenure tracks" and to defer tenure status long enough to allow thorough appraisal, exists, to the best of my knowledge, nowhere else in all government and stands as tangible proof of herculean and successful efforts to adapt government personnel policies to serve the ruthless insistence that the culture of science places upon professional excellence. In government, "disposal" mechanisms for scientists deserted by their muse are few and winnowing

"dead wood" is probably much more difficult than is the case in Academe. Government procurement regulations, designed to minimize favoritism in the expenditure of public funds, can complicate and delay purchases of scientific instruments, supplies and equipment. At one time or another, mostly in the past, NIH employees have encountered problems with: the receipt of outside income of the sorts regularly earned by academicians; with participation in the morally obligatory duties that attend membership in scientific and professional societies, e.g., holding office, editing scientific journals,etc.; and with travel, particularly abroad, to scientific meetings. Retirement benefits are non-portable. A mid-career NIH scientist cannot take accrued retirement benefits to an academic or industrial position without serious financial penalty and, therefore, tends to be frozen in situ even when a move might be beneficial to the individual, to the NIH, to the organization recruiting the employee, to science, and to the public good. Similarly, the necessity for a mid-career academic or industrial scientist to switch to a new retirement system upon entering government service has until very recently been a severe deterrent to hiring scientists from the outside; the Senior Biomedical Research Service, authorized for the NIH in 1991, may provide some relief for this problem when it is implemented.

For the NIH to have reached its present level of excellence and to have maintained it for at least four decades in the face of obstacles such as those cited is both an astonishing feat and an enormous tribute to the institution's enduring capacity for creative management.

A "Call to Arms" for All Who Value Biomedical Research

In issuing this "call to arms", I recognize that the response of the extramural community is not likely, at least initially, to be instant or enthusiastic. Sympathy for the plight of NIH intramural research is not, in my experience, a sentiment universally prevalent "out there". This seems to me to be regrettable, misguided, and potentially dangerous to the nations biomedical research enterprise. What the two sectors share in common is far greater and more important than the differences between them and both are likely to prosper more if mutual respect, understanding and support characterize their relationships. Among the misperceptions of intramural that I have encountered in the extramural community, several warrant mention.

One concept is that the only really suitable site for basic research is Academe. The logical consequences of this persuasion are detectable in every one of the many external examinations of the intramural research program that has ever been undertaken, usually articulated as a recommendation that intramural focus its energies on some mission or expand into some empty niche (e.g., "long- range research" or "high-risk research") that is different from that traditionally conducted in academic institutions but peculiarly appropriate to its unique institutional form as a government research laboratory. The fact is that, in general, intramural NIH conducts—with notable success—precisely the same types of research performed in Academe, in other non-government non-academic institutions, and, to some extent, in industry. Given the workplace environment that inevitably keeps their employer's categorical missions "front and center", intramural scientists may be more keenly aware of, and more responsive to, the health goals of the agency. But basically, the nature of most of the science pursued is identical, whether conducted in academe or in Bethesda. Many world class scientists simply prefer to devote themselves to full-time research in a government laboratory, free of routine undergraduate and graduate student teaching responsibilities and of the need to apply periodically and competitively for research grant support, even if the trade-off for this life-style requires putting up with certain inconveniences and sacrifices inherent in federal government employment.

Another idea I've heard articulated by academicians is that, were intramural to be abolished, the money expended for Bethesda activities would wind up in the extramural community. This is probably illusory. Firstly, there can be no assurance, at least in these politically turbulent times, that the savings accruing from downsizing or even abolishing intramural NIH would remain in research (vis-a-vis being dedicated to debt reduction, middle class tax relief, Medicaid, crime prevention, etc.). But whether or not the total resources available for research were to shrink, abolition of intramural would indubitably drive many of its first class investigators to academia, where they would almost certainly compete successfully for funds appropriated for extramural research; in fact, they might be competitive enough to take funds away from established academic grantees. The mid-level and senior scientists of my acquaintance that have left the NIH in the last decade are not only surviving but thriving in academe and industry. The proposition that the research resources available to the current denizens of the academic community

would be improved by the dissolution or constriction of intramural NIH strikes me as an extremely tenuous proposition.

A not infrequently heard recommendation that intramural research expenditures be capped at their current share, 11.3%, of the total NIH appropriation is also problematic. Perhaps it makes sense to cap the Bethesda effort, for the simple reason that the Bethesda site cannot comfortably accommodate many more people. But the validity of the proposition that intramural research, qua intramural research, should be "capped", relative to extramural, is not *a priori* compelling, nor are the criteria that should determine the distribution of appropriated funds between the two sectors. One assumption from which any discussion of this issue admittedly cannot prescind is that federal funds should be expended only on the highest possible quality research. Currently, most federally conducted and sponsored research is of high quality, wherever performed; and all would be, were not fallible human judgment the only possible basis for allocating resources. But that having been stated, the day may come when the question arises of whether the return on federal research investments is greater in the public (intramural) or the private (extramural) sector. The answer to that question, admittedly complex and a formidable measurement challenge, is also not immediately or intuitively obvious. In-house government research is demonstrably of very high quality; it must also, on the whole, be less costly since personnel costs—which represent about 70% of the expenses of research projects in the biomedical sciences—are held down in government laboratories to levels considerably below those prevailing for comparable talent in academic institutions. Exactly what a sophisticated and well designed study of the comparative return on investments made on intra- vs extra-mural research would conclude is not, to my mind, predictable. But should it turn out—as it well might—that the government realized a "bigger bang for it's buck" intramurally, policy makers would have to give serious consideration to expansion of intramural research, possibly with funds derived from extramural, preferably at some other site removed from an already overcrowded Bethesda campus.

The excellence of the NIH-supported extramural scientific research programs—be they project and center grants, or training, fellowship, and career development awards, or contract programs—is also victim of "reinvention", as currently applied. The decimation, three times over, of the "study sections" that have played so crucial a role in the impartial evaluation of research proposals will almost certainly compromise the quality of that process and probably force radical changes in the review and approval mechanisms for grant applications and contract proposals. The more than decimation of the extramural scientific and professional staffs of the DRG and the Institutes will: further reduce the capability of the review and approval machinery to select the most promising applicants for funding, thereby destroying the process that, above all else, has made America science peerless for half a century; and will cripple the capability of the NIH to manage awards with the rigor that the public expects as well as with the empathy and intellectual sensitivity that the dynamics of the scientific research process necessitate.

I therefore appeal to those of you in the extramural community to rethink the reservations that some of you may harbor about intramural research and recognize that unless the two major segments of the U.S. biomedical research community hang together—as logic and reason commend—they are likely to hang apart. The processes presently entrained at the NIH will inexorably cripple the institution. The effect of position cuts that impact most severely on the intellectual and creative leadership of the organization will almost inevitably cause the current extraordinary excellence to deteriorate. The "brightest and best", with the most attractive options will leave and their "draw" that, in the past, attracted promising youngsters will no longer be around. It is not only the absolute extent of personnel cuts that is destructive; the devastation they will wreak is potentiated by their prescribed distribution by grade level. We are now silent witnesses to what I can only call a catastrophe: not the dismemberment of just another government agency but the ruination of a national treasure.

In my opinion, it would be irresponsible for the biomedical scientists of this country, and their entourage of associates, supporters, advocates, and admirers, to permit this tragedy to continue to unravel without vigorous protest. As this process proceeds, the biggest loser will be the American public and all humanity, whose deliverance from disease, disability and premature death, is critically dependent on the persistent and sophisticated efforts to unravel nature's secrets by world class scientists.

Aux armes!

Table 1—National Academy of Sciences Membership

[By Section and Institution]

Fields of Science	Harvard	U. Calif. Berkeley	Stanford	M.I.T.	Calif. Ins. Technol.	Yale	N.I.H.
Sections 11–16: Mathematical and Physical Sciences	47	49	33	40	38	18	2
Sections 31–33: Applied Physical and Engineering Sciences	12	12	20	18	8	2	0
Sections 51–52: Anthropology and Psychology	8	11	10	5	0	9	2
Sections 53–54: Social, Political, and Economic Sciences	10	7	9	5	1	4	1
Sections 61–62: Applied Biological and Agricultural Sciences	2	5	0	3	0	0	0
Subtotal: Non-Biomedical Sciences	79	84	72	71	47	33	5
Sections 21–27: Biomedical Sciences	44	24	29	20	13	18	22
Sections 41–43: Medical Sciences	21	2	4	5	0	5	23
Subtotal: Biomedical Sciences	65	26	33	25	13	23	45
Total	144	110	105	96	60	56	50

NIH Intramural Programs and U.S. Colleges and Universities

[Publication Records 1973–1984]

Research Area	No. Papers	% U.S. Papers in Subj	Cities per Paper	Ratio: CPP Intra/CPP Extra	% Papers Among Top 10%	Avg. Influence
CLINICAL MEDICINE						
Intramural NIH:						
1973–76	4258	3.2	33.4	1.9	24.1	32.2
1976–80	5396	3.2	21.8	1.9	23.4	30.2
1981–84	5770	3.0	10.6	2.0	24.9	30.2
Univ/Med Schls:						
1973–76	86958	64.8	17.5	.....	10.3	20.3
1977–80	112174	66.4	11.7	.....	10.2	19.3
1981–84	129893	68.4	5.3	.....	10.2	18.1
BIOMEDICAL RESEARCH						
Intramural NIH:						
1973–76	2729	4.4	39.4	1.5	19.1	63.5
1977–80	3637	4.7	29.6	1.6	18.9	62.5
1981–84	3822	4.4	16.1	1.8	21.6	62.1
Univ/Med Schls:						
1973–76	50379	77.0	26.0	.....	10.0	47.7
1977–80	59420	77.5	18.6	.....	9.7	47.5
1981–84	66473	77.4	8.8	.....	10.0	45.7

AGENCY OVERSIGHT HEARING ON HHS: THE MISSION OF HHS

WEDNESDAY, MARCH 22, 1995

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HUMAN RESOURCES AND
INTERGOVERNMENTAL RELATIONS,
COMMITTEE ON GOVERNMENT REFORM AND OVERSIGHT,
Washington, DC.

The subcommittee met, pursuant to notice, at 10:10 a.m. in room 2247, Rayburn House Office Building, Hon. Christopher Shays (chairman of the subcommittee) presiding.

Present: Representatives Shays, Morella, Souder, Martini, Barrett, and Fattah.

Staff present: Lawrence Halloran, staff director and counsel; Doris Jacobs, associate counsel; Robert Newman, professional staff; Thomas Costa, clerk; Kate Hickey, Demi Greatorex, professional staff; Cherri Branson, minority professional staff; and Liz Campbell, minority staff assistant.

Mr. SHAYS. I'd like to call this hearing to order and to note the presence of a quorum and to begin. This is the second hearing on the Department of HHS, in which we have a number of very qualified witnesses. We're looking for opportunities for cost savings at HHS. We'll be looking at their budget authority; how they spend their money; how they're looking to coordinate.

We'll also be looking at waste, fraud and abuse, particularly as it relates to Medicare and Medicaid. Today we have three panels.

Our first panel is June Brown, who is inspector general for the Department of HHS; and Sarah Jaggar, who is the Director of Health Financing and Policy for the General Accounting Office, GAO.

Our second panel will be Patrick Fagan, a senior human services policy and analyst with Heritage Foundation; John Liu, senior health care policy analyst with Heritage Foundation; and Gail Wilensky, senior fellow at Project HOPE.

And then panel III we have Mary Suther, who is president and CEO of Visiting Nurses Association of Texas.

If I could call the first panel and welcome them.

[The prepared statement of Hon. Christopher Shays follows:]

PREPARED STATEMENT OF HON. CHRISTOPHER SHAYS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CONNECTICUT

This is the second oversight hearing to be held on the Department of Health and Human Services by this subcommittee in the 104th Congress. The subject of today's hearing is opportunities for cost savings at HHS.

In our March 1 hearing, HHS Secretary Donna Shalala discussed the department's FY96 budget request which calls for $716 billion of budget authority, a 7.5% increase over FY1995. Discretionary spending would increase $1.5 billion or 4% over FY95. The department also proposes to consolidate 190 of its 300+ programs into 22 performance partnership grants.

This hearing will explore ways to ensure that those consolidations produce real savings and improved service. Central to this hearing is the question of coordination of HHS services, and the opportunities to consolidate overlapping HHS programs and terminate the ineffective ones.

Witnesses today are representatives from the General Accounting Office, the Office of Inspector General at HHS, the Heritage Foundation, Project Hope, Visiting Nurses Association of Texas, and Community Legal Services of Philadelphia.

We look forward to the comments and recommendations of our witnesses, especially on the topic of waste, fraud and abuse in Medicare and Medicaid programs. Losses in federal health care spending are estimated by the GAO and others to be as high as 10% of total expenditures.

If these estimates are correct, losses due to waste, fraud and abuse in Medicare and Medicaid in FY95 could be in excess of $30 billion and will continue growing rapidly each year unless action is taken. These staggering losses are unacceptable.

We could finance the projected growth in these programs without spending one additional dollar if we eliminated this level of waste. That may be unrealistic, but we have a responsibility to look there first before we look to taxpayers to pay more for less health care.

Fraud in the Medicaid program includes schemes to divert prescription drugs, resulting in losses estimated to be over $1 billion annually. In 1994, GAO recommended that HHS direct HCFA to conduct a cost-benefit study on the automated Drug Utilization Review systems now being used by two-thirds of the states. Assuming that greater use of DUR would be a cost effective tool to prevent prescription diversion, we would like to discuss how the remaining states could take advantage of this system. The subcommittee would like to know the status of GAO's recommendation.

We welcome today's witnesses.

[Witnesses sworn.]

Mr. SHAYS. Nice to have you here. First, let me say, without objection, please submit any testimony that you would like and you are free to summarize your testimony. Both your testimonies are very important, so we want them on the record. Any statement by any member can be submitted. And I would also ask unanimous consent, as well, that members have the right, for 3 days, to submit testimony before the record is closed.

[The prepared statements of Hon. Constance A. Morella and Hon. Gene Green follow:]

PREPARED STATEMENT OF HON. CONSTANCE A. MORELLA, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MARYLAND

Mr. Chairman, thank you for scheduling this second hearing on the Department of Health and Human Services, focusing on options for making the Department's operations more cost-effective and streamlined.

In view of the enormity of the HHS scope of services, we have both an opportunity and responsibility to carefully review the Department's coordination and delivery of services. I look forward to hearing the suggestions and input of our many witnesses today. I hope that we can work to provide more cost-effective services, while also protecting the many critical health and human service programs within the jurisdiction of HHS.

Thank you, Mr. Chairman.

PREPARED STATEMENT OF HON. GENE GREEN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Thank you, Mr. Chairman. I believe that today's hearing will provide an opportunity to thoroughly examine the extent of waste fraud, and abuse in the programs HHS administers. Recently, we received testimony from Secretary Donna Shalala on how HHS is trying to make their programs work more efficiently. Her proposals in-

cluded improving the claims processing system and increase state flexibility in administering programs.

Today's panel will discuss how the law itself may encourage waste, fraud and abuse. They will point to the increase in the cost of home health service under Medicare since the 1988 *Bowen* v. *Duggan* case. I would especially like to learn to what extent this has been caused by waste and to what the increase can be explained by widening eligibility for the program.

The public deserves to have a government which wisely spends its money. It seems apparent to me however, that different groups are looking at the same data and coming to different conclusions: some see waste, fraud, and abuse while other see legitimate increases in eligibility for services based on the letter of the law. I hope today's hearing will provide us with a clearer explanation of the situation.

Mr. SHAYS. I would ask the ranking member, acting ranking member, Mr. Fattah, if he has any statement he'd like to make.

Mr. FATTAH. Thank you, Mr. Chairman. No, I do not, but I'd like to submit for the record for the ranking member, Congressman Towns, an opening statement.

Mr. SHAYS. Without objection, all testimony of any member will be able to be submitted.

Mr. FATTAH. I have no further opening statements.

[The prepared statement of Hon. Edolphus Towns follows:]

PREPARED STATEMENT OF HON. EDOLPHUS TOWNS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK

I want to thank my colleague, the Honorable Chris Shays, chair of this subcommittee for holding this hearing.

Today's hearing will discuss two topics of vital concern: home health care and childhood disability benefits. We are called here to examine allegations of fraud, waste and abuse in these programs.

Let me start by saying that health care fraud affects all of us. Taxpayers suffer when medicare and medicaid fraud exists. Private insurers are harmed when dishonest health care providers cheat the system. However, we must not forget that the people who are harmed most are those who rely on the health care system. Fraud may be expensive or inconvenient to you and me but it could be permanently disabling or fatal to the patient.

The inspector general of the Department of Health and Human Services has issued a report which found that fragmentation of medicare payment sources, supplies and providers raise concerns about cost-shifting, inappropriate payments and overuse of services. While I am concerned about these things, it seems to me that we should look for solutions. For instance, the use of physicians as case managers would help ensure that beneficiaries are properly selected, care is properly provided and progress is competently monitored.

Additionally, while we raise concerns about fraud and abuse, we have cut funding for the Health Care Financing Administration's (HCFA) anti-fraud and abuse activities. Due to this funding decrease, contractors can only review 5% of cases for fraudulent and abusive billing practices. Five years ago, they could afford to review 20% of claims for questionable practices. If we are serious and committed to looking for solutions, we should increase funding for HCFA's activities. We should enable them to examine a reasonable number of the 700 million claims they are expected to process this year.

Additionally, I believe an unfavorable view of increases in the number of claimants for the Social Security Administration's childhood disability program marks a shift in this body's focus. In 1992, I led twenty-five of my colleagues in a bi-partisan letter to the Social Security Administration requesting that they increase their outreach efforts to potential childhood disability claimants. This action was based on a Supreme Court finding that benefits had been unfairly denied to thousands of disabled children nationwide. It seems to me that this outreach effort is working. Additionally, the GAO and several independent studies have failed to find any evidence of application or assessment fraud among the 900,000 beneficiaries who rely on this program.

Moreover, our consideration of childhood disability benefits may be premature. On Monday, March 27th, the National Commission on Childhood Disability, headed by our former colleague, Jim Slattery begins a series of public hearings to examine

childhood disability concerns. It seems to me that our deliberations could be informed by their work.

Finally, I believe that we cannot afford to forget that we are not merely dealing with concepts of fraud and abuse or with cold calculations on savings. Both of these programs touch and concern the daily lives of millions of low income elderly and disabled Americans. We should not forget that they rely on these programs and rely on us to do the right thing.

Mr. SHAYS. Mr. Martini.

Mr. MARTINI. Thank you, Mr. Chairman. I have no opening statement at this time.

Mr. SHAYS. It's wonderful to have you both here. And we look forward to working with both of you and thank you very much for coming today. Ms. Brown, if you'd like to start.

STATEMENT OF JUNE GIBBS BROWN, INSPECTOR GENERAL, DEPARTMENT OF HEALTH AND HUMAN SERVICES; AND SARAH JAGGAR, DIRECTOR OF HEALTH FINANCING AND POLICY, GENERAL ACCOUNTING OFFICE

Ms. BROWN. Thank you, Mr. Chairman. Good morning.

Mr. SHAYS. Good morning.

Ms. BROWN. I'll concentrate my oral remarks this morning on concerns we have regarding home health care, nursing homes and durable medical equipment. However, you asked that I comment briefly on our work with children's disability benefits under the supplemental security income program, and I'll do that as well. The OIG is charged with protecting the integrity of programs of HHS, and promoting their economy, efficiency and effectiveness.

In fiscal year 94, we achieved 1,169 successful criminal prosecutions, and 1,334 administrative sanctions. We also generated savings, fines, restitutions, penalties and receivables of over $8 billion. This represents $80 in savings for each Federal dollar invested in our office; another way of putting it is, on average, $6.4 million in savings per OIG employee.

Let me turn first to the area of home health care. As you can see from our chart, costs have risen from $3.3 billion in 1990 to $12 billion in 1994. These costs are expected to reach $16 billion this year, and more than $22 billion by the year 2000 if left uncontrolled. The number of beneficiaries receiving home health services has increased 72 percent, from 1.9 billion in 1990 to 3.3 billion in 1994.

The average number of visits per person has also increased from 36 in 1990 to 65 in 1994, more than an 80 percent increase. Some of the things we are uncovering include one home health agency that claimed approximately $14 million in unallowable costs on its cost report during one cost reporting year. These items were unrelated to patients' care. They include personal airplane travel, lobbying, alcoholic beverages, promotional items, the work of the fiscal contractor, utility and maid service, payments on the owner's condominium, golf pro shop expenses, lease payments, a luxury car for the owner's son at college, and payment for cable television fees for the owner's mother.

In another home health agency in Florida, we found that 75 percent of the claims submitted did not meet Medicare guidelines. Visits were claimed, but not made. Visits were made to persons who were not considered homebound. Visits were made when physicians

denied that they authorized them. And visits were made to beneficiaries who did not want the service.

We have issued a draft report on the audit of home health service in Florida. We randomly reviewed home health agency claims in Florida, and found that 26 percent of the claims did not meet Medicare guidelines; 8 percent were there for visits to beneficiaries who were not homebound; 13 percent were for unnecessary services; and 5 percent were for visits that were either not documented, not provided, or provided less frequently than actually claimed.

The second area that I'd like to mention today is the issue of nursing homes. There are problems with billings between Part A and Part B, which I have described in my written testimony. One of the most prevalent problems is cost shifting. That is, billing separately under Part B for items which should be included under the daily rate of Part A.

One cause for these problems is that no single individual or institution is held responsible by Medicare for managing the beneficiaries' care while in a nursing home, and ensuring that only needed services are delivered to the patient. Some supplies or services may be unnecessary, but no one is charged with the responsibility of minding the store or making sure that patients get what they need within reason.

In fact, the opposite is true. The individual or business providing the services or supplies gains by billing the program. The nursing home gains by having their patients receive those items or services. And thus, we have a built in system for overuse of the services and supplies. The third area I'd like to focus on is medical equipment and supplies.

In DME alone—durable medical equipment—between 1990 and 1994, we achieved 131 successful criminal prosecutions and 38 civil monetary penalties. In 1993 and 1994, we excluded 114 providers or their employees. Our recent work suggests that an emerging problem in medical equipment and supplies has to do with marketing and targeting of patients in nursing homes.

We believe that this is the primary reason why Medicare allowances for incontinent supplies more than doubled in 3 years to $230 million in 1993, despite a drop in the number of beneficiaries using these supplies. This growth is illustrated on our second chart. For example, with the female urinary collection device, we went from virtually no billings in 1990 to $15.3 million in 1993.

I have a sample of this device with me today. This is the pouch, which costs a little over $7. But that was an extraordinary rise in the charges. We have found that, in many cases, just ordinary diapers—the type that you could find in the grocery store which costs about 33 cents each—were being delivered instead of these more expensive pouches that were billed to Medicare. The number of beneficiaries supposedly using these devices increased from 600 to 9,400.

We have launched a major national investigation into the marketing and billing of incontinence care kits and supplies to nursing home residents. The significance is, these are covered under Medicare, but the diapers are not.

I would like to address a broad question of how we can best protect Medicare and Medicaid programs from fraud and abuse. If you

ask me what is different today from several years ago in fraud fighting environment, I would point to three factors in particular.

The rising Medicare and Medicaid expenditures create a more attractive target, and, of course, that attracts the unscrupulous. There is increased sophistication and complexity in the fraud schemes that are being perpetrated, and inadequate resources are available to address the problem. The extensive amount of fraud in these programs illustrates the need for more investigators, along with attorneys, auditors and program evaluators, to penetrate the sophisticated schemes.

Because of the broad trend for Government downsizing, we support a mechanism to increase funding available for combating health care fraud and abuse, without drawing down from the U.S. Treasury or further burdening taxpayers. Under this concept, certain recoveries that are generated by our health care anti-fraud activities would be deposited into a reinvestment fund, with dollars available to fund additional enforcement activities.

Thus, the individuals who actually perpetrate the fraud against, and otherwise abuse, our Nation's health care system would foot the bill for increasing policing of these programs. This would be, of course, after restitution to the Medicaid trust funds and the affected Medicaid programs would be made. That would be done before any moneys were deposited into the account.

In the last Congress, this concept had wide bipartisan support. Aside from the issues of program fraud and abuse, you asked that I mention our work in the area of program expansion—disability benefits to children under the supplemental security income program, known as SSI. In recent months, we've issued two audit reports on this subject. The first report addresses the confusion we have found about the intent of Congress with regard to children with disabilities, particularly mental impairment.

If the Congress intends that the SSI program provide only cash assistance to children with mental impairments, then the program is successful. However, if the Congress intends that the SSI program help children overcome their disabilities and grow into adults capable in engaging in substantial gainful activity, then changes are needed. The second report presents the results of our review of State disability determination services, compliance with the SSI guidance when making disability determinations for children with mental impairment.

The results show that they do not always comply. We estimate that evidence in case files supports 70.3 percent of the cases that were allowed. The remaining cases were either incorrect or unsupported. A much lesser problem is found with the denied cases. Our review did not indicate any widespread coaching of children to perform in a manner that is not appropriate for their age. That's the criteria used by the court to determine mental impairment. There is a widespread belief that this is occurring. But in the cases we reviewed, actual coaching appeared to be isolated, rather than a trend.

In a third report, which will be issued shortly, we studied Medicaid usage before and after children became eligible for SSI. We also determined if children who had been denied SSI had access to other Federal assistance programs. We found that for the children

who were enrolled in Medicaid prior to SSI, utilization increased after their SSI eligibility began.

We also determined that more than half the children who were denied SSI were eligible for at least one other Federal assistance program including Medicaid. We are recommending that SSA, in working with the Commission on Evaluation of Disability in Children consider a couple of program enhancements. First, requiring that an evaluation be made during the disability determination process of the need for and appropriateness of prescribed treatment for children with disabilities. And second, ensuring that the children's access to prescribed treatment, which, if followed, would help them achieve independence and engage in substantial gainful activity be insured.

This concludes my oral testimony, and I'd be happy to answer any questions.

[The prepared statement of Ms. Brown follows:]

PREPARED STATEMENT OF JUNE GIBBS BROWN, INSPECTOR GENERAL, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Good morning. My name is June Gibbs Brown, and I am the Inspector General, U.S. Department of Health and Human Services. I am pleased to be here today to discuss issues relating to the Medicare and Medicaid programs.

As requested by the subcommittee, I will focus my testimony this morning on three areas where the OIG has serious concerns regarding the prevalence of fraud, waste, and abuse and where we plan on devoting significant audit, investigative, and evaluation resources. These areas are: (1) home health, (2) nursing homes, and (3) durable medical equipment. In addition, I will discuss our activities related to the growing area of managed care as well as some additional options which could be taken to improve the efficiency of the Medicare and Medicaid programs and to enhance the financial viability of the Medicare trust funds.

INTRODUCTION

Created in 1976, the OIG is statutorily charged with protecting the integrity of departmental programs, as well as promoting their economy, efficiency, and effectiveness. The OIG meets this challenge through a comprehensive program of audits, program evaluations, and investigations designed to improve the management of the Department and to protect its programs and beneficiaries from fraud, waste, and abuse. Our role is to detect and prevent fraud and abuse and to ensure that beneficiaries receive high quality, necessary services, at appropriate payment levels.

Within the Department, the OIG is an independent organization, reporting to the Secretary and communicating directly with the Congress on significant matters. We carry out our mission through a field structure of 8 regions and more than 60 field offices and with a staff of over 1,200 auditors, evaluators, and investigators.

In Fiscal Year (FY) 1994, we were responsible for 1,169 successful criminal prosecutions and 1,334 administrative sanctions against individuals or entities that defrauded or abused the Department's programs and/or beneficiaries. Last year, the OIG also generated savings, fines, restitutions, penalties, and receivables of over $8 billion. This represents $80 in savings for each Federal dollar invested in our office, or $6.4 million in savings per OIG employee.

The Medicare program is administered by the Health Care Financing Administration (HCFA). Medicare Part A covers hospital and other institutional care for approximately 37 million persons age 65 or older and for certain disabled persons. FY 1995 expenditures for Part A are estimated at $110 billion. Medicare Part B, which covers most of the costs of medically necessary physician and other non-institutional services, has estimated FY 1995 expenditures of $64 billion. At $177 billion, FY 1995 Medicare expenditures will have increased 9 percent over the FY 1994 level.

The Medicaid program provides grants to States for medical care for approximately 36 million low-income people. Medicaid outlays have risen at a dramatic pace, causing Medicaid spending to become the fastest rising portion of both the Federal and State budgets. Federal Medicaid spending are expected to reach $88 billion this year, an increase of 7.8 percent over the previous year. Eligibility for the Medicaid program is in general, based on a person's eligibility for cash assistance programs, typically Aid to Families with Dependent Children or Supplemental Secu-

rity Income. The Federal grant is open-ended, paying from 50 to 83 percent of the State's Medicaid expenditures, based on a calculation of the State's relative wealth.

HCFA administers the Medicare and Medicaid programs. The HCFA contracts with private insurance companies to process Medicare claims and to perform payment safeguard functions. Forty-three fiscal intermediaries make payments under Part A and Part B; 34 carriers make payments under Part B, and four specialty contractors make payments for medical equipment and supplies paid under Part B. These contractors operate at 62 sites across the country.

Over the years, HCFA has instituted many significant reforms to the Medicare program to control costs. Payment reforms have included implementation of a prospective payment system (PPS) for inpatient hospital services and a resource based fee schedule for physician services. Administrative reforms have included the regional consolidation of claims processing for durable medical equipment, prosthetics, orthotics and supplies. Medicare administrative costs have been low as a proportion of overall program costs: one percent of Part A claims and 3.5 percent of Part B claims. The implementation of the Medicare Transaction System (MTS) should further streamline claim processing functions.

The OIG and the State Medicaid fraud control units (MFCUs), have concurrent investigative authority in the Medicaid program. The MFCUs, supported largely (75–90 percent) by Federal dollars, devote approximately 1,200 personnel to investigating Medicaid fraud. Currently, Federal outlays for operation of the MFCUs are approximately $79 million. The units reported 683 convictions in FY 1994 with total recoveries of over $36.6 million. Approximately 25 percent of their caseloads involve patient abuse allegations, for which there is no monetary recovery.

The HCFA also recognizes the importance of protecting the Medicare program from fraud. A senior official in HCFA, reporting directly to the Administrator, is responsible for coordinating the program's anti-fraud activities. The HCFA has also required that Medicare contractors establish fraud units, and we anticipate that these units will increase the number and quality of case referrals to our office.

Nonetheless, as HCFA and we understand, protecting the Medicare trust fund requires continual vigilance. Because of the dollars at stake, the program will always attract unscrupulous actors who attempt to take advantage of loopholes or flout the law altogether in an attempt to enrich themselves at the expense of the taxpayer and the Medicare beneficiary.

Based on our investigative work and ongoing reviews of program costs, we have recently begun major initiatives in several areas where we suspect systematic fraud, waste or abuse: home health, nursing homes, and durable medical equipment. Because of the interest and focus on managed care, we have also developed an operational plan devoted to that area. These OIG-wide initiatives have brought the OIG's investigators, auditors and evaluators together as a team, communicating regularly with HCFA officials, to conduct a wholesale examination of these areas. Let me discuss our concerns and activities in each of these areas.

HOME HEALTH

Under its Part A services, Medicare pays for home health services. Among the services beneficiaries may receive under this benefit are: (1) part-time or intermittent skilled nursing care and home health aide services; (2) physical, speech, and occupational therapy; (3) medical equipment and supplies; and (4) medical social services. These services must be provided by a Medicare certified home health agency (HHA).

To receive this benefit, Medicare beneficiaries must be: (1) homebound; (2) in need of care on an intermittent basis; and (3) under the care of a physician with a plan of care established and periodically reviewed by a physician. Once these eligibility criteria are met, the benefit is unlimited as long as the services are considered medically necessary for the treatment of a beneficiary's illness. In addition, beneficiaries are not required to pay any coinsurance or deductibles (except for DME, which requires a 20 percent copayment).

Medicare expenditures for home health services have grown dramatically in recent years. In Fiscal Year 1990 the Medicare program spent $3.3 billion on home health. By 1994, 4 years later, Medicare was spending over $12 billion—a 263 percent increase. These costs are expected to reach $16 billion this year and more than $22 billion by the year 2000, if left uncontrolled.

During this same period, we have seen increases in both the number of beneficiaries using home health services and the average number of visits per beneficiary. The number of beneficiaries receiving home health services has increased 72 percent, from 1.9 million in 1990 to 3.3 million in 1994. Similarly, the average num-

ber of visits per person has increased from 36 in 1990 to 65 in 1994, more than an 80 percent increase.

Numerous factors have contributed to the recent growth in home health. The aging of the Medicare population and the development of complex medical technologies that can be provided in the home are two such factors. However, a significant program change in 1988 opened the floodgates for increased expenditures in the home health area. In that year, HCFA issued revised coverage guidelines that liberalized coverage of the home health benefit. The definition of the "part-time or intermittent" requirement was liberalized, and a reinterpretation of the "confined in the home" requirement was expanded to include persons who occasionally leave the home. These changes were largely made to comply with the settlement of a class action lawsuit, which alleged that Medicare contractors were improperly denying home health claims.

The OIG has observed several types of fraud in HHA operations, including cost report fraud, excessive services or services not rendered, use of unlicensed or untrained staff, falsified plans of care, and forged physician signatures and kickbacks. Between 1990 and 1994, OIG investigations led to 25 successful criminal prosecutions of HHAs or their employees and imposed three civil money penalties. In 1993 and 1994 alone, 39 HHAs or their employees were excluded from participating in the Medicare or Medicaid programs.

The following describes some of the work that we have done in this area to date:

We audited the cost report of one home health agency and found that the agency claimed approximately $14 million in unallowable costs during one cost reporting year. The unallowable costs included utility and maid service payments for the owner's condominium, golf pro shop expenses, lease payments on a luxury car for the owner's son at college, and payment of cable television fees for the owner's mother. Through cost reports, HHAs can charge general and administrative costs to the Medicare program. As a result, the OIG has proposed to exclude this entity from the Medicare, Medicaid, and all State health programs for a period of 7 years.

We recently issued a final report of an audit of a home health agency in Miami Lakes, Florida in which we found that 75 percent of the claims submitted by this HHA did not meet Medicare guidelines. Visits were claimed but not made; visits were made to persons who were not considered homebound; visits were made when physicians denied that they authorized them; visits were made to beneficiaries who did not want the service. We estimate that of the $45.4 million claimed by this HHA in 1993, well over half, $25.9 million, did not meet reimbursement requirements.

We have issued a draft report reporting on our audit of home health services in Florida. We randomly reviewed HHA claims in Florida and found that 26 percent of claims did not meet Medicare guidelines. Eight percent of the claims were for visits to beneficiaries who were not homebound. Thirteen percent were for unnecessary services. Five percent of the claims were for visits that were either not documented, not provided, or provided less frequently than actually claimed. Similar efforts are planned in other regions where our investigative work, and leads from HCFA, indicate that specific problems exist.

We have issued a draft report discussing the physician's role in home health care. This is an important area, since we know that many inappropriately paid claims (such as those we found in Florida) could have been prevented with more physician involvement. We conducted interviews with physicians and home health agencies across the country, and reviewed Medicare claims data for beneficiaries associated with the physicians we interviewed. We found that physicians generally have a relationship with patients for whom they sign plans of care. The physicians we interviewed report initiating referrals for home care, and report that they do review the plans of care they sign. But it was also clear from our interviews that physicians are most involved with patients with complex medical problems, and feel less need to involve themselves with patients with chronic, but less complex, conditions. It's also important to recognize that physicians don't make home visits themselves, and they don't directly manage the care the patient receives from the HHA.

We will issue a final report shortly which provides information about how non-Medicare payers structure and manage their home health benefit. We found that the primary difference between Medicare and other payers is not the benefit packages they offer, but the way they attempt to control home health costs. Other payers are more involved in assessing how their beneficiaries might benefit from home health care, and use case managers to ensure that beneficiaries are properly selected, care is properly provided, and utilization and progress monitored. Unlike Medicare, beneficiaries are assessed copayments and told

what the insurer has paid the HHA on their behalf. Other health plans often set limits on the benefit—capping the number of visits that can be made over a specified period, for example.

NURSING HOMES

Let me now turn to the issue of nursing homes. Our concerns regarding nursing homes fall into two primary categories: (1) fragmentation of responsibility and accountability and (2) transfers of assets to qualify for Medicaid.

Medicare pays for services delivered to beneficiaries in nursing homes under both Part A and Part B of the program. First, Medicare covers 100 days of extended care services for qualified beneficiaries in a Medicare participating skilled nursing facility (SNF). This benefit was designed to reduce the length of stay in acute care hospitals and transition beneficiaries to their homes or to custodial care facilities. To qualify for the benefit the patient must have spent at least 3 consecutive days in a hospital, and require daily skilled nursing care or skilled rehabilitation services. In 1993, Medicare spent over $5 billion for SNF stays, under Part A of the program for more than 728,000 beneficiaries.

But Medicare Part B also comes into play, regardless of who pays for the stay in the nursing home itself. In 1992, we estimate that Medicare Part B allowed approximately $4 billion for services delivered to 2.1 million beneficiaries in nursing homes. Services that can be billed under Part B for such patients include physician services, laboratory services, radiology services, ambulance, and medical equipment and supplies.

State Medicaid programs are required to cover nursing facility costs for eligible individuals over the age of 21. Approximately 2 million Medicaid recipients receive nursing facility coverage at a combined Federal and State cost of $25 billion. This represents approximately 24 percent of all Medicaid expenditures.

Fragmentation of Responsibility and Accountability

We are concerned about the provision of services and equipment to beneficiaries in nursing homes because no single individual or institution is held responsible by Medicare for managing the beneficiary's care while in a nursing home and ensuring that only needed services are delivered to the patient. Indeed, the incentives run in quite the opposite direction. A provider who offers therapy services to residents of nursing homes gains a market for his or her services; the patient may be happy to receive services of any kind, with any possibility that it might help them medically or socially; and the nursing home's own staff is relieved of caring for the patient during the time the provider is delivering services to the patient. Likewise, suppliers may deliver unneeded supplies to nursing homes for beneficiaries, but the nursing home has little incentive (except for limited storage space) to turn supplies away.

We are also concerned that there is cost shifting between Part A and Part B of the Medicare program in the provision of SNF services. The HCFA determines the daily rate it will pay for care in a SNF. This rate is calculated to include multiple services including room and board, nursing care, rehabilitation services, and other routine SNF services. For some services, SNFs can bill Medicare Part A on the cost report or bill Medicare Part B separately. As a result we have found:

In excess of $10 million was incorrectly billed to Part B for durable medical equipment provided to Medicare beneficiaries in SNFs in 1992. The statute requires that DME be billed under Part A, and we recommended that HCFA correct the system to prevent such payments and HCFA agreed.

Roughly $57 million in total enteral nutrition charges were allowed in both 1991 and 1992 under Part B when much of those costs should have been billed to Part A. It is clear that under Part A, patients' dietary needs should be covered by the SNF daily rate. Enteral nutrition is a liquid dietary substitute for patients who cannot survive on oral feedings.

As much as $55 million in 1992 were charged to Part B for rehabilitation therapy. Rather than the SNF providing the ancillary services and charging them to the Part A program, third party providers billed the therapy as Part B services.

As much as $44 million in 1992 was paid under Part B for surgical dressings, incontinence supplies, braces, catheters, and similar items.

Savings could result if these items were purchased by the nursing home, acting as a prudent purchaser and taking advantage of discounts, rather than being billed to Part B and reimbursed under fee schedules. We will issue a report shortly on the issue of cost-shifting, and further work on pricing of products under Part A and Part B will help determine the amount of savings possible by eliminating separate payment under Part B.

We also note that when services are billed under Part B, the beneficiary is liable for coinsurance and deductibles. In 1992, beneficiaries whose stays in SNFs were covered by Medicare paid up to $99 million as their coinsurance and deductibles for therapy, nutrition, and medical supplies and equipment billed under Part B.

The HCFA shares our concerns about fragmentation of billing for services delivered to Medicare beneficiaries in nursing homes and is working on possible solutions. One option would be a statutory "rebundling" provision for SNFs, similar to that for hospitals. Such an approach would also support work to establish a prospective payment system for beneficiaries in SNFs.

Transfers of Assets

One issue regarding Medicaid payment for nursing home stays involves wealthy individuals divesting themselves of assets in order to appear poor and meet eligibility criteria. To address this concern, the Congress has passed numerous reforms. We are currently in the process of reviewing State Medicaid recovery programs which were mandated by the Omnibus Budget Reconciliation Act of 1993 (OBRA '93).

While many States had programs prior to passage of OBRA '93, our survey found that 27 States currently have estate recovery programs. We found that mature recovery programs are generally successful and cost-effective and that existing programs provide lessons on operational challenges. Our work builds on a 1988 report issued by our office in which we found that State Medicaid programs had not taken full advantage of transfers of Medicaid beneficiaries' assets, liens, and estate recoveries to pay for long term care services.

In October 1994, we issued a report on how Medicaid and Supplemental Security Income recipients use trusts to shelter assets. We found that nationally, the use of trusts was growing and there was a significant impact on Medicaid recovering program costs. While OBRA '93 closed some loopholes involving the use of trusts, the statute contains exceptions for disabled SSI recipients which may prevent Medicaid from recovering its expenses. We believe that there are three areas where abuses may continue: (1) trust funds of disabled individuals could be spent so that the assets are depleted; (2) trust funds could be retained by the trusts upon the deaths of recipients, and (3) States may not have appropriate laws specifically dealing with recoveries from trusts. We believe that corrective action should be taken to close these loopholes.

MEDICAL EQUIPMENT AND SUPPLIES

We continue to focus on medical equipment and supplies, as we have in the past, but in closer partnership with HCFA and the newly established DME regional carriers (DMERCs). Our investigative activity continues to disproportionately (based on program expenditures) fall into this category of service. Between 1990 and 1994, our investigations led to 131 successful criminal prosecutions of DME suppliers or their employees. During the same period, we imposed 38 civil money penalties. In the last 2 years alone, we excluded 114 DME companies or their employees from the Medicare and Medicaid programs.

We often take a close, hard look at specific items of equipment or supplies when we see a significant increase in payments over a short period of time. In absence of coverage or coding changes, or new medical information about the proper use and application of technology, such increases have often been an indication of fraud or inappropriate billings.

For example, payments for orthotic body jackets—customized, rigid devices intended to hold patients immobile and treat patients with muscular and spinal conditions—went from $217,000 in 1990 to $18 million in 1992. We estimated that 95 percent of those payments were for devices more properly categorized as seat cushions rather than body jackets. As HCFA has moved to process such claims by specialty carriers, such problems are easier to spot and address. In fact, by the time we issued our findings on orthotic body jackets, payments were already on a downward trend because of this change.

Incontinence Supplies

Incontinence supplies are supplies used for individuals who have bladder or bowel control problems. The Medicare program covers these supplies when incontinence is of long and indefinite duration. Incontinence supplies include catheters and external collection devices such as pouches or cups. Catheters are flexible, tubular instruments used to control urinary flow. The HCFA will also reimburse for accessories that aid in the effective use of such devices, such as drainage bags, irrigation syringes, sterile saline solutions and lubricants. However, certain items, such as absorbent undergarments or diapers, are specifically excluded from Medicare coverage.

Medicare allowances for incontinence supplies more than doubled in 3 years despite a drop in the number of beneficiaries using these supplies. The amount allowed for incontinence supplies rose from $88 million in 1990 to $230 million in 1993, an increase of $142 million. During the same period, the number of beneficiaries receiving incontinence supplies fell from 312,000 to 293,000, causing the allowance per beneficiary to increase from $282 to $786, a 179 percent increase.

Most of these payments were concentrated in one carrier and a small number of suppliers and beneficiaries. We believe that questionable billing practices may account for almost half of incontinence allowances in 1993. Approximately $88 million was allowed for accessories that were not billed along with a catheter, indicating that coverage guidelines were not met. Another $19 million in allowances were made for beneficiaries who appeared to receive more supplies than necessary.

Information from nursing homes indicates that suppliers engage in questionable marketing practices to increase their business in incontinence supplies. Twenty-four percent of nursing homes have reported that supplier representatives decided the number of supplies to be delivered in a given month to beneficiaries. In addition, nursing homes have reported other practices by suppliers such as the routine waiving of beneficiary coinsurance payments as well as offers of inducements in exchange for allowing suppliers to provide incontinence supplies to patients.

Nursing homes have told us that some suppliers present them with false or misleading information. Twenty-two percent of nursing homes received false information from suppliers stating that Medicare is introducing "new broader coverage" for incontinence supplies. One out of ten nursing homes has been misinformed by a supplier that Medicare will cover other routine incontinence supplies such as absorbent undergarments if syringes, sterile solutions, and lubricants are purchased.

As a result of our concerns regarding incontinence supplies, we have launched a major national investigation into the marketing and billing of these supplies to Medicare beneficiaries in nursing homes.

MANAGED CARE

Given the growing interest and support for managed care programs, it is critical that these programs are well managed, financial and programmatic integrities are assured, tax dollars are protected from fraud and abuse, and quality of care as well as access to care is maintained. Therefore, we plan to undertake a number of reviews to address issues involving program integrity, quality and access to care, rate setting, accuracy of payments, and financial integrity.

Managed care's emphasis on preventative and primary care is cost effective and much less expensive than a reliance on emergency health services. Last year, Medicaid had a 63 percent increase in the number of beneficiaries enrolled in managed care plans (from 4.8 million to 7.8 million). There was also a 16 percent increase in Medicare manage care enrollment (from about 2.7 million to 3.1 million).

We have been involved in the managed care area for many years. Ten years ago, we investigated allegations of impropriety in a Florida HMO. Today, our concerns, as well as those of HCFA program officials and many others, extend to such issues as (1) the adequacy of beneficiary protections within managed care arrangements, and the quality of care beneficiaries receive; (2) the validity of payment methods; and (3) the financial viability of managed care plans. For example:

We just completed a study on the experiences of Medicare beneficiaries who had enrolled in risk based HMOs. We found that beneficiaries indicated that risk HMOs provide adequate service access for most beneficiaries who have joined and that risk HMOs generally adhere to Federal enrollment standards for informing beneficiaries about application procedures, lock-in, and prior approval for specialty care. However, we also reported that compliance with Federal enrollment standards for health screening and informing beneficiaries of their appeal rights appeared to be problematic.

We have been working with HCFA on ensuring that Medicare payments to HMOs are correct. We have completed several reviews that have identified overpayments to HMOs for beneficiaries improperly classified as being in an institution, eligible for both Medicare and Medicaid, or having end stage renal disease. Medicare increases its capitation payments for these individuals.

Our reviews of Medicaid HMOs indicate that rates may be set too high. When determining capitation rates, the Medicaid agency should consider the level and reasonableness of profits earned under the managed care contract, the amount of funds expended for medical care, and the impact of related party transactions.

IMPROVING PROGRAM EFFICIENCY

The 1995 edition of the Office of Inspector General Cost-Saver Handbook, also known as the Red Book, contains unimplemented OIG recommendations that result in cost savings. We estimate that these recommendations could save $25 billion annually and another $1 billion in one-time recoveries. These legislative, regulatory, and administrative options could be considered by policy makers to attain greater program efficiency and to enhance the viability of the trust funds.

The Subcommittee has requested that I outline actions that we have recommended that can be taken administratively. I would note, however, that most of the large dollars savings items that we have recommended are legislative in nature. These items include mandating Medicare Part A coverage of State and local employees hired prior to 1986, raising the Medicare retirement age to 67, expanding Medicare secondary payer provisions, revising payment methodologies for graduate medical education and indirect medical education, reducing Medicare payments for hospital capital costs, modifying Medicare payments for hospital bad debts, instituting copayments for Medicare laboratory services and making this part of the physician office payment, and eliminating Medicare disproportionate share payments. Of the $21.5 billion that could be saved by implementing our Medicare and Medicaid related recommendations, $19.2 billion annually could be attained legislatively, while only $2.2 billion annually relate to administrative items. Legislation is required to make structural changes and it is these changes that result in large savings. In fact, the Social Security Act in many ways is so prescriptive in how Medicare processes claims, what services are covered, and how reimbursement rates are determined that legislation is required for most of our recommendations.

Administrative action, however, can be taken in a number of areas to improve program efficiencies and to prevent program abuses. The following are some of our administrative recommendations contained in our most recent version of the *Red Book*.

Ambulance Transportation—Many payments for ambulance transports taking end stage renal disease beneficiaries to and from dialysis violate Medicare guidelines and should never have been made. We estimate that $66 million could be saved by preventing payments for such services (and $509 million over 5 years). We also believe that advance life support (ALS) transports should be paid for only when such services were medically necessary. By limiting reimbursement to the basic life support level unless ALS services are necessary, we estimate that $47 million could be saved annually (and $235 million over 5 years).

Oxygen Services and Payment—We have reported on the significant variations and shortcomings in the equipment and patient monitoring services that are provided to Medicare beneficiaries, which could affect the efficacy of the oxygen therapy. Given the complex nature of oxygen concentrator therapy, we have recommend that HCFA develop a strategy that will ensure that Medicare beneficiaries receive all necessary care. We are pleased the HCFA has agreed to address this issue by regulation.

We have also been concerned for some time about payments for oxygen concentrators. We are pleased that HCFA has begun to assess its pricing for such equipment. Based on currently available information, more appropriate pricing could result in substantial savings. In fact, we estimate that if Medicare were able to attain oxygen concentrators for the same price as paid be the Department of Veterans Affairs, savings of $567 million would result (or $4.2 billion over 5 years).

Physical Therapy in Physicians' Offices—We have recommended that HCFA take administrative action to prevent inappropriate payments for physical therapy in physicians' offices after finding that 78 percent of these procedures did not represent true physical therapy services. Actions which could be taken include conducting focused medical review, providing physician education activities, and applying existing physical therapy coverage guidelines for other settings to physicians' offices. We estimate that these actions would save $47 million annually (and $235 million over 5 years).

Medicaid Cost Sharing—While 27 States use some type of cost sharing in their Medicaid programs, these States did not report excessive administrative, recipient, or provider burdens. We recommended that HCFA promote the development of effective cost sharing programs and estimated that savings in excess of $120 million annually could be attained (and $768 million over 5 years).

Medicaid Payments to Institutions for Mentally Retarded People—The OIG has found that Medicaid reimbursement rates for large ICF/MRs are more than five times greater in some States than in others (ranging from $27,000 to

$158,000 annually per resident). We outlined a number of different options for controlling excessive spending for these services and estimated that savings in excess of $680 million could be attained annually (and $3.4 billion over 5 years).

Medicaid Generic Drugs—We have also recommended that HCFA identify and alert States to methods which would encourage the use of lower priced generic drug products in the Medicaid program. We found that annual cost savings to the Medicaid program could be as much as $46 million for only 37 high volume dispensed brand name drugs, if the reimbursement for those drugs was limited to the amounts set by HCFA for equivalent generic drugs (and $245 million over 5 years).

CONCLUSION

I appreciate the opportunity to appear before you today and to share with you some of our concerns and work we have done in the Medicare and Medicaid programs. The four areas that I have discussed with you today represent very important areas and we look forward to sharing the results of our work with HCFA and with the Congress.

Before concluding my remarks, I would like to address the broad question of how we can best protect the Medicare and Medicaid programs from fraud and abuse. If you asked me what is different today from several years ago in the fraud fighting environment, I would point to three factors in particular—(1) rising Medicare and Medicaid expenditures which create a more attractive target for the unscrupulous; (2) increased sophistication and complexity in the fraud schemes being perpetrated; and (3) inadequate resources available to address the problem.

First, when Willie Sutton was asked why he robbed banks, he responded "Because that's where the money is." Today's criminals may be more sophisticated, but in one way they remain true to their forebears. They go where the money is. In 1980, Medicare program costs were $34 billion. In 1990, that number had increased to $107 billion; and estimated 1995 costs are $177 billion. With that much money at stake, the lure of a fast buck is irresistible to criminals and con artists.

Second, we see a trend towards increased complexity and sophistication in the various schemes used to defraud the Medicare and Medicaid program. When we first started investigating health care fraud almost 20 years ago, we were primarily seeing instances of individual providers filing false claims for relatively low dollar amounts. Today we see increasingly complex schemes involving large groups of people and large dollar amounts. The environment of todays health care fraud involves complicated reimbursement issues, medical questions, financial arrangements, and sophisticated computer equipment. Recently, a major health care firm that owned over 60 psychiatric hospitals agreed to pay the Federal Government a record $379 million settlement. In 1992, a major laboratory firm agreed to pay the Government more than $110 million to settle fraud charges. The extensive amount of fraud in these cases illustrates the need for more investigators, along with attorneys, auditors, and program evaluators, to penetrate sophisticated schemes.

Third, despite the increased threat, the OIG's resources have declined in the past several years, from 1,411 employees in 1991 to 1,207 employees in 1995. By the end of FY 1994, 10 OIG investigative offices in 9 States and Puerto Rico were closed. Since 1989, the OIG has been required to implement the financial statement audit provisions of the Chief Financial Officer's Act of 1990, other new audit responsibilities, and over 32 new civil monetary and exclusion authorities, without additional funding for those new responsibilities. Our next challenge will be to adjust to the transfer of 259 staff to the Office of Inspector General at the Social Security Administration.

Funding our activities has been hampered by the discretionary freeze provisions of the Budget Enforcement Act. Budget constraints have produced the illogical result that spending on fraud prevention and detection—activities that pay for themselves many times over—has actually been curtailed. Because of this situation, we support a mechanism to increase funding available for combatting health care fraud and abuse without drawing down from the U.S. Treasury, or further burdening taxpayers. Under this concept, certain recoveries generated by our health care antifraud activities would be deposited into a reinvestment fund with dollars available to fund additional enforcement activities. Thus, the individuals who actually perpetrate fraud against, or otherwise abuse our nation's health care system, will foot the bill for increasing policing of those programs. Of course, restitution to the Medicare Trust Funds and the affected Medicaid programs would be made before any monies could be deposited into the account. In the last Congress, this concept had wide bipartisan support.

Again, thank you for the opportunity to appear before you today. I would be happy to respond to any questions you might have.

Mr. SHAYS. Thank you. We'll hear from Ms. is it Yeager or Jaggar?

Ms. JAGGAR. Jaggar. Sort of like Mick Jagger.

Mr. SHAYS. Mick Jagger.

Ms. JAGGAR. Sort of—like Mick.

Mr. SHAYS. I understand. It's very nice to have you here.

Ms. JAGGAR. Thank you.

Mr. SHAYS. And we welcome your testimony.

Ms. JAGGAR. Thank you very much. Mr. Chairman, and members, I am, indeed, pleased to be here today to contribute to the congressional debate on ways to obtain health care cost savings. I would like to give a short statement and have my full statement be submitted for the record.

We believe that rooting out Medicare and Medicaid fraud and abuse can save hundreds of millions, and perhaps billions, of dollars. The volume of services provided under Medicare and Medicaid is, as you know, growing, some would say alarmingly. Medicare contractors process more than 700 million claims a year, and Medicaid claims processors process more than 800 million claims a year, 350 million of which are for prescription drugs alone. We believe that Medicare and Medicaid are simply overwhelmed in their efforts to keep pace with profiteers bent on cheating the system.

Various factors contribute to this. In both programs there are strong incentives to overprovide services, weak controls to detect questionable billing practices, few limits on those who can bill, and little chance that profiteers will be prosecuted or required to repay.

While there are differences between Medicare and Medicaid, our work has shown that individuals or businesses that engage in fraudulent and abusive practices often target both programs, and sometimes the CHAMPUS, veterans affairs, and workers' compensation programs as well.

First let me talk a little about Medicare. We believe Medicare is in a strong position to combat fraudulent and abusive practices, but HCFA is not fully taking advantage of the program's substantial store of claims data to identify problems and correct them. We have found, for example, that fraudulent billing by providers serving nursing home residents is widespread. But HCFA has few controls to spot the nursing homes where these problems are occurring. Even nursing homes that increase their billings for a service from nominal levels to $1 million per year over a short time are not subjected to scrutiny, as was the case of one small nursing home that increased its therapy service billings in that range.

HCFA also does little to check its contractors' computerized controls to flag unusually high volumes of service. That is why a psychiatrist who billed Medicare for more than 24 hours of care per day was paid without triggering questions from the contractor's claims reviewers; or why a medical supplier was paid for huge quantities of surgical dressings for individual patients, more than would seem even possible for an individual to use.

Also, HCFA does relatively little to check its contractors' controls for assuring that only credible companies are given authorization to bill Medicare. For example, even companies that use post office

numbers as billing addresses or have little, if any, business history have been qualified to bill the program. This makes it easy for unscrupulous providers to bill the program extensively and then disappear, just as Medicare begins to ask questions.

HCFA has begun two major initiatives to address longstanding problems with inappropriate payments. First, it let a contract to design a single, automated claims processing system, called the Medicare Transaction System, or MTS, that promises greater efficiency and effectiveness. MTS is expected to serve as the cornerstone for HCFA's efforts to reengineer its approaches to managing program dollars. However, full implementation is at least 3 years away.

HCFA's second initiative involves giving greater prominence to fraud and abuse activities in Medicare. One individual now serves as a focal point for health care fraud and abuse activities, reporting directly to the administrator. Further, HCFA recently established special units at each contractor site to develop and pursue fraud cases within the Medicare program. HCFA has also taken several steps recently that make it more difficult for fly by-night providers to obtain authorization to bill a program.

Let me, for a moment now, talk about Medicaid, which is also intrinsically vulnerable to fraud. As you know, under Medicaid, States have the predominant responsibility to see that claims are processed correctly and that there are adequate fraud and abuse controls.

States are experimenting with measures to curb fraud and abuse, but their efforts are hampered by many of the same management problems that affect Medicare. For example, we found that States often were not successfully using their claims data to identify problem providers or recipients. This explains why a California pharmacist, during a 3-year period, routinely billed Medicaid for an improbably high volume of prescription drugs—in many cases, writing 20 prescriptions per day for individual recipients.

Curbing Medicaid fraud, however, is further complicated by several other factors. First, numerous jurisdictions have responsibility over Medicaid fraud and abuse matters. It is not unusual for a prescription drug fraud case to involve five or more State, local, and Federal agencies in its investigation, prosecution, and resolution. And this obviously slows things up.

Second, unscrupulous providers can reasonably anticipate very light penalties. In response to limited resources, prosecutors settle many cases short of conviction, and in any case, the penalties are light. Even in the cases where penalties are high, say $20,000 or more, the Medicaid agencies often recover little of the money.

Last, although providers convicted of Medicaid fraud are generally excluded from the program, offenders frequently retain some connection with health care delivery. In Florida, for example, we found that, of nine individuals charged with Medicaid fraud in 1990, five were still employed in pharmacies in 1992.

Recent State initiatives to prevent Medicaid fraud include the use of identification cards that resemble credit cards and monitor utilization, prescription filing systems that can instantly link orders to the filing physician, and data analysis techniques that can promptly identify physicians prescribing and patients receiving

high volumes of drugs. Recovery of program losses is also receiving more attention. Stronger tools are available, such as requiring certain high volume providers to post performance bonds or other forms of collateral as a condition of program participation.

In conclusion, we believe that, as the Nation's largest health care purchaser and payer, HCFA should lead in developing effective ways to manage health care expenditures. With respect to Medicare, this would entail such things as exploring opportunities to improve care management in settings such as nursing homes, where fraud and abuse has been a recurring problem; seeking ways to strengthen requirements for providers that seek authorization to bill the program; and developing and requiring contractors to implement better computerized checks to flag questionable claims or providers.

Because these efforts are funded out of the Government's discretionary appropriations, however, funding increases would necessitate spending cuts in other Government programs, or the kind of creative solution that Ms. Brown referred to.

With respect to Medicaid, we find similar problems that need to be addressed. Being a State-administered program, however, HCFA's role shifts from that of direct program management to one of leadership. This would involve documenting, guiding, coordinating and encouraging States' efforts.

Finally, the problems facing Medicare and Medicaid are faced by all payers, underscoring the need for comprehensive solutions. Administrative reform proposals from this and the last Congress present features that would help correct systemic weaknesses and oversight problems, without unduly restricting the freedom that patients and providers have come to expect when selecting their treatments.

This concludes my statement. I, too, would be pleased to answer any questions you may have.

[The prepared statement of Ms. Jaggar follows:]

PREPARED STATEMENT OF SARAH F. JAGGAR, DIRECTOR OF HEALTH FINANCING AND POLICY, GENERAL ACCOUNTING OFFICE

Mr. Chairman and Members of the Subcommittee: I am pleased to be here today to discuss the challenges that face the Congress in seeking health care cost savings. This is an important issue because rooting out fraud and abuse in Medicare and Medicaid can save at least hundreds of millions and perhaps billions of dollars. These two programs account for more than one-fourth of our national health care spending and, in fiscal year 1994, had over $300 billion in federal and state expenditures.

In summary, our work clearly demonstrated that Medicare—serving the elderly and disabled—and Medicaid—serving the poor—are overwhelmed in their efforts to keep pace with, much less stay ahead of, profiteers bent on cheating the system. Various factors converge to create a particularly rich environment for profiteers. For both programs, these include the following:

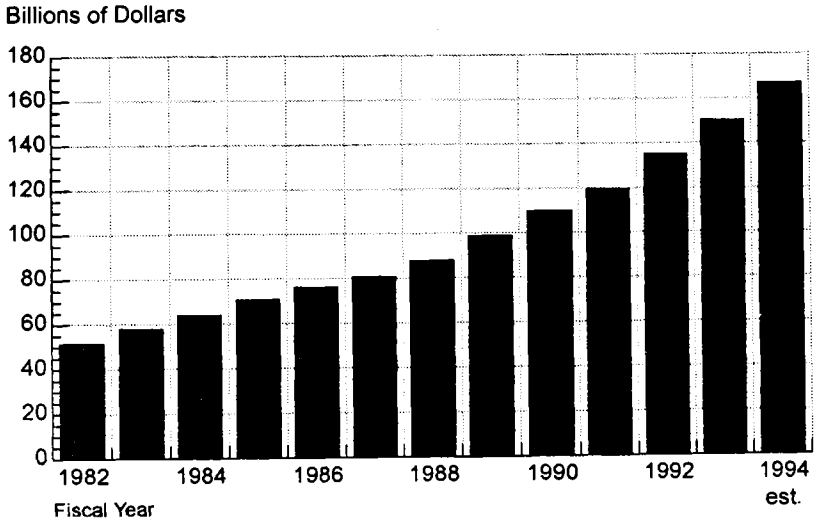
- **Strong incentives to overprovide services:** The programs predominantly pay providers on a fee-for-service basis with relatively little management of care.
- **Weak fraud and abuse controls to detect questionable billing practices:** Extraordinarily high volumes of services to individual patients or by individual providers do not necessarily trigger questions by claims reviewers.
- **Few limits on those who can bill:** Companies using post office box numbers have qualified to bill the program for virtually unlimited amounts.
- **Little chance of being prosecuted or having to repay fraudulently obtained money:** Many cases are settled without conviction, penalties are light, and providers frequently continue in business.

Solving these problems will require exploring options to make greater use of managed care strategies, such as preferred provider networks or health maintenance organizations (HMOs), greater investment in the people and technology needed to ensure that federal dollars are spent appropriately, more demanding standards for gaining authority to bill the federal programs, and exploring administrative reform options proposed in various bills introduced in this and the last Congress to address health care fraud and abuse.

BACKGROUND

Both Medicare and Medicaid fall within the administrative jurisdiction of the Health Care Financing Administration (HCFA) of the U.S. Department of Health and Human Services (HHS). Medicare is the nation's largest health payer. HCFA establishes regulations and policy guidance for the program and contracts with insurance companies—such as Blue Cross and Blue Shield, Travelers, and Aetna—to process Medicare claims and perform payment safeguard or payment control activities to ensure that Medicare dollars are used only to pay claims that are appropriate. These safeguards and controls are programmed into computer claims processing software. They trigger the suspension of payments by flagging claims for such problems as charging for an excessive number of services provided on a single day. The computer automatically holds the claim until the data are corrected. The development and implementation of these safeguards and controls are generally the responsibility of Medicare's contractors. In fiscal year 1994, Medicare contractors paid almost 700 million claims for about 36 million elderly and disabled Americans, totaling $162 billion.

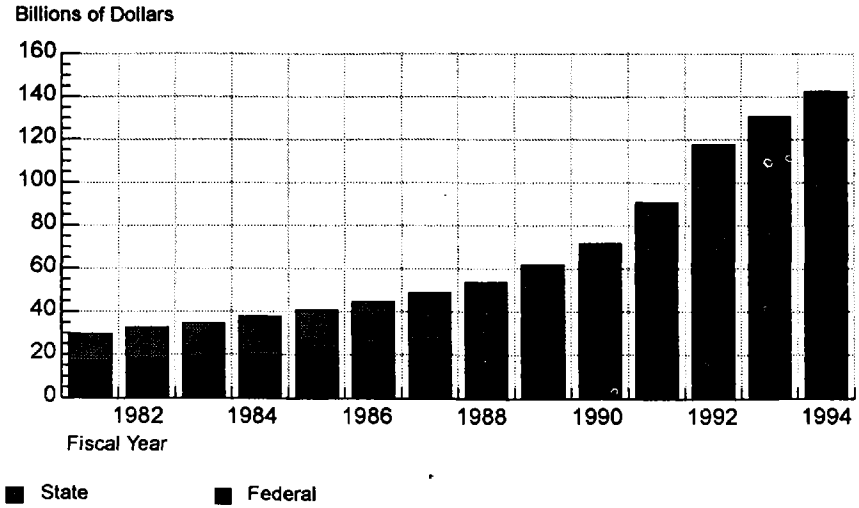
Figure 1: Medicare Spending 1982–94



Medicaid—the largest government health program for the poor—is a federally aided, state-administered medical assistance program. The federal government provides a share of each state's payment for services—between 50 and 83 percent—depending on the state's per-capita income. Each state administers the program through its own Medicaid agency. Each agency is responsible for ensuring that program dollars are spent appropriately in much the same way that Medicare holds its contractors responsible for payment control activities.

Medicaid spent about $143 billion (of which $81 billion was federal aid) on behalf of 34 million recipients during fiscal year 1994. Its size, structure, target population, and state-by-state variations render the program especially vulnerable to false billings and other fraudulent activities.

Figure 2: Medicaid Spending 1981–94



The introduction of managed care for Medicare beneficiaries and Medicaid recipients offers some promise of decreasing fraud related to overbilling or to providing unnecessary services. Though the consequences of fraud and abuse are similar—wasteful spending and inappropriate patient care—the forms it takes and the approaches used to address it are generally different for fee-for-service and prepaid health care providers.

In the fee-for-service reimbursement system, providers have the incentive to enhance their income by ordering too many services. Because fee-for-service providers bear little financial risk for the costs of services they prescribe, providers can inflate fees, services provided, or services billed. Fraudulent or abusive practices in the fee-for-service reimbursement system include overcharging for services provided, charging for services not provided, accepting bribes or kickbacks for referring patients, and rendering inappropriate or unnecessary services.

In contrast, prepaid health care providers, typically HMOs, are both insurers and providers of care. They bear the financial risk for their members' care in exchange for a fixed, predetermined fee per member. HMOs can, however, enhance their profits by minimizing spending on patient care; that is, by underserving their members. Consistent with this incentive, fraudulent or abusive practices found among some prepaid health plans in the Medicare and Medicaid programs tend to involve avoiding expensive treatments, underfinancing health plan operations, disregarding member complaints, providing poor-quality care, or using deceptive marketing practices, such as failing to reveal significant plan restrictions to consumers.

Although there has been a considerable shift from fee-for-service to managed care in Medicaid (now about 24 percent of enrollees, up from 10 percent in 1991) and to a lesser extent in Medicare (about 9 percent, compared with 6 percent in 1991), most care is still provided on a fee-for-service basis. For the foreseeable future, a significant though lower share of services is likely to continue on a fee-for-service basis, especially for Medicare beneficiaries.

MANY FRAUDULENT SCHEMES COMMON TO BOTH PROGRAMS

Our recent and ongoing work has shown that medical professionals or businesses that engage in fraudulent and abusive practices have targeted both programs, resulting in unnecessary Medicare or Medicaid expenditures.[1] Opportunities for fraud exist in both Medicare and Medicaid because each incorporates incentives to submit claims for services that are not needed, not provided, or overpriced. Moreover, each program has control weaknesses that result in paying providers' claims for improbably high levels of service or cost. The following are examples of abuses that have

[1] See the related GAO products section at the end of this testimony for a listing of reports and testimonies addressing this issue.

come to light through whistleblowers or some other fortuitous circumstance, not because program safeguard controls detected them.

• Over 16 months, a van service billed Medicare $62,000 for ambulance trips to transport one beneficiary 240 times.

• For one recipient, Medicaid paid for more than 142 lab tests—mostly duplicative—and 85 prescriptions during an 18-day period. One lab involved in this example billed Medicaid for more than $80 million in 2 years.

• In 1994, five individuals pleaded guilty to defrauding Medicare and Medicaid of approximately $4 million by using illegally obtained beneficiary identification numbers and billing the programs for large quantities of diagnostic services not provided.

Medicare contractors acknowledge that they have difficulty controlling widespread billing abuses for claims submitted for such things as medical supplies and home health, psychiatric, diagnostic, or rehabilitation therapy services. In addition, because the population served by Medicaid is relatively more transient and less likely to form a stable relationship with providers, additional opportunities for fraud result from the difficulty of verifying that patients are in fact eligible for Medicaid. Our recent investigations of Medicaid fraud have implicated psychiatrists, pharmacists, family practitioners, and clinical laboratories, among others.

Table 1 provides typical examples of fraud in both programs, drawn from completed or active fraud investigations.

Table 1: Examples of Medicare and Medicaid Fraud Investigations

Provider	Fraudulent Behavior	
	Medicare	Medicaid
Psychiatrist	Billed Medicare and was reimbursed for sessions that would have required nonstop counseling in excess of 24 hours per day.	Billed Medicaid for 4,800 hours a year or almost 24 hours each workday.
Physician	Billed Medicare for flu shots offered "free" to nursing home residents.	Billed Medicaid for abortions on women not pregnant, including one who had a hysterectomy. In 48 separate instances, he billed for 2 abortions within 1 month on the same patient
Ophthalmologist	.....	Performed unneeded cataract operations on Medicaid patients. In 5 years, he obtained $1 million from Medicaid, often telling patients that cataracts were contagious.
Physiological lab	Received over $2 million from Medicare for medically unnecessary trans-telephonic EKGs.	
Clinical lab	Received Medicare reimbursement for transporting laboratory specimens—corresponding to driving over 4.2 million miles in 2 years or almost 6,000 miles every day.	Bought massive quantities of blood from the poor; billed Medicaid $3.6 million for expensive, unordered, and unnecessary blood tests
Medical supplier	Submitted claims for huge quantities of surgical dressings, far exceeding demonstrated need.	
Podiatrist	Submitted claims for surgical procedures, but services provided were for routine foot care—usually not covered by Medicare.	Billed Medicaid for high-priced custom-made orthotics while providing cheap stock goods
Dentist	Billed and reimbursed for oral cancer examinations while providing routine dental care that was not covered by Medicare.	Billed Medicaid for treatments to nursing home residents already deceased

Moreover, federal and state fraud investigators concur that those involved in these violations rarely confine themselves to a single program, but rather submit inappropriate claims to Medicare, Medicaid, the Civilian Health and Medical Pro-

gram of the Uniformed Services (CHAMPUS),[2] the Department of Veteran's Affairs, private insurers, workers' compensation programs—whatever is convenient.

MANAGEMENT ILLS LEAVE MEDICARE CLAIMS SYSTEM VULNERABLE

Medicare is not managing care more effectively by using its substantial claims data to identify problem areas and implement corrective actions. Nursing homes, for example, provide HCFA an opportunity to reduce costs by adopting basic managed care concepts—identifying high-cost sites and encouraging providers to reduce costs. Nursing home residents are often a primary target of provider schemes to bill for unneeded or excessive services or items; abusive or fraudulent billing by providers serving nursing home residents is widespread. Providers that have recently been prosecuted or are currently under investigation for fraud by Medicare contractors and the HHS Office of Inspector General (OIG) include ambulance companies, suppliers of medical equipment and supplies, podiatrists, psychiatrists, and laboratories, some of which operate in multiple states.

HCFA could identify such schemes by compiling data on Medicare reimbursements per patient per day by nursing home. Identification of high-cost homes would be the first of various analyses to isolate problem nursing homes or services within homes. This approach would serve to pinpoint for HCFA the locations that require attention and the providers that serve those sites. The approach would also allow HCFA to establish benchmarks against which to measure the success of any corrective actions that it stipulates.

HCFA also does relatively little to check contractor controls to spot questionable providers or the overprovision of services. For example, even companies that have used post office box numbers as billing addresses or have little, if any, business history have qualified to bill the program. Further, there are no limits on the volume of bills that a new provider can submit. This makes obtaining a Medicare provider number easy for unscrupulous providers. They can then bill the program extensively and receive large payments over a brief period and disappear before (or soon after) Medicare begins to ask questions. For example, five clinical labs (that Medicare paid over $15 million in 1992) have been under investigation since early 1993 for the possible submission of false claims. The labs' mode of operation was to bill Medicare large sums over 6 to 9 months, and when they would receive inquiries from Medicare, they go out of business.

Moreover, for most services Medicare contractors do not have sufficient computerized checks to flag unusually high volumes of a service or supply item to a beneficiary or to the beneficiaries at a particular care site, such as a nursing home. These weaknesses explain why Medicare contractors processed, without questioning

- over $1.2 million in claims over 12 months from a supplier of body jackets to nursing home residents when the supplier had previously been paid about $8,500 for the previous year for the same item or
- almost $1 million in claims over 12 months for therapy services from a small nursing home that previously had only nominal therapy claims.

HCFA Initiatives

HCFA has begun two major initiatives to address longstanding problems with inappropriate payments. First, HCFA contracted for the design of a single automated claims processing system—called the Medicare Transaction System (MTS)—that promises greater efficiency and effectiveness. By replacing the 10 different claims processing systems now used by Medicare contractors with a single system, MTS is expected to serve as the cornerstone for HCFA's efforts to reengineer its approaches to managing program dollars. The new system, which promises to format claims data uniformly and produce comparable payment data, is expected to provide HCFA with prompt, consistent, and accurate management information. Full implementation is at least 3 years away, however.

HCFA's second initiative involves giving greater prominence to fraud and abuse activities in Medicare. One individual now serves as a focal point for health care fraud and abuse activities, reporting directly to the Administrator of HCFA. Further, HCFA recently established special units at each contractor site to develop and pursue fraud cases within the Medicare program. Before the development of these units, following up on fraud allegations and developing cases for referral to the OIG were often seen as collateral duties and given low priority. HCFA has also taken several steps that make obtaining authorization to bill the program more difficult for fly-by-night providers.

[2] CHAMPUS is a federal medical program for military dependents and retirees that pays for care received from civilian hospitals, physicians, and other providers.

SYSTEMIC PROBLEMS INCREASE MEDICAID'S VULNERABILITY

Medicaid also is intrinsically vulnerable to fraud. First, the program is large, with costs increasing at more than 10 percent a year. By the year 2000, the Congressional Budget Office anticipates that, without major changes, the federal share alone will approach $150 billion, surpassing the current total spent by federal and state governments combined. Medicaid generates a correspondingly large number of claims: approximately 800 million a year. This volume makes examining claims closely for abusive or fraudulent practices difficult.

Second, because Medicaid has traditionally paid providers on a fee-for-service basis and has nominal if any copayments, Medicaid offers no financial disincentives to heavy use by honest recipients, much less those who may participate in dubious schemes.

States have the predominant responsibility to see that claims are processed correctly and that adequate fraud and abuse controls are in place. While some states are experimenting with measures to curb fraud and abuse, including managed care alternatives such as HMOs, their efforts are hampered by the same management problems that affect Medicare, as well as resource limitations. As a result, data are used ineffectively and convicted offenders receive light penalties and their postconviction involvement in federal health programs is poorly scrutinized and inadequately controlled.

Data to Detect Fraud Are Not Effectively Used

State Medicaid agencies have claims data and other records that can be used to identify patterns of potential fraud, abuse, gross overuse, or inappropriate or medically unnecessary care. However, in our recent study of prescription drug diversion, we found that state Medicaid agencies—faced with unreliable and incomplete data—generally do not rely on analyses of their data to identify patterns of potential fraud or abuse. Instead, most alleged abuses are identified through tips or other fortuitous means. Other abuses are referred to prosecutors by the state agency responsible for administering the program, but even these abuses are seldom revealed by routine analysis of existing claims data.

An example from California illustrates how fraud goes undetected far too often. We found that a pharmacist was billing and being reimbursed by Medicaid for dispensing large volumes of prescription drugs. For 3 years the volume of prescriptions was improbably high—in many cases more than 20 prescriptions a day for a single recipient. The state's reporting system, however, did not trigger an investigation of the pharmacist nor of any of the recipients. A tip ultimately revealed the scheme.

Complexity of Administration Makes Extensive Coordination Necessary

Curbing Medicaid fraud is complicated by the numerous jurisdictions having responsibility. For example, a typical drug diversion case may involve five or more state, local, and federal agencies in its investigation, prosecution, and resolution. However, at the time of our study, no organizational unit within HCFA was dedicated to curbing fraud and abuse, and HCFA was not directly involved in drug diversion cases. It is too early to judge whether the recent appointment of HCFA's focal point for health care fraud issues can significantly improve coordination, but the appointment is a step in the right direction.

Financial and Other Penalties Are Light

Unscrupulous providers can reasonably anticipate very light penalties—if they are caught. First, in response to limited resources, prosecutors settle many cases short of conviction. Plea bargaining is common. Many first offenders are subject to what in Florida, for example, is called pretrial diversion, or equivalent agreements whereby their court records are sealed if they abide by the terms of judicially approved probation for 1 year.

Second, financial penalties are light even for a provider whose billings can be in the millions of dollars. In more than one-half the cases we reviewed across four states, restitution amounts were nominal—$5,000 or less. Providers usually paid these amounts. But in cases in which courts set restitution at $20,000 or more, the Medicaid agency recovered only a small percentage of the dollar amount established. In one case in which restitution was set at $220,000, only $4,000 had been repaid over 2 years later.

Although providers convicted of Medicaid fraud are generally excluded from the program, offenders frequently retain some connection with health care delivery and, therefore, have subsequent opportunities to commit violations. Federal laws are in place to exclude convicted providers from program participation, but apparently no one with authority and adequate resources is following up on individuals charged or convicted. In Florida, for example, we found that

• of nine individuals charged with Medicaid fraud in 1990, five—including a pharmacist excluded from program participation—were employed (as of July 1992) in pharmacies that served Medicaid recipients, and

• of five pharmacies charged with fraud in 1990, three were excluded from Medicaid participation. One pharmacist-owner sold his store but is still employed there as a pharmacist, and the other two re-enrolled in Medicaid under new ownership. One of the new owners is married to the convicted former owner.

Faced with such problems in following up on crimes within their own borders, it is not surprising that state officials cannot prevent incursion by offenders from out of state. We found that several providers in New York who were suspected or convicted of fraud, were associated with Florida health care facilities: a clinical lab, and a nursing home that reportedly receives both Medicare and Medicaid funds.

Some State Initiatives Appear Promising

States have some systematic controls designed to prevent prescription drug diversion and other types of Medicaid fraud. Because even the best up-front controls are never 100-percent effective, states also have procedures for pursuit, punishment, and financial recovery.

Advanced identification technology and automated systems that can flag suspicious activity can prevent or detect fraud early on. Recent initiatives in some states include (1) the use of identification cards that resemble credit cards and that monitor utilization, (2) prescription-filing systems that can instantly link orders to the filing physician, and (3) data analysis techniques that can promptly identify physicians prescribing and patients receiving high volumes of drugs.

Other initiatives focus on pursuit and punishment. One approach to swifter and more certain pursuit of offenders uses multiagency task forces to coordinate case development. Alternatively, the authorities can bypass the criminal pursuit process through innovative administrative remedies. In New York, for example, providers applying for Medicaid certification agree up front that the state can unilaterally cancel their participation without proof of fraud.

Recovery of program losses is also receiving more attention. Stronger tools are available, such as requirements that certain high-volume providers post performance bonds or other forms of collateral as a condition of program participation.

Although hard evidence of the success of prevention and detection measures and harsher sanctions is generally lacking, encouraging signs exist. For example, a combination of initiatives in New York is associated with an 8-percent decrease over five years in the number of Medicaid prescription claims and a sharp reduction in spending for the most abused prescription drugs.

EXPLORING ADMINISTRATIVE REFORM OPTIONS

In searching for solutions, we should not overlook some suggestions made in this and the last Congress for reducing vulnerability to fraud and abuse. Various administrative reform proposals include options worthy of exploration, such as streamlining and enhancing health care information systems and strengthening laws and enforcement mechanisms.

Regardless of reimbursement method—fee-for-service or managed care—the consensus is that streamlined and enhanced health care information is needed by Medicare and Medicaid. Such information can enhance the detection and pursuit of fraudulent and abusive providers. In addition, the ability to exchange such information across programs and between monitoring and enforcement agencies can further facilitate fraud prevention, pursuit, and punishment. Such information exchange would be one element of a broader program of coordination and cooperation.

Another reform that we and others have proposed involves legislation to enable Medicare program safeguard funding, which produces at least $11 for every dollar spent, to keep pace with the growth in program expenditures. On a per-claim basis, federal funding for safeguard activities has declined by over 32 percent since 1989. Indeed, adjusted for inflation, funding per claim has decreased by 43 percent. In large part, the decline in program spending for these activities corresponds with passage of the Budget Enforcement Act of 1990. That act established limits—or caps—on domestic discretionary spending, including spending for Medicare program safeguard activities. Exceeding these caps in one domestic discretionary account requires budget reductions in other accounts, such as those for education or welfare. This means that even though appropriating additional funds for safeguard activities would result in a net budgetary gain, under current law, it would necessitate offsetting cuts in other areas. Recognizing a similar situation with respect to Internal Revenue Service compliance activities, the 1990 act included a limited exception to the spending caps to facilitate adequate funding for such compliance activities. Therefore, the Congress is able to increase funds for such activities without cutting

funding for other domestic discretionary programs. If a similar exception were provided for Medicare program safeguards activities, it could ultimately lead to significant savings to the federal government.

CONCLUSIONS

As the nation's largest health payer, HCFA should be a leader in developing effective ways to manage health care expenditures. With respect to Medicare, this would entail such things as

- exploring opportunities to improve care management in settings such as nursing homes where fraud and abuse has been a recurring problem,
- seeking ways to strengthen requirements for providers that request authorization to bill the program, and
- developing and requiring contractors to implement better computerized checks to flag questionable claims or providers.

Because these efforts are funded out of the government's discretionary appropriations, however, funding increases would necessitate spending cuts in other government programs. We have been recommending since May 1991 that the Congress consider extending the budget option available to the Internal Revenue Service under the 1990 Budget Enforcement Act. If a similar option was available to Medicare, HCFA would be able to provide its contractors with the necessary incentive to prevent or recover losses resulting from exploitative billings.

With respect to Medicaid, we find similar problems that need to be addressed. Being a state-administered program, however, HCFA's role shifts from that of direct program management to one of leadership. This would entail documenting, guiding, coordinating, and encouraging states' efforts. HCFA could also address other—overarching concerns revealed by our study, such as whether—and how—state laws, federal requirements, and other factors inhibit prosecution or attempts to recover payment of claims subsequently determined not to be authorized by law. Moreover, while all jurisdictions have resource constraints that limit oversight, investigative, and prosecutorial efforts, an absence of federal leadership has kept states from making the best use of the resources they do have.

Finally, the problems facing Medicare and Medicaid are faced by all payers, underscoring the need for comprehensive solutions. Administrative reform proposals from this and the last Congress present features that would help correct systemic weaknesses and oversight problems without unduly restricting the freedom that patients and providers have come to expect when selecting their treatments. Adopting broad-based administrative reforms would significantly enhance the detection and pursuit of fraudulent and abusive providers.

Mr. Chairman and Members of the Subcommittee, I want to thank you for the opportunity to speak before you today. This concludes my prepared statement. I would be pleased to answer any questions.

Mr. SHAYS. Thank you both. As I listen to your testimony, I feel the frustration of a chairman who has five departments to oversee—we have HHS, Labor, Education, Veterans Affairs, and HUD as well. Our committee could spend all its time on not just one department, but a portion within one department. So what we're doing right now is we're kind of getting an overview.

And it's helping all of us decide where we're going to zero in. And we're going to zero in not just within a department, but within a department, we're going to zero in in some area in particular and play it out until the very end, until we see some tangible result from our work. I've been a Member 7 years now, and I have heard from you the tremendous abuse.

Your comment, Ms. Jaggar, of people who have abused the system and are still in the system. I'd like you both to spend some time and tell me what happens to some of the particular abusers? What is the penalty that they pay? Are they out of the system? Do they lose their license and so on? And we can maybe start with you, Ms. Jaggar.

You had a bar chart, and you showed on page 6 of your testimony, a psychiatrist, and a physician. I want to know what happened to these people. Here's someone who billed for more than 24

hours in a day, both Medicare and Medicaid. Do you know what happened to them; what penalties they paid?

Ms. JAGGAR. I could get the information specifically about the individual examples, because they come from different sources. We've done work in California, in southern Florida, in New York. The Medicaid work was done in several States. And I'm sorry I can't tell you the answer in that specific one. But there are different stories.

I saw you react when I mentioned the case where the individuals were again associated with pharmacies. In that particular instance, I know that there were several instances where an individual's spouse was now running and owning the pharmacy. The individual, who had been originally implicated in the fraudulent activity and punished for that, suffered the punishment, came back, and was then still associated with the provision of health care services through the pharmacy. But it was not directly him, it was his spouse who was now the owner and the operator of it.

Mr. SHAYS. Just give me examples of what happens to some of these people. It doesn't have to be that individual. Ms. Brown.

Ms. BROWN. Well, we have quite a few remedies at our disposal. One of the things that my office does is to exclude people from the program, which is comparable to debarring a contractor in the Department of Defense, where they can no longer work on any of the Government programs. I will give you just a couple of examples of the kinds of problems we've run into.

For instance, the place in Florida that I mentioned in my testimony that had over a 70 percent rate of false billing—a home health agency named St. John's. They immediately filed for bankruptcy when they felt that we were closing in on them. Therefore, we will have a great deal of trouble collecting any of that money back.

We were able to, of course, stop the advance payment that they had been accustomed to getting. But it's going to be difficult to recover some of the funds in that case. In another case——

Mr. SHAYS. What is the name of the company? Where is it?

Ms. BROWN. It's Saint John's Home Health care.

Mr. SHAYS. And where?

Ms. BROWN. It's in Florida.

Mr. SHAYS. Now, are they totally out of operation?

Ms. BROWN. No, they are still operating. We have done the audit of their books and records. And I was referring to that when I said there were so many false billings; that over 70 percent of their billings were false in this particular period that we audited.

Mr. SHAYS. I don't want to just belabor this, but you're losing me here. You're saying that you have accused them of 70 percent false billing.

Ms. BROWN. That's right.

Mr. SHAYS. And you're saying to me, they're still in business.

Ms. BROWN. Well, you don't immediately, upon presenting this, exclude them from the program.

Mr. SHAYS. Do you have an assistant who would like to assist you in this? You're more than——

Ms. BROWN. This is Mike Mangano, my Deputy.

Mr. MANGANO. Actually, they did file for bankruptcy, and they are now out of business. But we have a claim against them for almost $26 million for the claims that were unallowable. The worth of the company is very minor at this point. We'll never get that kind of money back. We'll be lucky to get about $1 million back. But they are out of business now.

Mr. SHAYS. Well, they're basically crooks.

Mr. MANGANO. Yes, sir.

Mr. SHAYS. They're basically crooks. Are they going to jail? So, the company is out of business, big deal.

Mr. MANGANO. Once we finished with the audit, we came up with this specific amount of unallowable claims. We immediately started a criminal investigation, and that's underway right now. Charges are being brought against them, and the investigation is going forward.

Mr. SHAYS. And when did you make your finding of the 70 percent?

Mr. MANGANO. We issued the audit report, probably, it was about October. And the investigation began immediately thereafter.

Mr. SHAYS. Before I ask Mr. Fattah to ask questions, can you give me an example of some others? I just want to have a sense—my sense is that people know that they can rip off this system with impunity, basically. That's my sense. My sense is that, Ms. Brown, in your testimony, you basically ended your conclusion, you said first, "when Willie Sutton was asked why he robbed banks, he responded, because that's where the money is."

"Today's criminals may be more sophisticated, but in one way they remain true to their forbearers—they go where the money is. In 1980, Medicare programs costs were $34 billion. In 1990, the number had increased to $107 billion, and estimated in 1995, $177 billion. With that much money at stake, the lure of a fast buck is irresistible to criminals and con-artists."

And then you make the point, it gets more sophisticated. My sense is that we've simply let people get away with it. We catch them; we tell them, you're caught; they go out of business and they continue to exist. And as someone who's voted for a lot of these programs I'm getting to the point where I just want to eliminate these programs. I don't want the Government to do it, because my sense is that the Government is not going to make sure that people, once they get caught, are going to pay for it, go to jail, be disgraced.

Ms. BROWN. Some sentences have been light, but I think we have come down pretty hard on a lot of others. We are very short of resources, another point I was trying to make. After the transfers to the Social Security Administration, we'll have about 125 criminal agents. And for a program this size, that's actually ridiculous.

Mr. SHAYS. Yes.

Ms. BROWN. The year I came to HHS, we had closed 10,000 cases without investigation because of lack of resources.

Mr. SHAYS. Well, that's a very important point to make. The few that you are able to catch, what happens to them? Think of all the others that know they can get away with it. I'm going to come back and ask more questions. And I've gone over my time. Mr. Fattah, you have time to ask a question.

Mr. FATTAH. Thank you, Mr. Chairman. Let me in some ways echo the chairman's concern. We had an incident in Philadelphia with a pharmacist who was billing an extraordinary amount—over $1 million—for the disbursal of prescription drugs in a neighborhood where there were a number of overdose deaths because of this particular type of drug mixture.

And when the prosecution took place, it was a paltry punishment for the principal player involved. But that was handled, obviously, through the U.S. attorney's office in Philadelphia. Let me say, however, let me just get to the real issue, though, about how you can really clamp down on some of this fraud. Now, I understand that Janet Reno has said that health care fraud is a major priority in her department.

Ms. BROWN. Yes.

Mr. FATTAH. Is there some type of interagency work group on this issue?

Ms. BROWN. Absolutely.

Mr. FATTAH. And talk a little bit more, because I think that you make an excellent point that you do need, in fact, more resources if we want to effectively combat this problem of criminals. But they are criminals with major resources who have created a fairly complex web of very intricate ways to bilk the system.

Ms. BROWN. Well, everybody claims they need more resources, and that's one part of it.

Mr. FATTAH. Some people actually do.

Ms. BROWN. The coordination effort, I felt, was critical in order to pull together all the resources that are scattered throughout the Nation looking at health care fraud. The group that you mentioned at the Department of Justice is headed by Jerry Stern who works for Janet Reno in charge of her health care coordination.

We have a group that meets at least monthly. The criminal division of Justice is represented, the civil division, my office, and the FBI. Then we bring in various others on an as-needed basis. We regularly go over all of the major cases and we have significant task forces operating throughout the country.

One of the biggest task force is in Philadelphia, where we worked there with the U.S. attorney. We have had a great deal of success with that approach. We're working many of these cases jointly.

Mr. FATTAH. Let me ask you a followup question. Is there some way in which the Congress could help by strengthening the legal framework under which these abusers could be punished? I know the Congress seems significantly enthusiastic in its effort to go after teenage mothers or others who may be similarly abusing the public trust.

Are there ways that we can tighten the criminal code and civil code that could assist you and this task force in your effort into health care fraud?

Ms. BROWN. There are a number of changes that would be very helpful.

Mr. FATTAH. Could I ask that you provide that to the committee and its members, if the chairman would receive it?

[The information referred to follows:]

RESPONSE TO WRITTEN QUESTION SUBMITTED BY HON. CHAKA FATTAH TO JUNE GIBBS BROWN

Question: Is there some opportunity in which the congress could help by strengthening the legal framework under which abusers could be punished?

Answer: We could work more effectively if the Congress could take action in two particular areas: ensuring adequate investigative resources and strengthening program exclusion provisions. Regarding resources, funding for OIG activities has been hampered by the discretionary freeze provisions of the Budget Enforcement Act. Budget constraints have produced the illogical result that spending on fraud prevention and detection—activities that pay for themselves many time over—has actually been curtailed. New resources are needed to fight burgeoning health care fraud and abuse. Accordingly, we support legislative proposals establishing a mechanism whereby funding to combat fraud and abuse is increased without drawing down from the U.S. Treasury or burdening taxpayers further. Under such an approach, financial recoveries derived from health care fraud cases (fines, penalties, damages, and assessments) would be deposited into an account to be made available for the future funding of fraud and abuse enforcement activities. Of course, full restitution of monies lost due to fraud should be made before any funds are to be deposited in the account.

Regarding strengthen the program exclusion provisions, let me give some background information. There are various conditions under which the law either requires or authorizes us to exclude certain providers from participating in Medicare, Medicaid and other State health care programs. These exclusions, when imposed, extend to preventing the individual or entity from participating in any Executive Branch procurement or nonprocurement program or activity. There are a couple of loopholes that need to be closed.

First, we have found that unscrupulous company owners move from company to company after company is convicted and excluded. As our authority now stands, if an owner is convicted and excluded, such as because of a program-related conviction, then we have no recourse to take action against the owner of the company. That individual is free to reincorporate or start another business with no fear of exclusion. If we were empowered to act against the culpable individuals in such a situation, then we would be able to close the door on "mobile" owners.

Second, we suggest that the Civil Monetary Penalty Law (CMPL) (section 1128A of the Social Security Act) be further strengthened by expanding its coverage to encompass employers who bill Medicare, Medicaid, and other State health care programs for services rendered, ordered, or directed by excluded employees. Currently, the "strict liability" standard for imposing monetary penalties only applies to the excluded provider for claims submitted, or cause to be submitted, for services that he/she renders while excluded. Expanding CMPL coverage to the employers of excluded providers would encourage health care employers to ascertain the program participation status of employees prior to submitting claims for program payment for services rendered, ordered, or directed by such individuals. Moreover, such an amendment would give the OIG the authority to hold the employer "strictly liable" for health care claims submitted for services rendered, ordered, or directed by an excluded employee. We encourage the Subcommittee to consider such an amendment.

Ms. BROWN. I'd be happy to do that. Thank you.

Mr. FATTAH. OK. And let me ask one followup question. Would it be possible that, or would it make a difference, if physicians were involved in the case management? On a case-by-case basis, could it, in fact, help identify what services are needed and which weren't and so on? And what efforts are being made in that regard?

Ms. BROWN. We definitely need somebody that's in charge of case management. That's done in the private insurance companies. We see a completely different effect as a result of it. We looked at those physicians who were involved with patients, and found that they seldom are actually visiting nursing homes and so on. They seem to be working the more complex cases, rather than the chronic things that they can't do a lot about other than the maintenance of the individual.

So there needs to be a decision as to who that case manager is. But that definitely is something I would recommend—that there is an individual who is responsible for case management.

Mr. FATTAH. Well, with the time that I have left, if you could go back, then, to my second question, and outline, if you would, just two or three points in which you think the Congress could take action that would be helpful in terms of the prosecution and effort to get at this health care fraud.

Ms. BROWN. Yes. Most of the statutes that we're working under, we can apply to Medicaid or Medicare. We need them to be more broadly applied so that they could be used for any of the illegal activities, regardless of which program was being defrauded. When we go in and do an investigation, we usually find that people are defrauding CHAMPUS, the Government health care insurance programs, and private practitioners, too, in the insurance industry. And so it would be helpful if we could broaden the language. We need a bill that would apply to health care specifically. Right now we're using kickback laws and others that have——

Mr. FATTAH. Do you use the RICO statutes at all?

Ms. BROWN. Yes, we do.

Mr. FATTAH. All right. You wanted to respond.

Ms. JAGGAR. Yes. If you don't mind my adding on, I have two different points I'd like to make. First of all, Senator Cohen, the chairman of the Senate Special Committee on Aging, has long been a foe of fraud and abuse. He reintroduced a bill which I might commend for your consideration, on January 19th. It's S. 245. It has been described as a kind of a reprise of some of the fraud and abuse legislation which was, as Ms. Brown mentioned, considered and, I think, had wide bipartisan support in the last Congress. It did get attached to most of the health care reform proposals, most aspects of it. And since none of those passed—both parties attached it—it went down also.

But it has many aspects that I think we and the IG believe would be very helpful, including some more specifications of penalties and forfeitures and more collaboration and coordination between different units and so on. And so that may be a framework. It certainly has many people's considered thoughts included in it that would be useful to you.

Mr. FATTAH. Thank you.

Ms. BROWN. We strongly support that bill. I testified before Senator Cohen yesterday to that effect.

Ms. JAGGAR. Right. I wanted also to mention to you something, which is that the kinds of fraud that we're talking about are associated with the sad nickname of "pay and chase." In other words, we have already paid, and then we're trying to collect the money. And so one of the things that we think is very important, and that HCFA and the contractors and many people are working very hard on, would be those kinds of things which would prevent the payment in the first place.

Thank heavens for computers. They will enable us, they do enable us, with proper resources and with attention and creativity to try to prevent the kinds of things from occurring. For example, it is possible for contractors who process the claims—I'm now speaking of Medicare contractors—to put out, in advance, a policy that

notifies people who are going to be billing that you have to bundle the services. Or that a daily rate covers these kinds of things. Then things aren't unbundled and billed separately.

Because, as you know, 1 plus 1 plus 1 sometimes equals 10, when it really should only equal 2 because of the economies of scale. There are methods like that which the contractors are putting into place, and which we endorse. There are also new kinds of computer technology and computer logic—it's called fuzzy logic—that different vendors are experimenting with.

And we think the Health Care Financing Administration should have the resources to take more advantage of those kinds of capabilities that would enable them to avoid incurring certain costs. So that the screens that they have in place when the bills come in prevent them from being paid in the beginning.

That cost avoidance is an important part of the fraud process that we didn't dwell on here, but I think you should be thinking of in your efforts.

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

Mr. SHAYS. Before calling Congressman Martini, I would like to have you think of calling on some of those people convicted of serious wrongdoing and have them come before our committee. I'd love to know how their mind works. I'd love to know how they justify what they do.

They may, in some cases, see the regulations a certain way and say, that's the way we can get our job done. But in other ways, they're just appearing to continue to rip off the system. The payoff is so big, you're chasing the money after you've given it.

Mr. Martini.

Mr. MARTINI. Thank you, Mr. Chairman. And first, I'd like to compliment you, Mr. Chairman, for holding today's hearing; and also thank the witnesses for their testimony; and follow up on some of what you've already asked. I'm here as a new Member, but I've heard my chairman this morning express his sense of frustration after being here 8 years. And listening to him and saying there's almost a feeling on many of our parts to just abandon programs because of the rampant fraud, waste and abuse that exists in so many Federal programs.

And frankly, I, too, agree, having been in the private sector for many years and having had little elected-official experience, that there's a prevalent attitude of Americans out there, when it comes to Federal Government programs to almost cheat these programs with impunity. And there's almost a sense, having been a formal Federal prosecutor for a while, there's almost a sense that it's OK.

I mean, it's a loophole which we are entitled to take advantage of. And I'm committed to—and the reason I'm here today is committed to work toward changing that mental frame. But I think we have to do other things as well. There's one example—we've talked so far this morning about the problems with the system.

And you mentioned just recently, pay and chase is so often the case. I'd like to just bring your attention to what's called the Nonemergency Medical Transportation Program. And in reviewing that in preparation for today, I find that last year, April 1994, Congressman Richard Baker brought to everyone's attention then that there

was abuse in the Medicaid unnecessary nonemergency transportation process.

And I'm looking at some newspaper articles, which back then, several Members of Congress called for a need to address this, a need to improve this, change this, et cetera. And it makes common sense to me. I think anybody reading these articles would agree that this was abusive; that taxi cab companies, particularly in certain areas of the country, were taking advantage of this apparently loose process of getting paid for transporting people to—actually, it was supposed to be for medical care, but in often cases it was to the mall, it was elsewhere.

And millions of dollars were being spent for that. What disturbs me is that we're here today, and then I see another newspaper article as recently as February 25, 1995, which says county cabs lead Florida in Medicaid fares. And once again, a year later, we see that there's apparently, from my observation, and anybody in the public reading these articles, would say that the Federal Government still has not gotten their program together or gotten their act together with respect to this.

And so my question to you is, what, if any, measures have been taken in a year to remedy this situation, to close some of those loopholes? Because looking at this almost as a lay person, I would think that there were things that could be done administratively that would have stopped this abuse. And yet a year goes by, and the abuse continues in proportions that are outrageous to most of us.

So I ask you, what measures were taken last year? And that probably was not the first time that you were aware of this abuse. And what measures have since been taken to try to correct that?

Ms. BROWN. We have done several reports in the area of emergency transportation. One of the issues was basic life support transportation, as compared to advanced life support, where Medicaid was often being billed for advanced life support transportation when it was unnecessary, when it was merely—perhaps an emergency, but the kind of thing that didn't require all the extra equipment that was available on the vehicle.

We proposed that the States contract with some of the available ambulance services, or have their own where they only billed us for the amount of service that was necessary. One particular area is with end-stage renal disease patients. We did some work in that area and found that people were using ambulance services to go in for their routine dialysis treatment. We could spot these because of the regularity of the service requirements.

Now, if somebody is unable to sit up and really is——

Mr. MARTINI. May I just, in the interest of the time factor here, I'm really referring to the use of taxicabs for what were routine, supposed to be, medical services. And yet it appears, in reading these articles, common sense would tell you this is being rampantly abused. So you talked about pay and chase and then you say that's often the problem, which I respect.

But this would seem to me some internal administrative regulations could quickly have nipped this in the bud. And that's the great sense of frustration that most Americans have with these programs. You're talking to me today, again, about another report.

And yet, I don't mean to—but that's too often what we hear. And a year goes by, and another $100 million are spent. And it would seem to me that this would not take this kind of effort to try to clean up.

Mr. MANGANO. There's a couple of points I would like to make. One, would depend on if these ambulance services were Medicare or Medicaid covered. If they were Medicaid, the State would be setting up the regulations and the enforcement mechanism to ensure that only the appropriate ones were taken. Our focus in our office has been around Medicare. Medicare has very strict regulations as to what services ought to be reimbursed. And ambulance services can, if there's an emergency situation and the person cannot sit up.

Ms. BROWN. But not the taxi service.

Mr. MANGANO. That's correct. No taxis are ever reimbursed by Medicare. This is an area that we have found fraught with fraud. There had been, as you rightly suggest, a number of times when taxicab companies that are less than ambulance companies have billed for Medicare services for ambulances. When we have found that, we have investigated them and prosecuted them criminally.

We've been pushing HCFA for the last 1½ years—the Health Care Financing Administration—to strengthen the regulations on ambulances. And just this last fall, they are convinced that they do need to do something in this area, and they're revising their regulations and their enforcement mechanisms to take care of the kinds of problems that you suggest.

Mr. MARTINI. Well, thank you. If my questions were misdirected toward you, but it had to do with Medicaid, primarily, and the use of taxicab transportation, which, if you read these articles, you become quickly outraged by the obvious abuse that's going on right now. And there's no indication in these articles that the Government is doing anything to stop this. And this would seem to be a minimum effort to stop this.

There's things here, for instance, lack of documentation of establishing where you picked the person up and where you take them to. So there's no documentation, and yet we pay for that fee. We pay for that taxicab rate, without even knowing that they were picked up at their home and taken to a doctor's office. They may have been dropped off at a mall. And that would be a simple effort to try to correct, I think. But thank you very much.

Mr. SHAYS. We've been joined by Mrs. Morella, and we give her the opportunity now to ask questions. It's nice to have you here.

Mrs. MORELLA. Thank you. Thank you very much, Mr. Chairman, for calling this meeting, too. It's very informative. There were two questions I wanted to ask this wonderful first panel. One has to do with SSI, particularly because as we look at this welfare bill that will be coming before us. As you note, there are some significant changes because of the problems that have arisen, I think, that you would concur with, with regard to definition of eligibility for children.

Would you like to comment on whether you think the welfare bill goes far enough; whether you think it's the right direction; or the misuse and abuse and, I suppose, fraud with that facet of SSI? I direct that to the inspector and the others. Thank you.

Ms. BROWN. Well, the SSI, of course, covers others as well as the children. But the children aspect——

Mrs. MORELLA. The children, particularly.

Ms. BROWN. There was a Supreme Court decision called the *Zebley* decision, which defined children's eligibility in terms of being age-appropriate behavior. I personally question whether that was what Congress intended when they included children who were mentally disabled. As a result, the system was flooded with new applicants. And thousands more entered the rolls.

There's been a lot of concern about whether or not these children are actually able to function in a normal manner as a result of the treatments they get, because all they're getting is payments—a monthly amount of money—which was, originally, in the law of SSI, intended to replace earnings. And children wouldn't have earnings anyway. There's no restriction of any kind on whether or not the money is used for the children's benefit.

So the family can buy whatever they consider necessary. We found that over 80 percent of the children could overcome their disabilities; that these disabilities were something that they could outgrow, or with some special assistance, outgrow and lead a normal life. Therefore, we were proposing that there be some kind of requirements and evaluation, and that they are receiving the right kind of training or medical assistance during the time they are under SSI, in order to overcome their disabilities.

Mrs. MORELLA. So, I guess many of them—they called it what, the attention deficit syndrome?

Ms. BROWN. Attention Deficit Disorder.

Mrs. MORELLA. Disorder. But as you say, it's simply age-appropriate behavior. So evidently the welfare bill is going further in that regard. But it also does address the use of drugs and alcoholism, in terms of taking those people off the rolls. Any comments on that? We've had a lot of abuse.

Ms. BROWN. Yes. There's another aspect of the SSI program which covers drug addicts and alcoholics. We did some work in that area and we found that, although the rolls kept growing for people on this program, that virtually nobody was ever getting off of it except due to death or going on some other disability program which was the result of perhaps a liver disorder or something that was resulting from their addiction.

The changes proposed there, I think, will be very helpful. Where the people have got to be in treatment during the time they're collecting the money, and there would be a 3-year limit on how long they could be under the program. It would give them more incentive to get better, where, otherwise, it was a disincentive.

Mrs. MORELLA. I'm glad to hear that. One final question for the GAO. I notice that one of the agency recommendations is that the Administration on Aging should revise its current method of calculating State grant funds under Title 3 of the Older Americans Act to allot more funds in proportion to current elderly populations, as required by law.

I'm on the steering committee on this White House Conference on Aging. I'm very interested in that recommendation and what's happening and what caused the recommendation to come about.

Ms. JAGGAR. Actually, it's a rather complicated issue. We have a report on that. We would be glad to come up and give you or your staff a briefing and go through the details. It's a formula dispute. And, of course, formulas are so important because that determines who gets how much of the money. And at this point, there's basically a disagreement—I'm tremendously oversimplifying this—between the Administration on Aging and GAO.

We recommend that the formula be calculated in a certain way. They recommend a different way. And we would be pleased to go through the——

Mrs. MORELLA. Splendid. Which way would help the State of Maryland on it? [Laughter.]

Ms. JAGGAR. We'll come and talk to you about it.

Ms. MORELLA. Good. Thank you. Thank you very much, Mr. Chairman.

Mr. SHAYS. I'd like to first ask both of you to help me define what adequate is, in terms of the number of inspectors. Do we base it on the total number of inspectors per $100 million of outlays, per the number of contractors? How do we determine what you need to do your job, both of you?

Ms. BROWN. All right. My staff is about 1,200 people. It has been reduced from almost 1,500 in 1992, which, I think, was a more reasonable number. We have more programs and more responsibilities now than we did at that time.

Mr. SHAYS. Would you come back to the committee and try to give us a sense of how many contractors we're dealing with? Give us some sense of guideline as to what it was 5 years ago versus now. Do you have more contractors in the business? Do you have a lot more outlays? Obviously, you do.

I still think 1,200 is not a small number of people, if used well.

In your statement, Ms. Brown, you said, "If you ask me what is different today from several years ago in the fraud-fighting environment, I would point to three factors in particular—one, rising Medicare and Medicaid expenditures which create a more attractive target for the unscrupulous; two, increased sophistication and complexity in the fraud schemes being perpetrated; and three, inadequate resources available to address the problem."

And then down later you say, "Today we see increasingly complex schemes involving large groups of people, large dollar amounts. The environment of today's health care fraud involves complicated reimbursement issues, Medicare questions, medical questions, financial arrangements and sophisticated computer equipment." Then you say this: "Recently, a major health care firm that owned over 60 psychiatric hospitals agreed to pay the Federal Government a recorded $379 million settlement."

Think of what I just read. Why wouldn't you mention the name of the firm?

Ms. BROWN. I'm happy to mention the name of the firm.

Mr. SHAYS. No, but just think about it. Just think about our mentality a second. You're telling me that in your judgment, they ripped off the system.

Ms. BROWN. Yes.

Mr. SHAYS. And you have a settlement in which you're getting close to $400 million.

Ms. BROWN. Yes.

Mr. SHAYS. And yet you intuitively decided you wouldn't even mention the firm's name. And they're still doing business. And they basically defrauded the system?

Ms. BROWN. That's National Medical Enterprises. They had 60 psychiatric hospitals. Part of the settlement was that they had to sell these hospitals, or divest themselves of the hospitals. There are ongoing criminal prosecutions going on for individuals that were involved in that. But the name has been widely publicized. I guess just in the writing of it, the point was——

Mr. SHAYS. I think it's a mentality, I honestly do, because there are other examples, Ms. Brown. "Psychiatrist billed Medicare and was reimbursed for sessions that would have required nonstop counseling in the excess of 24 hours per day. Billed Medicaid for 4,800 hours a year, or almost 24 hours each work day." That psychiatrist got away with just being called "psychiatrist."

"Physician billed Medicare for flu shots offered free to nursing home residents. Billed Medicaid for abortions on women not pregnant." That's beautiful. "Including one who had a hysterectomy. In 48 separate instances, he billed for two abortions within 1 month on the same patient." I mean, that's a crook, who is identified as a physician. And I can go on.

"A clinical lab received Medicare reimbursement." Don't you get a sense of where I'm coming from? I mean, why are we letting them get away with it. I mean, see, my sense is that they should be called before the committee and they should be asked why they did it, 100 different questions. And if they have good reasons, fine. If they don't, a little humility in this process wouldn't hurt them.

But if they get away with it—and there are a lot of them evidently. And it seems to me they get away with it. So I guess what I would like you to do, if you would, Ms. Jaggar, is would you give me the names of each of these individuals? And I'm going to ask my staff to call them up. And I'm going to just ask them—they may have some interesting stories to tell.

Ms. BROWN. Mr. Chairman, if I could just mention, we did exclude 1,063 people from the program last year so that they cannot work on any Government programs. Although we haven't named them all in our testimony, we are not ignoring the fact and not taking action.

Mr. SHAYS. You know what would be interesting, would be to go back and find out how many of them are back in the system somehow. I bet a lot of them are; I really do. I'm not putting blame on you all.

We're going to work closely with the minority on this issue. It's not a Republican or Democratic issue. There are a lot of people ripping off the system. And I really think there's a mentality that says, do it until you're caught and stop and then wait awhile and then do it again when time has run out. And the payoff is just so significant.

So I think what one of our tasks will be is to make it uncomfortable for them. Mr. Fattah.

Mr. FATTAH. Thank you, Mr. Chairman. Let me congratulate you for the work that you have done to get at this problem with the meager resources at your disposal. I have a kind of a general ques-

tion, and we hear this term a lot, and it's actually in the committee's work-up, waste, fraud and abuse.

Ms. BROWN. Yes.

Mr. FATTAH. So if you could, as the inspector general, if you could help me understand in a general sense, how much of the problem, if we could quantify this, how much is on the side of waste and how much is on the side of fraud and abuse, and see if you could help me with that. And also, this issue of the people who are perpetrating the fraud—to what degree is this weighing in on the corporate and kind of profiteering side of fraud, and then individuals who are somehow abusing these programs. If you could just make some general comments about those questions, it would be helpful.

Ms. BROWN. OK. Of the 8 billion, over 6.6 million of that is in legislative changes. Those are various types of what I would consider wasteful or inefficient practices of some kind. And we have been able to point those out to the Congress, and they have made legislative changes so that fixes were in the works. And we are able to have savings as a result of that.

There have been administrative changes in over $200 million as a result of that. Audit disallowances account for almost $900 million. These are where we find unallowed costs are included in the billings. It's very important to audit these contracts to make sure that we're not overpaying. We have over 300 billion investigative receivables. These are the kinds of things that are a result of fraud.

That's kind of the breakout of the 8 billion.

Mr. FATTAH. OK. Did you want to comment?

Ms. JAGGAR. I do, because I think your question also goes to the broader issue in the health care world, if I understand it correctly?

Mr. FATTAH. Right. If we have limited resources, we wanted to go after this problem, on which side of the ledger would we be focused if we wanted to be most effective at getting at the heart of the problem?

Ms. JAGGAR. I don't think that your question, if you'll forgive me, can be answered the way you'd like it to be because there are so many different aspects. Of course, it's such a huge industry—$1.2 trillion, or one-seventh of the economy. But even in the areas like Medicare as a secondary payer, something we've not addressed here today, where if you're an elderly person and say your spouse works so you have coverage under your spouse's health policy, that policy would pay first before Medicare does.

Even that runs into hundreds of millions of dollars a year. Now, it's not easily classified as waste. It's waste—someone else should pay for it first, that's the law. It's not fraud, probably. It's not abuse. But you see, it's a complicated issue.

Further, in the identification and the development of the problems that we find here, many times we would identify, through using computer screens, "an aberration." The immediate reaction is "Gosh, this looks weird. How come—just to use the vernacular—how come these numbers are so big when before they were so small? Is this a mistake?" You don't know until you get the data and you start pursuing the problem. And this is why it's so expensive. Just because you identify something that looks very confusing doesn't mean that there's fraud. It may be real.

Then, once you get into it, you say, oops, this may be fraud. Then you have to develop it. So, there's not an easy answer.

Mr. FATTAH. Let me ask one last question, then, Mr. Chairman. These providers who fraudulently ripped off the system, are they just able to rip off the Government, or are they also ripping off private sector entities also in these billings? Because Congressman Martinez, I believe it's him, kind of indicated that he was frustrated because these people are able to get at the Government.

My understanding is that with these crooks, as the chairman called them, have been quite ingenious and also able to rip off people who are not as perhaps inefficient as the Federal Government supposedly is.

Ms. BROWN. You're absolutely right. The same kind of thing is happening throughout the health care industry. And it's one reason for the growth in costs. In some cases there's a difference. I mentioned in my testimony that most of the insurance companies will have a care manager for someone in a nursing home, and they will see to it that proper care is given, but not excessive care.

So there are some things we can learn from the private sector. There are some things they learn from us, as well. If I could, I'd like to respond a little more to your other question.

Mr. FATTAH. OK.

Ms. BROWN. One of the things that we do in our work planning that I think is critical is, we use our audit or evaluation resources to go into those areas where there has been fraud or some other kind of misdeed that has occurred to make sure that the system is fixed. Now, we're not able to stay ahead of it; we're always lagging behind. But we do put a great deal of effort into that process.

And that's where we get these legislative changes and administrative changes and so on, because we go in, find out what is the newest area, through some kind of exception reporting, which has been mentioned, where we find that there's been tremendous growth—9,000 percent growth in the female urinary collection devices, not male, just female—and find then that there's some kind of a glitch in the system that we can fix. Then we pursue that.

Mr. FATTAH. I guess the heart of my question was that there seems to be a lot of interest among politicians in someone abusing food stamps or someone applying and staying on unemployment too long or welfare. And what I'm trying to understand is that there doesn't seem to be the same level of interest, except, perhaps, from the chairman who I've seen this morning passionately concerned about pharmacists and other people who are really ripping off millions from the system, but who somehow escape the same kind of passion and anger of those of us who supposedly are protecting the public from these abuses.

And I was trying to get a sense of, on balance, where the heart of this problem really rests, and whether it was with these individual abusers or whether or not these corporate crooks deserve more of our attention and resources.

Ms. BROWN. I agree with your conclusion there.

Mr. FATTAH. Thank you. Thank you, Mr. Chairman.

Mr. SHAYS. I thank the gentleman. We've been joined by Mr. Barrett, Wisconsin. Mr. Barrett, you have the floor.

Mr. BARRETT. Thank you, Mr. Chairman, I appreciate your holding the hearing. I apologize for being late. I was in another hearing that coincided exactly with the time of this hearing. I perhaps will follow up on Mr. Fattah's comment about concentrating on issues that affect poorer people. But rather than doing just that, I want to touch on one issue that is generally associated with poorer people, and one that is generally associated with wealthier people to sort of balance things out.

I obviously didn't get a chance to hear your testimony, Ms. Brown, but I saw in your testimony that you touched on the whole issue of transfer of assets, nursing homes, the growth of trusts, and what we should be doing there. If you could comment on that and what steps you think Congress should take to deal with that problem is my first question. My second question deals with SSI and children, which deals with poorer children. So let's start out with the first issue, if you would, please.

Ms. BROWN. All right. We have found that when a person passes on, the estate is not able to repay some of the Medicaid money that's been paid out in their behalf, because they have put their assets in a trust to protect those assets from the cost of their long-term care. Afterwards, we try to get that money back from the trusts. In many cases, those assets have been protected in a way that the Government can't get at it.

And I would be glad to supply some suggestions as to legislative changes that would be helpful.

Mr. BARRETT. I would be very interested in doing that. Have you taken any steps thus far to legislatively address that issue?

Mr. MANGANO. Actually, we've been conducting a number of studies since probably 1988. And a number of the recommendations that we have made have already been built into legislation to tighten that area. The concept here is, the persons on long-term care are being supported by the Medicaid program. And that's fine and appropriate. But if they have assets, the assets ought to be recovered to pay for their care when the assets are no longer needed by the person.

A number of the suggestions that we've made over the years have been built in where the State agencies are required to attach those assets after the person passes on and collect them. About 27 States around the country do have fairly aggressive programs now to go after the assets. Those programs are very cost-efficient. What we'd like to see is an extension into some of the areas that Ms. Brown just mentioned—the trust areas that are protected by law right now. Where those resources ought to be reclaimed by the programs, the laws ought to allow that to happen.

Mr. BARRETT. Is this use of trusts something that is new, or has it grown rapidly?

Mr. MANGANO. There has been a skyrocketing increase in the practice of law called elder law. And as a matter of fact, a report that we did in 1988 became one of the first calling cards of the elder law persons. They went through and saw all the loopholes in the law and began to develop their practice to go out and counsel people, now, here's how you can get around the Medicaid law by using this loophole or that loophole.

Elder law has skyrocketed and it's a big business around this country today to help people divest their assets, pass them on to their children well before they become eligible for a nursing home. So you're right on target by identifying that.

Mr. BARRETT. OK. The second issue I wanted to talk about was the issue of SSI and disabilities in kids. And obviously, this week on the floor, we're debating welfare reform. That issue is addressed in the Republican bill. It's addressed somewhat in one of the Democratic alternatives. What are your feelings? Is there a problem? Should it be addressed?

Ms. BROWN. One aspect of the SSI program for disabled children was a part of a Supreme Court decision called the *Zebley* decision. In that decision, they made a determination that age-appropriate behavior was the criterion that should be used to judge whether or not a child was mentally disabled. And as a result of that determination, they would then get an income per month. That monthly income is over $400 a month in many cases for each child, with no limit on the number of children in a family.

So, as you can imagine, there are people who see these families with more than one child having this regular income coming in, and they feel that the children are not that handicapped. And, in fact, we did a report that showed that, I believe it was, 83 percent of the children could overcome their handicap with the proper training. Now, there are no criteria that these children should receive any particular type of training or personal benefit from the funds that go to that family.

I do think there's room there for Congress to reconsider the definition—whether this is what they intended in providing this income, using that definition. I also feel that there could be a requirement where certain medical kinds of benefits should go to those children to take care of their handicap, to make sure that they become productive citizens as a result of the treatment that we're providing. The money that we're providing should go to treatment.

Mr. BARRETT. Thank you very much.

Mr. SHAYS. I thank the gentleman. I just want to quickly just ask one question as it relates to home care. Home care has no copayment; is that correct?

Ms. BROWN. That's true.

Mr. SHAYS. When I was visiting a Section 8 housing about 1½ months ago, I was told by residents that they routinely invite home care providers to come in, to talk to them, to help them clean up their room, et cetera and so on. No copayment at all; no disincentive to the patient for calling someone to come and keep them company. Let me just say that we write the law that way, so obviously, we're not blaming anyone else.

And I would make a point in regards to Mr. Barrett's questions. We've written a law to allow for divestiture after 3 years, correct? In other words, after 3 years—and that's the law. And a lawyer advising a client in a family would risk—lawyers at least like to tell me they would risk this—but certainly advising their patients of their rights is very important. We may need to revisit the law.

Mr. MANGANO. Mr. Chairman, with regard to home health agencies, to get the benefit, the beneficiary must require skilled nursing

care on an intermittent basis. The person must be homebound, and the person must have a physician certification that they require these services. So the kind of case that you just mentioned would be outright fraudulent.

Mr. SHAYS. OK. And because it would take the physician, and it would say that they're homebound.

Mr. MANGANO. That's correct.

Mr. SHAYS. And yet I was talking to them in the basement as they were coming to an event.

Mr. MANGANO. That's correct. But this industry does have its problems. And you've pointed one of the issues, and that is copayment. We've done some additional analysis, and looking at private payers, what do private insurance companies do to keep the cost down? One of the things that they do is a copayment. Another is that they have a case manager to require that all the services are provided.

Another is a limitation on the number of visits. There is no limitation in the Medicare program.

Mr. SHAYS. The gentleman, for the reporter, was Michael Mangano. Make sure you leave your card with her. You got away with not being sworn in, which is a real trick in this committee.

Mr. MANGANO. I swear to tell the truth.

Mr. SHAYS. I know you do. I thank all of you. We will be working closely together. If my staff isn't in daily, at least weekly, communication with you, I'd like to know about it. And I also want to say to you, it's very important for me that your reports and your work get public attention. And I just asked my executive director of the committee to write to all the inspector generals to invite you to ask us to hold hearings on any issue that you have had a focus on, that you think needs to have attention.

And we will give that request a lot of weight. I thank you very, very much for coming. The next panel is comprised of three individuals: Patrick Fagan, John Liu, and Gail Wilensky. And it's nice to have all three of you. Is there anyone else who's joining you, because I want to swear them in now, rather than have them come in later. OK, Gail Wilensky has not yet appeared. If she appears, I'd like to be told about it.

[Witnesses sworn.]

Mr. SHAYS. The acting ranking member has a question which I think is a very valid one, and I'd love him to——

Mr. FATTAH. Mr. Chairman, I raise the question to you. The testimony of the two gentlemen before the panel seems to be significantly off point from what is indicated as the expected focus of this hearing. And I'm trying to, perhaps, elicit a response from you as to—especially if the next panel of witnesses is, indeed, on point—to what we have just been talking about, where we are in this process.

Mr. SHAYS. I think that's a very fair request. The purpose of this hearing is to have a sense of our cost savings in the department, to look at waste, fraud and abuse in ways for cost savings. And I do note that Patrick Fagan is going to talk about evaluating HHS programs. And John Liu is going to be talking about streamlining.

What's on target in this committee is to look at cost savings that can take place in the Department of HHS. Is that your sense? Is that what both you gentlemen will be addressing?

Mr. LIU. Yes, Mr. Chairman. It was our understanding that the purpose——

Mr. FATTAH. Not to belabor the point.

Mr. SHAYS. No, we're not going to belabor it. This is important. And I want to establish a coherent practice so the majority and minority are not surprised, and we work well together. So let's talk.

Mr. FATTAH. We just spent more than 1½ hours talking about, for instance, fraud and abuse and specific funding programs in the department. None of the testimony by the two gentlemen here relates to that, as far as I can identify. At least 95 percent of it doesn't. Mr. Liu's testimony is policy judgments about whether we should be funding a national AIDS program office, or rather we should be investing in minority health care professionals.

It is a separate line of discussion. It would seem to me, then, the issue of how corporations and others are abusing reimbursement practices in home health care or how children are being misclassified in SSI. And again, not to prevent them from testifying, I'm just saying that it seems to me that we've kind of turned the train around and we are off focus.

And I do note that there's another panel, and their testimony is on point to what the committee just got finished discussing.

Mr. SHAYS. When we describe what we're going to do, we said the second hearing will explore how HHS could improve effectiveness in economy of its operations and programs. Essential to the hearing is the question of coordinating of HHS services and the opportunity to consolidate a multitude of HHS programs. Basically what I'd like both of you to focus in on is, we're always going to be, in every hearing, focused on waste, fraud and abuse.

The central point of this hearing is ways to affect opportunities for cost savings at HHS. So if you could focus your time and attention on that, that would be well. Mr. Fagan, I'll be delighted to have you speak first.

STATEMENT OF PATRICK FAGAN, SENIOR HUMAN SERVICES POLICY ANALYST, HERITAGE FOUNDATION; AND JOHN LIU, SENIOR HEALTH CARE POLICY ANALYST, HERITAGE FOUNDATION

Mr. FAGAN. Great. Actually, I'd like to come right to the point that Mr. Fattah has raised, because I think it's——

Mr. SHAYS. Sure. And let me just make this point to you. Any reference and comments you want to make about the testimony you've already heard, you both have been in the room, you're more than welcome to do that as well. Thank you.

Mr. FAGAN. Sure. Actually, I used to serve as a Deputy Assistant Secretary at HHS in the Office of Planning and Evaluation. And we were in each year on the whole clearance of the HHS' budget before it went forward to the Office of Management and Budget. And in there, there was an analysis of everything. And it is based on that experience that I have formed my own conclusions that there's a tremendous amount of waste—not fraud and not abuse—

but a tremendous amount of waste right within the very structure of HHS.

And there's a tremendous amount of moneys to be saved by having a look at that. As I have stated in my testimony, HHS is so big, there is so much of it there, that I would suggest nobody knows all of HHS. There are so many different agencies and subagencies within HHS who all address—or not all, but many of them address the very same issues, sometimes without even knowing that they exist.

In the last couple of years, while I was there in the Bush administration, it was a very good——

Mr. SHAYS. How many years were you there?

Mr. FAGAN. I was there for 4 years, from the beginning through to the end of the Bush administration. And I was in the—my purview was social services. But I also did a fair bit in aging, because the part of ASPE, as it's called, the planning and evaluation think tank of HHS that looks over things also had overview on what is going on in aging. And I did like the comments and the question by Mr. Barrett, actually, by the way, was right on line about that whole massive growth in the legal expertise of how to shelter assets and all the rest, to the detriment of the Federal Government, is a big, big area.

But coming back, within HHS itself, I would contend nobody—I know definitely that nobody at the top of HHS—knows the extent of the whole agency. If you were to get a description of HHS right down to the division level, with the mission of each division, the budget it spends, the tasks it has undertaken, you will find, time after time after time again, throughout HHS itself, with everybody with very good intentions and with top professional work, a tremendous amount of waste.

Because there is no coordination. Over the last 30, 40 years, essentially, HHS has grown massively without ever having to had to defend itself; without ever having had an overall audit. I would suggest, if you wanted to get real savings, massive Federal savings, do an audit of HHS. Find out where the overlaps are. If there are none, great. But I contend there are many.

Let me give you one example. My background is a social scientist. I have a great almost passion for good use of data. And it's a great way, by the way, to build across party differences, across ideological differences, to find out and start out with good, descriptive data that everybody agrees with. Because part of my purview was aging and disabilities in ASPE, where we use a lot of research, I had some familiarity with where research was going on.

But just 4 weeks ago, I got a fax letter from CDC, where I had inquired about some data. And on the top of the fax was a division of disabilities research. I was very surprised. I thought I knew where the disability research was going on. Now, I hadn't made a particular effort to fully find it all when I was in HHS, but I never knew that that existed down in CDC.

There are other areas—if you look at the whole area of surveys, which I have submitted on here, there's a tremendous frustration on the part of the survey directors. And those I know, they're very good professionals—a tremendous amount of work being done. But

there is a real lack of coordination, not just surveys within HHS, but the other agencies, actually, that are part of your purview.

If you were to look at all the surveys that go on, the national surveys, the lack of coordination of strategy—and I contend that as we move in, and we're now at the very beginning of the information age—the future role of the Federal Government is going to be massively involved in having good data, particularly if you devolve more and more down to the States.

It's by the comparison of how States are doing differently with pretty much the same distributions of money. But some States are going to be doing better than others. And as you get that story out, the citizens of one State are going to demand, how come our State isn't doing as well with pretty much the same amount of revenues? It will force a tremendous amount of reform. As I've suggested here, actually, when Secretary Bennett was in the Department of Education, he had for a short while a use of data which was called the wall chart, which did an interstate comparison of how States were doing.

That resulted in a tremendous amount of pressure for reform at the State levels. But that is no longer there. Those reforms save a tremendous amount of money, increase a tremendous amount of productivity. So the more you push productivity, the more you get out of your bang for your buck, the less waste you have. So this is why you contend all of this is very much on target and appropriate to your mission.

Where the waste in HHS begins is here in Congress, if it doesn't demand that oversight, if it doesn't know what's going on. It's almost like if you were to take an analogy with an international corporation owning factories that it doesn't know exist; of employing managers doing tasks that it isn't aware it does; or of having factories competing each other or tripping over each other. That is a waste that starts here.

And that's why I suggest it is so big a task, the size of HHS, it's as big as the Canadian economy. Not the Canadian budget, the Canadian economy. To have a description of that would be very enlightening. The other suggestion that I make in there for an open-book policy which would be very easy to introduce in the next couple of years. Not easy this year, but easy over the next 3, 4 years.

There is a finance officer at every level of Government, right down to the lowest level. I suggest that every finance officer in HHS, and in all other departments across the Federal Government, submit on disk and get into a central computer, exactly what was spent on what for what purpose by whom; very simple. Just get it up there. That itself will be a tremendous reform at pushing efficiency and effectiveness within the departments.

And that openness, where the citizens can look and see, it will cause—I'm sorry to say—I suspect for a while it will cause Congressmen grief, and as a result, it may not get enacted. But as citizens look and see, it's a great way, the openness of the book, it's almost like the inspector general would have a couple of million ancillary inspector generals looking at stuff.

That sort of openness will push a tremendous reform and help—actually the civil servants inside HHS that I got to know are very dedicated people. And the instance I was going to take was that of

where in the last couple of years there's been a big push for case management and integration of services. Well, right within the Hubert Humphrey building, people who are involved and trying to pull off integration of services couldn't pull it off within Hubert Humphrey building, in terms of reconciling regulations, because different subagencies within the same building have territories which overlap and mandates which give this group power to regulate and that power to regulate there.

If you can't pull off an integration of regulation within Hubert Humphrey building, how can you pull off an integration of services at a local level or across the country?

[The prepared statement of Mr. Fagan follows:]

PREPARED STATEMENT OF PATRICK FAGAN, SENIOR HUMAN SERVICES POLICY ANALYST, HERITAGE FOUNDATION

My name is Patrick Fagan, and I am the Senior Policy Analyst for Family and Culture at The Heritage Foundation. I was also a Deputy Assistant Secretary for Planning and Evaluation in the Department of Health and Human Services (HHS) for four years during the Bush Administration. My testimony represents my personal views on reforming that Department and should not be construed as representing any official position of The Heritage Foundation.

I wish to thank the Chairman and the Committee for this chance to testify on this important matter.

HHS has grown massively in size and budget since the beginning of the war on poverty in 1965, though some of its functions predate that time.

Under the protection of Congresses that were supportive of expanding government functions, and with a strong belief in the efficacy of government services, HHS has never really had to justify itself and its performance, and as a bureaucracy has responded with continuous growth of overlapping agencies, subagencies and divisions. By now HHS is like a mushroom system: we know it is there because some if it becomes visible but its infrastructure is hidden, vast and out of view below the surface. The very nature of all bureaucracies makes performance evaluation difficult; in HHS it is presently impossible.

I suggest that nobody has a full description of HHS. Descriptions at the agency level exist, but it is below the agency level that the real confusion begins. Congress needs to make sense of HHS even before reforming it. To accomplish this Congress needs a clear and detailed description of HHS. Such a description would go down to the division level in all agencies and would be accompanied by a mission statement of every division, a list of all major projects undertaken in the last five years that bear on that mission, total budgets for the divisions for those years and total number of staff with GS levels for each division. It is only at the division level that you will be able to see the vast overlap of functions . . . an overlap that thwarts any effective service of the nation, as bureaucrats stumble over conflicting regulations and areas of responsibility.

The business world has already undergone a massive change of its bureaucracies driven by the loss of market share and of profits as the fast flow of information in this computer age permitted smaller and nimble companies to serve customers better, with higher quality and lower prices. Quick responsive decision making was impossible in the large corporate bureaucracies. Such bureaucracies are now a thing of the past in business.

Academia is about to undergo a vast shakeup as information becomes almost free and universally accessible through Internet.

Government likewise must also now undergo a similar massive shakeup because the work of bureaucracies is mainly information work. Congress needs to lead the bureaucracies into the information age and help them serve the nation well by reforming their operations. The confluence of Congress's desire to reform HHS with the arrival of new computer technologies make that reform both timely and more possible than any time in the last three decades. To begin this process it is time to conduct a radical review of HHS in particular, the biggest and the most sprawling of all the civil service bureaucracies.

THE MAJOR TASKS OF HHS

HHS, like other federal bureaucracies, is involved with the distribution of three major resources: money (or material), data and insight . . . three very different

types of resources which demand three very different types of operations and organizational cultures.

1) The distribution of material resources to the states; this primarily involves the transfer of monies so that states may provide services and support to those in need; e.g. Medicare, Medicaid, and AFDC.

2) The procuring and distribution of national survey data which describes how we are faring as a nation on issues of interest such as health indicators, disease prevalence, poverty rates, drug and alcohol addictions and the myriad other data a modern nation needs to guide its next plans and actions. Among the many agencies in HHS (and also in many other departments) there are many national surveys conducted on different issues.

3) The development and dissemination of insight knowledge in areas where further insight and wisdom is desirable nationally: the National Institutes of Health, are the biggest example of this but again many divisions in different agencies are also devoted to this type of knowledge, e.g. the Center for Disease Control.

I would submit that these three missions, money, data and insight, cover the bulk of HHS services to the nation,[1] and are the areas which call for intense assessment and overhaul. The goal of reform of HHS is to bring about as parsimonious a realignment of people and work around these missions as is possible. A well functioning bureaucracy will do these well, quickly, and as cheaply as possible.

(1) Distribution of Money

HHS is not, or should not be, in the business of delivering services, for all health and social services are delivered at the local level, far removed form HHS direct observation, knowledge or insight, and thus its competence to direct. HHS's contribution is the transfer of monies which makes the delivery of these health and social services possible.[2]

I and a number of my colleagues at The Heritage Foundation are looking at major reforms of Medicaid and Medicare, and other HHS programs. We are close to finishing this comprehensive study and will be glad to make it available to the members of the Committee and their staff. Though the recommendations will be very detailed we will be glad to review them in their particulars.

OPEN BOOK ON THE FINANCES OF HHS

There is a reform that will be very informative to the nation, and which will help keep politicians and civil servants mindful of the taxpayers who support the programs they legislate and administer.

At the end of every fiscal year every budget officer in HHS ought to submit to a common computer data base the summary of all spending for the year just finished: who spent what money, for what purpose, and if monies were passed on who received them, for what purpose, and what product or service is expected to be derived, by when.

Every financial officer in the civil service does this work as a normal part of his job. By making the details public and available to scrutiny, the whole funding stream becomes an open book, capable of being perused by citizens of all ages and levels of education. By lodging this data into government computer data bases the information is always there for retrieval and scrutiny. The very openess will aid Congress because the citizens will inform members of issues that do not make sense. Furthermore it is an openess that ought to be present, because it is the taxpayers money that is being spent and it is good for the taxpayer to be able to review how his money is being used.

If the federal government leads in this open financial book policy, state and local governments will follow, for citizens will demand it.

Nothing will have as great an effect in ensuring ongoing continuous reform as the continuous process of investigation by the citizenry of spending by government.

(2) Distribution of Data (descriptive knowledge)

Data has the potential of displacing the need for much of the present regulatory apparatus. Through data legislators, journalists and citizens can know how we as a nation, a state or a locality, are doing on issues of importance to us such as pov-

[1] There is a clear regulatory function for a number of product areas, such as food and drugs. I leave these areas for others with competence in these fields.

[2] If there were a relatively equal distribution of wealth and income across the nation there would be no need for this role, as state taxes could displace this money distribution to the states.

erty rates, out of wedlock births, crime, addictions. Data not only informs it moves people to change. As behavioral psychologists know from their treatment of individuals, the very act of observing one's behavior changes the behavior, frequently quite a lot. So also at the national level: the annual tracking of out of wedlock births and their concomitant effects in health, dependency, lower educational attainment, crime and addictions will, over time, have quite an effect on the national attitude towards out of wedlock births.

Data is extremely important to political leadership, the fundamental role of government, a role that far surpasses program and program legislation. An illustration from the war on drugs and the SAMHSA agency is instructive. As you know from recent reports and testimony before Congress drug use among teenagers is rising again. The gains from the war on drugs are being wiped out. As testimony showed a large part of the gains were brought about by leaders tracking the data, and getting the word out on the effects of drugs (The "Just Say No" Campaign). Conveying the information was the critical part of HHS work in the reduction drug intake.

(1) Survey Reforms Needed

National surveys need to be conducted in such a way that interstate comparisons are possible, so that those working on eliminating problems will be stimulated to do at least as well as others elsewhere. For instance if the tuberculosis rates increase in some states, but decrease in others because of measures taken, it will not be long before the attention of citizens and professionals will bring about change. This can all be accomplished without regulation, but instead by a clear description of reality . . . by good survey data.

(2) "Wallcharts"

Interstate comparison charts on all issues involved in block granting ought to be requested by Congress. As Congress rightly begins the reforms of relieving States of the burden of federal regulations and unfunded mandates, it is nonetheless gathering taxpayers monies and passing them on to State governors for them to spend, with little or no accounting to federal bureaucracies. This is acceptable only if there is accountability to the nation's taxpayers. The simple way to deliver this accountability is through interstate comparison charts on key issues of concern. Former Education Secretary William Bennett caused quite a flurry of reform activity at the state level in education by releasing the Department of Education's "Wall Chart": a comparison of state scores on a number of educational indices. It was powerful in its effects.

However you will notice that the "Wall Chart" is no longer available. It did not long survive Dr. Bennett's departure from the Department of Education. The heat it caused governors and educational professionals in those states that were doing poorly resulted in sustained lobbying for its removal. Within this unhappy result is evidence of the power of simple descriptive data. It can be much more powerful than regulation in bringing about desired results and in causing reform.

(3) Rationalizing national surveys across departments

Many different national surveys are spread around the federal agencies. There is need for much greater communication between all the different survey teams, and a sharing of research opportunities and budgets to make the most of these survey undertakings. There is a tremendous amount of expertise and opportunity wasted for lack of such communication and flexibility.

(3) Procuring and distributing knowledge and insight

Scientific Insights

There are two different types of insight knowledge that HHS and its research branches deal in: biophysical and technological insights of the hard sciences and insights derived from the social sciences and the delivery of services (a social-behavior activity).

Physical Sciences vs Social Sciences Insights

Many advances have been made in the hard sciences areas with well known benefits in the applied medical field. The same cannot be said for insights (as opposed to the descriptive social data of the survey type) from the social science institutes. For instance the social science institutes did not predict the social consequences to the nation of the massive breakdown in marriage and family. The institutes have not yet addressed the issues of effective prevention of such breakdown.

One of the key differences between the two types of institutes is that the physical institutes are very clear about the goodness of the goals they have in research and are driven to achieve these breakthroughs. In the social science institutes the goals

are unclear for the debate on the social goodness of goals is a very ambivalent or embarrassing domain for the social scientists. By comparison with their physical science peers the social science research is ambivalent at its strategic core.

The vast discrepancies between the performance in the physical sciences and the social science research institutes calls for a review of the strategies behind the HHS social science research agendas as well as the performance of the institutes and agencies themselves . . . institutes and agendas that Congress allocates monies for each year.

Best Practices Insights in Human Service Delivery

The effect of evaluation data on human service delivery has been close to zero. I can think of no substantive change in social service delivery because of the corrective feedback of evaluation data. The interference of legislative, bureaucratic and special interests block such continuous mini-reforms. This is another reason for the federal government to get out of the business of program delivery.

However the federal government can do much to stimulate improvement in service practice . . . again through the sharing of information. Around the country in all types of services there are compelling examples of great success in helping those in need. I suggest that the simple, and cheap way of helping spread these practices is to have clear descriptions of them available. By making these available on computer data bases that are tapped into Internet and by grouping them by service type the federal government can do more for quality improvement than by regulating such services.

To return to the drug issue again: there is a big bureaucracy in SAMHSA that is devoted to drug addiction service delivery and monitoring. I suggest that it can be collapsed into a service which describes best practices and is disseminated through Internet, where it is readily available to all . . . a vast increase in effectiveness coupled with a vast reduction in bureaucracy and cost.

Thus most of SAMHSA can be collapsed into an information gathering and dissemination service:

1) the procuring of good survey data and effects data and its dissemination through the media (mainly a public relations effort, that might best be contracted to the private sector)

2) procuring the descriptions of best practices in service delivery and the dissemination of this knowledge through Internet.

Beginning the Overall Reform of HHS: Commission to Review HHS

I suggest that Congress form a Commission to Review HHS and that the Commission have five task forces:

1) First Task Force: To compile a clear description, as outlined above, of HHS down to the division level. This description ought to be done in standard format and be completed by each division director who ought be held responsible by Congress for the veracity of the description submitted. It is important that such descriptions not be cleared through the upper levels of the bureaucracy before being forwarded to the Commission, for it is precisely in such clearances that the special interests of the bureaucracy will come to operate and possibly to obfuscate.

2) Second Task Force: To review and recommend reforms on the streamlining of all money distribution functions of HHS.

3) Third Task Force: To review and recommend reforms on all national survey operations of HHS.

4) Fourth Task Force: To review and recommend reforms on all insight research of HHS in the social science research fields.

5) Fifth Task Force: To review and recommend reforms on all service practices research in the special services areas.

6) Open Book Financial Reform Task Force: To review an recommend how the reporting of all government spending, at the lowest levels of the federal government, can be made available to the citizen through computer technologies.

Clearly the first task force would need to complete its work before the other five could begin their work.

HHS is now the size of a major national economy. Too much of it is hidden in layers of bureaucracy, and too much of its spending is unknown to Congress and the citizenry of the country. It is time to get full and open descriptions. This achievement alone will propel many reforms in turn.

I hope these ideas and suggestions are useful to the Committee and I am grateful for the chance to present them.

Mr. SHAYS. Can you deal with more specifics?

Mr. LIU. If I may.

Mr. SHAYS. Mr. Liu.

Mr. LIU. With respect to the ranking member's question as far as the focus of this hearing, the first panel primarily focused on the issue of fraud. And our understanding of the issue of waste, whenever you have a duplication of Government programs within an agency, spending taxpayer dollars, purporting to achieve the same goal or mission statement, that would be considered waste.

And my written testimony is not meant to reflect any kind of opinion on the policy that is being projected or achieved by those goals. I have merely reiterated from the appropriations report as well as the authorizing committee report which authorizes these programs which HHS operates under. And basically repeated the goals, the mission statements and the desired outcomes these programs have.

And in doing so, in going through the appropriations bill as well as the administration's budget for 1996, I have found programs that appear to duplicate each other as far as their mission statement. And that is why I have highlighted a few.

Mr. SHAYS. Mr. Liu, you're very welcome to go through your testimony. So feel free to. It's very on target. And take your time. We're not in a rush. What are the points in your testimony that you would like to highlight?

Mr. LIU. Well, the points are, as far as Mr. Fagan mentioned earlier, HHS has a request of $716 billion for FY96. The Secretary of HHS, I understand, will be going before the House Budget Committee to explain her request on behalf of the administration. In reviewing the budget for FY96 in comparison to FY95, we find an increase of $50 million over FY95.

However, the budget also proposes a modest reduction of 1.5 percent of full-time employees at HHS as part of the administration's reinventing Government, down to 125,000 employees. Now, my knee-jerk reaction was, if you're going to reduce the number of full-time employees and, as they propose in their budget, streamlining and consolidation of certain programs, why, then, are they asking for an additional $50 million over FY95?

And in the process, I did find that HHS did consolidate certain programs into what they have called clusters in Secretary Shalala's proposal. What they have done, basically, is consolidate certain programs within HHS. And instead of reducing, perhaps, the funding or instead of going after these programs and seeing if they are efficient, if they are achieving their purported statement goals, all they've done is give it a new name.

And what I've done in my testimony is questioned the validity of whether or not some of these programs are achieving those goals, or whether or not some of these programs are——

Mr. SHAYS. Why don't you give us an example?

Mr. LIU. For example, the National Health Service Corps is a program which has been in existence for over 20 years. Its primary purpose is to increase the supply of primary care physicians, nurses, related health care providers in rural and underserved areas. According to the GAO, and in the report I have here before you, they have found that this program has not lived up to its expectation.

It is written into the administration's health care bill last year doing health care reform, and on both sides of the aisle, that there is still a desperate need for primary physicians, nurses and other providers in those areas. And that is why they included specific legislation which would increase the number of doctors and nurses in those areas. This is a program, last year, which roughly had 3,000 participants throughout the country.

In FY95, the National Health Service Corps, combined, got $125 million. That's roughly $41,000 per participant. Now, the question that is raised, that I am raising is, is there waste going on in this process? Because you are now assuming that every participant went to either Georgetown or Harvard or Yale or a private school, and is getting $41,000 worth of education.

Second of all, this is a system which has been subject to fraud and abuse. As I highlighted in my footnote, the Washington Post has run several articles in the past, detailing specific instances, and I did mention their names, of doctors which went to private medical schools at the expense of taxpayers, promised to serve in a rural or underserved area or an Indian reservation, and reneged on their deal.

And one doctor even had the gall to declare bankruptcy when the Department of Justice and HHS went after her to ask her to repay her loans. That is just one instance.

Mr. SHAYS. OK. So one example of what you would have us look at is focus on this program. What would be another program?

Mr. LIU. Another program would be the loan guarantee program. And that is a question of whether or not the GL loan program is a proper function of Government. Basically, the Government is underwriting student loans for individuals who wish to pursue health professions. If that is Congress' intent, to continue participating in the underwriting business, you can transfer that duty over to Sallie Mae, which is an entity which does exist which is out there and also underwrites student loans.

Another example would be community and migrant health centers. In Mr. Waxman's report in 1993, the authorizing committee for the Public Health Service Act—in the May 1993 report, roughly 300 migrant health centers were also funded by community health centers. Now, here's an example where you have good intentions, good goals, where these programs perhaps should be consolidated and streamlined. And perhaps their funding should be placed in a block granting process.

Because why should one health center have to apply repeatedly for different loans from different programs when they are receiving moneys from the same source, the Federal Government? Why should they not—why not just come one time, and why come back two, three, four times to get your funding? It just doesn't make sense. And again, that is just one example.

Another example would be Title 7 and Title 8 of the public health service. Again, I cite a GAO report from this last Congress, which went to Chairman Kennedy and the ranking member, Senator Kassebaum, and, on the House side, Chairman Dingell and the ranking member, Congressman Moorhead, detailing, again—I am not questioning the policy or the desired goal of these programs.

What the GAO questioned was whether or not these programs were being run efficiently.

In this report, they cite that the Government has spent over roughly $2 billion over the past 10 years for Title 7 and Title 8 programs. In general, those programs are to increase minority participation in health services, the underserved, underprivileged, as well as increasing primary care doctors in underserved area and inner cities and rural areas.

Again, the GAO's report concluded several times that these two programs themselves were being held to no accountability. Basically, they were coming back to Congress repeatedly asking for funding. Yet they were not showing that they had achieved these goals. And if that is not waste, then the taxpayers must get a different dictionary and find out what waste is.

Because if Congress is not dictating through HHS, show us certain results, we are holding you accountable by a defined standard, which is not in the current form, then basically, you are spending taxpayer dollars and it is going down a black hole and you're not achieving these desired results.

[The prepared statement of Mr. Liu follows:]

PREPARED STATEMENT OF JOHN LIU, SENIOR HEALTH CARE POLICY ANALYST, HERITAGE FOUNDATION

My name is John Liu. I am a policy analyst for Domestic Policy Studies at The Heritage Foundation. My testimony represents my personal views on the issue of reforming the Department of Health and Human Services, and should not be construed as representing any official position of The Heritage Foundation.

I wish to thank the Chairman and the Committee for the opportunity to testify on the important issue of reforming one of the nation's largest federal bureaucracies, the Department of Health and Human Services.

Despite President Clinton's promise to re-invent government and end welfare as we know it, the executive branch has requested $716 billion in budget authority to fund the DHHS' programs and salaries of 125,445 full time employees (FTE). Evidence of the Administration's reluctance to make the politically hard decisions of streamlining an overbloated federal bureaucracy was further defined during the appearance of Donna Shalala, the Secretary of the Department of Health and Human Services when called as a witness before the House Subcommittee on Appropriations for Labor, Health & Human Services, and Education on January 12, 1995. While the purpose of the hearing was to solicit specific rescission recommendations within the DHHS, the Secretary of Health and Human Services did not make one such recommendation in either her written or oral testimony.[1] Questions from various members of the subcommittee pertaining to the efficacy of certain programs did not elicit recommendations from the Secretary for their continued existence or possible elimination.

Mr. Chairman, by calling this hearing to explore ways the federal government can end waste, mismanagement, and fraud, the American public has much to be encouraged about. The Department of Health and Human Services is a prime example of a federal agency which Congress has allowed to wander off from its original purpose—ensuring the public's health. Instead, this is an agency which has given in to intensive lobbying by special interest groups through the creation and expansion of specific programs which benefits the public in a minimal way, if at all. The DHHS administers approximately three hundred programs. To be sure, a large part of the blame rests with the authorizing committees in Congress which are responsible for creating these wasteful, duplicative, and inefficient programs.

Mr. Chairman, the DHHS has made a request of $716 billion for fiscal year 1996, an increase of $50 million as compared to the fiscal year for 1995. Interestingly enough, the DHHS also intends to reduce the number of FTE's from 127,211 to 125,445, a modest reduction of 1.5 percent. This is puzzling because in the Adminis-

[1] Donna Shalala, Secretary of Health & Human Services, written statement before the House Subcommittee on Appropriations for Labor, Health and Human Services, Education, January 12, 1995.

tration's promise to re-invent government, Vice-President Gore told the American people that streamlining federal bureaucracies would cost them less! For some reason, this has not happened within the Department of Health and Human Services. With fewer FTE's requested for 1996, the question naturally presents itself—"Where is this money going?"

While the Clinton Administration has made token attempts to "streamline and restructure the bureaucracy" at the DHHS, careful scrutiny reveals that any such transformations are cosmetic at best. Simply squaring off a number of programs into a "cluster" and re-naming it does not go far enough. This is nothing more than a game of shifting and shuffling programs and bureaucrats within the department. There are plenty of opportunities to eliminate programs within the DHHS that either duplicate each other in function or have not proven to be effective in carrying out their purported goals. In light of the fact that the DHHS has not reviewed the programs under its jurisdiction to determine their legitimacy, the responsibility now shifts to the Congress to carry out the will of the American people. It is respectfully submitted that the following policies be considered by this Committee and others prior to enacting a budget for fiscal year 1996:

First, the Congress should impose a moratorium on funding for any program where the administering agency, in this case the DHHS, has not demonstrated and cannot show conclusively, that it has succeeded in its mission and purpose statement. In short, a cost-benefit analysis. The heaviest burden should fall upon the oldest programs, and without a doubt they should be held to a higher level of strict scrutiny.

Second, the moratorium should also extend to programs that can be folded into a block grant with streamlined federal regulations and rules. The Congress is under no obligation whatsoever to fund programs that have been poorly designed, micromanaged, and corrupted with fraud and abuse. To this extent, your committee can send a clear and resounding message to the various authorizing committees—that the initial responsibility lies with them, and unless they can guarantee to the American taxpayers the efficacy of the programs they authorize, no funds will be appropriated.

Third, as this committee reviews the categorical programs within the DHHS, a fundamental question should be asked. Could these programs instead be designed and administered more efficiently by a city council, local county board of supervisors, or private community groups? If the answer is yes, then such programs should be eliminated

Fourth, Congress should review the programs within the DHHS to see which ones are duplicative of each other. As outlined below, scrutiny reveals that significant savings can be achieved through the elimination of several programs in the DHHS.

Keeping these four policies in mind, the following recommendations may be of interest to members of this committee.

NATIONAL HEALTH SERVICE CORPS (NHSC)

Program Description: The primary goal of the National Health Service Corps (NHSC) has been to provide incentives to health care professionals to work in underserved rural and urban areas through the Field placements and Recruitment programs. Combined, these two programs were appropriated $125 million for fiscal year 1995. That is $1.2 million over the comparable fiscal year 1994 appropriations. The NHSC attempts to alleviate the shortage of health care professionals by recruiting physicians and other health care professionals to provide primary care services in what are designated as "Health Professional Shortage Areas (HPSA's)." There are three principal recruitment mechanisms: the scholarship program, the loan repayment program, and the volunteer program.

Recommended Change: Eliminate the NHSC has currently structured. Three specific changes should be made to the legislative authority found within Title III of the Public Health Service Act:

1) Congress should re-examine the original mission statement and goal of the NHSC. A restructuring of the program is also warranted.

2) Second, Congress should articulate a concise and uniform set of standards to determine the program's progress or success in fulfilling its stated objective—the increase of health professionals in federally designated medically underserved areas (HPSAS).

3) Drastically streamline the bureaucracy and eliminate unnecessary staff charged with operating the NHSC. For example, Congress approved $123 million for this program in 1994, or $41,290 per participant.

First Year Savings: $123,517,000

Rationale for Change: The National Health Service Corps has been in existence since 1970. In its 24 years of operation, the NHSC has done little to alleviate the shortage of physicians and health care professionals in rural and urban areas. In 1994, Congress approved $124 million for this program which had approximately 3,000 participants. This equates to an average of $41,290 per participant in the National Health Service Corps. Despite the financial incentives, the shortage of physicians in rural and certain urban areas remains high. This problem was highlighted during the debate over National Health Care Reform last year.

What the Congress needs to realize is that like any other profession, physicians and health care providers always take geographic location, quality of life, and living expenses into consideration when deciding where they will choose to work. Furthermore, it is relatively easy for physicians to take advantage of the program. In at least two articles printed in the Washington Post, stories of fraud and abuse detail how the program has failed in its mission.[2]

Congress should also explore a restructuring of the recruiting process for the NHSC. Instead of recruiting NHSC personnel prior to graduating from medical school, the program should recruit physicians to work in underserved areas as they near completion of their residencies. The main reason for this is that the circumstances and priorities of medical students change during their four years of school. They vary from family reasons, financial reasons, to a change in heart and mind in realizing that they will be forced to practice medicine in a desolate and isolated part of the country.

HANSEN'S DISEASE SERVICES

Program Description: Congress spends $20.1 million annually to support the operation of the Gillis W. Long Hansen's Disease Center in Carville, Louisiana. According to the fiscal year 1995 House Appropriations report, the center operates as a research and treatment center for persons with Hansen's disease (leprosy).

Recommended Change: This program should be eliminated.

First Year Savings: $20,826,000

Rationale for Change: With respect to the research functions performed at the center, it would be more appropriate for the National Institutes of Health to conduct these functions within its current operating budget. After all, the NIH is the focal point for support of the nation's biomedical research activities. Specifically, the NIH is charged with conducting biomedical research in its own laboratories at the 300-acre campus in Bethesda, Maryland and providing grants to universities throughout the nation to promote research by individual scientists. Treatment should be carried out at an alternative health care facility (hospital, clinic, etc.) in the area. The Tulane University Medical Center is located nearby in New Orleans, LA. The Louisiana State University Medical site is also in New Orleans, LA.

NATIVE HAWAIIAN HEALTH CARE

Program Description: Established in 1988, this program was created to provide primary care services and disease prevention services for native Hawaiians. Congress appropriated $2,976,000 for this program in FY 1995. The funding supports primary health care centers for Native Hawaiians, their related administrative costs of the Papa Ola Lokahi, (consortium of Native Hawaiian health care organizations), and a health professions scholarship program for Native Hawaiians.

Recommended Change: This program should be eliminated.

First Year Savings: $4,297,000

Rationale for Change: This program is unnecessary for two main reasons. First, Hawaii is the only state in the union that requires employers to provide health insurance for their employers, and it has public programs to provide coverage to residents not insured through the employer mandate. Second, the network of commu-

[2] On April 17, 1991, Washington Post staffwriter Robert F. Howe detailed this problem. U.S. taxpayers sent a Ms. Sheila E. Carroll through four years at Georgetown Medical Center. In return, Dr. Carroll promised to practice in an underserved area in the country. Upon graduation, Dr. Carroll was assigned to an Indian reservation. She never went. Instead, she joined a practice in Manassas, VA and on top of that, she filed for bankruptcy asking to be excused from paying back her loans. Mr. Howe writes that Dr. Carroll is "[O]ne of more than 500 former medical students who have defaulted on loans made through the National Health Service Corps Scholarship Program," since its inception. On June 4, 1992, another story ran in the Washington Post detailing the abuse of this program by staff writer Liz Spayd. A Dr. Susan O'Donoghue borrowed money through the NHSC program for four years of medical education at Georgetown University Medical Center. When O'Donoghue borrowed the money, she agreed to work four years in an underprivileged community. Needless to say, the article goes on to describe how she did not fulfill that obligation.

nity health centers in Hawaii are capable of serving Native Hawaiians who lack private health insurance or do not qualify for Medicaid. Members of the Hawaii Congressional Delegation even went so far as to lobby the Clinton Administration during the health care reform debate in the 103rd Congress to exempt the state of Hawaii from the Clinton Health Security Act. In a bill offered by Senator George Mitchell on behalf of the Clinton Administration, a specific provision was included exempting the State of Hawaii from the Health Security Act.[3]

HEALTH EDUCATION ASSISTANCE LOANS PROGRAM

Program Description: Designed as a loan guarantee program, the Health Education Assistance Loan (HEAL) provides federal insurance for student loans approved by private sector lenders. The HEAL program has been appropriated $29 million for fiscal year 1995. Students pay an insurance premium to help offset a portion of the federal costs associated with loan defaults. In general, the HEAL program requires the federal treasury to serve as an underwriter/guarantor for such loans.

Recommended Change: Eliminate the HEAL program.

First Year Savings: $29 million

Rationale for Change: If the Congress maintains the belief that the federal government has a proper and legitimate role in overseeing student loans to students in the health professions, then it should simply transfer the responsibility over to Sallie Mae. Sallie Mae already acts as a guarantor for student loans. Alternatively, the private sector should be able to carry out this function effectively and efficiently with no cost to U.S. taxpayers.

NATIONAL INSTITUTES OF HEALTH—OFFICE OF THE DIRECTOR

The Fiscal Year 1995 appropriations conference report provides $218.4 million for the Office of the Director (OD) at the National Institutes of Health. The report recommends that $8.5 million be allocated for the Director's discretionary fund. Within the Office of the Director are programs which duplicate the functions and purpose of existing programs within the Health Resources and Services Administration (HRSA). These programs are:

1) OD's Minority Health Initiative
2) OD's Office of Behavioral and Social Sciences Research

OD'S MINORITY HEALTH INITIATIVE

Program Description: In general, the Minority Health Initiative program supports research training activities that promote the participation of minorities in health professions education.

Recommended Change: Eliminate the MHI.

First Year Savings: It is unclear as to how much funding the Office of the Director intends to obligate towards this program in FY 96.

Rationale for Change: In comparing the MHI's goals to those under the Title VII and VIII HRSA programs, i.e. Centers of Excellence, Health Careers Opportunity Program, and Faculty loan repayment program, it is apparent that these programs should be streamlined and consolidated. Since the efficacy of such programs are already in question by the General Accounting Office, (see Block Grant section), the Director of the NIH should work closely with the Congress and the Secretary of Health and Human Services in devising a program that will recruit minorities and disadvantaged individuals into the health professions. Furthermore, the Congress should work with the deans of the nation's medical colleges in devising a program that will effectively place more primary care providers in medically underserved areas.

OD'S OFFICE OF BEHAVIORAL AND SOCIAL SCIENCES RESEARCH

Program Description: Another suspect office within the OD is the Office of Behavioral and Social Sciences Research (OBSSR). The FY 1995 conference report states that the OBSSR will "[d]evelop an overall plan to evaluate the importance of lifestyle determinants that interact with medicine and contribute to the promotion of good health; foster a comprehensive research program, etc."

Recommended Change: Eliminate the OBSSR

First Year Savings: N/A due to lack of records

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[3] Senator George Mitchell, "The Health Security Act, S.2351," August 12, (legislative day, August 11), 1994. Title 1, Subtitle F, Part 3, Subpart A, Sec. 1522, p.243.

Rationale for Change: Physicians routinely advise their patients on the importance of healthy lifestyles such as healthy diets, plenty of exercise, the need to drink alcoholic beverages in moderation, the harmful effects of smoking etc. It is hard to discern a need for the Office of Behavioral and Social Sciences Research. The total NIH budget was $11.33 billion for 1995. There are a number of different types of research conducted through the NIH work, but two different types stand out: physical sciences research and social research.

Great advances have occurred in the physical sciences research. The same cannot be said as clearly nor as strongly for the social sciences research, and it is time for a review of any contributions, if any, that have been advanced through the social sciences research.

While Congress can say that Americans have benefited from the work of basic scientific research conducted at the NIH, the same cannot be said for the social science research conducted there. Some would even contend that the guiding ideas and assumptions behind much of the social science research has had a deleterious effect on the nation as the ideas of the social sciences have displaced the ideas of right and wrong, good and bad, morality and responsibility. Differing opinions aside, an audit and overview of the spending and results of the sciences over the past few decades is overdue. The Office of Behavioral and Social Sciences Research was unstaffed and their report unwritten at last budget.

ASSISTANT SECRETARY FOR HEALTH—OFFICE OF THE ASSISTANT SECRETARY FOR HEALTH

PHYSICAL FITNESS AND SPORTS

Program Description: Congress appropriated $1.4 million to fund the President's Council on Physical Fitness and Sports in FY 95. The purpose of this council is to improve the public's health and physical fitness through sports programs and athletic programs.

Recommended Change: Eliminate the President's Council on Physical Fitness and Sports.

First Year Savings: $1.4 million

Rationale for Change: Despite the good intentions of this program, it does not play a vital function in furthering the public's physical fitness. Our nation's schools, both public and private make physical education a requirement as part of the educational curriculum. P.E. classes, after school sports, are the foundation of encouraging our nation's youth to pursue physical fitness and athletic programs. Local communities already sponsor exercise classes in neighborhood gyms. YMCA's, YWCA's, Pop Warner football, Little League programs, etc. are all local in nature. Neighborhood fitness centers, aerobics classes are constantly advertising in the print, radio, and television media the benefits of getting physically fit. Health insurance companies are providing discounts to employers who show documentation that their workforces are taking part in exercise and fitness classes. Elimination of the Physical Fitness and Sports Council is warranted.

MINORITY HEALTH

Program Description: Approximately $20 million per year is appropriated to fund the Office of Minority Health. The purpose of this office is to implement and monitor the recommendations of the Secretary's Task Force on Black and Minority Health and for the formulation and development of policy issues affecting minority health. Another directive from this committee to the Office of Minority Health was to "[c]arry out activities to improve the ability of health care providers to deliver health services in the native languages of limited English proficient populations.

Recommended Change: Eliminate the Office of Minority Health

First Year Savings: $20,592,000

Rationale for Change: The Office of Minority Health is redundant of another program within the Department of HHS—the Office of Research on Minority Health (ORMH) which is under the auspices of the Office of the Director of the National Institutes of Health. Under the ORMH program, two stated goals are clearly defined. First, the ORMH is to improve the health status of minorities. Second, the ORMH is to increase the participation of minorities in biomedical research. These goals are accomplished by working with minority institutions, and community organizations to develop and fund minority health and training programs.

The private sector is already reaching out to minority groups that are not proficient at speaking English, for example, the Chinatown in San Francisco, CA is home to one of the largest Chinese immigrant populations in the country. Over 95 percent of the store-owners, customers, and residents speak Chinese as their first

language. This population is served by "The Chinese Hospital." This institution provides health care services to patients who have not mastered the English language and feel more comfortable receiving health care from providers who speak Chinese. The quality of care is on par with the other fine hospitals in San Francisco, including the University of California, San Francisco Medical Center. In Southern California, FHP Health Care, one of the nation's largest HMO's recently announced an insurance plan that is specifically designed to serve the health care needs of Southern California's Asian American population. It is referred to as the "Allied Plan." This HMO connects Asian patients with a network of Asian physicians who can speak 17 languages and dialects. It is predicted to succeed because in the words of Dr. Samuel K. Zia, medical director of Allied Physicians of California, "We understand the culture, we speak the language and we care about the health of the people." FHP has already expanded the concepts of its Allied Plan to the Hispanic community in Southern California. Again, the private sector is able to accomplish the same goal without taxpayer funds. Absent a compelling argument for retaining the Minority Health program under the Office of the Assistant Secretary for Health, the OMH should be eliminated.

OFFICE OF THE SURGEON GENERAL:

Program Description: The Surgeon General, who reports to the Assistant Secretary for Health, serves as an advisor to the Assistant Secretary for Health on policy matters pertaining to the Public Health Service. The Surgeon General is responsible for the administration and management of the commissioned corps, which includes recruitment and retention of commissioned officers. According to the Congressional Research Service, estimated fiscal year 1993 appropriations for the Office of Surgeon General was $8.2 million. In addition to a $115,000 per year salary, the Surgeon General is provided with housing on the NIH campus in Bethesda, Maryland.

Recommendation: Eliminate the Office of the Surgeon General and require the Assistant Secretary for Health to re-assume such duties and responsibilities.

Rationale for Change: While the Office of the Surgeon General carries name recognition among the American people, the reality is that the OSG no longer runs the Public Health Service. In 1968, President Johnson reorganized the Public Health Service in a manner that transferred a majority of the Surgeon General's responsibilities to the Secretary of Health and Human Services and delegated to an Assistant Secretary for Health and Scientific Affairs. In doing so, the actual Office of Surgeon General was abolished and the Surgeon General became an assistant to the Assistant Secretary of Health with the responsibility of advising on professional medical matters. The bottom line—the Surgeon General became the Public Health Service's spokesperson to the public on certain health issues. As a matter of record, the position of Surgeon General was consolidated with the Assistant Secretary for Health during the Carter administration.

In comparing the duties and functions of the Surgeon General, it is apparent that they duplicate activities within the Office of the Assistant Secretary for Health (OASH). According to the Administrations budget outline for fiscal year 1996, the OASH is responsible for the following programs:

* Adolescent Family Life
* Disease Prevention/Health Promotion
* Office of Minority Health
* National AIDS Program Office
* National Vaccine Program Office
* Office of Health Policy, Planning & Evaluation
* Office of Women's Health

In summation, the distinguished Senator from Delaware, Senator Joe Biden was quoted as saying, "[Wle could eliminate it and the lives of Americans aren't going to fundamentally change."

NATIONAL AIDS PROGRAM OFFICE

Program Description: The functions of this office are to provide leadership to and coordinate HIV and AIDS-related programs with the Assistant Secretary for Health. According to the conference report, NAPO is responsible for identifying long range strategies that are critical in planning and directing the future course of the epidemic. Congress appropriated $1,750,000 to fund the National AIDS Program Office in FY 95.

Recommended Change: Eliminate the National AIDS Program Office.

First Year Savings: $1,739,000

Rationale for Change: This responsibilities charged to the National AIDS Program Office belong to either the Office of the Director for the NIH or Centers for Disease Control and Prevention. As mentioned earlier, "The Office of AIDS Research, in the Office of the Director of the NIH, is responsible for coordination of the scientific budgetary, legislative and policy elements of the NIH AIDS research program.[4] This is clearly a leadership role that has been designated to the OAR in legislative authority. NAPO should be eliminated.

ADMINISTRATION FOR CHILDREN AND FAMILIES

LOW INCOME HOME ENERGY ASSISTANCE PROGRAM (LIHEAP)

Program Description: The $1.3 billion per year LIHEAP program was designed to assist low income households meet their monthly utility bills during the energy crisis in the early 1980's.

Recommended Change: Eliminate the LIHEAP program.

First Year Savings: $1.3 billion .

Rationale for Change: An energy crisis no longer exists in the United States. Since the enactment of LIHEAP, the private sector, primarily through the energy companies, have provided financial assistance to low income households in paying their energy bills. For example, the Potomac Electric Power Company (PEPCO) has a "check-off" program which encourages residents in local communities to contribute each month towards a fund that helps pay the bills of lower-income residents. Many Members of Congress favor the elimination of LIHEAP.

FOOD AND DRUG ADMINISTRATION

FDA BUILDINGS & FACILITIES:

Program Description: Congress approved approximately $18 million in fiscal year 1995 for buildings and facilities operated by The Food and Drug Administration (FDA). The fiscal year 1996 budget includes approximately $8.5 million for its buildings and facilities. This figure is illusory and deceptive. In 1992, Congress appropriated $200 million for consolidation of the 40 plus FDA headquarters facilities. Since then, the original consolidation proposal has been revised. The latest figure for the consolidation project includes a $890 million building and facility construction proposal. Additional funds will be requested in future General Services Administration (GSA) budgets as completion is not expected until the middle of 2003. The current consolidation plan calls for phased in construction of new facilities on newly purchased property in Montgomery and Prince George's Counties, Maryland.

Recommended Change: Cancel the FDA consolidation program.

Savings: A minimum of $890 million.

Rationale for Change: This new FDA compound is expected to facilitate 6,000 FDA bureaucrats, and an estimated 750 visitors each day. The proposed facility it to be built on 2.6 million square feet of space. Putting that in perspective, the Department of Defense has about 4 million usable square feet in the Pentagon. This site will take approximately nine years to complete at the earliest. Also, the site will include the following: A health club for FDA employees, a new FDA commissioner's suite, FDA broadcast studios, a visitors center.

BLOCK GRANTS

HEALTH RESOURCES AND SERVICES ADMINISTRATION

HEALTH RESOURCES AND SERVICES

Programs that should be Block Granted: Community Health Centers, Migrant Health Centers, Health Care for the Homeless, Public Housing Resident Program.

In general, there are five major programs within the Department of Health and Human Services which seek to provide primary health care services to rural and urban areas that have traditionally been classified as underserved. They are 1) The Community Health Center (CHC) program, 2) The Migrant Health Center (MHC) program, 3) The Health Care for Homeless program, 4) The Public Housing Resident Program, and 5) The National Health Service Corps program. With the exception of the National Health Service Corps program (see earlier section), these four programs should be folded into one single program and block granted. Combined, these four programs cost U.S. taxpayers $756.5 million for fiscal year 1995. While the mission and purpose of these programs are difficult to argue against, the taxpayers de-

[4] Ibid, p. 71.

serve to know whether or not it is money well spent. In a May 1993 report issued by the Subcommittee on Health and the Environment of the House Energy and Commerce Committee, it was reported that approximately 300 Migrant Health Centers were also being funded by the Community Health Center program. These two programs alone, received $681.6 million in appropriations for FY 95. Consolidating and streamlining of these programs would further the improvement of public health programs. Through the elimination of layers of bureaucracy and targeting of appropriated funds, the states will be able to better serve those in need of such services because more money will be available for the providing of health care, as opposed to paying unnecessary salaries, administrative overhead, and miscellaneous expenses. Congress should consider freezing current spending levels for these programs by using 1995 as a baseline, and then allowing room for growth indexed to the rate of inflation. The goal of providing quality necessary health services to the medically underserved will be achieved in a fiscally sound approach without jeopardizing the integrity of the various programs.

Health Professions Funding: Centers of Excellence, Health Careers Opportunity Program, Faculty Loan Repayment, Health Professions Student Loan Recapitalization, Scholarships for Disadvantaged Students, Allied Health Special Projects, Area Health Education Centers, Interdisciplinary Training, Advanced Nurse Education, Nurse Practitioners/Nurse Midwives, Professional Nurse Traineeships, Nurse Disadvantaged Assistance, Nurse Anesthetists, and Exceptional Financial Need Scholarships.

The next category of block grants focuses on programs that share several common goals: to increase the supply of primary care doctors, nurses, and health professionals, the promotion and advancement of encouraging minorities and individuals coming from financially disadvantaged backgrounds to pursue a career in the health professions. While the initial recommendation pertaining to these programs evolve around the application of a block grant, it is premised upon two factors. First, the Secretary of the Department of Health and Human Services must explain to the authorizing committee, in this case the Commerce Committee, each program's specific mission statement and purpose. Second, the Secretary shall present and explain what common type of measuring requirements are being adopted to determine a program's success or lack thereof in achieving that previously stated objective. Absent a compelling argument or definition by the Secretary, it will be suggested that the authorizing committee of jurisdiction eliminate such programs.

In FY 93, the Congress appropriated approximately $354 million for 42 health professions training programs that are designed to increase the supply of health professionals throughout the country. In a GAO Report to Congress issued in July, 1994, identified are thirty programs established under Titles VII and VIII of the Public Health Service Act aimed at improving access to health care by 1) increasing the supply of primary care providers and other health professionals, 2) improving their representation in rural and medically underserved areas, and 3) improving minority representation in the health professionals.[5] Title VII programs focus mainly on physicians, dentists, physician assistants, allied health personnel, (health related occupations that function to assist or complement the work of MD's, nurses, and other specialists in the health care field). Title VIII programs concentrate on nurses, nurse practitioners and nurse midwives. Programs that are authorized under these two Titles include the: Centers of Excellence, Health Careers Opportunity Program, Faculty Loan Repayment, Health Professions Student Loan Recapitalization, Scholarships for Disadvantaged Students, Allied Health Special Projects, Area Health Education Centers, Interdisciplinary Training, Advanced Nurse Education, Nurse Practitioners/Nurse Midwives, Professional Nurse Traineeships, Nurse Disadvantaged Assistance, Nurse Anesthetists, and the Exceptional Financial Need Scholarships program. In general, these programs provide loans for students and grants to institutions to increase the number of primary care physicians, especially in underserved areas, as well as increasing the participation rate of minorities in the health professions.

While the block granting of these programs will address the issues of eliminating unnecessary administrative bureaucracies and the need to operate in a fiscally responsible manner, the Congress, especially the authorizing committees needs to seriously re-examine their effectiveness and apply a cost-benefit analysis of the Title VII and VIII programs. First, while approximately $2 billion has been appropriated for the thirty Title VII and VIII programs, last year's debate on health care reform highlighted the continued shortages of primary care physicians in medically underserved areas. Members in both the House and Senate who represent large rural

[5] General Accounting Office, "Health Professions Education, Role of Title VII/VIII Programs in Improving Access to Care is Unclear," GAO/HEHS-94-164, p. 2, July 1994.

areas and urban areas plagued with poverty constantly reminded their colleagues of the immense obstacles their constituents faced in seeking primary care services. The Clinton health care reform proposal even went so far as to mandate racial quotas in the health professions.[6] In the subsection entitled "Training of Underrepresented Racial and Ethnic Minorities and Disadvantaged Persons," the bill includes a program to "[I]nclude a program to support projects to increase the number of racial and ethnic underrepresented minority and disadvantaged persons in medicine, osteopathy, dentistry, advanced practice nursing, public health, psychology, and other health professions . . ."

Despite the immense amount of federal funding that has gone into programs like the Health Careers Opportunity Program, Scholarships to Disadvantaged Students, and Centers of Excellence, "[E]valuations have not shown that these programs had a significant effect on those changes that have occurred in the supply, distribution, and minority representation of health professionals."[7] Despite the shared objectives of increasing primary care physicians, their geographic distribution, and recruitment efforts of minority and/or disadvantaged students, the authorizing committees have not to date defined a common outcome goals or measurement of success. While the DHHS under the Bush Administration attempted to decrease the level of funding for the Title VII and VIII programs by 64 percent (approximately $156 million) in fiscal year 1992, the Congress under democratic leadership opposed any such attempts.

As a matter of record, the Congress took the extreme opposite view and expanded funding for the Title VII and VIII programs by roughly 20 percent in fiscal years 1992 and 1993. While these funds would have been well spent had they achieved their objectives, the GAO makes two disturbing observations that support the argument that these programs should not only be block granted, but outright eliminated. Specifically, the GAO states:

- The supply of primary care physicians and general dentists has increased in all types of urban and rural areas but the distribution patterns in HPSAS (federally designated Health Professional Shortage Areas) have remained relatively unchanged for the past 15 years. This indicates that HPSAS may be caused more by individual community or population characteristics rather than overall geographic maldistribution between urban and rural areas.
- The number of African-Americans, Hispanics, and Native Americans in health education and practice has increased faster than the rate for all races combined. However, HHS' evidence that these increases will significantly improve access to care for underserved populations is inconclusive.[8]

Despite federal efforts to increase minority and disadvantaged populations in the health professions, and placement of primary care physicians, nurses, and other health professionals in medically underserved areas, it is apparent that intervention is no longer warranted. Absent a compelling articulation of the DHHS' objectives and a reporting requirement utilizing a common outcome measurement by which to gage the respective programs' success, the Congress should eliminate the aforementioned Title VII and VIII programs immediately. In the words of the GAO, "Our review points to the need for the Congress to rethink the role of Title VII and VIII programs in improving the supply, distribution, and minority representation of health professions."[9]

The irony behind the Title VII and VIII programs is despite their intent, no substantive evidence has been produced to justify their existence. Contrast that with the private sector where the number of nonfederal primary care physicians providing patient care in the United States increased by about 75 percent between 1975 and 1990, the GAO is absolutely correct in its statement that the Congress should rethink its approach towards the Title VII and VIII programs.[10] The FY 95 appropriations for the aforementioned Title VII and VIII programs combined was $172,666,000. As mentioned earlier, these programs should be eliminated absent any compelling explanation by the Secretary of the DHHS.

While the recommendation has been made to eliminate a number of Title VII and VIII programs under certain circumstances, this is not mean to indicate that Congress has been relieved of its responsibility to achieve their stated goals. This rec-

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[6] Senator George Mitchell (D–ME), then the Majority Leader in the U.S. Senate offered a bill in the nature of a substitute on behalf of the Clinton Administration. It is S. 2351, the "Health Security Act," August 12 (legislative day, August 11), 1994. Title III, Part 3, Subpart A, Sec. 3081, p. 575.

[7] General Accounting Office, "Health Professions Education, Role of Title VII/VIII Programs in Improving Access to Care is Unclear" GAO/HEHS–94–164, p. 2, July 1994.

[8] Ibid, p. 4

[9] Ibid,p.14.

[10] Ibid, p.29.

ommendation assumes that a majority of the Members of Congress still want to increase the recruitment and more importantly, the retention of minorities and individuals from disadvantaged backgrounds to serve in the health professions. Congress should not have a problem with the goals of these programs. Congress should have a problem with having spent literally billions of dollars over the past decade on attempting to achieve the goals without having any idea whether or not the programs' objectives have been achieved. Therefore, it is incumbent upon the Congress and the DHHS to work together and replace the Title VII and VIII programs by defining a clear and concise mission statement with uniform guidelines that can measure the degree of success of a new program.

Rural Health Research, Rural Outreach Grants, State Offices of Rural Health

Combined, these three programs have been appropriated $44,080,000 for FY 1995. In general, these programs are designed to coordinate public and private efforts in improving the delivery of health care services to medically underserved rural areas. While some of the defined goals within these programs overlap with those in the Title VII and VIII programs, it is clear that a distinct need exists for individuals residing in rural areas. According to a May 1993 report by the House Committee on Energy and Commerce, "As of 1990, about 22.5 percent of the U.S. population lived in non-metropolitan areas. These rural residents face some different health care problems than do urban Americans. Overall, rates of acute health care problems are comparable to those of urban residents; however, fetal, infant, and maternal mortality are disproportionately high in rural areas."[11] Absent a consolidation/merger of these three programs, the block granting of their funds would facilitate the streamlining and coordination of providing health care in rural areas.

RYAN WHITE AIDS PROGRAMS

Title I—Emergency Assistance

Title II—Comprehensive Care Programs

Title III—Early Intervention Programs

Title IV—Pediatric Demonstrations

With respect to Titles I–IV of the Ryan White AIDS Programs, the Congress approved $633 million for the fiscal year 1995. By consolidating these four programs into a single block grant, the funding will be better targeted for urban and rural areas that have a disproportionate number of patients with either HIV or AIDS. In order to ensure that these funds are allocated in an accountable and precise manner, several policy objectives must be met.

1) Limiting the spread of HIV through traditional public health interventions; i.e. routine diagnosis, confidential reporting, voluntary partner notification must become the basis for containing the epidemic.

2) Education programs create awareness but are not as effective in modifying behavior absent personal, test linked knowledge of one's own and one's partner's HIV status. Programs that do not include diagnosis should receive less funding.

3) HIV/AIDS care programs should be continued, but only if the dollars are allocated to people afflicted with HIV/AIDS and not those who have already passed away from the disease. Formulas must be changed so that individuals who are affected today are the primary beneficiaries.

4) Prenatal HIV testing for all pregnant women should become a standard medical practice. Providing AZT treatment to pregnant women who are HIV positive reduces the probability of the infant being born infected with the HIV virus by threefold (26% to 8%).

5) HIV partner notification programs should be implemented. This is a standard public health procedure for most other contagious and sexually transmitted diseases. To be certain, legitimate concerns exist regarding the confidentiality of HIV/AIDS patients that information may be leaked out of public health departments. However, public health departments have reported over 400,000 cases of AIDS without a single breach of confidentiality in any of the fifty states.

6) When Ryan-White is re-authorized, the Congress should consider implementing the following policy recommendations pursuant to releasing block grant funds.

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[11] Staff of the Subcommittee on Health and the Environment, "Report on the Major Programs Within the Jurisdiction of the Subcommittee on Health and Environment for the use of the Committee on Energy and Commerce. U.S. House of Representatives," Committee Print 103–G, May 1993, p. 74.

a) Only living patients with HIV or AIDS needing necessary medical care should receive benefits. Any formula that is based on AIDS prevalence should be discarded.

b) Any patient living with HIV or AIDS who needs medical care should qualify for those funds based on where they currently reside, not where they were diagnosed.

c) Means testing requirements should be made a mandatory requirement prior to any individual benefiting from Ryan White funds. The rationale for this is clear—federal funds should go to those who duly have no other resources.

7) Research in HIV/AIDS needs to be restructured. The federal government through its grants process has spent billions of dollars on "AIDS" research, concentrating on end stage AIDS cases as opposed to the full spectrum of the HIV disease. Furthermore, research subjects must be more representative of the present HIV epidemic. It is imperative that the HIV/AIDS research projects include more people of color, more women, more children, and residents from rural areas.

Mr. SHAYS. Before I open it up for starting our questions, Mr. Fagan, do you have anything you want to add?

Mr. FAGAN. Two examples occurred to me of areas where, in the broad direction, without an accounting and a need to rejustify their strategy before Congress, there is a lot of waste. The National Institute of Child Health and Development, about which work I know a fair bit. Now, we do know that the whole nation is beginning to have grave concerns about what is happening in the breakdown of family.

I would contend if you look over at the research moneys spent by that institute, by very good people doing excellent work, but the strategy is not yielding what the country would hope for. We were not forewarned by the Institute of the dangers the country was heading into, for instance, in the whole area of unwed teen motherhood. They have spent over 10 years, 15, almost 20 years of continuous research money, and there's no insight coming out of there on how to reduce out-of-wedlock teen pregnancies.

That's from the premier social science institute in the country. I would suggest there's been a lot of wasted money there. That's a lot of waste. Now, that's the big picture. It's almost like they can drive the engine very efficiently and everybody's doing it well, but there's a tremendous waste because if you want to get to one place, but you're heading somewhere else, there's a huge inefficiency there.

I would also contend, actually, if you come right within HHS itself, it is an open secret in HHS, but not much discussed on the Hill, that one of the agencies there—the Agency on Aging—is itself a waste of taxpayers' money. It is not well-run. It is locked into the regulations. And from its relationship with the Hill over the years, it has been protected. But it is an agency that is in need of real reform.

And I would suggest straight off that if you look at it and its work, it's not that there isn't a huge or great work to be done with the elderly in the country, but what is happening in AOA is itself an embarrassment within the civil service and within HHS itself. There are two areas. In the broad area for investigation to reduce waste, they are there.

Mr. SHAYS. Let me open it up for questions, and thank you both for being here. The purpose of our committee, as we pursue how to allocate our time, is to hear ideas in general of ways that we should be focusing our time and energy. So your testimony is invaluable in that effort.

And Mr. Fagan, you make the point so well when you point out that the HHS budget is larger than the gross domestic product of many large countries, and you cited Canada. And I'm thinking if you had to look at Canada and understand every part of its gross domestic product, it would take a lifetime. And yet, in a sense, we have that task. It's an interesting analogy.

One of the areas that I'm being forced to look into is the fact that Medicare and Medicaid are growing at 16 percent a year, collectively. They're growing at slightly less than 10 percent a year. They comprise about 16 percent of our total Federal budget. In domestic spending, discretionary, there's no growth. We're in a hard freeze. President Clinton, President Bush deserve credit for basically holding the line on discretionary spending.

But it's going up significantly in entitlements. When you look at Medicare and Medicaid, what are the first things that come to mind as ways to slow the growth? Not necessarily to cut the growth, but to slow the growth.

Mr. FAGAN. Well, Mr. Liu is the real expert on that. Let me, however, just very quickly point out on the strategy. Again, if your strategy is wrong, the details are wrong.

Mr. SHAYS. OK.

Mr. FAGAN. In Medicaid and Medicare, we have an entitlement. It's a draw on the community. Unless we are committed to a corresponding input into the community, eventually you become bankrupt. And that's a strategic thing. It's a broader issue.

Mr. SHAYS. Well, it raises a question that I wrestle with. I vote on 33 percent of the Federal budget. And I've been here 8 years, and two-thirds of our budget is on automatic pilot. Gramm-Rudman focused in on discretionary spending; it ignored the entitlements, and the entitlements went on. I would love to find a way that I would be forced, as a Member of Congress, to vote on every entitlement every year.

And I realize the concept of an entitlement is that if you fit the category, you get the benefit. So it's hard to know every year how much we have to spend. But if you all are able to find a solution to that challenge and force Congress, give us a way to force us every year—because I would love to be held accountable, and every other member, to say, well, if this is important, what are you willing to give up?

We are putting so much new money into entitlements. Mr. Liu, you basically said $50 million a year, but some of that is Social Security, correct—$50 billion a year.

Mr. LIU. Correct. Well, actually I am correct because the administration acknowledges that SSA will become a separate agency from HHS and take that into account.

Mr. SHAYS. Right. If that were taken out, how much would the increase be?

Mr. LIU. It's still the $50 million.

Mr. SHAYS. It's $50 million, so it's not including the increase——

Mr. LIU. That's my understanding of their budget, yes, Mr. Chairman. Getting back to your question about Medicare and Medicaid, how the spending is continually growing and what the Congress can do to either slow the rate of growth or even reduce the rate of growth, my colleagues and I and Dr. Wilensky is a colleague

in a working group that we are in, in looking at ways to slow down the growth of Medicare.

As you correctly pointed out, it is rising at double-digit inflation, and even surpassing the rate of medical inflation, which is estimated to be 5.6 percent, by the CBO. So Dr. Wilensky was going to explain how managed care could induce savings in the area of Medicare. What we have been looking at in other areas is perhaps the issue of providing vouchers to senior citizens as an option to the current system, because the current system is a fee-for-service system.

And, as you mentioned, it is perceived as an entitlement. What the committee should clarify to their constituents, perhaps, is that Part A really is the only entitlement part of the Medicare program, because the HI—the Hospital Insurance trust fund—we all are forced to pay that 2.9 percent payroll tax each pay period into the HI trust fund.

However, the latest trustee's report shows that this fund will go insolvent by 2001 unless significant reforms are done to the Medicare program. Part B is an entirely involuntary program and, as such, is not an entitlement. Seniors enroll in Medicare Part B, the physicians insurance portion of Medicare, because it is a very good deal. It is basically subsidized by the taxpayers to the tune of roughly 80 percent, or perhaps 75 percent. This year alone, the Medicare enrollee is paying a premium of $46.10 a month.

That is roughly 30 percent of the true actuarial value of the Medicare Part B premium. Who is picking up the rest of that tab is the taxpayers. So what you have as a possible way to slow down the Government's spending on Medicare, first of all, is perhaps to restore the original contract under the Johnson administration, back in 1965. When they enacted Medicare, the Medicare Part B premium was supposed to be a 50–50 split between the enrollee and the taxpayer. Basically it was a half-half contribution. Unfortunately, because of rising health care costs, Congress and the Health Care Financing Administration, perhaps for politics or for policy standards, has reduced that original contribution and scaled it back down to 30 percent this year. And actually, legislatively, and over 1993, the Medicare Part B premium contribution is going to be scaled back to 25 percent in FY96, forcing taxpayers to pick up the additional 75 percent.

And that is why you have proposals, perhaps, to raise the enrollee's contributions, since it is voluntary, it is voluntary, to raise it back, perhaps, to the original contract. And that would yield $123 billion in savings over 5 years.

Mr. SHAYS. Let me call on Mr. Fattah. When you come around a second time to me, I would like to know what different options exist to replace an entitlement with a program that would enable us to have to vote every year on the expenditure, but still have the flexibility to pick up new enrollees if they come into the system. In other words, if you block grant and it runs out in September, how do you deal with that?

Mr. Fattah.

Mr. FATTAH. Thank you, Mr. Chairman, and I thank the two gentlemen for their testimony. You have proposed that the Low-Income Home Energy Assistance program be eliminated, the National Pro-

gram Office for AIDS, the Minority Health Initiative and so forth and so on. And you say in your document, as does Mr. Flanagan?

Mr. FAGAN. Fagan.

Mr. FATTAH. Fagan—that these are your personal views. They don't represent the views of the Heritage Foundation; is that correct?

Mr. LIU. Correct.

Mr. FAGAN. Correct.

Mr. FATTAH. OK. However, you do work for the Heritage Foundation.

Mr. LIU. I do.

Mr. FATTAH. OK. Can you tell the committee—and if you can't today, can you share it with the chairman and share with the other members—the Heritage Foundation, how is it funded?

Mr. LIU. Sure, I can explain right now, actually. The Heritage Foundation is a private, not-for-profit, nonpartisan think tank.

Mr. FATTAH. I've got the structure.

Mr. LIU. We are a 501(c)(3) organization. As such, we do not lobby Congress. We do not receive any Federal or State dollars. We are solely supported by private contributions.

Mr. FATTAH. Individuals, businesses?

Mr. LIU. They are individuals or trusts or businesses.

Mr. FATTAH. Would there be individuals who presently do business with the Federal Government or in the health care industry? And if so, if there are individuals or businesses that presently are providers of health care under these programs, could we have the list of those names?

Mr. LIU. I would be more than glad to bring that back to our treasurer and have it submitted to the chairman.

Mr. FATTAH. Because I think it's important. I think it's important that the committee understand the views that are being expressed and whose views they represent so that we can make sure that we have all the cards on the deck here. Because I do note that, even though you make these proposals to eliminate programs that help people, there's nothing in your comment about any of the massive fraud and abuse that we heard about from the inspector general, from the GAO, of corporate crooks, as the chairman called the criminals who are ripping off billions of dollars from the system.

Mr. LIU. Correct. That's a two-pronged question. The first question, to take it one step further, actually, one of the suggestions that I was going to make here, in asking us to disclose who our contributors are, I would, as part of this subcommittee's responsibilities, perhaps, is to require full disclosure from all groups who come before Congress and testify; and disclose one, what their status is as far as profit or not for profit, and second of all, also disclose if they receive any Federal dollars to lobby.

Because what you find on a continuous basis is the Congress both authorizing and appropriating money to programs who then in turn give out, through the grant process, to private groups out in the private sector. And then also they come back and lobby this committee as well as other committees for the stated goals as well.

Mr. FATTAH. I agree with you. But you also would recognize, for instance, if you had an association, a not-for-profit, that was funded primarily by defense contractors who then came and lobbied the

Congress on defense appropriations, that the fact that they didn't receive directly Federal dollars does not, in and of itself, clear up the picture about why they may have such strident viewpoints for a particular matter.

So what I'm trying to get you to do is just to help the committee understand, perhaps, whether or not the Heritage Foundation and its associates have any undue influences that would hinder their more objective testimonies in these hearings.

Let me get to your specific testimony now. You want to eliminate a $20 million program to encourage minorities entering the health care professions, as part of your written testimony before the committee.

Can you tell the committee what percentage of doctors in this country are represented by underrepresented minorities?

Mr. LIU. I assume you're talking about the Office of Minority Health, is that correct, Mr. Fattah?

Mr. FATTAH. Yes.

Mr. LIU. I do not know that specific percentage. I can review the GAO report.

Mr. FATTAH. Do you know the number of doctors that are African Americans, who are practicing doctors now?

Mr. LIU. In the United States?

Mr. FATTAH. Yes.

Mr. LIU. I do not know the exact number.

Mr. FATTAH. Hispanic?

Mr. LIU. No.

Mr. FATTAH. OK, but you recommend that we eliminate this program, right?

Mr. LIU. I recommend that the program be eliminated because it duplicates an existing program within HHS, which has the same purpose.

Mr. FATTAH. Thank you. I want to get to this logic. So if you took that logic, that any program that was aimed at a similar or same purpose is therefore a waste, that you would have to eliminate much of the defense appropriations, right?

Mr. LIU. I'm not following you, Mr. Fattah.

Mr. FATTAH. Let's take law enforcement. If the FBI is after crooks and the DEA is after crooks and the local police are after crooks and the State police is after crooks, that some of those—all but one of those are waste, under your logic that you're using now.

If you're saying that there's only one way to go after and try to include minority doctors, or one program.

Mr. LIU. No. What I am saying is that Congress, or the authorizing committee, has not stated by what degree they measure success in these programs.

Mr. FATTAH. But therefore the program should be eliminated?

Mr. LIU. It will be eliminated or redefined.

Mr. FATTAH. Well, you call for eliminating of this program.

Mr. LIU. I do call for elimination.

Mr. FATTAH. And let me continue. You call for its elimination without having any, seemingly, based on my first question on this matter, understanding of the entirety of the picture as relates to why it is in the national interest to increase the participation of minorities in the health care profession.

Mr. LIU. Mr. Fattah, like I stated earlier in the beginning, I do not question, nor have I questioned, the need to increase minority representation in the health professions. As a minority, I would assume I'm a minority, even though by the GAO, Asian Americans are not mentioned as a minority in the health profession. I would make that part of the record.

It only mentions African Americans, Hispanics and Native Americans. It does not mention Cubans or Pacific Islanders or even women as a minority. But getting back to your original question of whether or not I recommended elimination of this office because I consider it waste, by looking at the legislative language and the appropriations support from FY95, as well as the authorizing language of the House Energy and Commerce Committee, on which I served as former staff——

Mr. FATTAH. I think you're being repetitive. I heard your statement on that matter earlier.

Mr. LIU. No, no. I want to answer your question, Mr. Fattah.

Mr. FATTAH. OK.

Mr. LIU. Is that the Office of Minority Health, its stated goals and mission statements and this language here that is passed by Congress duplicates the Office of Research on Minority Health, which is under a different agency in HHS, which is the Office of Director of the National Institutes of Health. And if you look at that program, again, it is not only to improve the health status of minorities, which I do think is very crucial and significant; but two, is to increase the participation of minorities in biomedical research, through encouraging them and providing ways for them to attend medical school and nursing school or chiropractor school, or whatever.

Mr. FATTAH. I read your testimony. Let me ask you one final question, Mr. Chairman, if I could. You put in your footnote on page 6 the whole issue of the case of Miss Sheila Carroll from the Georgetown Medical Center. And you indicate, as part of your rationale for your recommendation related to the National Health Service Corps program, this particular story that appeared on April 17, 1991.

And the footnote goes on to talk about some 500 students who benefited from this program, who perhaps did not live up to their responsibilities. And I have a twofold question. What is the total number of students who benefited from this program over the 20-year period?

Mr. LIU. I would say several thousand, over several thousand students have.

Mr. FATTAH. Do you know the answer?

Mr. LIU. Not specifically.

Mr. FATTAH. So it's difficult for the committee, then, to understand the relationship between either this 1 case or the 500 that are referred to, in proportion to the overall pool of students who have benefited.

Mr. LIU. This 500 number, actually, I'm glad you raised that, are only successful prosecutions and convictions, if you will, Mr. Fattah, not how many pending ongoing cases there are.

Mr. FATTAH. Can you help us with those numbers?

Mr. LIU. I'd be more than glad to follow up and submit. But that is really the IG's office's responsibility in pursuing that.

Mr. FATTAH. But you understand my difficulty with understanding the validity of the research that led to these recommendations, absent some picture of the overall number of students who benefited, the number of students who benefited but yet haven't fulfilled their responsibilities, and any examination of why, in fact, those particular number of students did not live up to their responsibility.

It's difficult to deal with making a recommendation and not having the foundation so that we can look at it and the committee can judge for itself how reasonable and rational such a recommendation would be.

Mr. LIU. This is just one example of fraud, and why the program should be eliminated. The real underlying reason why the National Health Service Corps, in my opinion, should either be eliminated or restructured is that, if you spend $156 million a year on a program to increase the number of physicians and related health care providers—nurses, et cetera—in underserved areas, and the GAO's own report—the GAO's own report, not mine, but the GAO's report—says that this program has not met its goals, and it has a defined common goal, and you even have, during the health care debate last year, on both sides of the aisle citing the need to increase providers in these areas, I would question, is that money being well spent?

And it is not being well spent, as the GAO suggests.

Mr. FATTAH. Again, your logic would have us follow, then, to the degree that funds that we have appropriated to the FBI have not solved all crimes in our country, that those dollars are being wasted because the goal is not being met.

Mr. LIU. That's apples and oranges, Mr. Fattah.

Mr. FATTAH. If you follow the rationale of your logic, the issue is, are the students that are being helped going back and providing this service in underserved areas. And to point out one particular instance where that was not the case doesn't help the committee understand whether or not——

Mr. SHAYS. One of your points, Mr. Liu, is to say that, take a look at the GAO report that finds some significant problems with the programs. And I think that's a fair request for us to do.

Mr. FATTAH. I also think it's fair that the witness has taken a look and be able to tell us how many students have been in the program.

Mr. SHAYS. Right.

Mr. LIU. It's not just that, but as I mentioned, I can state with definition, in FY95, as I stated, roughly 3,000 participants across the entire country participated in this country. And this program got $156 million to benefit 3,000 participants. And as I calculated, that's roughly $41,000 per participant. And again, as I said, that's assuming that every one of these students went to a top-notch or a private, very expensive medical school or nursing school.

And I do not believe that nursing school or even some medical schools cost $41,000 a year.

Mr. SHAYS. I hear the point of both gentlemen. The point is, he would have preferred if you had some more statistics to make your

point. But in your mind, you're satisfied with the fact that we need to look at this issue, based on the numbers that you're looking at.

Mr. Souder, if you wanted to try to ask some questions for 5 minutes. And I'll go and vote and you can adjourn when you're done. And Mr. Barrett, if you want to come now, and then we can come back. Is that alright with you?

Well, do you want to wait while Mr. Souder is asking his questions? Either way.

Mr. FATTAH. OK, I'll wait.

Mr. SOUDER [presiding]. I would also like, for the record, that if the Heritage Foundation submits their background, that people on panel III and others should give their background, too, as to where their funding comes from and that there's an equality of witnesses. First, I want to start with a question, probably more directed at Mr. Liu. In Medicaid, and particularly in the Medicare, I notice in my own family and friends, and I wonder if there's any national data that increasingly, with the rising cost of medical care, many families are faced, such as my mother and father-in-law, within a very short period of time having their entire savings depleted.

Historically, families used up the money on medical care. Increasingly, what we're facing within our family as well as most of my friends and my generation, is having our parents pass through the money because the savings will be gone so fast that they might as well pass it through and have the Federal Government pick it up. And, it's been a major cost shifting to the Federal Government. Is there any data on this?

Mr. LIU. There is. And actually, as the first panel mentioned, on Mr. Barrett's insight, was that the Medicaid system is being subjected, unfortunately in this case, legally, through various loopholes in the current law, that they are allowed to pass on their savings so that they won't jeopardize their assets, which is understandable. And I think one avenue Congress might want to pursue is encouraging the working families as well as those approaching retirement about the wisdom of purchasing private, long-term care insurance.

If you look at the numbers of individuals who are not purchasing private, long-term care insurance, like myself, who are working and putting, perhaps, into medical savings account so that when I do retire, I will have accumulated sufficient funds to purchase long-term care insurance. I think that is a very wise avenue that Congress might want to pursue.

And if you look at the numbers, it is absolutely correct that you have families that are out there hiring lawyers at $400 an hour so that they can somehow protect their assets. Yet they don't think it's wise to purchase private long-term care insurance, and in the process, pay their monthly premium, but then have the private sector pick up their care when they do get ill when they're over 65.

And I do think Congress really does need to look into the area of encouraging families and individuals to purchase private long-term care insurance. Whether or not you make that available through a tax credit or allow them to put this money into an MSA, which is currently being discussed in Ways and Means, I think those are very wise options so that the Government, through the Medicaid program, particularly, does not have to spend that much money.

Because that portion alone in Medicaid is one of the largest chunks of money going toward long-term care, and still nursing facilities, by the way.

Mr. SOUDER. Well, you get some tax deduction with it and while that would be nice for the Federal Government, what is the benefit of having a medical savings account so that, in effect, you pay for your care, rather than the Federal Government paying for it? In other words, exhortation isn't going to do it; the amount of deduction probably is not going to do it, because you could have been covered anyway. The fear of the Government being broke may do it.

Mr. LIU. Right.

Mr. SOUDER. Is there a way or do you know of anybody who has looked at ways to protect more of our savings? In other words, if you have a medical savings account, combined with catastrophic coverage, but you could have more of your savings exempt that isn't in the medical savings account as well, and not have to go down below a threshold if you acted responsibly, as opposed to if you hadn't?

Mr. LIU. That is precisely the point, Mr. Souder, that my colleagues and I are looking at. And we'll be more than glad to share our results with you, because we do believe that part of the responsibility does lie with the individual and the family to purchase private long-term care insurance. And like you mentioned, by combining an MSA with a catastrophic policy, when that individual hits 65 years old and should they need long-term care, there will be sufficient funds set aside that has been accumulated over the past 30, 40 years that that person is working, will be there to provide for that kind of care.

In ways that you can do it to provide an incentive, like I mentioned earlier, was perhaps providing a tax credit. I would suggest, as opposed to a flat tax credit, you might want to do a sliding scale, based on the individual's income to make that attractive and more affordable.

Mr. SOUDER. OK. We're going to take a brief recess. We've got 5 minutes left to vote.

[A brief recess was taken.]

Mr. SHAYS. Mr. Barrett, you have the dias, the floor.

Mr. BARRETT. Thank you very much, Mr. Chairman. I appreciate your holding the hearing. I'm going to probably massacre your name, too, Mr. Liu. One of the programs I see in your testimony is a program dealing with Hansen's Disease Service. Can you talk a little bit about that?

Mr. LIU. Sure. That is a project that is in Carville, LA, which conducts research as well as provides care to patients suffering from Hansen's Disease, otherwise known as leprosy. And the reason why that categorical program had been requested to be eliminated is because there is medical research being done within NIH, as well as other private universities and public universities, in the area of leprosy.

And I actually got a letter from this institution down in Louisiana, because I had recommended this during a recision hearing, echoing their support. And I was very surprised—echoing support that this program be eliminated as structured, because there was

not enough money going to patient care. And basically, a lot of this money was going to the building facility.

If you go down to Louisiana, I saw a picture on a news program, this is a project that was started by the request of Senator Johnson. And it is this project here that—the people that run this place that the money is not being used efficiently down in Carville, LA.

Mr. BARRETT. How long has this program been receiving money?

Mr. LIU. In looking at OMB's budget, at least for the past 4 years, and it could be longer.

Mr. BARRETT. Is it authorized?

Mr. LIU. I do not know that. It was in the appropriations report.

Mr. BARRETT. OK. If you could get me the information and the letter, I would appreciate that.

Mr. LIU. Sure.

[The information referred to follows:]

The Gillis W. Long Hansen's Disease Center located in Carville, Louisiana has been receiving federal funding since 1921. The funding for the last five years is listed below.

[in millions]

Year	Amount
1991	$19.8
1992	19.5
1993	20.0
1994	20.7
1995	20.8
1996 requested	20.8

PATIENTS' FEDERATION
GILLIS W LONG HANSEN'S DISEASE CENTER
CARVILLE, LOUISIANA 70721
February 9, 1995

Mr. Lawrence M. Sauer,
Director, Division of Legislation

SIR:

Refers to your letter dated January 18, 1995, no file reference, addressed to Mr. J. Corrigan, Director, Division of Legislation concerning HRSA Legislative Report relating to Possible Rescissions in DHHS Programs.

From the tone of your letter, there were some very interesting topics discussed dealing with the outbacks and budget constraints by the various witnesses.

The members of the Patients' Federation would like to add some comments in addition to the statements made to the Subcommittee by the various witnessess.

We feel that a statement made by Dr. Robert G. Harmon, M.D., MPH, Administrator, Assistant Surgeon General, HRSA, during a visit to the center in November 1991 to the effect that "the HHS is the most inept, incompetent, and disorganized department he has ever come across." This falls right in line with the statements made by witnessess during the Subcommittee hearings.

As you are probably aware, this is one of the highest cost plants and the largest part of the budget for the center goes toward the maintaintence. Additionally, there still remains a 2 to 1 ratio of employees to patients, most of which continue to receive 25% hazard, or as they call it, incentive pay.

The Patients' Federation has had a proposal before HHS to give those patients able and desiring to do so, a stipend in order that we could be a part of society and live our remaining years in dignity, but because of socioeconomic mores are unable to do so. This proposal was given the title of "A19 Legislative Proposal" and would reduce budget constraints considerably. Am forwarding to you a copy of this proposal concerning the stipend and the savings that would be realized if it were implemented. As you can readily see that under the heading "Cost", the overall cost to

the Government would decrease because the Center facility will be more effectively and efficiently utilized.

There have been a number of studies commissioned that have entailed thousands of dollars to complete, and every one has stated emphatically that this center is no longer feasible in light of modern medical findings that Hansen's Disease no longer poses a problem for the public. The studies have included that a stipend for those patients desiring to do so should be forthcoming and the remaining patients be placed in nursing homes or hospitals in the Baton Rouge area. Also the studies and findings indicated that there were many duplicate programs that overlapped others and that are being done at the CDC and NIH.

To this date and time not one study has been implemented not has any item mentioned even been considered much less acted upon. Even Dr. Jacobson's proposal which dealt mostly with the Nitzkin Study went unheeded.

Had this been the case, the PHS could have gotten away from these high plant costs and turned the center over to the BOP, who spent millions of dollars to upgrade the center for their use, and then had to walk away from it and see all this money flatly waisted at taxpayers expense, a good number of them patients and staff. At this time the ratio was 3 to 1, employees to patients and they felt that the patients should be held hostage in order for them keep their jobs and their 25% additional pay.

Additionally a time and motion study was completed by Mr. Lloyd H. Fagg, DFS, and transmitted to the Associate Administrator for Operations and Management, HRSA, on October 7, 1993. This time and motion study, if it had been implemented, would have reduced costs at the center close to a million dollars.

Also included is a newspaper article from the local Baton Rouge paper concerning the recommended relocation.

We are in receipt of your note dated October 3, 1991 on the subject of Carville Stipend Q&As.

In case you have not been apprised, the Center received 3.7 million dollars obtained by Sen J. Bennett Johnston's office in addition to its 1994 budget. This money is being spent on everything imaginable except patient care.

We concur wholeheartedly with Mr. John Liu that the DHHS spends literally billions of dollars each year on wasteful, duplicative, and unsuccessful programs and should be terminated. The Gillis W. Long Hansen's Disease Center could be dealt with as outlined above.

The bottom line Mr. Sauer is that Headquarters, the Administration, and Washington does not care or give a damn one way or the other and the patients are the ones being hurt.

PUBLIC HEALTH SERVICE FISCAL YEAR 1994 LEGISLATIVE PROPOSAL

STIPEND RELATED TO HANSEN'S DISEASE PATIENTS

Authorize living stipend to Gillis W. Long Hansen's Disease Center long term care residential patients who desire to move permanently from the Center

Current Law: Section 320 of the Public Health Service Act authorizes care and treatment without charge at the Gillis W. Long Hansen's Disease Center in Carville, Louisiana, to any person suffering from Hansen's disease who needs and requests care and treatment for the disease.

Proposal: Provide an additional option for PHS to discharge its statutory responsibility for providing care to the Hansen's disease patients now residing at Carville. Amend Section 320 of the Public Health Service Act to permit the payment of a monthly stipend of $2,000 to any current long term care residential Hansen's disease patient of the Gillis W. Long Hansen's Disease Center, Carville, Louisiana, who elects to move off the Center site. This amount is to be changed annually to reflect the rate of inflation as reflected in the Consumer Price Index. Outpatient and acute hospital care for Hansen's disease related illnesses will remain available to patients who elect to receive this stipend. Residential patients must make the election of a stipend in lieu of residential care within 12 months of being notified of the option. If institutional care is required in the future, PHS has the option of providing it outside of Carville.

Rationale: This proposal provides alternative living arrangements for the current residential patient population of approximately 180 patients at the Center by assuring them with a source of guaranteed income. The average age of current residential patients is 70 years. The Public Health Service will continue its life long commitment to these Hansen's disease patients making it easier for PHS to free the Carville campus.

Effect of Beneficiaries: A recent petition from the Patients' Federation that represents the patients of the Gillis W. Long Hansen's Disease Center indicates that up to 100 of the current 180 patients will accept the stipend option should it be authorized. The stipend will provide these aged patients an option that they currently do not have to leave the Center permanently with a guaranteed source of income. The Government's life time commitment to these patients will continue for outpatient and acute hospital care associated with Hansen's disease. There will be no negative impact on the residential patients who do not elect the stipend. These patients, mostly the very aged and infirm, will be provided lifelong residential care that they currently receive.

Family and Federalism Impact: None

Effective Date: The effective date of the stipend option will be upon enactment and will extend to 12 months after the patient is notified of the option that each can exercise. This "window of opportunity" will encourage patients who desire to exercise this option to do so quickly.

Cost: The overall cost to the Government will decrease because the Center facility will be more effectively and efficiently utilized. The annual expense is estimated to be $2,400,000 in stipend cost and $240,000 in contract care costs for a total annual cost of $2,640,000.

Contact Person: Jimmy Mitchell, (301)443–4814 or (301)443–2380

RELOCATING HANSEN'S CENTER RECOMMENDED

BY CHRIS FRINK—WESTSIDE BUREAU

CARVILLE—A consultant's report recommends moving the Gillis W. Long Hansen's Disease Center out of the hospital here, a group of patients learned Thursday. But the center's director is not packing up his office.

"They keep emphasizing a new location because this place is not cost-effective," Jack Pendleton told a meeting of more than 50 patients. Pendleton heads the center's Patients' Federation.

"We thought we'd let you know what they are planning—this place is history," said federation board member Ray Ellwood.

The report, prepared for the U.S. Public Health Services by a New Orleans consultant, was released Tuesday.

However, any changes in the program or the Carville site will be slow in coming, said Dr. Robert Jacobson, the center's director, in an interview after the meeting. "It's a long way between proposing something and Congress passing it," he said.

"If it happens at all, it's a ways down the road," Jacobson said. A realistic scenario involves gradually moving the program from the Carville facilities to Baton Rouge over a five- to seven-year period, he said.

Hansen's disease used to be known as leprosy and the Carville site became a "leprosarium" in the late 1880s. The U.S. Public Health Service Act provides free care and treatment for Hansen's disease at Carville.

Pendleton repeatedly emphasized Congressional approval. "It's going to take legislative action," he said. "There is no guarantee of anything, this is just a semi-final draft."

There is no firm timetable for acting on the report, Jacobson said.

Jacobson also noted the recommendation to move the program is not the first. "This is the first in a series of efforts," he said.

The report recommends moving patients out of the sprawling, "antiquated" hospital complex into a yet-to-be determined facility in Baton Rouge.

"The Carville facility is no longer a cost-efficient site," said the report's preliminary draft. "The program should have been relocated to an urban medical center many years ago."

Patients who can care for themselves would be offered a monthly stipend—the report suggests $2,000 per month—to move back into the outside world.

"It's going to allow patients to go out and live out their lives in dignity," Pendleton said.

More than 150 Hansen's disease patients live at the hospital, Pendleton said after the meeting. About 40 are bed-ridden, he said.

Patients who cannot or do not want to leave the program would be kept together, Pendleton said. "They're going to try to find a facility where they can move the Hansen's disease patients as a group," he told the patients.

Some have been there for decades; all were forced by health officials to come to Carville, he said, Pendleton was sent to Carville from Phoenix in 1960 after he was diagnosed with the disease.

"Staff have estimated that 40 to 60 residents might take advantage of this offer," the report said. "The Patients' Federation estimates about 100."

Several patients said after Thursday's meeting that they did not want to leave. "I'm 81 years old and I came here to retire," said a man who wanted to be identified only as Johnny. "I figured it was the best place for me."

Johnny said he had been in and out of Carville several times since he first was confined in 1935, "I had to come here, I didn't have any choice."

In his years at Carville, Johnny said he became part of a "family" with the other patients and it's a feeling he is afraid any move would destroy.

Mr. BARRETT. I'd like to also go back to the concerns that——

Mr. SHAYS. I'm just going to inject myself a second. When we do make the requests, it really would be helpful to follow through. And I'd like to make sure that you send a copy to our staff so that we know.

Mr. LIU. Sure.

Mr. SHAYS. Thanks.

Mr. BARRETT. I'd like to follow up on some of Mr. Fattah's questions about the National Health Service Corps, and, in particular, the woman who was mentioned in the footnote. You indicated in your footnote that she joined a private practice and filed for bankruptcy. Was the loan dismissed in bankruptcy?

Mr. LIU. Excuse me?

Mr. BARRETT. Was the loan dismissed?

Mr. LIU. Not according to the Washington Post, it wasn't.

Mr. BARRETT. OK. So even though she tried to commit fraud, it didn't work.

Mr. LIU. Well, she did commit fraud. She first of all, did not go practice at the Indian reservation, where she agreed, as part of her contract, to go serve. And the second part of that is that, in trying to escape paying back the Government the cost of her education at Georgetown and declaring bankruptcy, to my knowledge, the article did not state that the Government had successfully gotten back the tuition and other expenses it paid for.

Mr. BARRETT. OK. In your written testimony, you talk about 3,000 participants. Is that 3,000 participants a year?

Mr. LIU. That was only for FY95. And actually, in following up on Mr. Fattah's question, I did look for the detailed report. Between 1985 and 1989, enrollment in the National Health Service Corps scholarship program declined from a high of 1,600 in 1985 to 215 in 1989. So it obviously varies from year to year, as to the number of participants. The only reason why I cited the 3,000 figure is, that's the most recent figure from the Congress from its appropriations report for FY95, as well as the dollar figures, which is $142 million.

Mr. BARRETT. If you could get for the committee the loan default rate, I think that would be helpful as well. You used the figure 3,000 participants, and I thought, well, if there's 3,000 participants and the program has been in existence for 21 years, that comes out to less than 1 percent default rate.

Mr. LIU. But that was for FY95.

Mr. BARRETT. Right, I understand that. But I think it's important for us to have a feel for what the actual loan default rate is here. Do you have a suggestion as to how we deal with attracting physicians to the central cities?

Mr. LIU. Yes, I do, Congressman Barrett. My understanding of the National Health Service Corps is that the Government, in seeking to attract more primary care physicians in underserved areas is, before the student enters med school, actually, as part of the "this is how we're going to help pay for your education," the medical school, through this program says, hey, you have an opportunity to not pay for your tuition if you agree to serve in one of these designated areas that are defined as underserved by the Federal Government.

Now, that is done when the student is just out of undergraduate school. So they're probably 21, between 21 and 24 and pretty much unsettled down. And I would suggest, in talking to my friends who went through the process of medical school, your priorities change during school. Either you've gotten married or your wife or your husband doesn't want to move to a certain part of Montana or an Indian reservation.

Those goals change throughout those 4 years of medical school, as well as residency. I would suggest that the authorizing committee in this case, Commerce, perhaps change the timeframe in which they seek to recruit these students; maybe toward the end of their residency.

Mr. BARRETT. OK. I understand what you're saying. But that wouldn't be eliminating the program, that would simply——

Mr. LIU. That wouldn't be eliminating it, that would be restructuring it.

Mr. BARRETT. OK, I understand. Let me just, if I could, Mr. Chairman, have an additional minute or two. If I could go to the LIHEAP program just for a second. This is a program that, my understanding, traditionally benefits people from the North Central part of the United States and the Northeast part of the United States.

The Northwest, I would imagine, doesn't need as much help because, in some areas, at least, they're served by power companies that by law are required to sell their power at a lower cost.

Mr. LIU. Reduced rate, right.

Mr. BARRETT. What is your feeling on that?

Mr. LIU. Speaking in light of the fact that the House has passed the recision bill, which did include recisions for the LIHEAP program, the reason why it is included in this——

Mr. BARRETT. No, no, no. My question is—I understand why it's included here. I'm wondering whether you have the same vigor and intensity against government-run utilities in the Northwest part of the country and the TVA for that matter.

Mr. LIU. No. I mean, basically, I concur with you that areas of the upper Northwest should pay their "fair market value" or rate of those services.

Mr. BARRETT. So even though they're not doing it now and even though it's not occurring in the TVA area, I must acknowledge that when I talked to my colleagues in Wisconsin and explained to them why this program was so easily eliminated, I explained to them that the new leadership in the House, the top three people, the top five people, are either from Texas, Louisiana, or Georgia, so they don't have any need for this program.

So it seems to me that we're picking at one area of the country which, I think, accurately tries to serve the poor people. And in other areas where we have Government subsidies, I don't see this Congress moving to deal with those problems.

Mr. LIU. I only focus on programs within the purview of HHS, so that's why.

Mr. BARRETT. If you were speaking personally, what is your feeling?

Mr. LIU. Philosophically, I would agree with you there. The reason why LIHEAP is mentioned here is because, again, that is a program that operates within the Department of HHS.

Mr. BARRETT. OK. If we are unable to get at those, in effect, subsidies that affect not only poor people, but middle-class and wealthy people in those other parts of the country, you still think, even if we can't touch those subsidies, we should still go after the poor people in the North Central and Northeast part of the country?

Mr. LIU. I don't consider going after the "poor people." What I hope to articulate is that this program was enacted in the early 1980's, when we did have an energy crisis because of an oil embargo. And during that time, your colleague, Mr. Obey, introduced—was one of the main authors and sponsors of the LIHEAP program.

And during my previous testimony before the Appropriations Subcommittee, I argued that that situation no longer exists and, as a matter of fact, the private sector is already picking up this concern. PEPCO, for example, as I mentioned, out in the West Coast, what was PG&E also has similar programs as far as private customers checking off a certain box and designating how much they would like extra.

Mr. BARRETT. And of course here, I assume the prices are lower than they are in the North Central, because——

Mr. LIU. You're right, it will vary. But the main program was for LIHEAP was that it was enacted during an energy crisis. And back then, you had a situation that did warrant a need to supplement low-income households.

Mr. BARRETT. Thank you.

Mr. SHAYS. I thank the gentleman. Does any other Member wish to ask questions of this panel? Mr. Fattah.

Mr. FATTAH. Yes. Mr. Chairman, thank you for your indulgence.

Mr. SHAYS. No problem, that's the point of the hearing.

Mr. FATTAH. I'll move through it as quickly as possible. Your recommendation, as I read it, recommends eliminating the National Health Service, the NHSC, as currently structured. And then you indicate that the first year savings would be $123 million. Is that the totality of the budget for that program?

Mr. LIU. That is the totality of the budget from FY95. That would be the minimum amount of savings you could score.

Mr. FATTAH. So your recommendation is to eliminate the program.

Mr. LIU. As I worded it in the testimony, "as presently structured." As I just recommended to Congressman Barrett, if you were to maybe make some changes within the program and allow that to run for a year or two or possibly longer, as defined as Congress sees fit, to see if restructuring the National Health Service Corps

actually is working to retain, not just attract physicians, but retain them.

During the break, I mentioned to your staffer that part of the problem is that the way it's currently structured, you have no continuity of service in these areas, because a lot of times a doctor will go to an area and serve for a year, realize he or she does not like serving in the area and, legally, can buy their way out of serving in that area. So you don't solve the problem by having doctors or nurses there.

Because they'll say, I don't want to work in this part of town; I would rather pay back my loan and go into private practice where there's a more lucrative career than stay in that area. So that's why you need continuity in this program, which is thoroughly lacking as is currently structured.

Mr. FATTAH. Let me just go on a little bit. When you refer to this GAO report that you held up to the committee. The report indicates that the National Health Service Corps—is that the exact title of the program?

Mr. LIU. Yes.

Mr. FATTAH. The National Health Service Corps supplied about half of the physicians working in community and migrant health centers in 1989, as well as nearly one-fourth of the IHS physicians, and about 40 percent of the physicians in BOP facilities. Nearly 10,500 NHSC scholars, including physicians, dentists and nurses and other health professions, have been placed in health programs for the underserved since 1980.

The report seems to indicate, notwithstanding the fact that there may be some improvements made in this program, but the report doesn't seem to suggest that either we could afford, in the terms of the need for care in these areas and for physicians, to eliminate the program. You didn't mean, by your earlier indication of your reliance on the GAO report, that the GAO report called for the elimination?

Mr. LIU. I did not state that the GAO recommended elimination. What I said was, in using this GAO report as——

Mr. FATTAH. I just wanted to clarify that.

Mr. LIU. Sure.

Mr. FATTAH. And one last point is, I know the Heritage Foundation has an extensive network of information. Are you aware of any organizations and entities that have been principally involved, in terms of either providing care or advocating for improved health care in rural and urban and communities that are served by this program that want this program eliminated?

Mr. LIU. I do not know of any group that would like to see that program eliminated.

Mr. FATTAH. Thank you very much for your testimony.

Mr. SHAYS. I thank the gentleman. Mr. Souder.

Mr. SOUDER. I wanted to follow up with a brief question or two on that. Are the programs in HHS that are oriented toward the stated minority preference medical providers unique, or are there programs similar in the Department of Education and other places?

Mr. LIU. One of my colleagues who is an expert in the Department of Education could be more competent. But in my understanding, there are crossovers in programs between HHS' programs

and those of the Department of Education. Getting back to that issue that, specifically, Mr. Fattah had asked me if I knew of specific numbers of African Americans or Hispanics in the areas.

I don't want to go through the whole chart here for you, but the GAO Report HEAS 94–164 in July 1994, has a detailed chart on the number of African Americans and Hispanics that have entered the various health professions, which is why I said perhaps this program should be either restructured or eliminated because it duplicates another program, is that it says, on page 44, "Generally, the numbers of African Americans, Hispanics and Native Americans have increased at a greater rate in health professions than in the U.S. population as a whole."

And it goes on to further state that it is not because of this program that you have that, because back on page 29 the number of nonFederal—that means physicians who did not enter this program—"nonFederal primary care physicians providing patient care in the U.S. increased by about 75 percent between 1975 and 1990." So the question that I pose to the committee and to the Congress is, is this a wise use of Federal dollars?

I do not question the goals, and I stated that.

Mr. SOUDER. Given the fact that there are other education programs that pay student loans, Pell Grants and so on, do you know of anything where there would be a focus on the end result, rather than the beginning of the process? For example, are there any programs to subsidize the facilities in the low-income area or a voucher to pay part of the cost of nursing, and other types of programs where you wouldn't reward people who don't follow through?

Mr. LIU. I'm not aware of any specific program, but that would be a good suggestion for the Congress to pursue.

Mr. SOUDER. OK, well, thank you.

Mr. SHAYS. Mr. Barrett, do you have any questions?

Mr. BARRETT. No, I don't.

Mr. SHAYS. Mr. Fagan, before we let you both go, I want to be clear again as to your expertise when you were working the Bush administration for HHS.

Mr. FAGAN. I was Deputy Assistant Secretary in the Office of the Assistant Secretary of Planning and Evaluation. And in there, for the first 1½ years, my purview was social services policy, which involved, on the one hand, the AFDC, foster care, the social service and all of HHS. And on the other side, it was disabilities and aging. There were two divisions.

Mr. SHAYS. You have a tremendous background of overview.

Mr. FAGAN. Yes.

Mr. SHAYS. You were in HHS and the whole——

Mr. FAGAN. It was the big picture thing, and that's why my testimony went more to the big picture than to——

Mr. SHAYS. Right, but I would just like to touch on that expertise a bit. When you look at this issue, you're not coming and saying the Clinton administration is screwing up. Your point, it seems to me, is to say HHS is very large and we don't have a handle on it; is that correct?

Mr. FAGAN. That's right. My disappointment would be that the Bush administration never got a handle on it.

Mr. SHAYS. That's mine, as well. I mean, we had an opportunity and we didn't seize that opportunity. What is the best way for a Secretary to get a handle on this department, other than just having an initial audit? If I were a new Secretary coming to HHS, I would have an audit of the entire department and say, whatever we found, it happened under someone else's watch. And from that point on, hold me accountable for what improvements I can make.

But what would you do to try to get a handle on this agency? Because this committee is going to try to get an appreciation of the tasks. And we're going to then decide where we put our focus. How would you get a handle on it? Where would you put the greatest focus if you were a committee of a staff of eight, of which we have five departments, so I have two people, basically, that can focus in on HHS?

One, how would you get a handle, and two, where would you put your focus on? Would it be HCFA, would it be the institutes, would it be FDA would it be Centers for Disease Control? It's not that, it's called——

Mr. FAGAN. Centers for Disease Control, yes.

Mr. SHAYS. I mean, where could we make the best contribution?

Mr. FAGAN. OK, well, first, how to get a handle on it. I would suggest that you work with the assistant secretary in personnel. If there's anyplace where there's most likely some data bank on all of HHS, it would be there. Then I would essentially issue a survey to every—get an address label, and go from this committee directly to each division director, and ask the very same questions, and have them submit it on data disk.

HHS is quite—this is standard practice there. So that as the questionnaires are answered in hard copy, they're also on data disk for you so that you can compile. And I would put the questions in such a thing as, what is your mission, because you want to know where the overlap in missions are. And get a brief description of that.

What is your budget; what are the major tasks you have done; how many people are in there? And I would compile that from the division director level. I would not go through the senior management, because the whole push of bureaucracy anywhere, under any administration, is to protect itself. And the flushing out of this data and making it clear will itself, without almost doing anything else, bring about, I suspect, major reforms. So that's how I would get the data.

Mr. SHAYS. I'm struck by the fact that outside HHS, we also would have different departments and agencies that are going to be doing some of the same tasks that HHS is doing.

Mr. FAGAN. HUD, Education, Agriculture, Labor, there would be a tremendous amount of overlap. And from your committee, you have that wider purview, I would do it, then, to all agencies.

Mr. SHAYS. Let me ask you the second question.

Mr. FAGAN. The second question.

Mr. SHAYS. We could literally just spend all our time as a committee on FDA. I mean, how they certify drugs, how they certify equipment. We could spend all our time on HCFA. So, given that fact, where would you spend the primary amount of your time if you were the committee now?

Mr. FAGAN. If I was the committee, personally, I would go—I think the reform of HHS itself, because I think there is such a push, there's going to be such a push by the increasing budget of HCFA, of Medicaid, Medicare, Social Security. Other things are going to push that reform. That's too big a growing elephant. The country is going to be clamoring for things there.

Where the likelihood is where major reform that this committee would do that probably nobody else will do is the rationalizing of the different departments, in terms of mission statement and lining up personnel behind missions. That's where I would put this committee's energy.

Mr. SHAYS. OK. Does any other Member have a followup question before we end?

Mr. LIU. Mr. Chairman, I just wanted to note a correction in review of the budget. The FY96 budget request does include the Social Security Administration. Earlier I had——

Mr. SHAYS. So of that, the $50 billion also includes—thank you for doing that.

Mr. LIU. Thank you.

Mr. SHAYS. Mr. Fattah.

Mr. FATTAH. Yes. Mr. Flanagan.

Mr. FAGAN. Fagan.

Mr. FATTAH. Fagan. But Flanagan I'd take, it's a good Irish name.

Mr. SHAYS. Can I say, I am really enjoying the difficulty of my colleague with both of your names, because his name is Chaka Fattah. I'm going to get his name right eventually, but I am really enjoying this. [Laughter.]

Mr. FATTAH. Mr. Fagan, could you just give a concise answer to a question on the welfare reform issue that's being debated now on the floor? You're very interested in the ability, in the usefulness of the Federal Government, collecting data so that that data can be manipulated in ways that could be helpful in the policymaking process and priority setting.

Does this welfare reform proposal, better termed the Personal Responsibility Act, have within it the kind of data collection capabilities that would be useful at the Federal level? Given your experiences inside the Government and now as a commentator on the outside.

Mr. FAGAN. I think survey data could be very useful in welfare reform. And I would suggest that it be gathered nationally in such a way that you could——

Mr. FATTAH. I'm asking you, in the legislative proposal before the House is the requirement of the collection of data sufficient for someone like yourself and others to be able to have data that would be useful?

Mr. FAGAN. To the best of my knowledge, that's not addressed in this bill. And I would also suggest, as I was talking with your staff member, I'm not too sure that the welfare bill debate is the place in which to discuss the gathering of data.

Mr. FATTAH. OK.

Mr. FAGAN. There are lots of data which you can gather at the same time. You would have a great interest, for instance, in welfare, on maternal health, on family structure, on education, on

community characteristics. So in order to make sense of how the welfare reforms at the State level are going, you would need to have that data. So I totally concur that it ought to be there.

Mr. FATTAH. But maybe not in this vehicle, maybe at some other point in the process.

Mr. FAGAN. Yes, but soon. I'd be right for it. And I'd be glad to work with you, your staff at least in submitting ideas on how that might be done.

Mr. FATTAH. Thank you very much, and I apologize for mispronouncing your name, Mr. Fagan. Mr. Liu, I have one last question for you.

Mr. LIU. Sir.

Mr. FATTAH. And it goes through this issue—because your written statement and just now your oral response to one of my colleagues talks about the fact that you say neither African Americans or minorities, Hispanic and African Americans are being represented in the pool of physicians now at a higher increase in proportion than the majority. Is that your statement?

Mr. LIU. Correct. I was quoting page 44 from the report.

Mr. FATTAH. OK. Now, you are aware that, first of all, that the number of African American physicians in this country is sufficiently below their proportion in the population.

Mr. LIU. As would be Asian American physicians, as well.

Mr. FATTAH. Right, I understand. Let me just follow through here for a minute. About 2.6 percent, I think, is the last time I saw the pool; and dentists are below 2 percent. Now, you are aware when there was a time in this country at public universities and private universities that African Americans were not allowed to matriculate by force of law or practice.

Mr. LIU. I am. And that was why the National Health Service Corps, as well as these other programs, were enacted.

Mr. FATTAH. You are aware of that, though.

Mr. LIU. I am aware of that.

Mr. FATTAH. OK. You are aware that there's a correlation between the households of children, the educational attainment rates of their parents as it relates to the abilities of their children to pursue a higher education, and especially as it relates to first professional school degrees?

Mr. LIU. I do see that, but I do not see how that pertains to the efficacy and efficiency of——

Mr. FATTAH. I'm going to get to that, I'm just trying to build my case here.

Mr. SHAYS. Fairly quickly.

Mr. FATTAH. Fairly quickly, Mr. Chairman. The point I make is that if there were barriers at one level, to infer that there's less of a reflection in the pool of physicians and health care professionals now that those barriers have been removed that would be, perhaps, in terms of flushing out the number of students who could, in fact, and should be matriculating in professional schools now, that it would increase the pace above the majority of the population, because it had been artificially deflated.

Mr. LIU. If I can address that. I do understand where you are coming from. But if I could take that one step further, since you mentioned that State laws as well as the Federal law prohibited

certain populations of certain races from entering into public schools.

Mr. FATTAH. African Americans.

Mr. LIU. African Americans, right. There was also a Federal law which placed a certain population in concentration camps in the 1940's for no apparent reason other than the fact of their skin color, which also prohibited them, at that time, during those years of concentration, from entering public or private school, correct?

Mr. FATTAH. I'm aware of that.

Mr. LIU. However, in not one of these reports I've mentioned have you seen the mention of Asian Americans or Pacific Islanders as a minority representation in the health professions. No. 2, I only made those references according to the GAO report. I am quoting, I am not making new numbers up. I am quoting tables and charts.

Mr. FATTAH. Right.

Mr. LIU. According to the GAO. Now, if there's a dispute, then that's what the GAO.

Mr. FATTAH. I'm not making a dispute. I'm trying to understand why it would be so that African Americans would be outpacing the majority, in terms of entrance and matriculation——

Mr. LIU. As a percentage.

Mr. FATTAH. Right. I'm saying that it would seem to me that logic would flow that if you artificially held back a class of citizens from participating and then allow them to participate.

Mr. LIU. In the private sector——

Mr. SHAYS. We may end up having a hearing on this, and we will have reports in front of us and so on. And we would be happy to invite you back to do that.

Mr. LIU. I'd be glad to come back.

Mr. SHAYS. I think your original effort here was just to say, take a look at this.

Mr. LIU. Exactly.

Mr. FATTAH. That is after he proposed that we eliminate a $40 million program that encouraged minorities to go to medical school. That was his testimony. And I don't think we should sugarcoat it.

Mr. LIU. Mr. Chairman, if I may. As the written testimony and oral testimony articulates, I do not want to discourage, nor have I ever advocated discouraging minorities from entering the health professions. What I question is the efficacy and the duplicative nature of this particular program. And I cited several programs operating within the same agency—the Department of Health and Human Services has several other programs with the same purported goals.

And the question then is, do you either block grant those programs or do you restructure those programs as they currently exist? Because apparently, they are very expensive and according to members on both sides of the aisle, they have not achieved their stated goals, which is to increase physicians and primary care physicians in rural and underserved areas.

Mr. SHAYS. May I just clarify one point? My understanding—this is the very first program I ever voted on as a Member of Congress in 1987. I knew nothing about the program and yet it was my first vote, so it was a memorable one. The basic thrust of this program

was to provide doctors in underserved areas, whether it was Bridgeport, CT or not.

Mr. LIU. They're two separate programs.

Mr. SHAYS. Now, two separate programs, or two separate goals?

Mr. FATTAH. No, that's what I'm saying. I think that the chairman is——

Mr. LIU. The Minority Health Initiative. The program that Mr. Fattah mentions is a minority health program. And as I mentioned, it duplicates another program within the Office of the Director at the NIH.

Mr. SHAYS. Right.

Mr. FATTAH. OK, well, then just so we can clear it up. The first discussion about the National Health Service Corps——

Mr. LIU. Right. That's a Title 3 program.

Mr. FATTAH. There's a separate program referred to in his testimony on page 9.

Mr. LIU. Right.

Mr. FATTAH. Having to do with recruiting minority and disadvantaged Americans into the health care professions. And this is a $20 million appropriation in which the recommendation is that that program be eliminated. And the testimony, I think, in the committee was that first of all, I asked about the number of physicians who happened to be African Americans in the overall pool, and why it was felt that we could now eliminate this program. And that's where this whole dialog began at.

Mr. SHAYS. Sure. Thank you. Mr. Fagan, before we close, one last word. Happy to have it, and then we'll get on our way to finish up.

Mr. FAGAN. It's very quick. I'd just like to get on the record, because Mr. Fattah raised it at the opening. At the Heritage Foundation, my personal experience has been that senior management is very, very careful to protect all the analysts from lobbying, from donors or anybody else. We really do do independent work. And there is a great sense of, if you want to call it, it's akin to academic freedom.

Granted, they select people based on where they know they're coming from and their expertise, as I was for my expertise in the human services and family area. But then they give you carte blanche. For instance, my testimony was not reviewed by senior management. It really is my own; they do give you that freedom.

Mr. FATTAH. I don't condemn anyone's source or philosophies. But academic freedom is something that you would find at the most liberal universities and the most conservative-minded professor or in reverse that may be the case. From all that I've seen of the Heritage Foundation, you would have to admit that it's a group of like-minded individuals, at least, who have a particular and peculiar focus on public policy.

Mr. FAGAN. Oh, sure. We're a conservative foundation.

Mr. FATTAH. And therefore, I think it would be helpful to the subcommittee, at least to this member of the subcommittee, to have some sense of from whence this——

Mr. SHAYS. Gentlemen, I'm going to break this up now, if I could.

Mr. FATTAH. Thank you.

Mr. SHAYS. I just want to say, the Heritage Foundation will always be welcome here. We value your reports. We will not depend

just on the input of the Heritage Foundation, but we will be asking you to come in the future. And thank you very much for coming. We're going to get on with our next witnesses. We're going to have Mary Suther and Gail Wilensky, who was supposed to be on the second panel.

We have a practice in this committee, regardless of who comes before it, whether the Secretary or anyone else, to swear in our witnesses.

[Witnesses sworn.]

Mr. SHAYS. I didn't hear a loud yes, but I make the assumption both said yes. Happy to hear your testimony. You have particular expertise and we're happy to have you pursue that expertise.

The overall thrust of this effort is to help this committee begin to see how we focus our time and attention on HHS; where we should put our time and energy, based on a whole variety of issues, problems or just the tremendous sums of money we put in a particular part of HHS.

So please feel free to focus on your expertise. But this is a hearing that gives us a general overview. We will be getting into great depth once we decide where our focus will be. Help us to decide where our focus should be.

Mary, I'd love to hear your testimony. Thank you.

STATEMENT OF MARY SUTHER, PRESIDENT AND CEO, VISITING NURSES ASSOCIATION OF TEXAS, ON BEHALF OF NATIONAL ASSOCIATION FOR HOME CARE; AND GAIL WILENSKY, SENIOR FELLOW, PROJECT HOPE

Ms. SUTHER. My name is Mary Suther, and I am pleased to testify on the National Association for Home Care. NAHC is how I will refer to it. I have almost 40 years of experience in health care, most of which has been in the nonprofit sector. That's not to mean that we don't run it like a business, because every businessman or woman in Dallas will tell you that a non-profit operation is run probably more efficiently than most of their private businesses; they will testify to that.

We not only provide home health care and hospice, but we also provide Meals on Wheels and meals for children, as well as other programs. I also serve on the board of directors for the National Association for Home Care for the last 4 years, and have chaired the fraud and abuse committee, as well as chairing the new task force on prospective pay. And I think that's an extremely important activity in terms of fraud and abuse.

Home health care does represent a small but growing part of the Medicare program. There are many contributing factors to the growth, and some of those were mentioned this morning. One factor has been the introduction of prospective pay for hospitals under the Medicare benefit, resulting in patients being discharged quicker and sicker, and doubling the number of Medicare hospital patients discharged to home health care.

I remind you, when you double the number of patients discharged from hospitals, and the intention was to decrease the cost of hospital stays, you obviously shift that money. So you have a higher percentage in home health. That also was intended to decrease those payments. Other factors have included policy and cov-

erage clarifications, allowing the Medicare program to provide the level and type of services that Congress intended, and the lessening of personnel shortage in various parts of the country that increased the number of home health agencies that were formed.

Also contributing to the cost of home care, the increasing cost, is some of the regulations that have been passed in the last few years. OSHA regulations and some other regulations have added to that cost. And of course, most importantly, is the growth of the aging population in this country. Not to mention the fact that the population that utilizes home care most frequently is that population over age 85. And that is the fastest growing segment in the population.

So obviously, there is some increased need there for home care. The Medicare home care benefit still represents a relatively small portion—only 8.7 percent of the Medicare budget for 1995. Current trends indicate that the home health benefit has peaked, and that increases will fall to 7.8 percent by 1997, and will later plateau. You saw this morning a copy of a graph showing, up to 1995, a very sharp increase in home health. But it didn't go beyond that. That rate of increase will start to decline.

With the advent of miniaturization and simplified technology, home health has moved well beyond the traditional boundaries, making it possible for millions of patients to receive reduced cost care to eliminate, altogether in some instances, more costly in-patient treatment. In fact, in our own agency, we serve people now in the home that, 20 years ago, could not even be cared for in an intensive care unit.

And 10 years ago, intensive care units did provide that care in intensive care. A number of studies document the ability of home care to hold down the use of more costly care. The past decade has seen dramatic increases in awareness among physicians and patients about home as an appropriate and safe, often cost-effective setting for the delivery of health care services. A Lou Harris poll found that the American public supports home care 9 to 1 over institutional care.

The instance of established fraud and abuse in home care is low. However, a single occurrence is not acceptable and must be eliminated. Growth brings with it the potential for unethical or illegal behavior. NAHC believes it is the responsibilities of all parties involved—patient, payers and providers—to act aggressively to uncover, report and act against fraudulent or abusive home care providers.

NAHC is engaged in longstanding efforts to maintain the highest degree of ethics and values in home health care industry through a combination of member education, cooperation and assistance to enforcement agencies and consistent support of federally legislated proposals designed to combat abuses in the home care programs, as well as to increase the budget for the agencies that need to enforce this.

In fact, NAHC met with June Gibbs Brown to suggest acting on the south Florida St. John's situation that she brought up this morning; to make sure that that was aggressively pursued, as we recognized it needed to be in the industry. Another measure that can be taken to prevent fraud and abuse is to enact a per episode

prospective payment system. And I think this is extremely important.

We have long supported a fair and equitable prospective payment system for home care, so long as it's been tested and proven to be an improvement over the current cost base reimbursement system, which I believe can lead to abuses in home health care. We've been strong supporters of HCFA demonstrations that would test PPS. We have some concerns about the demonstration as it's currently constructed, since it will not resolve the case mix problems that have stymied the development of an acceptable PPS model.

The demonstrations should be reoriented to deal with these case mix problems now, rather than set aside for later, and then people say we don't have adequate data to determine what really does make a difference in cost in home health care. We have that opportunity now. We're incurring those costs now. The demonstrations being done as we speak. And so it's important that something be done to resolve the case-mix problem.

And we would invite this committee to assist us in seeing to it that that does get done. You have a copy of a letter in my testimony, to Mr. Vladeck.

In my written testimony, there's a detailed list of recommendations that Congress can undertake to further combat fraud and abuse in the Medicare program. First, enact all payer anti-fraud legislation. Second, provide a private right of action under anti-kickback provisions.

Third, offer whistleblower protection for good faith activities in providing information. Fourth, institute an anti-fraud review system at the Office of the Inspector General of the Department of Health and Human Services and at the Department of Justice, where planned activities can be subject to analysis prior to implementation. Fifth, commit adequate resources to develop expertise and strategic plans to combat improper underutilization within managed care.

And I know some have testified that managed care is a method of cost savings, and, indeed, it can be. We see a dichotomy in managed care, however. We find HMOs contracting with home health agencies in California, for instance, allowing so few visits that it's virtually impossible to do anything for the client. On the other hand, there are very good managed care systems, so we would like to make certain that fraud and abuse doesn't occur on the opposite end of the spectrum, as well as, in the overuse and abuses.

Last, we think enactment of provisions to regulate home infusion therapy services should be strongly considered. It's one of the areas in which you read about a lot of fraud and abuse. There are very few regulations, if any. Some States have regulations, but there are very few measures being taken to regulate that particular industry.

I know that early on, you looked at the growth of the Medicare program and the growth of the home care program.

And while I don't have the figure with me, I was sitting back there, when you were asking for figures earlier, trying to figure in my head what percentage of that 16 percent growth is related to the increase in aging, and what percent is due to inflation, and what percent is due to the older population growing, and what percent is due to fraud and abuse. And it looks like, to me, in my

head, there's about 3 percent unaccounted for there. I don't know the percentage of fraud and abuse, but there are very few known cases, proven cases of fraud and abuse in the home care industry. However, those cases are large cases, very large cases. And I think much can be done in terms of prospective pay and looking at the recommendations made by our national association.

Something was earlier mentioned about decreasing costs at HCFA. I will say that I've had the privilege to serve as the chairman of a task force to reduce paperwork on several occasions with our national association. The first one was during the Carter administration. Very frankly, we didn't get very far; we didn't reduce one piece of paper. Six years ago, this committee was reconstituted, and guess what, I was named chair again, during the Bush administration.

And we did make some progress. We were able to eliminate a couple forms. You think that's not much, but when you're looking at millions, that is a lot. So I think some things have been done. And HCFA is improving in their organization and their ability to deal with problems as we see it in home care. And that's been a constant improvement over the last 4 to 6 years.

Also, I would like to recommend that health care—and this wasn't part of my formal testimony, nor is it part of the national association's recommendation—but in listening to the gentleman who had been at HHS before, I would like to recommend that the Government look at form following function, the way it does in private industry and at every other facility in the world, except health care. In health care, form follows reimbursement instead of function.

But I would think that we could, by utilizing the techniques utilized in efficient businesses, we certainly could cut a lot of waste and duplicative efforts.

[The prepared statement of Ms. Suther follows:]

PREPARED STATEMENT OF MARY SUTHER, PRESIDENT AND CEO, VISITING NURSES ASSOCIATION OF TEXAS, ON BEHALF OF NATIONAL ASSOCIATION FOR HOME CARE

My name is Mary Suther. I am president and chief executive officer of the Visiting Nurse Association of Texas, a non-profit home care agency in Dallas. I am pleased to represent the National Association for Home Care at this hearing. NAHC represents nearly 6,000 Medicare-certified home health agencies and hospices, and the individuals they serve. Until this month, I chaired the NAHC Government Affairs Committee for 4 years and continue to serve on its Fraud and Abuse Task Force.

I want to commend you, Mr. Chairman, for calling this important hearing today on issues related to controlling growth in Medicare costs and improving care. As you know, home health represents a small, but growing part of the Medicare program. More enrollees than at any previous time are accessing in-home health services—about 9 percent in 1994 compared to 2 percent 20 years ago. There are many contributing factors to this growth, and my testimony will attempt to detail the most significant of these.

At the same time, however, we need to make absolutely sure that this growth is appropriate. NAHC has a long history of aggressive action to ensure against fraud and abuse in the Medicare home health benefit. The second part of my testimony will speak to the issues of fraud and abuse in home care and NAHC's activities and recommendations to help eradicate these illegal and unethical activities. Finally, I also would like to take this opportunity to make a few comments about prospective payment.

FACTORS INFLUENCING RECENT AND HISTORICAL INCREASES IN THE UTILIZATION OF MEDICARE'S HOME HEALTH BENEFIT

The home health benefit has been a maturing program for most, perhaps all, of its existence in the Medicare program. In Medicare's earliest years of operation, home health expenditures amounted to only about 1 percent of the total. Therefore, although the benefit has increased at an average rate of 23.5 percent per year, it still represents a relatively small proportion of Medicare spending—only about 8.7 percent of the total estimated for 1995.

Congress has long considered home health care a cost-effective benefit and has taken steps over the years to encourage its utilization. For example, Congress eliminated the prior hospitalization requirement and the 100 visit limit, the home health deductibles, Part B copays and broadened participation to include nonlicensed proprietary agencies. These amendments removed barriers to needed home health care and recognized the advantages of home health services over other acute care settings from the standpoints of patient preference and cost-effectiveness.

The home health benefit became especially useful in meeting the needs of patients who were discharged from the hospital "quicker and sicker" as a result of the 1983 enactment of the Medicare hospital prospective payment legislation. The percent of all Medicare hospital patients discharged to home health care increased to 18 percent compared to only 9 percent in 1981.

Technological advances have also done much to make the home a safe and effective acute care setting. These factors together with the aging of the population, the increased paperwork burden, and an increased public and professional awareness of home health care have all contributed to the home health benefit's rapid increases over the past 25 years.

Estimates from the Health Care Financing Administration's (HCFA) Office of the Actuary indicates they believe that the benefit has matured and that expenditure increases will fall to 7.8 percent by 1997 (see attached chart).

FACTORS AFFECTING RECENT GROWTH

The home health benefit increases that have occurred in the 1989–1992 period are almost double the 23.5 percent average experienced over the life of the Medicare program but have already begun falling to lower rates. As indicated above, NAHC believes this peaking is temporary and that it has been influenced by several recent events.

Coverage clarification

In the mid-1980s, Medicare adopted documentation and claims processing practices that created general uncertainty among agencies about what services would be reimbursed. The result was a so-called "chilling effect" in which some Medicare-covered claims were diverted to Medicaid and regrettably some patients went without care. This "denial crisis" led in 1987 to a lawsuit (*Duggan* v. *Bowen*) brought by a coalition led by Representative Harley Staggers and Representative Claude Pepper, consumer groups and NAHC.

The successful conclusion of this suit gave NAHC the opportunity to participate in a rewrite of the Medicare home health payment policies. Just as a lack of clarity and arbitrariness had depressed growth rates in the preceding years, NAHC believes the policy clarifications that resulted from the court case have allowed the program for the first time to provide beneficiaries the level and type of services that Congress intended.

The correlation between the policy clarifications and the increase in visits is unmistakable. The first upturn in visits (25 percent) came in 1989 when the clarifications were announced; and an even larger increase took place (50 percent) in 1990, the first full year the new policies were in effect. However, growth in the number of visits is beginning to return to more modest levels.

Personnel shortage

Throughout much of the 1980s, the home care industry, along with the rest of health care, was suffering from a personnel shortage. Although there are still acute shortages of certain disciplines, it would appear that conditions have substantially improved. This increase in available staff allowed the number of certified home health agencies to increase from 5,676 in 1989 to 8,100 in 1995.

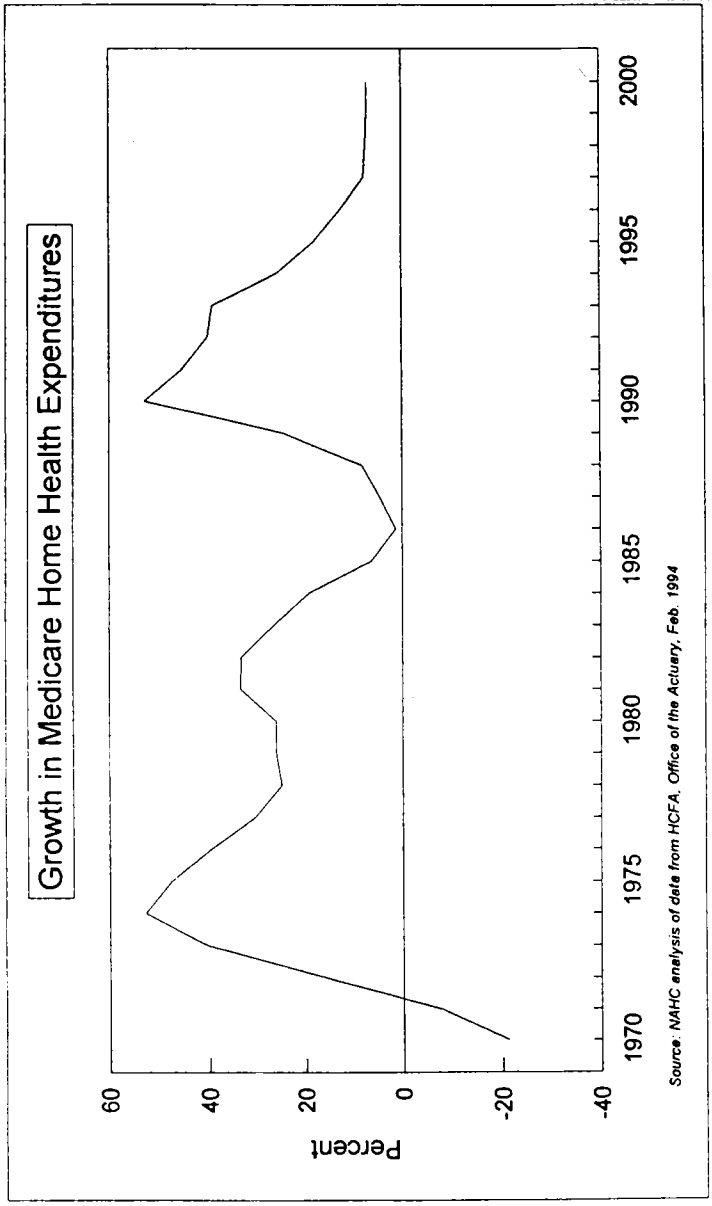
New legislative requirements

In the past five years, the home health program has seen the addition of several costly legislative changes, including the OBRA–87 home health aide training and competency testing requirements and the Clinical Laboratory Improvement Amend-

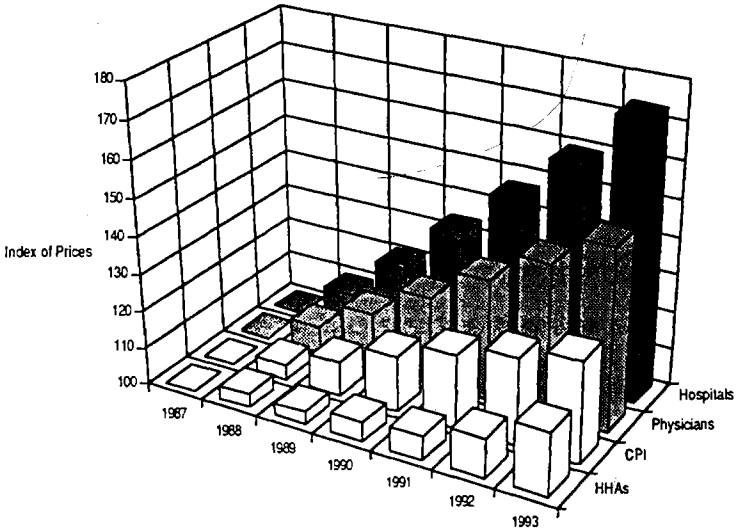
ments of 1995. The costs associated with these changes are reflected in visit charges.

New administrative changes

The 1992 OSHA mandate regarding employee protection from transmission of HIV and Hepatitis B, including employee vaccinations, is a cost that must be borne by employers.


Growth in Medicare Home Health Expenditures
Percent
60
40
20
0
-20
-40
1970
1975
1980
1985
1990
1995
2000
Source: NAHC analysis of data from HCFA, Office of the Actuary, Feb. 1994

NAHC Data Show that Home Care Is Still a Good Buy



Data collected from various sources and analyzed by NAHC show that from 1987 to 1993 the cost of living or consumer price index (CPI) increased by 27.1%, the cost of physician's services increased by 48.5%, and hospital costs soared by 73.4%. By contrast, home care costs increased by only 17% during the same period—about 60% of the increase in the CPI, and far below the rates of increase for other health care providers.

UNDERLYING FACTORS FUELING MODEST GROWTH

As mentioned above, the growth in the Medicare home health benefit is moderating and can be expected to fall to more modest levels in the next two years (i.e., to 7.8 percent by 1997). Sustaining this lowered growth rate are a number of underlying factors that have always influenced growth in home health utilization. Foremost among these is the pursuit of cost-effective alternatives to institutional care.

Cost-Effectiveness

Home health has moved well beyond its traditional boundaries, making it possible for millions of patients to prevent, reduce or eliminate altogether their need for more costly inpatient treatment. A number of studies have documented the ability of home care to hold down use of more costly care. For example:

A home health agency in Michigan has developed an in-home cardiac recovery program that reduces the hospital stay for patients who require coronary artery bypass grafting (CABG) surgery by 50 percent. The typical CABG patient requires six to ten days at a hospital. But with the in-home cardiac recovery program, these patients can be discharged within two days of surgery. With hospital charges averaging $1,756 per day, enormous cost savings can be achieved through a four to six day reduction in hospital care. In addition, the study found that CABG patients using home care experienced superior outcomes than those who received longer hospital stays but no post-surgical home care.

An in-home crisis intervention program developed for psychiatric patients has been effective in reducing hospital admissions, length of stay and readmissions. A two-year analysis, involving more than 600 patients, revealed the following findings: 80.7 percent of patients referred for hospital care could be treated at home instead; when inpatient admissions were necessary, the average length of stay could be reduced from 11.97 days to 7.48 days by adding elements of the in-home care program: and patients who received home care services were less likely to be readmitted for hospital care (11.8 percent of home care patients were readmitted compared to 45.9 percent of patients who did not receive home care services.

A study conducted by Lewin/ICF examined differences in the cost and effectiveness of inpatient care plus home care versus a shorter inpatient stay and more home care for patients hospitalized with a hip fracture, chronic obstructive pulmonary disease (COPD), and amyotrophic lateral sclerosis (ALS) with pneumonia. It found that for all three diagnoses, cutting inpatient days and substituting more home care days reduced costs by: $2,300 for hip fracture patients, $520 for COPD patients, and $300 for ALS patients.

An innovative home care program for patients with chronic obstructive pulmonary disease (COPD) that was developed and tested in Connecticut has produced significant cost savings. The overall goal of the program was to provide more comprehensive home care services to COPD patients who previously required frequent hospitalizations. The results found that the per-month costs for hospitalizations, emergency room visits, and home care fell from $9,836 per patient to $2,508 per patient, a savings of $328 per patient per month.

The American Diabetes Association has conducted research which shows that the total economic cost of diabetes is over $91 billion a year in the U.S. The home care component of these costs is only $37 million or just .04% of the total costs. Yet, studies have proven that aggressive long-term treatment of diabetes conducted in the home significantly reduces the risk of diabetic complications including blindness and kidney failure.

These studies highlight one of the primary reasons that home care will continue to be utilized in the future—it is a cost-effective benefit that works for millions of Americans.

An Aging Population

The fact that the U.S. population is growing older is a significant trend that has and will continue to influence future need for home health services. Older individuals are more likely to need home care and they are likely to use more home care services than younger individuals. For example, the National Medical Expenditures Survey found that individuals over age 85 were three times more likely to use home care as the general elderly population, and their resource consumption was also significantly higher. Individuals over age 65 used an average of 63 visits whereas individuals over age 85 used an average of 71 visits.

Improved Access

Access to in-home services has also improved over the years, as more home health agencies choose to participate in the Medicare program. In 1967, there were 1,753

agencies certified for Medicare purposes. By 1980, that number had nearly doubled to 2,924. As of January 1995, a total of 8,100 agencies were providing services under the program. This represents a marked improvement for enrollees' access to home-based services. Currently, there is one agency for every 4,893 Medicare enrollees, compared to one for every 11,136 enrollees in 1967. Although access varies somewhat from state to state, for the most part enrollees who need home health care now have access to it.

Public Awareness and Preference

The past decade has seen dramatic increases in awareness among physicians and patients about the home as an appropriate, safe and often cost-effective setting for the delivery for health care services. For example, a 1985 survey found that only 38 percent of Americans knew about home care; by 1988, over 90 percent of the public not only understood home care to be an appropriate method of delivering health care, but also supported its expansion to cover long-term care services as well. A new poll conducted in 1992 by Lou Harris and Associates, found that the American public supports home care by a margin of 9 to 1 over institutional care. Nearly 89 percent of all accredited medical schools now offer home health care in their curricula.

Technological Advances

Over the years, sophisticated technological advances have made possible a level of care in the home that previously was only available in hospitals and other institutions. The most significant of these advances have been the introduction of home infusion therapy and radical improvements in ventilator equipment.

Additional Factors

Litigation and workers' compensation claims are two additional factors that affect the cost of delivering home health services.

The Medicare home health program will serve an estimated 3.6 million beneficiaries this year, and expenditures are expected to reach $16 billion. That represents an average increase of nearly 23.5 percent a year in the past 28 years. Much of the increase can be attributed to one-time expansions or clarifications that were specifically designed to allow more individuals access to additional in-home services. Home health growth is beginning to moderate, and it can be expected to fall to more modest levels in the next two years (i.e., to 7.8 percent by 1997).

Sustaining this lowered growth rate are a number of underlying factors that have always influenced growth in home health utilization. These include increased pressure to find cost-effective alternatives to institutional care, a dramatic shift in the age distribution of the US population, improved access to home-based services, and the transfer of hospital technology to the home. These factors in combination with strong public preference for in-home care indicate a future of additional need for and use of home health care.

FRAUD AND ABUSE

As in any area, growth brings with it the potential for unethical or illegal behavior. NAHC strongly believes it is the responsibility of all parties involved—patients, payors, and providers—to act aggressively to uncover, report, and act against fraudulent or abusive home care providers.

The National Association for Home Care (NAHC) has taken a leadership role in combatting fraud and abuse. It has been engaged in a longstanding effort to maintain the highest degree of ethics and values in the health care industry through a combination of member education, cooperation with and assistance to enforcement agencies, and consistent support of federal legislative proposals designed to combat abuses in health care programs.

In January 1994, NAHC implemented a broad new policy governing member conduct. While America has enhanced home care as the site of choice for meeting its health care needs, the growth of the industry has unfortunately been accompanied by a few unscrupulous providers of care who seek only to profit illegally at public expense. The incidence of established fraud in home care services is low. However, even a single occurrence of fraud or abuse is not acceptable and it must be eliminated.

The principles of NAHC's policy are as follows:

I. POLICY ON MEMBER SELF-REGULATION

Where a NAHC member, agency, individual member, or an applicant for membership has been determined or is controlled by an individual who has been determined to have violated a criminal or civil law in either Federal or State Court on issues

related to fraud and abuse, the NAHC Board of Directors may consider the imposition of sanctions, including the termination or rejection of NAHC membership.

II. POLICY ON PUBLIC RELATIONS

NAHC shall respond proactively and reactively to any public relations crisis concerning fraud and abuse activity in home care and hospice.

III. POLICY ON EDUCATION OF MEMBERS

Consistent with its mission and commitment to provide educational opportunities for members, and for the purposes of promoting standards of quality and ethics in the delivery of home care and hospice services, NAHC will provide education regarding issues of fraud and abuse in home care and hospice.

IV. POLICY ON ENFORCEMENT

It is the responsibility of any NAHC staff person or any NAHC member to report to the appropriate legal authority any violation of fraud and abuse laws. No report shall be made by NAHC staff except where sufficient information has been obtained which demonstrates that there is a substantial likelihood that the law has been violated. Witnessing or having knowledge of a crime and not reporting it would constitute unethical behavior.

Generally, NAHC will not investigate suspected acts of fraud and abuse. However, when government enforcement officials fail to act to address flagrant violation of the fraud and abuse law. NAHC maw act in civil enforcement action where authorized by a super majority of the Board of Directors.

V. POLICY ON SUPPORTING FRAUD AND ABUSE LEGISLATION

NAHC shall actively support and/or initiate legislative and regulatory measures appropriate to prevent or combat fraud and abuse in the home care and hospice industries.

VI. POLICY ON REQUEST FOR ASSISTANCE

NAHC's assistance to member agencies under investigation for health care fraud and abuse shall be available where it is determined that it is in the best interests of the home care and hospice industry at large.

This policy is the embodiment of the efforts of NAHC since its inception in 1983. Its enactment in 1994 was an affirmation of NAHC's commitment to maintain a leadership role in this troubling area. Evidence of NAHC's commitment is most evident in support of legislative efforts to control fraud. In 1993 and 1994, and continuing today, NAHC has publicly supported and worked to advance legislation which would expand existing health care fraud laws under Medicare and Medicaid to all payors in health care. This expansion would work to eliminate activities which escape scrutiny because of the lack of controls in certain states which allow for conduct with private health insurance payments that would be illegal if federal payments were involved. NAHC has also aggressively supported the creation of a private right of action under federal anti-kickback laws to supplement the limited resources of government enforcement agencies. In this same respect, NAHC has repeatedly supported increased funding for the Office of Inspector General at HHS.

Legislation is also needed to control the quality and delivery of home infusion therapy services. This $3 billion segment of the home care industry operates under virtually no regulatory controls and presents an environment for improper, but not necessarily illegal, conduct to occur. In 1994, NAHC highlighted the need for controlling legislation such as that offered by Congressman Sherrod Brown in the so-called "Sarah Weber" bill.

Fraud has also existed within the Medicaid programs. The states' Medicaid anti-fraud units have proven success in attacking this area. NAHC has and continues to support the continuation of these programs.

Legislation alone cannot control fraud and abuse. Health care providers must have a comprehensive understanding of the standards of conduct that are allowable. Internal self-audit and self-enforcement must be done to minimize the risk of illegal activities. Over the past several years NAHC has provided extensive education on the issues involved in health care fraud. National workshops have been held at our regional conferences, annual meetings, and annual law symposiums. State home care associations have joined in this effort to extend this education to the greatest degree possible.

The public must also be fully involved in the process of fighting fraud. It is the health care consumer and the taxpayer who are ultimately the injured parties. While the government should increase the information it provides to the public about known schemes and scams, the health care industry must also do its part. In accordance with the NAHC fraud and abuse policy, the home care industry has

not only cooperated with media investigations but has worked to engage the attention of the media to focus on important areas of concerns. For example, NAHC played a crucial role in exposing issues of home care fraud to the public in a Business Week article in March 1994. (attached) Currently, NAHC is working with ABC News on a developing segment regarding home infusion therapy. NAHC believes that increased public awareness is a valuable means of oversight.

One of the most important roles that the home care industry plays in this area is actively integrating its knowledge and expertise with the enforcement authorities. Over the years, NAHC has acted as an extension of the investigatory arm of federal and state enforcement authorities. On the simplest of levels NAHC has connected individuals and providers of services who have evidence of fraudulent conduct with the HHS Office of Inspector General. At more involved levels, NAHC has presented a focus for enforcement authorities on where to commit resources in their home care efforts. For example, NAHC met with Inspector General June Gibbs Brown in April 1994 to outline several areas of concern. Specifically, NAHC suggested a sweeping effort to eliminate the abuses existing in the case of subcontracted care by home health agencies, particularly in South Florida. Growing evidence demonstrated the existence of illegal referral kickback's between Medicare-certified home health agencies and subcontractors, as well as, inadequate safeguards to ensure that billed care was delivered care. Further, NAHC described arrangements that had developed between hospitals and home health agencies where free discharge planning services were provided to hospitals in exchange for patient referrals. This is only one example of how NAHC has actively worked with enforcement authorities including the OIG, FBI, and the GAO. As a final note, NAHC has authorized staff to engage in self-enforcement activities under the False Claims Act to initiate litigation against health care providers where enforcement authorities have not acted to stop illegal activity.

Historically, fraud and abuse in health care has taken the form of false claims in Medicare cost reports, billings for services never rendered, and kickbacks for referrals. These types of fraud are now being replaced with an entirely different form of abuse found in managed care. While in the traditional fee-for-service system incentives exist for overutilization and overcharging. But managed care may create financial incentives to improperly underutilize care. The health care consumer is harmed doubly in these circumstances: financially, care is prepurchased but not delivered; and healthwise, necessary care is lost. NAHC strongly recommends that Congress and the enforcement authorities take a long hard look into the abuses in managed care. New strategies must be developed to address this new type of fraud. Clinicians, rather than accountants, will need to operate at the heart of this effort. Good managed care can help bring about economy and efficiency in health care. Bad managed care, controlled by financial greed, can mean the death of the patient.

RECOMMENDATIONS TO COMBAT FRAUD AND ABUSE

1. Enact all-payor anti-fraud legislation.
2. Provide a private right of action under anti-kickback provisions.
3. Offer "whistleblower" protection for good faith activities of information.
4. Institute an anti-fraud review system at OIG and DOJ where planned activities can be subject to analysis prior to implementation.
5. Commit adequate resources to develop expertise and strategic plans to combat improper underutilization within managed care.
6. Enact provisions to regulate home infusion therapy services.

PROSPECTIVE PAYMENT

Finally, I would like to make a few comments about a prospective payment system (PPS) for home health care. PPS would be one way to create incentives for cost-effective utilization management. For example, in a per-episode PPS model, providers would receive a single payment when a patient is admitted that would cover the entire episode of care rather than paying for individual visits when they occur. In this system, providers would have an incentive to manage utilization in the most cost-effective manner.

NAHC has long supported a fair and equitable PPS for home health, as long as it has been tested and proven to be an improvement over the current cost-based reimbursement system. To this end, we have been strong supporters of the HCFA demonstrations that would test PPS and the mechanisms within PPS to adjust payments for case-mix variation.

Now, however, we have some concerns about these demonstrations, for one, the demonstration as it is currently constructed, will not resolve the case-mix problems that have stymied the development of an acceptable PPS model. NAHC believes that

the demonstration should be reoriented to deal with these case-mix problems now rather than set aside and left for some later time.

NAHC has made a number of recommendations along these lines to HCFA, and we would appreciate any assistance that your committee could provide in urging HCFA to act on these recommendations (see attached letter to HCFA Administrator Bruce Vladeck).

Once again, thank you for the opportunity to testify on these important issues, and I welcome any questions you may have.

NATIONAL ASSOCIATION FOR HOME CARE,
WASHINGTON, DC.
September 23, 1994

Bruce C. Vladeck, Administrator,
Health Care Financing Administration,
Department of Health and Human Services
Attention: BDP–779–NC
P.O. Box 7517
Baltimore, MD 21207–0517

DEAR MR. VLADECK: I am writing to request a meeting with you to discuss plans for phase II of the home health PPS demonstration.

Our concern is that the demonstration will not resolve the case-mix problems that have stymied the development of an acceptable PPS model. Under the demonstration, PPS rates will be based on each agency's own costs during its base year. This is acceptable for a 3-year demonstration but not for an ongoing program. Although a year-end case-mix adjustment will be tested to take account of changes that may have occurred since an agency's base year, that adjustor has practically no predictive value. Its R-squared value is only 9.79 percent. This poor performance could be improved by the inclusion of additional variables. A model consisting of 40 some data elements has been developed that has been given high marks for its predictive power.

Indicative of the weakness of the system is the fact that the demonstration designers have found it necessary to protect participants against 99%, 98% and 97% of any losses in demonstration years one, two and three respectively.

It seems to us that the demonstration neither satisfies the mandate in OBRA–90, which calls for the development of a new payment system, nor the widespread desire to find a cost-effective alternative to cost reimbursement. NAHC believes that the case-mix problems should be dealt with now rather than set aside and left for some late time—presumably 5 years or so from now when the current study is completed.

While we made our concerns known when we first learned of the design of the demonstration last month at an industry briefing and have subsequently offered to discuss the matter further, we have now reached a point where we are concerned that we may be running out of time. Home health agencies will be recruited to participate in the demonstration in the near future.

If you would like to have any additional information, please call me or Bob Hoyer, our Vice-President for Public Policy and Research.

Sincerely,

VAL J. HALAMANDARIS,
President.

SOCIAL ISSUES—INVESTIGATIONS

IS FRAUD POISONING HOME HEALTH CARE?

CRITICS SAY LAX REGULATIONS ALLOW OVERCHARGING AND ABUSE

Tom Henry had a good thing going. By padding bills for services provided through six home health-care agencies he owned in Lebanon, Tenn., he easily collected more than $4.4 million from Medicare and Medicaid over four years. Henry spent much of the money on a new home, cars, and lavish toys, including furs for his wife, a jaunt with friends to Cancún, and a trip to Hollywood to appear on *Wheel of Fortune* (he lost). Henry was finally caught and convicted of fraud in 1992, after his schemes became too blatant to escape the notice of insurance investigators, who alerted federal authorities.

The case of Tom Henry is only one of countless instances of fraud and abuse plaguing the rapidly expanding $31 billion home health-care industry. Most are

purely financial rip-offs, such as one involving a Florida man sent to prison on Feb. 14 for, among other things, billing Medicaid for home care rendered to three people who turned out to be dead. But other crimes involve willful actions of neglect, abuse, and incompetence that jeopardize the lives of the aged and ill people receiving care at home.

Among the myriad scams already uncovered:

• Kelly Kare, a home-care company in New York, sent "untrained, unqualified, and unlicensed workers" to care for sick and elderly patients. Their competence was so lacking that one client, Ronald Callahan, had to have his sister teach his alleged nurse how to catheterize him. By the time Kelly Kare's owner was convicted, she had billed New York Medicaid more than $1.1 million for fraudulent services.

• In Miami, a network of eight companies is charged with offering milk supplements and nutritional therapies free to health consumers who didn't need them. The companies then allegedly billed Medicare $14 million, claiming that the products were medically essential. This case, pending in federal court, sparked 14 probes nationwide into similar scams.

• Robert Desrochers, the owner of two home health-care agencies in Alhambra, Calif., paid the salaries of discharge planners at 10 hospitals as part of his service as long as they sent patients to his agencies. He then shifted that cost, among others, to Medicare. He was convicted of fraud last year. Prosecutors say his scheme is not unusual.

Problems in the industry are not limited to newly formed companies or fly-by-night operators. Some of the largest companies in the industry, such as Caremark International Inc. and T2 Medical Inc., are under federal investigation for alleged kickback schemes. Hospital Staffing Services Inc., based in Fort Lauderdale, Fla., is being probed for its Medicare billing practices. All three companies deny wrongdoing.

"Next Frontier." Predicting how much fraud and abuse costs consumers is tricky. One congressional estimate puts it at 10% of total expenditures, or $3.1 billion. If the current level of malfeasance continues, experts say, it could wipe out some of the anticipated savings from caring for patients outside hospitals. "Home health care is the next major frontier for fraud and abuse," says Edward J. Kuriansky, New York Deputy Attorney General and special prosecutor for Medicaid fraud. "We've just scratched the surface."

Of course, instances of criminal conduct occur in other segments of the health-care industry. But the nature of home care makes it uniquely susceptible. In hospitals, doctors, nurses, and administrators all monitor the quality and cost-effectiveness of care patients receive. But home care is largely unsupervised. With ill-defined or nonexistent pricing guidelines, poorly conceived federal regulations, and a patchwork of uneven state and local laws, the home-care industry is primarily accountable to itself.

Though the industry has tightened its standards, the guidelines have little or no effect on the thousands of home-care companies that don't belong to the trade groups. And federal investigators are far too understaffed to meet the growing caseload. "We've only been dealing with the most blatant cases because of the lack of manpower," says Jeanne K. Damirgian, an assistant U.S. attorney in Miami. "Only now are we moving into more sophisticated schemes."

The fraud epidemic comes at a time when the industry is experiencing exponential growth. More than 7.1 million people are expected to receive some care in their homes in 1994. That's up from 5.9 million in 1987, the industry's trade group says. Home care, which provides the services of nurses and aides, and home infusion therapies, which include delivery of drugs intravenously, are expected to grow 35% in 1994, according to the Commerce Dept.—three times faster than the rest of the healthcare industry. The other industry segment, durable medical equipment, such as oxygen tanks and wheelchairs, is also growing fast.

The federal government is picking up a sizable percentage of the tab. Medicare and Medicaid expenditures for home care ballooned to $18 billion last year, from just $8 billion in 1990, according to Home Health Line, an industry newsletter. The Health Care Financing Administration, which manages Medicare expenses, predicts a 166% increase in its home-care spending by 1996.

The boom is being fueled largely by the perception that home care is less costly than more traditional venues. A 1991 industry study compared the average cost of treatment in hospitals with treatment in the home for patients with hip fractures, a common ailment treated through home care. It found that by sending patients home six days earlier than normal, $2,300 was saved. That translates into an annual savings of $575 million to Medicare, the study showed.

Such savings, coupled with pressure from insurers to cut costs, is compelling hospitals to release patients sooner. And advances in treatments and technologies have

made it possible to provide sophisticated care, such as chemotherapy and respiratory therapy, almost as easily in living rooms as hospitals.

MANY LIMITS. Perhaps nothing has done more for the industry's bullishness of late than the Clinton Administration's plan for health-care reform. Clinton's proposed package specifically calls for universal coverage of short- and long-term home care. Many insurance companies now offer only limited home-care coverage—or none.

Since Clinton's election, Health Force, an owner and franchiser of nursing and home-aide agencies based in Woodbury, N.Y., says that responses to its newspaper ads seeking franchisees have more than doubled to as many as 125 per week. In Louisiana, the number of Medicare-certified homehealth agencies jumped from 270 to 442 in 1992. Growth has been so rapid that Louisiana, along with other states, has placed a moratorium on the opening of new agencies.

Amid the home-care industry's explosive growth, critics are calling for stepped-up enforcement and better guidelines to regulate providers. Although Congress attempted to make some fixes in 1987 by establishing training standards for home health aides and a national hot line for consumer complaints, abuses have proliferated. "There are so many pieces of home care," says Charles P. Sabatino, assistant director of the American Bar Assn.'s Committee on Legal Problems of the Elderly. "Some are state programs. Some are Medicare. There is licensed, unlicensed, and hightech home care. And there is no comprehensive approach to accountability."

A look at the regulatory landscape makes that all too clear:

• Only seven states regulate home infusion as a distinct industry, leaving this segment most open to rampant wrongdoing, experts say. "The regulatory environment for these services is a little bit like Dodge City before the marshals showed up," said Representative Ron Wyden (D–Ore.) at a hearing last May.

• Virtually no state or federal licensing requirements exist for the 10,000 companies providing durable medical equipment. Although the industry's trade group, the National Association of Medical Equipment Suppliers, imposes standards on its members, only 20% of the businesses belong to the group.

• For the nursing and home-aide agencies, 10 states and the District of Columbia lack special licensing requirements, though certification through a series of inspections is needed to participate in Medicare and Medicaid. Laws that are in place lack consistency in standards, training, or licensing. Independent providers, which make up $3.5 billion, or 17%, of the home nursing business, operate largely outside any regulatory framework. And no federal law requires these agencies to check whether job applicants have criminal records.

Certainly, the concept of home health care is sound and, when implemented correctly, comparatively economical. And the majority of home-care providers do deliver exemplary services. Industry leaders and trade groups have taken it upon themselves to devise rules aimed at ensuring high-quality service. Olsten Corp., based in Westbury, N.Y., the largest provider of nurses and aides for the home, spends close to $2 million annually on compliance programs, which include a criminal background check on job applicants.

But Olsten and some other companies stop short of suggesting that their self-policing mechanisms be applied to the industry at large. Instead, they prefer to rely on a competitive marketplace to wipe out malfeasance.

ETHICS CODE. Trade groups, including the National Association for Home Care, strictly scrutinize their members and have been pushing to expand government oversight. In addition to abiding by Medicare regulations and state laws, members must get the blessing of the Joint Commission on Accreditation of Healthcare Organizations or a similar accrediting body. For accreditation, members must meet stringent standards, including a requirement of 75 hours of training for home-care aides, continuing education for nurses, and agreeing to abide by an ethics code. But these moves only go so far. The standards affect only association members—allowing independent operators to play by their own rules.

So, legislators are readying another try. One bill, scheduled to be introduced in March by Representative Sherrod Brown (D–Ohio) and Senator Howard M. Metzenbaum (D–Ohio), would set limits on prices home infusion firms can charge for their products, establish quality standards for the industry, and require federal licensing. The measure in part responds to protests about extreme disparities in prices for drug therapies offered by home infusion companies. For example, 500 mg of Neupogen, an anti-infection drug, can cost from $266 to $1,128, according to Principal Mutual Life Insurance Co.

THE PRICE ISN'T RIGHT

RANGE OF COSTS FOR DRUGS CHARGED BY HOME-INFUSION COMPANIES *

* Charges include certain overhead costs such as delivery and mixing of drug compounds

- Ganciclovir (480 Milligrams) Used as antiviral treatment for AIDS $150 to $800
- Neupogen (500 Milligrams) Anti-infection drug $266 to $1,128
- Pentamidine (300 Milligrams in syringe) Antipneumonia drug $180 to $450
- Gammagard (23 Grams) AIDS treatment to boost immune system $1,100 to $3,300
- Rocephin (2 Grams) Treatment for Lyme disease $147 to $384
- Zinacef (1.5 Grams) Treatment for various infections $135 to $338

C.A. Piccolo, CEO of Caremark, the largest provider of home infusion therapies, concedes that legislation needs to address "escalating costs." But he adds that prices for home-infusion drugs appear high because they reflect numerous overhead costs that must be included in drug charges to get reimbursement from insurance companies. "Insurers won't reimburse us as a line item for services," he says. "They insist that we factor it into the cost of the product."

Another bill, sponsored by Representative Charles E. Schumer (D–N.Y.) would increase funding for health-care fraud investigators as well as provide stiffer penalties for offenders—especially in cases resulting in injury or death to patients. Resources available for uncovering health-care fraud are woefully inadequate. The number of inspectors with the Office of the Inspector General of the Health & Human Services Dept. has been cut to 249 from 298 since 1989, while workloads have multiplied.

On the local level, New York's Erie County set up an employment registry this year to track home-care workers who have criminal records or other troubling pasts. The law was adopted after local police reported a spike in complaints of abuse against senior citizens by home-care workers, including one of an 82-year-old blind woman with Alzheimer's disease who was so badly beaten that her ribs were broken. Other patients were persuaded to transfer bank funds to their caretakers or open credit-card accounts for them.

In the private sector, insurance companies have launched their own crackdown. They more frequently decline to pay bills as submitted, citing unsubstantiated or inflated claims. Principal Mutual is demanding more proof that services billed for were actually delivered and necessary. At Northwestern National Life Insurance Co., a full-time investigator has been assigned solely to reviewing bills submitted for home nursing services.

HUGE BILLS. Perhaps nothing illustrates the potential perils of home care better than the story of Sarah Weber, a little girl in Cleveland Heights, Ohio, who suffered from cerebral palsy. From the age of 5 until her death last July at age 10, Sarah was able to live at home with the help of intravenous drugs and nutritional therapy.

In congressional hearings last May, Sarah's mother, Marie Kostos-Weber, testified that Sarah's bills for her extensive treatments ranged from $95,000 to $120,000 a month—an amount that ate up the family's $1 million private insurance policy limit in less than a year. She stated that after checking with a health-care consultant, she estimated it cost close to $1,000 a day more to treat Sarah at home than in the hospital. When her insurance lapsed, it took a court order to prevent Critical Care America Inc., Sarah's home-infusion provider, based in Westborough, Mass., from cutting off Sarah's supply of medicine, according to congressional records.

But Sarah had other problems. According to a lawsuit Kostos-Weber filed last September against Critical Care, which alleges overcharging and poor quality of care, she contends that the company mistakenly delivered a lethal dose of the wrong drug for Sarah's intravenous therapy. Fortunately, Kostos-Weber caught the mistake, she says. But when she tried to complain to the state health department, she was referred to the Attorney General's office, which in turn referred her to the National Alliance for Infusion Therapy, an industry lobbying group based in Washington. "There was no one to turn to," says Kostos-Weber. "This is a totally unregulated industry. The health department didn't even know what infusion therapy is." Critical Care, which was recently acquired by Caremark for $175 million, declined to comment on the pending litigation except to say that it "will vigorously defend itself."

It's clear that as health care moves further into the home, it is bringing a whole new set of problems for providers, insurers, regulators, and consumers. Although greater regulation is essential, lawmakers must be careful not to overregulate. According to a yet-to-be-released study by the George Washington University Health Policy Project, North Carolina, Virginia, and Minnesota have come up with the best

regulatory mix. Their laws defining home-health agencies are flexible enough to make most services fall under some regulation. The marketplace, too, will impose more scrutiny and reform, and industry trade groups are trying to improve quality.

CASE MANAGERS. Experts say one of the most effective ways to curtail abuses is to increase the role of doctors. "If there is a power broker in home health-care services, it's the doctor," says William Dombi, director of the Center for Health Care Law in Washington, D.C. The American Medical Assn. has advocated using doctors as case managers for home health-care services. That position is backed by an independent study Aetna Life Insurance Co. concluded in 1993. It found that more physician involvement would curb abusive practices. It noted that in many cases it reviewed, doctors had not even seen the patients for whom they were prescribing treatment.

As the law stands now, doctors have little incentive to take a hands-on approach to home health care. They are not paid by insurers for work relating to home health-care planning.

The eventual shape of health-care reform will likely have the greatest impact on the industry. The Clinton plan does include new criminal penalties for bribes and kickbacks in the home healthcare industry as well as tougher civil penalties for falsified billing claims. But these provisions—though they go a long way toward separating the good from the bad players—are only a starting point. The architects of health-care reform must address all the present-day abuses and problems before they inadvertently create a whole host of new ones for the future.

WHO'S BIG IN HOME CARE

1993 TOTAL REVENUES

Home Nursing and Aids—$21 billion
- Olsten, Westbury, N.Y.
- Interim Healthcare, Fort Lauderdale, Fla.
- Visting Nurse Services of New York, New York City

Durable Medical Equipment—$6 billion
- Homedco Group, Fountain Valley, Calif.
- Abbey Healthcare Group, Costa Mesa, Calif.
- Lincare, Clearwater, Fla.

Home Infusion Therapy—$4 billion
- Caremark International, Northbrook, Ill.
- T2 Medical, Alpharetta, Ga.
- Medical Care America, Dallas

MOST COMMON FRAUDS IN HOME CARE

Phantom Services—Charges assessed for services never rendered or visits never made by nurses or aides.

Padding Bills—Home health-care providers include improper overhead expenses in their charges for nursing or drug-therapy treatments. Also, home aides are billed out at rates for registered nurses.

Telemarketing/Door-to-Door Schemes—Home nursing and durable medical equipment agencies offer "free" services or equipment to consumers in order to get their Medicare billing numbers, which are then used for fraudulent billings.

Kickbacks—Doctors, social workers, and hospital discharge planners refer patients to agencies in exchange for payments.

[Due to the high cost of printing, the attached material has been retained in the subcommittee's files.]

Mr. SHAYS. Thank you. Dr. Wilensky.

Dr. WILENSKY. Thank you, Mr. Chairman, and members of your subcommittee, for inviting me to appear before you. My name is Gail Wilensky, and I am currently a senior fellow at Project HOPE, which is an international health education foundation. I was formerly an administrator at a health care financing administration during the Bush administration. I am here today, however, representing only my own views.

I know that the focus of today's hearing is on the potential for administrative savings for Medicare, HCFA and HHS in general. I would like, in part, however, to focus on some of the broader issues

of how Medicare can be changed so as to resolve some of the financial problems facing Medicare, and do so in ways that support and augment those occurring in the private sector. But I will have a few comments to make, and will be glad to respond to questions about other administrative savings from HCFA or HHS.

Medicare has some major weaknesses and is in serious need of reform. I say that not as a HCFA basher—I'm very proud of having been the administrator—but in recognition of where we are today. The most significant problems concern the financing of Medicare, and they are both short-term and long-term problems. In the short term, the increased spending on Part B, which is funded by the general fund, represents a major drain in the budget and therefore, increases the deficit.

And in the long term, the trust fund is going bankrupt—2001 is the current forecast. And therefore, there are serious questions about the financial liability of Medicare in designing a program that will be sustainable in the 21st century. At a time when spending in the private sector appears to have slowed dramatically, spending for Medicare continues in double digits, low double digits, but double digits, nonetheless. Between 1983 and 1991, Medicare had a better rate in cost control than did the private sector.

Mr. SHAYS. I'm sorry.

Dr. WILENSKY. Than did the private sector.

Mr. SHAYS. It had a better rate.

Dr. WILENSKY. It had a better rate of cost containment. It grew slower in Medicare than in the private sector. But that changed in 1991. From 1991 to 1993, Medicare spending per capita, in real terms, grew 6.5 percent versus 4.7 percent growth in the private sector—about a 50 percent increase in the rate of spending in real terms per person covered in Medicare, relative to the private sector. And in the year since those figures, 1993 to 1994, Medicare grew at least twice as fast as health care spending per capita in the private sector.

Medicare continues to be a fee-for-service program, despite the fact that there are enormous changes going on in how health care is organized and delivered in the private sector. And it has represented both the limited availability of, and participation in other organizational structures involved in health care. There are about now 2.5 million beneficiaries in HMOs, representing a little more than 6.5 percent of the population.

And while the growth has been quick in the last year or two, it still represents a very small part of the Medicare population. Now, there are several reasons why you see this very small population in managed care. In the first place, Medicare subsidizes the main competitors to HMO, which is fee-for-service medicine. And it does so implicitly because most of the increase used in the health care services that comes from eliminating Medicare's cost sharing is paid for by Medicare.

That is, Medicare pays dollar for dollar in Part A, and 80 cents on the dollar in Part B for increased use. In addition, there have been some questions about whether Medicare pays the right amounts for HMOs. There appear to be some inadequate adjustments for risk selection, which has produced overpayments in some cases and underpayments in other cases.

There also appears to be a lot of variation in terms of payments between counties and in payments over time. But the biggest deterrent has been in the very limited number and types of HMOs and other managed care options that are available to the elderly. Medicare Select, a PPO offering, was only available in 15 States, and only for 3 years. Point of service plans, which are very popular because they're a network that people can opt out of when they want to see a physician that's not part of the network or go to a facility, are not allowed in Medicare.

Risk-based carve-outs, that is negotiated prices to take care of high-cost or high-volume procedures like heart bypass procedures, are not allowed, except on a demonstration basis in Medicare. HMO group-only contracts, which would allow employers to continue in covering their employees when they become 65, in a managed care, are not allowed under Medicare rules.

If Medicare is to significantly increase its managed care enrollment, it has to make available more varied and flexible options. But it also has to do more than just make them available. You have to change the incentives as well. It seems to me that we have a number of goals that we ought to keep in mind when we go about making changes: increasing consumer choice for the elderly; providing incentives for accessible, high-quality, patient-oriented care; encouraging cost-conscious behavior by the elderly, as well as the people they see; and incorporating some of the innovative, cost-reducing delivery system reforms that have been occurring in the private sector; and last but not least, laying the groundwork for a fiscally solvent Medicare program for the future.

In order to do that, we'll have to change the basic incentive structure, open up the options available, provide the elderly with the information needed to make sure that they make appropriate decisions for themselves. There is little incentive right now for an elderly person to seek out cost-effective physicians or hospitals, or to use lower-cost durable medical equipment, laboratories, home care, or out-patient hospitals.

And there's very little reasons for hospitals or physicians to provide the most cost-effective health care they can. They do not get rewarded if they do so. We need, ultimately, to reward the elderly for choosing more cost-effective plans, to provide incentives for physicians and hospitals to order and prescribe cost-effective health care, and be willing to share the savings which an aggressive reorganization of health care can produce.

I think the way to start is to use the payment mechanism that is now used for HMOs, which is called an AAPCC, or an average adjusted per capita cost. That could become the basis of some sort of a certificate, or what we in the 1980's sometimes call vouchers, to encourage cost-effective choices. We need to redesign this AAPCC, make it more stable, do a better job of accounting for risks, and open up the choices to which the payment can be made.

Ultimately, it may be appropriate or desirable to vary the payment with income or wealth, but you don't have to make that decision now. That's something that a future Congress can think about. There are some very specific changes to the Medicare program, I think, that this Congress has to think about—making sure that

PPOs, our so-called Medicare Select program, is available to people in all States. It's a very timid change, but the least to start with.

Allow point of service plans to be offered to the elderly if they want to choose them. Allow for these partial capitation plans, or these carve-outs, they're sometimes called, for oncology or for diabetes care or for other types of care. Refine and revise the capitation rate. Don't have it linked to fee-for-service spending in Medicare; that makes no sense. Experiment with setting the level by a competitively bid level or some other way from the one that is now used.

Try to use other calculations of the capitation payment for areas that can't have competitive bids because they're too small. Use an annual enrollment period for all people on Medicare. The 30-day enrollment/disenrollment period that now exists encourages churning. It encourages bad behavior on the part of the plans and on the part of the elderly. Get rid of the 50–50 rule that was put in place to protect the elderly, by saying there could be no more than 50 percent Medicare beneficiaries, and go to more direct measure of consumer satisfaction and outcomes.

It's a lousy way to have a proxy for quality, and it discourages growth in high Medicare areas. And let HMOs and fee-for-service price underneath the Medicare payment if they want, and share the savings with the elderly. These kinds of changes would substantially increase the availability of more flexible types of health care for the elderly. They would take care of some of the provisions that inhibit the growth of managed care and replace them with more direct measures and some incentives to choose more cost-effective health care plans.

To the extent that you set the Medicare payment at the level of the lowest cost plan in an area, you will encourage the elderly to choose more cost-effective health care plans, which may or may not turn out to be managed care plans. That will be as it is. There are some specific administrative issues that I think you need to consider. One has to do with how you set the payment for HMOs.

There's a recent study that got a lot of publicity that Mathematica Policy Research put out, saying that Medicare paid too much to HMOs for the elderly. Now, there's a lot of debate about whether that was an accurate assessment. And there is also debate about whether or not savings from HMOs can continue over time, or whether they're just a one-time savings.

We'll know more in the next couple of years, because of the enormous growth in the private sector, about whether they can continue saving over time. In my view, there is no question that risk-based plans can save money. They fundamentally change the incentives facing providers of health care services. And to the extent that Medicare hasn't achieved savings, it's because they haven't come up with the right pricing strategy or other administrative problems.

We need to spend a little more time learning how to adjust for risks. But if you choose the 30-day enrollment/disenrollment, you will stop the churning. And that is an easy change to make. To the extent that you increase the use of risk-based plans, you'll also lower the number of specific claims that are made to HCFA, and

that will lower some of the administrative costs. Although it won't be a big savings.

Another kind of administrative savings would be the use of regional carriers for clinical lab payments. And I raise this because I pushed very hard to go to regional carriers for durable medical equipment as a way to reduce fraud and abuse. When this only represents 5 percent of a payment of a Part B payer, which was true for durable medical equipment, it's easy for fraud and abuse to slip through.

And the same is true for clinical lab payments. If you concentrate the claims in a few number of carriers who do nothing else but worry about clinical lab payments, they will be able to spot probable fraud and abuse, and it will also save a little bit of money. But you really need to be careful right now because of the interest in Congress to save money, to make sure that the kinds of savings you make in Medicare don't push you in a direction which is inconsistent with the reformed Medicare structure.

Some will move in the right direction and some won't. And let me give you a couple of examples. If you were to add a 10 percent coinsurance for home health, or a fixed copayment for rehabilitation hospital admissions, both of which are areas which have shown enormous increases in the 1990's—40 and 50 percent growth rates during some years—you would raise some additional revenues; you would lower utilization in these areas; and you would make managed care plans that tend to include them as part of the package price more attractive.

Bundling acute care services, which was mentioned, capitating those parts of Part A which are outside of DRGs, would also have the incentive of having more cost-containment in those areas, and make managed care plans tend to cover those components more attractive. If you reduce payments to indirect medical education or direct medical education, which is also being considered, as it has been every year, you will affect academic health centers and teaching hospitals, but you will not have an effect on moving to a more choice-based system of Medicare. It will be indifferent with that regard.

But if you take out very large reductions in overall physician fees, for example, you could lead physicians to try to compensate with additional volume increases, which would mitigate some of the savings and exacerbate the divisions between fee-for-service and at-risk medical practice. So how you go about accommodating the need for short-term revenue increases while setting the stage for more fundamental change in the incentives, information and options that are needed to reform the Medicare program, is something that you need to consider jointly.

It will take some time to realize the gains from restructuring and reforming a Medicare program. And because of that, it's important to start making these broader reforms, while you're on the lookout for more savings, as soon as possible. To my mind, this session of Congress is none to soon to start. Thank you.

[The prepared statement of Dr. Wilensky follows:]

PREPARED STATEMENT OF GAIL R. WILENSKY, SENIOR FELLOW, PROJECT HOPE

Mr. Chairman and members of the subcommittee, thank you for inviting me to appear before you. My name is Gail Wilensky. I am a senior fellow at Project HOPE, an international health education foundation, and a former Administrator of the Health Care Financing Administration during the Bush Administration. However, I am here today representing only my own views on Medicare and my testimony should not be regarded as representing the position of Project HOPE or any other organization.

I recognize that the focus of today's hearing is on the potential for administrative savings from Medicare and the Health Care Financing Administration. My remarks, however, will focus on the broader issues of how Medicare can be changed so as to resolve some of the financial problems facing Medicare and how to do so in ways that support and augment changes that are occurring the private sector. I will also comment on a few administrative changes that could provide some modest savings.

THE NEED FOR REFORM

Medicare has some major weaknesses and is in serious need of reform. The most significant problems concern the financing of Medicare, which pose both short term and long term difficulties for the program. In the short term, Medicare Part B represents a major drain on the budget and therefore exacerbates the deficit. In the longer term, Medicare is not financially viable and its future insolvency raises serious questions about the design of a program that will be sustainable in the 21st century.

At a time when spending in the private sector appears to have slowed dramatically, the increase in spending for Medicare continues in double digits. Between 1983 and 1991, Medicare spending grew more slowly than did the private sector. (See Chart 1). But since 1991, Medicare has grown substantially faster than spending in the private sector, 6.5% versus 4.7% growth in real spending, per capita. The differential in spending growth between Medicare and the private sector for the 1993–1994 period is at least two-fold, according to the Congressional Budget Office, although much of the data for this period remains preliminary.

PRESENT STRUCTURE OF MEDICARE

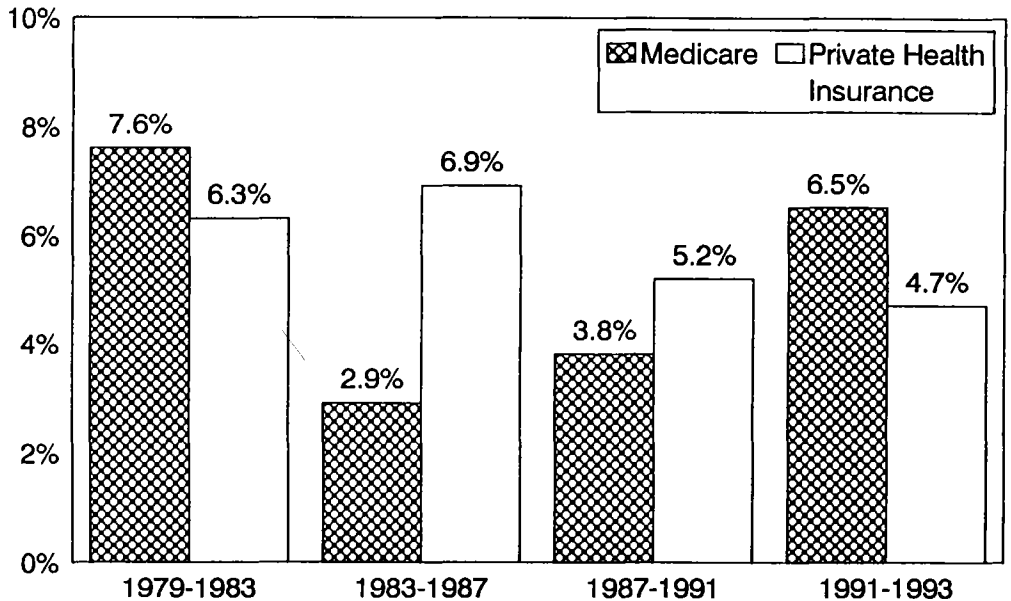
Despite all of the changes occurring in the private sector, Medicare continues to remain a fee-for-service program, with limited availability of and participation in managed care. The projections for 1995 indicate an expected enrollment of 2.5 million beneficiaries in HMOs, representing 6.6% of all enrollees (See Chart 2). The enrollment in HMOs has grown rapidly over the last few years relative to the non-Medicare population (Chart 3), but that is because the HMO-enrolled Medicare base was so small.

There are several reasons that explain the low managed care population in Medicare. First, Medicare subsidizes the main competitors to HMOs. Fee-for-service Medigap is implicitly subsidized, since most of the increased use in health services that comes from eliminating Medicare's cost-sharing is paid for by Medicare. Employer provided supplemental insurance is also subsidized because it is provided tax-free to the beneficiary. In addition, there have been problems with Medicare's payments to HMOs. Inadequate adjustment for risk appears to have produced overpayments to some HMOs, and probably underpayments to other HMOs as well. However, this is more of a problem for HCFA, and explains why to date there appears to have been little savings associated with the HMO growth, although that finding has been subject to some dispute. Of greater relevance is the substantial variation in payment levels between counties and the substantial variation in payment levels from year to year. In addition, questions have been raised about the accuracy of HMO payments in terms of its component measurements, and about the effects of having a large HMO enrollment in the non-Medicare population on spending in the Medicare population.

What is probably the most significant deterrent to managed care growth, however, is the limited types of non-HMO managed care options that are currently available to the Medicare population, the very population that most needs and probably most desires flexibility. Medicare Select, a PPO offering, was limited to offerings in 15 states, with a three year sunset provision. That authority is in the process of being renegotiated, but its need for reauthorization reflects the difficulty that managed care plans have had within the Medicare framework. Point-of-service plans, which allow patients to opt out of their network and choose other physicians or facilities, are not currently allowed. Risk based "carve-outs," like the package price heart bypass demonstration, are also not allowed except on a demonstration basis. And

Chart 1

Real Change In Medicare Expenditures Per Enrollee and Private Health Insurance Per Member, 1979-1993 (In Percent).

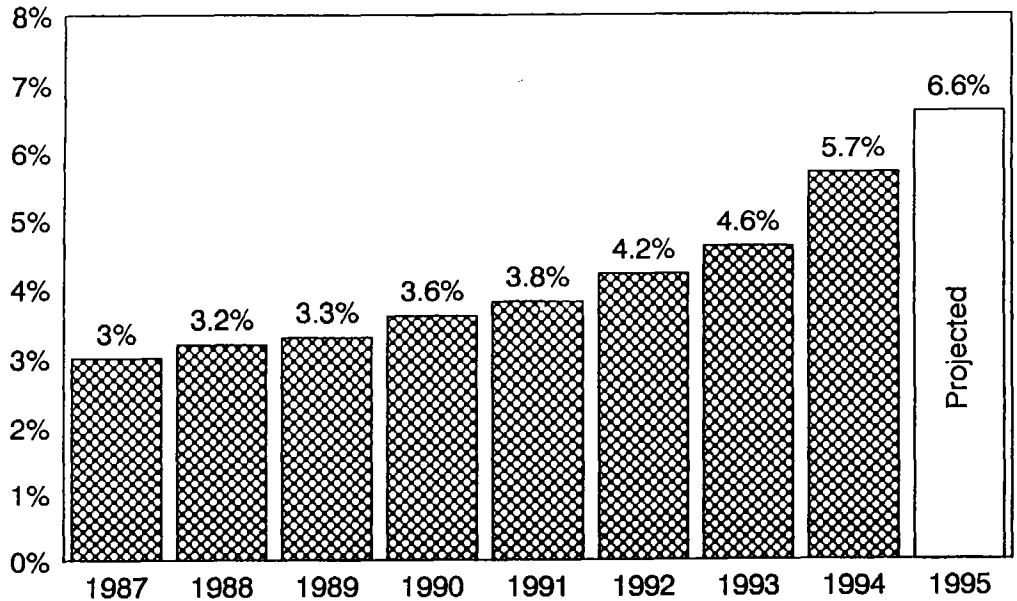


Source: ProPAC analysis of data from HCFA, Office of the Actuary.

Chart 2

HMO Growth

Percentage of People Eligible for Medicare Enrolled in HMOs

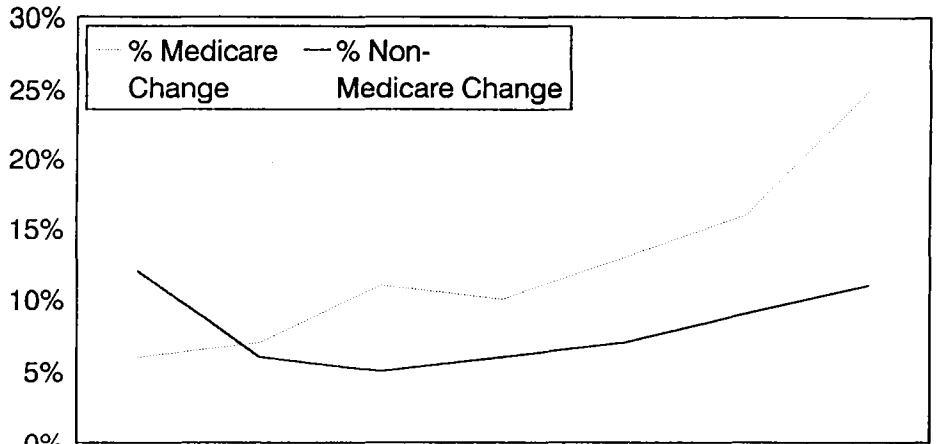


Source: New York Times.

Chart 3

Relative Growth In HMO Enrollment

Medicare (Risk HMOs) and Non-Medicare Populations



	1988	1989	1990	1991	1992	1993	1994
% Medicare Change	6%	7%	11%	10%	13%	16%	25%
% Non-Medicare Change	12%	6%	5%	6%	7%	9%	11%

Source: HCFA OMC; Group Health Association of America.

HMO group-only contracts, which would permit employers to establish an HMO/CMP plan which enrolls only their own retirees who are Medicare beneficiaries, are also not allowed.

If the Medicare program is to significantly increase its managed care enrollment, the first requirement must be to make available the more varied and flexible options that have been and are in the process of being developed in the private sector. But availability will probably not be sufficient. In order to see substantial growth in managed care, it will also be necessary to change the incentives facing the elderly.

GOALS AND STRATEGIES FOR A REFORMED MEDICARE PROGRAM

Changing a popular program is always difficult, and changing a popular program involving the elderly is especially difficult because change raises fears and concerns about the future. The income of the elderly has generally been determined by past actions and can not easily respond to new incentives or rules. This means we had better be clear about our goals for a reformed Medicare program and our strategies for accomplishing the goals. These goals should include at least the following:

increasing consumer choice for the elderly;
providing incentives for accessible, high-quality, patient-oriented care;
encouraging cost-conscious decision-making by the elderly;
incorporating the innovative, cost-reducing delivery system reforms from the private sector into the Medicare program;
laying the ground work for a fiscally solvent Medicare program.

To achieve these goals it will be necessary to change the basic incentive structure associated with Medicare, open up the options available to the elderly and provide them with the information needed to make choices appropriate for each individual. Currently, there is little incentive for an elderly person to seek out cost-effective physicians or hospitals, or to use lower cost durable medical equipment, laboratories, or outpatient hospitals. And similarly, hospitals and physicians have little reason to provide the most cost-effective care if there is any medical gain to be had from providing more services, and some reason to fear legal repercussions if they do less than they might have done and the patient has an adverse outcome. Ultimately, we need to reward the elderly for choosing more cost-effective health care, to provide incentives for physicians and hospitals to order and prescribe cost-effective medicine, and to be willing to share the savings which an aggressive reorganization of health care can produce.

I believe that the use of a better designed Adjusted Average Per Capita Cost (AAPCC) payment, the payment currently used for HMOs, could become the basis of a voucher or Medicare certificate which would encourage cost-effective choices. In order to make this transformation, it would be necessary to redesign the determinants of the AAPCC to make it more stable and to take better account of the risk selection that appears to occur, as well as open up more choices toward which that payment can be made. Ultimately, it may be appropriate or desirable to vary the amount of the payment with the income and/or wealth of the elderly person, thus transforming Medicare into an income-related voucher or payment, but that is a decision that need not be made in 1995. Some specific changes that I would recommend would include the following:

Allow Medicare Select, the preferred provider payment system, to be available in all 50 states.

Allow Point of Service plans.

Allow partial capitation or risk-based "carve-out" plans.

Refine/Revise the capitation rate.

Break the link to fee-for-service spending;

Experiment with basing Medicare's contribution to the premium on a competitively bid level; use this amount for Medicare's contribution for fee-for-service plans as well.

Experiment with alternative calculations of the capitation payment for areas that can't support competitive bids.

Move to annual open enrollment period for all changes in Medicare related policies; discontinue 30 day disenrollment policy for HMOs.

Remove 50/50 rule for HMOs serving Medicare beneficiaries; require outcomes based reports plus consumer satisfaction measures to be available to all potential enrollees.

Allow HMOs to price underneath the Medicare payment and rebate savings to the elderly (and share savings with the government).

The above changes would substantially increase the availability of more flexible types of health care for the elderly, remove provisions which inhibit managed care growth and where appropriate, replace with more direct measurements and provide

some incentives to choose the more cost-effective health care plans. To the extent that the payment is set at the level of the "lowest cost plan" in the area or determined by the difference between the lowest and the average cost plan, Medicare would provide a strong incentive for the elderly to choose cost-effective health care plans that meet their needs and demands, which may or may not turn out to be managed care plans.

SOME ADMINISTRATIVE ISSUES AND OTHER SHORT TERM SAVINGS

Some have cited a recent study by Mathematica Policy Research indicating that Medicare spent more on HMO enrollees than they would have if those same individuals had stayed in a fee for service program as reason to be indifferent to the growth of risk-based managed care in Medicare. But the fact is that risk based plans have been shown to save money, at least in the short term, because they fundamentally change the incentives facing providers of health care services. There is some debate about whether these savings can continue over time or will only occur in the short term. Given the growth in the large variety of managed care plans that is occurring in the private sector, we will probably be in a better position to assess whether savings can continue for at least some time several years from now.

To the extent that Medicare has not achieved savings from HMOs, it is because of HCFA's current pricing strategies and/or other administrative practices. One way to fix the problem would be to find a way to adjust for risk selection that is better than the way it is now done. This problem of improving risk adjustment mechanisms is one that needs more attention for reasons of both public sector and private sector problems of selection. But another way to substantially reduce the problems from favorable selection, to the extent that they are occurring, is to move from a 30 day enrollment cycle to an annual enrollment period. This would stop a lot of the churning that is now occurring and would substantially reduce any favorable selection. In addition, there is some debate about the accuracy of the Mathematica study but the current 30 day enrollment/disenrollment policy clearly encourages selection by both the elderly and the plans they choose.

To the extent that the use of risk based managed care increases, it will also produce some administrative savings. These plans do not receive payment for individual services and their growth would therefore reduce some of the claims-processing charges that HCFA now faces.

An additional change in administrative practices that could produce modest savings would be the use of regional carriers to pay for clinical laboratory charges rather than the current Part B carriers. Concentrating the payment among a small number of carriers allows for more effective payment-safeguard strategies which should reduce fraud and abuse in an area that has been notorious for such problems. This was the rational that was used to justify the use of regional carriers for durable medical equipment payment.

Of even greater importance, however, is the need to be very selective about the types of short term savings that are pursued to be sure that they are consistent with a reformed Medicare structure. Some changes are consistent with the move to an incentive-based choice structure, some are neutral and some may move the system in the wrong direction. For example, adding a 10% co-insurance for home health, or a fixed copayment for rehabilitation hospital admissions would raise some additional revenues, lower utilization in these area, and make managed care options more attractive. Similarly, "bundling" post-acute care services, capitating those areas of Part A, which have been growing very rapidly over the last several years and will continue to grow more rapidly than the remainder of Part A for the rest of the decade, will also make managed care plans that tend to cover these components more attractive and discourage their utilization in the fee-for-service world. Reducing payments to indirect medical education or direct medical education would be neutral with respect to its effect on the choice of the elderly regarding cost-effective health care plans, although it will obviously affect academic health centers and teaching hospitals. But large reductions in overall physician fees could lead physicians to compensate with substantial volume increases, which would mitigate some of the savings and exacerbate the divisions between fee-for-service and at-risk medical practice.

I believe it is possible to accommodate the need for short-term revenue increases while setting the stage for the more fundamental changes in the incentives, information and options that are needed to reform the Medicare program. Since it will take some time to realize the gains from restructuring and reforming Medicare, it is important that these reforms be started as soon as possible. This session of Congress is none too soon to start.

Mr. SHAYS. I thank both of you. Dr. Wilensky, tell me what is the biggest danger if Congress tries to capture too much savings in Medicare? And where would be the most likely to capture this unrealistic savings?

Dr. WILENSKY. There are two fundamental choices to get money out of Medicare. One is to whack at provider fees. That's basically what we've done for the last 5, 10, 15 years. And the other option is to try to redesign the benefits and the basic incentive or something about the population covered.

Now, if we just go and try to whack at provider fees—physicians, hospitals, home care, rehab hospitals—and not change the fundamental incentives associated with this program, we will first be pushed into slash and burn strategies.

I mean, really, big time reductions, which will either have a very major impact on access for the elderly, or lead to a lot of gaming as providers of services try to find other outlets to recapture some of the reductions. If you do some reductions, but try to restructure the basic incentives so that the elderly have a reason to care about what they spend on health care services, you have a much better chance.

Let me give you a couple of examples. Right now, the elderly do not gain if they either choose a more cost-effective health care plan, other than, they can get more benefits for what Medicare is willing to spend. But if they can find a durable medical equipment supplier, like oxygen or a wheelchair provider, of if they go to home care, which has been a huge growth area that is cheaper than the average, they don't gain anything from it.

The Government doesn't even gain anything from it. Nobody, particularly, gains from it. There's no incentive and there's no sharing of the savings. So one of the things to do is to offer to rebate part of the savings if the elderly can beat Medicare's price. And the elderly are a group that are very cost-conscious and do a lot of shopping, in general, as many of the merchants who deal with them have found out.

So it's this notion of, can you change the incentives, make it worthwhile for the elderly to think about what is important, where they want to go. Make it worth their while, and at the same time, selectively find areas where you might do some reductions of provider payments and/or some increases in copays that the elderly face, especially if there are ways they can avoid them, like going to managed care.

I don't want to require people to do this. I don't want to force them to do it. I want to have Medicare be willing to pay for the lowest cost set of services in an area, and let anybody buy anything else that's important to them.

Mr. SHAYS. It sounds to me to like you describe both the carrot and the stick in a sense.

Dr. WILENSKY. Yes, absolutely. I am describing both.

Mr. SHAYS. Why, of all the institutions that I've come across in Government, was HCFA the most vilified by anyone who dealt with it? Now, admittedly, it was the medical profession that dealt with it. But it was the most vilified. It makes me wonder, do you think that HCFA just took sensible laws and sensible regulations and

just went crazy with them, or do you think that the laws and regulations just became absurd?

Dr. WILENSKY. Well, think about what we're trying to do with HCFA. Medicare is a program that was designed to increase access to care for the elderly, which was a perfectly reasonable goal when it was set up in the 1960's. The elderly had a lot of trouble getting insurance and health care—the low-income end because they couldn't buy insurance, even if they weren't poor.

What was done is, we set up a program that was vintage 1960's medicine. It was designed to look just like Blue Cross/Blue Shield in the 1960's. That was the way to protect it. And for a lot of political reasons, it was done that way, as well, to sell it to the medical profession. The problem is, here we are in 1995, it still looks just like the 1960's organization and structure of Medicare.

So the only way Medicare can try to restrain spending—we increased all this access and we increased spending in a very major way—was to try, through harassment and hassle and Government-administered pricing, otherwise known as DRGs and Medicare fee schedules to set the prices we would pay and then to try to harass and hassle all the providers of services so that they didn't provide too many services, since the elderly had no reason to care, particularly, about going to use more services, as long as they thought they were getting any benefit whatsoever.

So we really designed a program that had a hassle and harassment as its major way to try and restrain spending. In addition, in the last 10 years, Congress has done a lot of micromanagement, in prescriptive legislation that HCFA got to implement. And much as people like me said, hey, we didn't pass CLIA. I assume it wasn't my idea to pass CLIA. I just got to write the regulations that implemented, which got me into enormous difficulties around the country.

Or I wasn't there when they passed RBRVS, the relative value scale, but I was there when HCFA implemented this change in 9,000 payment codes for physicians. So one of the reasons is that HCFA implements enormous amounts of regulation that reflect laws that the Congress chooses to pass.

Mr. SHAYS. As a Member of Congress, I speak with every type of health care provider. They will always defend their program, and then they will chop in little pieces what other providers do. Nurses will tell me, doctors will tell me, they can't live under Medicare fee schedule. Nurses will tell me that they will have a doctor who will visit five patients in 5 minutes and say, how are you doing, check and so on.

And yes, they can't make money for a 15-minute visit, but when it's a 1-minute visit and they've seen five people, they do quite well. And so I end up getting a pretty low opinion of how this system sorts itself out. I'm coming to the conclusion that we try to tighten it here, and there will just be ways people will try to make it work.

Dr. WILENSKY. But that's because the incentives are so bad. And it's why, looking at Medicare as though it were a premium equivalent, that is, there's an amount Medicare is willing to spend for somebody. My money, I'd rather have that amount get a little smaller for a high-income or high-wealth people. But that is a separate issue. But if you look at it as saying, there's an average pay-

ment, a premium payment that Medicare is willing to pay for someone, and you want to now encourage people think about what is they can buy with that, and to buy what is, for them, the most sensible plan.

For some people it will be absolute fee-for-service medicine is very important. For others, it might be a Kaiser type of HMO. I think you can even, if you're willing to be a little more daring, for Mr. Souder, think about the notion of when someone turns 65, to say, we'll give you one time to think about, do you want to go into a medical savings account catastrophic option? Medicare will take the actuarial value and buy you a catastrophic plan and put some money aside if you want to have control over that.

But if you don't change the incentives, don't be surprised that physicians try to make up in volume the very low fees we sometimes pay.

Mr. SHAYS. Ms. Suther, I basically accept the kind of recommendation that Dr. Wilensky made, that a 10 percent base copayment could do wonders in terms of reducing usage and bringing extra income and so on. Why wouldn't that be a sensible thing? We do copayment for other areas.

Ms. SUTHER. I think the major reason is that those that are overutilizing services now, the providers that are overproviding now, will provide even more services if a copay is on a per-visit basis. Because if they provide a greater volume, that's going to decrease the cost of that unit of service. Instead of looking at the whole of cost for health care, or the whole of cost for at least home health care or nursing home care or hospital, if you can't do it in the home, as a total whole, you don't go out and buy a house by looking at a price for nails and planks and so forth.

You need to look at the cost of that episode of care with some kind of incentive, some kind of payment if the risk is greater in that particular case; for instance, if it takes longer to care for that kind of person. And that's what we're trying to identify with this new study that's being done. But if you just add a 10 percent copay, there are providers out there that will just increase the utilization and never even collect the copay.

Reputable providers——

Mr. SHAYS. Wouldn't that be fraud, if they didn't collect the copay?

Ms. SUTHER. Yes, and it's happening now.

Mr. SHAYS. Yes, but just think what you said.

Ms. SUTHER. Yes.

Mr. SHAYS. No, you just made a comment that you basically think there will be a way they'll get around the system by not asking for the copay.

Ms. SUTHER. That's right. And the collection, now then the reputable providers—that will put many of the reputable providers out of business, because last time we had a copay in home care, it cost us more to collect the copay than we received in copay because of the regulations related to how many times you had to bill and how you had to do it. And that was back in the late 1970's and early 1980's, and it cost us $9 to collect $5 then.

Mr. SHAYS. Your response opens two other questions for me. But let me just ask Mr. Fattah if he would like——

Mr. FATTAH. Yes. I'd like to really continue, to some degree, the same line. You mention in your opening testimony that, even though the incidents may be few, that the fraud problems have significant price tags attached to them. And I just wonder if you could share with the committee one or two examples of fraud on the provider side.

Ms. SUTHER. Well, I think inspector general——

Mr. FATTAH. Before you do that, let me just say one other thing. I'm very familiar with the Visiting Nurses Association in my home State and in Philadelphia. They do a wonderful job, and I just want to mention that. I do know that you are the president of the association in Texas. Thank you.

Ms. SUTHER. Actually, I'm the president of the Visiting Nurses Association in Texas. It only serves 47 counties of the 250, but we serve both the rural and the inner city, which many don't. This made me forget the question. Oh, some instances of fraud and abuse. I think that the most recent ones in the news were First American, ABC Home Care. That's the one I read about this last week. Healthmaster, also out of Georgia, was another one that I read about this last week.

The ones that the inspector general cited today from south Florida. And they're instances that our association has brought to the attention of the Government and individual home health agencies have brought to the attention of the Government. And there simply aren't enough workers to investigate those.

Mr. FATTAH. Well, you suggested in your testimony that you thought a private right of action, under anti-kickback provisions, could be helpful. Could you elaborate on that?

Ms. SUTHER. Yes. If I could bring private action against some of them, or my voluntary board of directors—I have 5,000 volunteers working in my organization—and if we were allowed to bring action under private rights, we would do so, because we have very conscientious citizens in our community. And when they observe fraud and abuse, they like to bring it to the attention of the authorities.

Mr. FATTAH. OK. And I had one other question. You testified that legislation is needed to regulate home infusion therapy services. And why do you believe that this service is in need of a special Federal action?

Ms. SUTHER. Well, all home care—medical services—need some kind of regulation to protect the public. We don't need unnecessary or duplicative regulations, but we do need something to protect the public. There are very few regulations now in effect for infusion therapy. And it is probably one of the therapies that has the greatest opportunity for infection and harm to people that are receiving this service.

And it's $3 billion of the $12 home health billion bill. So it constitutes 25 percent, according to some figures I read this morning in somebody else's testimony. It constitutes 25 percent of the home care benefit, yet there are no regulations regulating it.

Mr. FATTAH. OK. Thank you. Thank you, Mr. Chairman.

Mr. SHAYS. Thanks gentlemen. Mr. Souder.

Mr. SOUDER. I wanted to follow up with Dr. Wilensky on a couple of things. You listed a few points when you said that the Medicare

Select and the point of service plans, the risk-based, carve outs, and so on were currently discouraged and were not allowed. Where is the resistance coming from? Is it from seniors who don't want it of providers?

Dr. WILENSKY. No, they are not allowed by law. The Congress has not allowed these program options to be available for seniors to purchase. Now, the one exception was what was called Medicare Select, which was passed by I was administrator, which was supposed to have been to allow PPOs to be available, period, just as they are very frequently by the under 65. In a last 2 or 3 a.m. maneuver, Mr. Stark put on the 15-State, 3-year sunset provision, so that they, in fact, were only allowed to be offered in 15 States. Although States had been informally offering them before, it wasn't clear whether they were allowed or not.

And it's authorization ran out. If by June the Congress hasn't reauthorized Medicare Select, you won't even be able to get something as limited as a PPO. So it's very clear, if you don't change the incentives, how attractive some of these plans will be. But right now, the issue is, except for very traditional, rigid HMO's, the elderly can only buy rigid HMO's or use our card fee-for-service medicine. If they want to buy anything else, they can't; it's against the law.

I assume if they do so, evil things happen to the seller.

Mr. SOUDER. My question is really, as a freshman, being relatively ignorant of some of the processes here, who is putting the pressure on Congress? In other words, when you look at that you'd say, well, this is a pretty logical thing to do. In other words, if we tried to change this, where would the opposition come from? Who doesn't want this?

Dr. WILENSKY. Well, I think it's been a variety. There has been a very paternalistic attitude, in my view, on the part of Members of Congress, to not allow the elderly to have choices. That was in response to a real concern, I will add. I mean, the real concern was that the elderly were buying lots of little policies. But one way to have stopped that problem would have required easy to understand information about what you're buying and what it costs.

The Congress in 1991 took a different strategy of saying, by law, we will only allow 10 Medigap policies to be sold, and we'll rely on the National Association of Insurance Commissioners, NAIC, to set up what those 10 should be. Similarly, many Members of Congress thought PPOs, at the very least, would be a good idea. Mr. Stark has very strong views, both against HMOs in general, except Kaiser happened to be, among other places, in Oakland, and otherwise against any other of the risk-based plans.

And he was in a very powerful position to not have them happen. I think also there was a sense for a while that Medicare was doing, through a regulatory structure, the Government-administered pricing as well or better than the private sector. So it was a philosophical issue of how you try and go achieve cost containment. Right now this sort of jigs up. The private sector is really having much better success in terms of restraining growth and spending.

Medicare is in double digits. Part A goes belly up in 2001; and Part B is a big drain on the Treasury. So the Congress is getting pressed to think a lot harder about how to get money in the short

term and restructure in the long term this program, or it has a complete mess on its hands. But there has been this very paternalistic attitude about not giving the elderly choices, as opposed to saying, here's the information, here's an incentive; you choose what you want.

Mr. SOUDER. Do you think under managed care some of the concerns about physicians trying to adjust their services to recoup some of the costs would be addressed because it would be more flexible?

Dr. WILENSKY. Well, the idea in the risk-based groups that are part of a network is, it takes a lot of the decisions the Federal Government otherwise has to deal with and puts them in the local hands of the group that is providing all of the health care services—whether home care makes sense as opposed to being in the office or being in a hospital, and whether, if doctors have an investment in an imaging center, are they using it too much?

Well, if the group has a capitated amount that has to cover all the services, it's their problem to figure out whether this is the best place to go and whether it makes sense to have people in home care or not. If that person is with them, and that person can vote with their feet and change and go to another network, there's a lot of incentive on the part of the health care plan to worry about whether they're giving good care.

And there's a lot less itemized issues for the Federal Government to get involved in.

Mr. SOUDER. I wanted to ask one more question on copayment, if I may. At the end of your testimony, you said that one of the side things that can happen if you went to the co-insurance for home health care is, it could make managed care more attractive. Could it also make hospitalization and other things look more attractive, and we go right back to where we're using more expensive services?

Dr. WILENSKY. Well, again, the idea is, if you—in the first place, there is a lot of oversight that goes on in hospitals, and there's a fixed payment. So the only way hospitals can try to make up is if they try to increase volume, admissions. But there are so many other reasons why they're not able to do that that I don't think that's likely to occur. What you do want to do is bundle payments. It may be bundling all the payments when you discharge someone from the hospital, if we could figure out who to give that money to.

So there is one group that is worrying about how many visits and whether high cost or low cost, or better yet, to have a bundle of money that covers all of the non-hospital care or all of the care for the person. Because otherwise, as a Government tries to save money on one item, it encourages movement to some other area. Now, the fact is that having a copayment will get seniors—unless providers engage in fraud and don't collect it—it will ask the seniors to think about whether or not this visit makes sense.

In the area of home care, it's not just prices that have gone up. The number of people served and the number of visits per person served since 1990 has increased huge numbers of times. You don't know what those numbers look like. I will be glad to send you over a table that shows you not just the increase—the 40 to 50 percent increase in spending in some years in the early 1990's—but the

number of people per 100,000 served, or per 1,000, I forgot what the unit is, and the number of visits for those served.

It will really surprise you how big that's increased. Having people pay a little share of the bill, 10 percent of the bill, get's them to think about whether this really means anything to them. And if they don't want to deal with that, then they can go into an HMO, where it's all covered as part of the packaged price. It's their option. They don't have to. It makes HMOs a little more attractive, because they tend not to have coinsurance.

Ms. SUTHER. Could I address that, too, briefly?

Mr. SHAYS. Definitely, you may.

Ms. SUTHER. I serve 8,000 patients a day. And of those 8,000 people, over 40 percent of them could not pay $350 a year copay. Their average income is $7,500. We have a large percentage of our people who would have to pay a copay of over $900.

About 4 years ago, Robert Wood Johnson gave us a grant to study buying behavior of health and social services for elderly citizens.

And we found that people that were brought up during the Depression years had different buying behaviors than people who are coming along now, especially in terms of social and health care services. And we found that they would do without those services until they were totally in need of total support in the home, total nursing home care or total hospital care. And therefore, the cost would be much greater in the end.

They would do without food. They would do without everything to buy their medications. But then, if they thought that help was coming in for something, they simply wouldn't take care of that. And to test that, we had a test group in low-income housing and we had an upper-income group that had a higher discretionary income. And we found the buying behavior of the low-income people and the high-income people as exactly the same if they came along during those Depression years.

Now, we're seeing some change in that buying behavior for a younger population. Because the younger population has been taught and educated to buy more prudently. I agree that some kind of incentive needs to be there. For our own employees, we have an incentive to decrease health care costs. If they're overweight, they have a higher premium, or they get a discount if they're not overweight, if they don't smoke. So I agree with some kind of incentive for positive behavior.

But when you're dealing with a group—the primary users of home care today are over 80 years of age—and you can't change that buying behavior easily. Now, I do think what Dr. Wilensky said about changing HMOs, allowing people to change every 30 days certainly has increased the cost of prospective pay and decreased the cost in HMOs, because we find that all the time. A person's in an HMO 1 month, when they get a problem, they opt out of the HMO and they go into fee-for-service.

So there are a lot of things that need to be done. And they shouldn't be done in haste, because when you change one thing, you change everything. And so you need to look at it in totality before making those changes.

Mr. SHAYS. Are you done? Mr. Fattah.

Mr. FATTAH. Yes. I just had a quick question and concern on this issue of copay. You seem to be suggesting that not only should we go to a copay, but that it would cause people to pause before they went to a health care provider, because they obviously would be having to pay part of the cost. Isn't it true that part of the real problem in health care is that people don't see doctors soon enough? And that things get out of hand and then it costs more on the back end?

But my actual question, and I hope that you can respond to my comment, too, is that since normally copays don't take into account income, that the people at the bottom end of the real income stream here may actually have to, for fiscal reasons, not seek the kind of help that they would need. So, if you could just comment quickly.

Dr. WILENSKY. They're related. In the first place, through the qualified Medicare beneficiary program, called QMB, and Medicaid itself, you cover the premiums and copays for lowest income and for people above the poverty line for their premiums for those at 25 percent above the poverty line.

Mr. FATTAH. So we would be paying for it anyway.

Dr. WILENSKY. So, for the very lowest. Not for everybody, but for the very poorest.

Mr. FATTAH. OK.

Dr. WILENSKY. The second thing is, look, if you make something free, don't be surprised if people use a lot of it. And if you look at the numbers of home care use since 1990, you are going to see annual increases in spending—I'm not kidding—40 to 50 percent per year. Now, there was a reason this started going on. And the question is, what do you want to do about it?

Now, one way is to have a copay to get people to say, is there a reason that you went from something like 38 or 40 visits per persons served to 68 or 70 visits per person served? Another is, if you don't want to pay copayments, you know that there's a managed care plan around that you can go to and you don't have to pay copays. If you want the option to go whoever and wherever you want, whenever you want, and there's no charges associated with it, don't be surprised if you spend a lot of money.

Mr. FATTAH. I understand. But I'm just not sure that you were responsive to the crux of my question, though. I wasn't here last year, but as I recall the health care debate, there was some notion and there was some number being mentioned in which an overwhelming amount of our health care dollars as a country was being spent on a person at the last few months or 6 months of their lives.

Dr. WILENSKY. That's incorrect. Health care spending is concentrated.

Mr. FATTAH. OK.

Dr. WILENSKY. Ten percent of the population account for 70 percent of the dollars. But there is this myth that a totally disproportionate amount of money is spent in the last 3 months or 6 months of life. In Medicare, 28 percent of the dollars go to people in their last year of life. And that number has been relatively constant over the last 20 years. It's actually slightly less concentrated for the elderly than for the non-elderly.

And the reason is because the elderly use a lot of services all the time. So when they get really sick and concentrate their spending, it's less concentrated. Now, do you want to have incentives for people to use preventive care? Well, part of it is by education. Part of it is by getting them in HMOs. If somebody is in an HMO and that HMO is responsible for them, they, as well as the person, have an incentive to do the things that count.

It's why Medicare HMOs show better preventive care in detecting uterine cancer.

Mr. FATTAH. But you do realize that some of the resistance from elderly populations that join HMOs is that it restricts their choices. And especially as people get older, they are in a comfort zone with their particular physician or whoever has been treating them. And in order to sign up for an HMO——

Dr. WILENSKY. They may or may not find one that has the right mix for them of physicians. As it's more and more common in the under–65 population, they may well find it easier to find their physician in an HMO that will take—I mean, this is not strange——

Mr. FATTAH. But in the older population, that's not the case. And I won't prolong it. I think you understand my question, and I do understand your comments.

Dr. WILENSKY. Yes, and it really is the issue of, if you want to have people have full coverage and no constraint about how and where they can go. So they're not going to help you try to restrain spending. And the providers can outgain and outmaneuver any control system I've ever seen, because their incentives are more direct. Just don't be surprised that you've got double digit spending in the program, as harassed and hassled as we have made it.

Mr. FATTAH. Thank you.

Mr. SHAYS. I'd love to just go on record as saying that Medicare and Medicaid recipients can't avoid being part of the changes in the health care industry, and we can't allow our Medicare and Medicaid to go up at 10 percent plus a year when it's now 17, 16.5 percent of our total budget. So we're going to have to find 100 different ways to encourage people to get into those systems, in my judgment.

Ms. Suther, what did you want me to gain in this article that would not make me very, very concerned about fraud in home health care?

Ms. SUTHER. Well, we're very, very concerned about fraud in home care. And our association has been working on this. We started the committee 2 years ago.

Mr. SHAYS. Right, but relate it to this article. I mean, I'm sure you read it, because it's part of your testimony. It is just one story after another of horror stories. And, candidly, your comment to me about if we had a copayment, it would encourage fraud, your testimony is that fraud isn't a problem. This article is that fraud is a gigantic problem.

Ms. SUTHER. No, that's not my testimony.

Mr. SHAYS. OK, I missed your testimony. I must have missed a main thrust of it. I thought you were saying we do not have a serious problem of fraud in home health care.

Ms. SUTHER. I said the proven instances of fraud in home care are very, very low, percentage wise.

Mr. SHAYS. And if I recall, you said it's primarily in the bigger institutions.

Ms. SUTHER. No, I said, however, there are——

Mr. SHAYS. Hold on a second, please.

Ms. SUTHER. There are large institutions——

Mr. SHAYS. Would you answer the question?

Ms. SUTHER. Yes. I said unfortunately many of the proven instances have been very large, or many of those that are before—that have not been tried right now, that are indicted right now are very large. And unfortunately, some types of things that they're found on, one of the ones now, is very small things.

Mr. SHAYS. What I heard you say was that there have not been a lot of cases of fraud. It's been primarily in the major users of health care, some of the larger providers of home health care.

Ms. SUTHER. I said proven cases.

Mr. SHAYS. Yes, those are the proven cases. The implication, to me is that we didn't have a problem. Now, I'm understanding that I must have taken that and made an assumption. Do we have a problem of fraud in home health care?

Ms. SUTHER. I think there probably are more abuses than fraud.

Mr. SHAYS. Do we have a lot of abuse?

Ms. SUTHER. I don't know how much abuse. I do know that there is some abuse.

Mr. SHAYS. Do you think we have a serious problem of fraud in home health care? That's the question.

Ms. SUTHER. Well, to me, one case is serious.

Mr. SHAYS. Well, I'm not talking about one case.

Ms. SUTHER. OK. I can't say that the industry is rampant with fraud and abuse. I don't think it is.

Mr. SHAYS. OK. Then answer this question. Why would you have wanted me to read this article? Why would you have included it in your statement? It is just a gigantic indictment of our home care system and how we deal with fraud in it. So what's the answer?

Ms. SUTHER. Well, I think primarily to let you know that our association is trying to police itself and our providers and the members in that association. And in our lengthy written testimony that I submitted to you, there are the things that we're trying to do as an industry to police ourselves. And we would request that Congress look at the additional things that we looked at that we've recommended.

Mr. SHAYS. I appreciate the suggestions you made. We talked about home care charging a fee implied it would lead to significant abuses, and that people would not charge the recipient. That is a terrible indictment of the people that work in the system. I can't believe that would be true.

Ms. SUTHER. The disreputable agencies would do that. The reputable ones would not. And as I mentioned, the reputable ones, then, would not be available to provide services. And I would hate to think that my parents would not have a reputable agency available to provide services to it.

Mr. SHAYS. Is the fraud the bad guys who put the good guys out of business?

Ms. SUTHER. Well, the bad guys would increase the ways they get to patients, No. 1. No. 2, if I have to take a loss on the uncol-

lected 10 percent copayment, I'm a nonprofit agency and my community will give me money to provide indigent care. But my community will not make up the difference between—will not make up bad debt, which that, in essence, would become.

Mr. SHAYS. Yes.

Ms. SUTHER. And there's no way that our agency that's been in business 60 years and other home care agencies that have been in business for over 100 years providing care can continue to provide care to the low-income people that cannot afford to make that copay.

Mr. SHAYS. I think the argument about low income being able to make a copay is a very valid argument, believe me, I do. We're going to end this hearing. But Mr. Fattah, do you want to make any closing remark before we end?

Mr. FATTAH. I just want to thank the chairman for allowing me to participate in the hearing. Thank you.

Mr. SHAYS. Thank you. It was wonderful to have you participate, and it was nice to have all our witnesses, and I thank you for coming. I appreciate both of you having to wait the longest. Thank you. This hearing is adjourned.

[Whereupon, at 2:20 p.m., the hearing was adjourned subject to the call of the Chair.]