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MONITORING CMS' VITAL SIGNS: IMPLEMENTATION OF THE MEDICARE PRESCRIPTION DRUG BENEFIT

HEARING

BEFORE THE

OVERSIGHT OF GOVERNMENT MANAGEMENT, THE FEDERAL WORKFORCE AND THE DISTRICT OF COLUMBIA SUBCOMMITTEE

OF THE

COMMITTEE ON HOMELAND SECURITY AND GOVERNMENTAL AFFAIRS UNITED STATES SENATE

ONE HUNDRED NINTH CONGRESS

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MONITORING CMS' VITAL SIGNS: IMPLEMENTATION OF THE MEDICARE PRESCRIPTION DRUG BENEFIT

TUESDAY, APRIL 5, 2005

U.S. SENATE,
OVERSIGHT OF GOVERNMENT MANAGEMENT,
THE FEDERAL WORKFORCE, AND THE
DISTRICT OF COLUMBIA SUBCOMMITTEE,
OF THE COMMITTEE ON HOMELAND SECURITY
AND GOVERNMENTAL AFFAIRS,
Washington, DC.

The Subcommittee met, pursuant to notice, at 10:07 a.m., in room SD–342, Dirksen Senate Office Building, Hon. George V. Voinovich, Chairman of the Subcommittee, presiding.

Present: Senators Voinovich, Akaka, Levin, Carper, Lautenberg, and Pryor.

OPENING STATEMENT OF SENATOR VOINOVICH

Senator VOINOVICH. Good morning. The Subcommittee on Oversight of Government Management, the Federal Workforce, and the District of Columbia will come to order. Good morning and welcome to today's hearing, entitled "Monitoring CMS' Vital Signs: Implementing the Medicare Prescription Drug Program." This hearing will provide an opportunity to continue our examination of the management challenges confronting the Centers for Medicare and Services and ensure that the agency has the financial and human capital resources it needs to get the job done.

There is much at stake. For many, access to prescription drug medications is a matter of life and death and a decent quality of life. Today, conditions that used to require surgery or in-patient care can now be treated on an out-patient basis with prescription drugs. However, often times the cost of these medications is prohibitive. We have to ensure seniors have access to these life-saving medications and take advantage of the new benefit. If it is properly administered, the new Medicare benefit in my opinion will result in the most significant improvement in public health since 1965 when Medicare came into existence.

CMS has learned many lessons during the recent implementation of the new Medicare drug discount card, which will assist it as it continues with implementation of the full prescription drug benefit. While I do believe there are still a number of hurdles the agency must overcome before the launch of that full Medicare drug

benefit in 8 months, we would be remiss not to recognize the success CMS and Dr. McClellan have had in the past year.

Since the last hearing I held on this topic in April 2004, CMS has successfully enrolled more than 6.2 million seniors in the discount drug card program. These seniors are saving between 12 and 21 percent of the cost of their prescription medication. In addition to those savings, I believe the most important part of the discount drug card is the transitional assistance for low-income seniors—those under 135 percent of the Federal poverty level. These individuals received $600 in 2004 and 2005 to help pay for prescription drugs.

I am pleased that 1.75 million low-income seniors have taken advantage of the transitional assistance to date. Getting these seniors enrolled took considerable work, and I saw this first hand. I am proud to say that I join with CMS and the Ohio Senior Health Insurance and Information Program (OSHIIP), the Ohio Area Agency on Aging, and other community groups that traveled around Ohio last year. We held 14 roundtables and training sessions to educate and encourage seniors without drug coverage, especially those with low incomes, to sign up for the card. Together, my staff held an additional 426 sessions throughout Ohio. I want to thank CMS and the OSHIIP program in Ohio for participating and assisting us in efforts to get Ohioans signed up for the program.

And, Mark, I want to thank you for coming on two occasions to Ohio to help us get the job done. In fact, we went to the training session together for an hour.

It has paid off for some 279,000 seniors in Ohio who have signed up for the drug card. These individuals are expected to save about $134 million on the cost of their drugs in 2005. Ohio's low-income beneficiaries, who enrolled in the program by the end of 2004, will have access to $73 million in direct financial assistance with drug costs. While these seniors will be able to take advantage of these savings until the full benefit begins, it is now time to turn our attention to the full drug benefit.

Using the experience of the implementation and the ongoing enrollment in the discount card over the past years, it is the responsibility of Congress and the Administration to make certain that CMS has the means to implement the much larger and more complex, full drug benefit in an efficient and effective manner.

Preparing to administer the program in the tight 2-year time frame is quite a challenge. However, from what I have witnessed, CMS is well on its way. On January 21 of this year, CMS took a crucial first step toward fulfilling the Act by publishing the final regulations for the new drug benefit and the enhanced health coverage options through the Medicare Advantage program. I understand that the agency has an ambitious timeline to review and approve potential plan sponsors, work with employers and retirement systems that choose to apply for the retiree subsidy, assist States in adapting their prescription savings plans to help their beneficiaries further benefit from the new Federal coverage, and, of course, communicate and educate Medicare beneficiaries about their options and ultimate enrollment in the plans. Having the right people at CMS is the key to successful implementation of this program.

And even before the passage of the Medicare Modernization Act, CMS—and this is what we are here to talk about today—was coping with administrative challenges. For example, a 2002 report by the National Academy of Social Insurance highlighted the fact that between fiscal years 1992 and 2002, benefit outlays increased 97 percent and claims grew by 50 percent; however, program management funds increased only 26 percent, and authorized full-time equivalent positions grew by 12 percent.

Currently, 18 percent of CMS' workforce is eligible to retire, and the number is significantly higher, 30 percent, in the Senior Executive Service. In addition, over the past 3 years, CMS has lost a quarter of its career executives to retirement. If that does not seem like enough of a daunting challenge, 46 percent of the existing CMS workforce will be eligible for regular retirement by 2009. These statistics will sound familiar to anyone knowledgeable of the Federal Government's human capital challenges.

Before I introduce the witnesses, I would like to remind my colleagues that the purpose of this hearing is not to discuss the details nor the merits of the program. I know there is still some controversy about the program. We are here to determine if the agency has the wherewithal to get the job done, to get it out on the street. I understand some have concerns surrounding the program. However, it is the law. We are here today to ensure CMS has the resources and personnel capacity to ensure that the benefit is implemented as Congress has directed.

I would now like to call on Senator Akaka for his opening statement.

OPENING STATEMENT OF SENATOR AKAKA

Senator AKAKA. Thank you very much, Mr. Chairman. I have long supported efforts to establish a meaningful Medicare prescription drug benefit for the elderly and disabled, and I remain committed to improving the Medicare prescription drug benefit so that seniors are able to obtain all of the medication that they need.

However, I voted against the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 because it offers a false promise to all seniors. Under the MMA, new prescription drug plans will be available to individuals covered by Medicare beginning in January 1, 2006. The Center for Medicare and Medicaid Services (CMS) recently issued the final regulations implementing this benefit.

MMA coverage, in my mind, could actually, I feel, harm many seniors. For example, Hawaii's seniors who have incomes below 100 percent of the poverty level and obtain their medication through Hawaii's Medicaid program will be worse off under this plan because they will have to make co-payments for their prescription medications. I fear that too many low-income seniors will not be able to afford these co-payments. Creating a barrier that will prevent some low-income seniors from obtaining needed medications will likely increase overall health care costs. Denying necessary medication could lead to more hospital visits and other health-related costs.

Mr. Chairman, I intend to introduce legislation shortly to remove the co-payment requirement for dual-eligible beneficiaries, and I hope my colleagues will support me in this effort.

Mr. Chairman, I am also concerned that Medicare and Medicaid dual-eligible seniors may have to alter their existing treatments because of the formularies imposed by prescription drug plans. For example, HIV and AIDS patients and individuals in nursing homes may be forced to alter the physician prescription because their formularies for their Medicare prescription plans are too restrictive and are less generous than their existing Medicaid drug coverage. More must be done to protect the ability of beneficiaries to obtain for themselves the best possible treatment, rather than being subject to arbitrary formulary determinations.

Senator Voinovich, I thank you for calling today's hearing to discuss with our witnesses the implementation of Medicare Part D. This portion of Medicare will be difficult to administer due to the complex design of the prescription drug benefit plans and low-income subsidies. In particular, I look forward to discussing today what steps will be taken to ensure that seniors will have access to the information necessary to make informed choices among private plans and utilize the benefits for which they may be eligible.

This is a complicated task. Different communities have diverse needs and challenges that must be met to make sure that underserved populations will not be unfairly denied access to assistance. It will be critical that access not be denied to seniors because of language or cultural barriers or to those who do not have access to the Internet, or even a telephone. We must take steps to ensure that even those in isolated communities, such as those on the island of Molokai, are provided with the information necessary to utilize all of the benefits that they may be entitled to under the MMA.

I look forward to the testimony, and I want to add my welcome to Mark McClellan, Marcia Marsh, and Ann Benjamin.

Thank you very much, Mr. Chairman.

Senator VOINOVICH. Thank you. Senator Levin.

OPENING STATEMENT OF SENATOR LEVIN

Senator LEVIN. Thank you, Mr. Chairman, and thank you for holding this important hearing. As we all remember, a few years ago we had a vigorous debate about the future of Medicare and the best way to deliver an affordable, voluntary, universal, and guaranteed prescription drug benefit to our seniors. Many seniors, retirees, were skeptical of the Medicare bill that was enacted in 2003, and, quite frankly, so was I. Now, 2 years later, we are beginning to get some answers which I hope we will hear about today. For example, what is the increased cost of the drug benefit since the Department of Health and Human Services is apparently barred from negotiating lower prices for Medicare beneficiaries? How many retirees will lose the solid prescription drug coverage that they now have?

These were major concerns back in 2003. The law has given the Centers for Medicare and Medicaid Services, or CMS, the authority to fashion implementing regulations that could possibly ease some

of the problems. I hope to hear today about what CMS is planning to do with that authority.

The Administration has been less than forthcoming in providing accurate information to Congress about the cost of the Medicare drug benefit. In 2003, while the Administration was publicly stating that the drug benefit would cost no more than $400 billion over 10 years, the chief actuary for CMS, Richard Foster, had internal documents predicting costs closer to $534 billion. When Congress asked Mr. Foster to provide those estimates during the House and Senate debate on the bill, the former CMS Administrator refused to make either Mr. Foster or those estimates available. New budget documents now project a cost in the neighborhood of $720 billion.

The huge increase in the cost of this program in just 2 years from the original $400 billion price tag goes beyond sticker shock. Accurate cost information and honest cost projections are critical as the drug benefit is implemented early next year and Congress begins to evaluate both the program and possible changes to it. CMS needs to satisfy the people of this Nation that it will provide accurate cost information.

A related issue is the CMS decision to use critically needed administrative resources to produce covert broadcast materials to try to promote the new Medicare drug benefit. Last year, CMS distributed a videotape on the program benefits in the guise of an actual news report, when in reality the reporter was a paid actor.

CMS is not alone in this. Political consultants and commentators were paid hundreds of thousands of dollars to promote Department of Education policies and tens of thousands to promote a program at the Department of Health and Human Services. This type of covert journalism is just plain wrong. And although last year the Government Accountability Office, the GAO, concluded that this practice violated Federal law, a memorandum by the Administration released just last month states that the Executive Branch is "not bound" by GAO legal advice. Disguising the hand of government in broadcast materials is not only against the law, it undermines the operation of a free press. Government should be protecting a free press, not trying to buy it. It is my hope that CMS will tell us today that it will end the use of covert broadcasting materials to promote the Medicare drug benefit and to use those critically needed resources for administration of this program.

I want to especially commend Senator Lautenberg for his early blowing of the whistle on these abuses and for his persistence in this matter. It has been brought to the attention of the public as an abuse which must be corrected, and I salute him for it.

I would like to thank Dr. McClellan for appearing here this morning and for his public service over the years, and I look forward to his testimony as well as the testimony of the other witnesses.

[The prepared statement of Senator Levin follows:]

PREPARED STATEMENT OF SENATOR LEVIN

Thank you, Mr. Chairman, for holding this hearing. I know that many seniors and retirees are skeptical of the Medicare bill that was enacted in 2003, and quite frankly, so am I.

As we all remember, we had a vigorous debate 2 years ago about the future of Medicare and the best way to deliver an affordable, voluntary, universal, and guaranteed prescription drug benefit to our seniors.

Now, 2 years later, we are beginning to get some answers, which I hope we will hear about today. For example, what is the increased cost of the drug benefit since the Department of Health and Human Services is apparently barred from negotiating lower prices for Medicare beneficiaries? How many retirees will lose the solid prescription drug coverage they now have. These were major concerns of mine in 2003. The law has given the Center for Medicare and Medicaid Services or CMS the authority to fashion implementing regulations that could possibly ease some of the problems. I hope to hear today about what CMS is planning to do with this authority.

Another concern that needs to be aired today is the fact that, from the beginning, this Administration has been less than forthcoming in providing accurate information to Congress about the cost of the Medicare drug benefit. For example, in 2003, while the Administration was publicly stating the drug benefit would cost no more than $400 billion, the chief actuary for CMS, Richard Foster, had internal documents predicting costs closer to $534 billion. When Congress asked Mr. Foster to provide those estimates during the House and Senate debate on the bill, the former CMS Administrator refused to make either Mr. Foster or those estimates available. New budget documents from the Administration now project a cost in the neighborhood of $720 billion.

The huge increase in the cost of this program in just 2 years from the original $400 billion price tag goes beyond sticker shock. Accurate cost information and honest cost projections are critical as the drug benefit is implemented early next year, and Congress begins to evaluate both the program and possible changes to it. CMS needs to satisfy the people of this nation that it will provide accurate and honest cost information.

A related issue is the policy decision to use covert broadcast materials to try to promote the new Medicare drug benefit. Last year, CMS distributed a videotape on the program benefits in the guise of an actual news report when, in reality, the reporter was a paid actor. Political consultants and commentators were paid hundreds of thousands of dollars to promote Department of Education policies and tens of thousands to promote a program at the Department of Health and Human Services. This type of covert journalism for hire is plain wrong. And although last year, the Government Accountability Office (GAO) concluded that this practice violated two Federal laws, a memorandum by the Administration released just last month states the Executive Branch is "not bound by GAO legal advice."

Disguising the hand of government in broadcast materials is not only against the law, it undermines the operation of a free press. Government should be protecting a free press not trying to buy it. It is my hope that CMS will tell us today that it will end its use of covert broadcasting materials to promote the Medicare drug benefit. I commend Senator Lautenberg for his early blowing the whistle on these abuses and his persistence in this matter.

I would like to thank Dr. McClellan for appearing here this morning. I look forward to his testimony as well as the testimony of the other witnesses.

Senator VOINOVICH. Senator Lautenberg.

OPENING STATEMENT OF SENATOR LAUTENBERG

Senator LAUTENBERG. Thanks, Mr. Chairman, and thanks, Senator Levin, for mentioning the fact that I had been following this trail of what I will call propaganda very arduously. And, Dr. McClellan, you have been on the job long enough to look back longingly, I assume, and wonder which job was a more welcoming one. But you have the intelligence and the backbone to do these things, so we are not going to take it easy on you, I promise.

It has been almost a year and a half since President Bush signed this law that is going to make such profound changes in the Medicare program, and we have since learned that the information given the Congress during the debate on this bill was false. The cost was understated by hundreds of millions of dollars, and, unfortunately, the deception did not end there. Since the bill was passed, the Administration has engaged in illegal propaganda, defined by

the GAO, in what I will call an attempt to sell this bill of goods to the American people. And it was done by producing the video news releases, as mentioned by Senator Levin, distributed to local television stations for use in their news programs. And as someone who saw these videos on their local stations, they could believe that they were listening to a valid news commentary instead of a sales pitch.

In fact, at one point they featured a fake news reporter paid for by the government and reading a script prepared by the government. And it is not news. It is government propaganda. But the viewers who were exposed to this material on TV stations around the country had no way of knowing that. These videos were produced with money from the Medicare trust fund. Three propaganda releases were produced, two in English and one in Spanish. And in one script, the Administration suggested that the local news anchor in doing the video concluded her remarks by being identified as Reporter Karen Ryan, and she helped sort through these details. That was described by the news anchor. But Karen Ryan was not working for a news organization that was part of our free press. She was working for the government and getting paid to say what they wanted her to say. And, again, that is not news. That is propaganda.

On May 19, 2004, the Government Accountability Office issued a legal opinion that HHS and CMS had violated the law by using taxpayer dollars to fund covert propaganda.

Now, I asked GAO to investigate this matter further to determine exactly where the Administration had crossed the line between legitimate information and political propaganda. And it is wrong to pull the wool over the American people's eyes. And if you try to do it with their own money, it is illegal.

But that was not the end of the matter. Basically, HHS and the Centers for Medicare and Medicaid Services thumbed its nose at the law. It is bad enough that the Administration crossed the line between information and propaganda, but it is even worse to ignore a legal opinion from the Government Accountability Office. When you do that, you are telling the American people that we are not accountable. And I ask what kind of an example that sets.

Mr. Chairman, if the Administration or the White House, can say those laws do not apply to us, well, what laws do apply to them? I think all laws apply to all of us, and one of the things that I want to do is make sure that redress can be sought in the courts by organizations to break through the sovereign immunity proposition. To question that in the courts we should not have to do that, and normally one would not be able to do it. But we have to find an opportunity to give the public an honest account on this.

Mr. Chairman, I look forward to hearing from Dr. McClellan.

Senator VOINOVICH. Thank you, Senator Lautenberg. Senator Carper.

OPENING STATEMENT OF SENATOR CARPER

Senator CARPER. Thanks, Mr. Chairman.

To Dr. McClellan, welcome. It is good to see you, and we thank you for your continued service in this role.

I just want to follow up briefly on Mr. Lautenberg's comments. There is obviously a difference between propaganda and information that is really meant to inform seniors as they try to make what can be difficult decisions between now and the beginning of next year. And the key is, as in most things, to find the right balance. And in our own State, as one who voted for the Medicare bill—a tough decision, maybe the toughest that I have cast here in my first 4 years in the Senate—I have a strong interest—and I know it is shared by our at-large Congressman, Congressman Castle—that we do the best job we can to figure out how to take the State's drug benefit—we have a State drug benefit that we signed into law during my time as governor—and how do we really wrap these two benefits together so that we have a State benefit and a Federal benefit, that they complement each other, and we derive the very best benefit, not complex but as comprehensive as we can, for our seniors.

And in the end, I think back on my own Mom, who recently passed away, and how confusing things like this are to her and, frankly, to all of our mothers, grandmothers, and grandfathers. We need to focus real hard—and we are certainly trying to do that in my own State with our own congressional delegation—on making sure that older folks and their children understand what their options are and make the right choices.

Having said that, Mr. Chairman, I would just reiterate, as others have, that we are pleased to have this hearing today. We are grateful to you for calling us together. This legislation signed into law is obviously an important one for our country and an important one for a lot of our citizens. The policies that we have adopted obviously cannot be implemented if CMS does not have the resources and the staffing that you need. We understand that, and we want to be supportive to meeting your needs.

I again want to congratulate Dr. McClellan for the job that he has done so far in getting this historic piece of legislation off the ground. Obviously, there is a lot to be done, but I appreciate the complexity of the task that has been presented to CMS and believe that you and your colleagues have done a good job so far.

I think that the next 8 or 9 or 10 months will in large part dictate whether this program is going to be successful. The launch and all kinds of things—my friend here, Carl Levin, is from Detroit. They worry a lot about the auto industry, and I do, too. We have got a couple of big auto plants in my State. We worry about launching new public sector. We are going to launch a new Pontiac, Solstice, from our GM plant in Wilmington later this spring. The launch has to be perfect in order to help ensure the future of that car and, frankly, help ensure the future of the company.

Having said that, the launch of this Medicare drug benefit will in large part, I think, help to determine whether it is going to be around for a while and whether it is going to realize the potential and promise that it has.

We need to make sure that all stakeholders have access to the information that they need and that they understand the changes that are to come. We need to be able to present this information to people so that folks the age of my mother, who died in her 80s last week, can come close to understanding it and that their chil-

dren and others around them can understand it if their loved ones cannot.

We need to make sure that States, for example, receive ample assistance from CMS to identify the dual-eligible population, and I think this is vitally important. Seniors who comprise this dual-eligible population often have special needs, and we must make sure that this population is transitioned smoothly into the new benefit, or as smoothly as possible. We need to make sure that doctors, pharmacists, nursing homes, and other providers understand the new benefit and how it will affect their patients. And, finally, we must ensure that CMS has the resources that are needed to oversee the many plans that we hope will participate.

CMS is responsible for ensuring that plans do not discriminate against beneficiaries, that their formularies include a sufficient array of drugs so that seniors can get all the medications that they need, and that the plans have appropriate safeguards in place to deal with the complaints and appeals and other disputes that are sure to come.

Again, I just want to repeat how important it is that we do this right, get it right the first time out, and I am committed to seeing that this historic new benefit is implemented as smoothly as possible, and I hope that CMS will continue to do the good work that you have begun in this regard.

Mr. Chairman, thank you.

Senator VOINOVICH. Thank you, Senator Carper. That is exactly why we are here today. We want to make sure this thing is launched properly and that people take advantage of it.

I would like to welcome Dr. Mark McClellan today. Dr. McClellan has been serving as CMS Administrator since March 25, 2004. It has not even been a year since Dr. McClellan has taken over. He succeeded Tom Scully, who left the agency before the program he promoted was launched, leaving you perhaps in the lurch a bit. But Dr. McClellan is used to taking on daunting challenges.

Prior to taking this post, he served the Bush administration in the Food and Drug Administration and in the White House as a member of the President's Council of Economic Advisers. Success at any agency is the result of strong leadership, and that begins at the top. I have been impressed with Dr. McClellan's drive and dedication. I look forward to hearing from him about the challenges he has identified and the steps the agency has taken to address them in order to ensure that all 43 million Medicare beneficiaries have the opportunity and information they need to take advantage of the drug benefit.

Testifying on our second panel of our witnesses today are Marcia Marsh from the Partnership for Public Service and Ann Womer Benjamin from the Ohio Senior Health Insurance Information Program, and she is the Director of the Department of Insurance of Ohio. Both Ms. Marsh and Ms. Benjamin have partnered with CMS throughout the past year to help the agency advance different aspects of the drug benefit. They will provide valuable insight about the agency's progress and thoughts on how CMS might better position itself to ensure the successful implementation of the benefit.

It is the custom of this Subcommittee, Dr. McClellan, and the other two witnesses, that you are sworn in. Will you stand and I will administer the oath. Do you swear that the testimony you are about to give this Subcommittee is the truth, the whole truth, and nothing but the truth, so help you, God?

Dr. MCCLELLAN. I do.

Ms. MARSH. I do.

Ms. BENJAMIN. I do.

Senator VOINOVICH. Let the record show they answered in the affirmative. Dr. McClellan, welcome.

TESTIMONY OF HON. MARK McCLELLAN, M.D., PH.D.,[1] ADMINISTRATOR, CENTERS FOR MEDICARE AND MEDICAID SERVICES

Dr. MCCLELLAN. Mr. Chairman, thank you.

Chairman Voinovich, Senator Akaka, and distinguished Members of the Subcommittee, I want to thank all of you for inviting me to provide an update on the implementation of the Medicare Modernization Act of 2003 and, in particular, on bringing critically needed help with drug costs to all Medicare beneficiaries. With the important new hiring and management provisions and the support for our agency that were included in the Medicare law, we are on track to provide new prescription drug coverage and new Medicare Advantage plan options to our 43 million beneficiaries to help them both prevent diseases and keep their medical costs down. Millions of low-income beneficiaries, almost a third of our beneficiaries, will receive comprehensive prescription drug coverage at little or no cost.

Mr. Chairman, you and your colleagues have long emphasized the importance of healthy and up-to-date government organizations to provide effective, up-to-date government services. Thanks to your leadership, the Medicare law has given us new authorities to reform our agency, to bring new expertise and perspectives to our dedicated professional staff, to meet our new responsibilities in providing these up-to-date benefits in Medicare. And I want to thank this Subcommittee, and particularly you, Mr. Chairman, for providing CMS with the flexibilities needed to hire individuals quickly with the skills required to implement the new Medicare law. Using the new authorities that you have provided, we have undertaken nothing less than what has been called an extreme makeover of our most important resources at CMS—our human resources.

We have revamped our entire human capital management plan and our hiring process, and we have realigned our functional groups inside of CMS. Through this strategic process, we have been building a staff that possesses new talents aligned with our new services, including individuals with expertise in drug benefits, in pharmacy services, including the specialized pharmacy services provided in nursing homes, in retiree health benefits, in contracting with health plans, in disease management and prevention, in quality measurement and quality improvement programs, and in many other areas related to helping our diverse population of seniors and population with disabilities get more up-to-date, preven-

[1] The prepared statement of Dr. McClellan appears in the Appendix on page 42.

tion-oriented, personalized care. In fact, we have brought some of these talented people out of retirement.

We appreciate the additional resources provided by Congress and the flexibilities in our hiring process, especially our management staff authority. Aided by the direct hiring authority and the Federal Career Internship Program, CMS has hired a total of 345 new employees. We are on track to a commitment of about 400 in place right now, and we expect close to another 100 beyond that.

We have also restructured within CMS to improve our ability to use these human resources to meet the requirements of the Medicare law. Using our new hires and our updated agency structure and business processes, we have worked to develop an effective system for providing reliable access to quality prescription drug plans and to Medicare Advantage plans throughout the country. We have combined the expertise and experience of our staff with that of the experts who have joined the agency, including leaders from the Federal Employees Health Benefits Program, pharmacists, or other health professionals and benefit managers from the private sector. Much like FEHB, we have sought to develop a transparent process that provides predictable and sensible oversight. And we have augmented our own capabilities by listening carefully to ideas and perspectives from many diverse outside groups through an extensive public comment process about our regulations and guidances and application materials and other support documents.

For example, as part of our work with the potential prescription drug plan and Medicare Advantage sponsors, we held four conferences around the country. Sponsors found the opportunity to meet with our leadership and our subject area experts extremely valuable. March 23, as you mentioned, was the deadline for sponsors to submit applications to participate in the program in 2006, and we are holding a similar conference in Baltimore today to make sure that we are very clear about the requirements for the final bids that are due on June 6.

I am pleased to say that we have seen a very strong response from organizations interested in participating in the Medicare Advantage and prescription drug plan programs, clear evidence that our new hires and our restructuring are getting the job done. Based on the high interest level, CMS is confident that throughout the country beneficiaries will have access to prescription drug plans on schedule on January 1, and we do not think we will need the so-called fallback provision because all areas of the Nation are on track for having sufficient health plans.

In fact, we have already seen an unprecedented response to our implementation of the new Medicare Advantage program in 2005. We have received over 130 new Medicare Advantage plan applications this year, including 50 plans completely new to the Medicare program and around 80 new preferred provider organizations, PPOs. And we have received more than 70 proposals for expanded service areas.

As a result, we are headed for 49 States participating in the Medicare Advantage program this year. Based on the applications that have come in, we expect well over 90 percent of all Medicare beneficiaries to have access to these lower-cost health plans in 2005, and that is the highest level ever in Medicare's history. And

it is not just in the big cities anymore. Three-fourths of rural beneficiaries will have access to a Medicare Advantage plan.

These much improved health plan options are really important because they enable beneficiaries to get better benefits and to lower their health costs more than ever. Based on the benefits that are available now, Medicare beneficiaries can save an average of almost $100 a month when they enroll in a Medicare Advantage plan compared to traditional Medicare with its gaps in coverage or to buying an individual Medigap plan to fill in these gaps. And with our increased use of risk adjustment that targets additional payments to Medicare Advantage to beneficiaries with chronic diseases, there are greater opportunities than ever for beneficiaries with chronic illnesses to save through the comprehensive benefits and better coordination of their care. In fact, more than 40 plans are offering special needs programs, that is, programs specifically targeted to our beneficiaries who are frail and have multiple illnesses, this year, and we expect well over 100 special needs plans next year.

But we know that providing up-to-date benefits is not enough to lower health care costs and improve health for our seniors. For this reason, we are developing and implementing a comprehensive education and outreach campaign, including unprecedented collaboration with other government and private organizations, to support our beneficiaries in getting help with Medicare's new coverage.

The three phases of this education campaign focus first on awareness and the sources of help; second, on education to make an informed choice; and, third, on targeting those who have not made a choice yet, to help them understand the benefits of the program later in 2006.

Our central office and our ten regional offices are working with the Social Security Administration, the Administration on Aging, with other Federal agencies, with States, with State Health Insurance Assistance Programs (SHIPs), plans like the one you mentioned, with employers, unions, national and community-based organizations, and private organizations to educate beneficiaries and their caregivers and others at a grass-roots level to give them the support they need to make an informed choice. So, Senator Carper, that is very important, as you said.

And, of course, we appreciate the support of Members of Congress, like all of you, to help educate beneficiaries about how they can get this help to lower their medical costs. Groups like OSHIIP in Ohio and the Access to Benefits Coalition and you, Mr. Chairman, have been very important assets for seniors, and it has been extremely helpful in getting us moving in the right direction for implementing the law effectively.

We are working hard at CMS, and we have made a tremendous effort to move toward full implementation of the new benefits created under the Medicare law on schedule. So, again, I want to thank you for the opportunity to update you on our progress in implementing the Medicare prescription drug coverage and for your support in making sure we have the strongest possible organization to take advantage of the tremendous opportunities provided by the Medicare law. I want to thank all the Members of this Subcommittee who may want to add to the Medicare benefit legisla-

tively and bring in even more coverage, but who are also working with us constructively to make sure that we are using the Medicare law that we have now to get the most help to seniors.

Thank you very much, and I would be happy to answer any questions you all may have.

Senator VOINOVICH. Thank you, Dr. McClellan.

All of us are interested in having our people take advantage of the program. I know in my State we have 650,000 people that are at or below 150 percent of poverty. Many of those people today, most of them, have no drug coverage. This new plan will provide them with drug coverage. For a generic drug they will pay $3. For a name brand drug it will be $5. So it is really important that these folks get all the information they need to take advantage of this wonderful benefit that is being made available to them.

A new Congressional Research report on beneficiary information concluded about the program, the temporary card, "The outreach and education experience of the discount card program can offer lessons for implementing the Medicare prescription drug benefit beginning in 2006. Then decisions beneficiaries must make are likely to be more complex and the stakes higher for not enrolling or selecting a prescription drug plan that does not target an individual's needs as well as alternative plans."

What I would like to know is what lessons have you learned thus far in implementing the card, the temporary card, that are going to accrue to the benefit of fully implementing this program.

Dr. MCCLELLAN. Mr. Chairman, as you know, the Medicare discount drug card program was a temporary program that we implemented quickly to provide help to seniors who were paying the highest prices for their medicines, and especially seniors who were having to choose between drugs and other basic necessities. That drug card, as you mentioned, is now providing assistance to almost 6.5 million beneficiaries. Those millions of beneficiaries are getting billions of dollars in drug savings.

Let me talk about two types of lessons we have learned. One is on the operational side, and the other is on the outreach and educational side.

On the operational side, we found some challenges when drug discount providers had only a limited amount of time to get an application together and get it in to us. So with the drug benefit we are taking advantage of the additional time we have. It is not a lot of time, but it is more than we had to implement the drug card, to have some discussions between the potential drug plan sponsors and the Medicare program. We have modeled this on the way the Federal Employees Health Benefits Program successfully does business. We have an exchange of information to help make sure that we have answered questions and overcome obstacles with the drug plans being developed, that they meet all of our standards and that they do so in a way that provides the best deal for beneficiaries. That is paying off with the tremendous response that we have seen for participating in the drug benefit next year.

The next part is on outreach, and we have seen that direct interactions with beneficiaries over a prolonged time period can really help in informing them about new benefits. This is not just a new finding with the drug card. We have known for every low-income

assistance provision that the Department of Health and Human Services ever implemented, as well as other changes in Medicare benefits. The more we give seniors and our beneficiaries clear and simple information and the earlier we can start, the better.

We have taken several steps to do just that. For example, we have worked with the Social Security Administration to develop and finalize a low-income subsidy eligibility application, which is being field-tested right now, and in the next month or so will be sent out nationally to everyone who may be eligible for the low-income subsidy. That gives us even more time to get low-income beneficiaries enrolled. Previous low-income assistance programs often took a decade to get up to 50 percent participation, we are going to try and overcome that by using simpler forms, by getting them out earlier, and by relying on much more extensive grassroots support.

Senator VOINOVICH. Are the number of plans going to be less than the number of cards available under the old program? The problem is that so many seniors just had too many options available and it made it very difficult for them. In addition to that, many of them are not computer literate. Maybe 15 years from now it will be fine, but the fact is they are not computer literate. Have you done anything to try and reduce the number of options that these individuals will have available to them?

Dr. MCCLELLAN. Senator, we do not know exactly how many drug plans are going to be available. I am confident that we are going to have a significant availability of drug coverage in every area of the country. I don't think it is going to be anything like the overall numbers with the drug card. But we have also learned——

Senator VOINOVICH. Well, are you going to put people into a program? If you recall, at the end, because we were very upset because so many low-income people were not taking advantage of it, you identified people that were eligible and sent them the information. At that stage of the game they were in a program, and then if they did not want to, they could opt out of it.

Dr. MCCLELLAN. Right. We are going to get our identifiable low-income beneficiaries into drug coverage. So for the dual-eligible beneficiaries, people who are in Medicaid drug coverage now and are going to transition to Medicare drug coverage in January, we are working with the States to identify all dually-eligible beneficiaries early. Additionally, we are working to ensure they are notified in early October about the plan that they will be assigned to in January, if they do not make a choice on their own. That gives them, their caregivers, their institution, if they are in a facility, and their health plan 3 months to prepare for their transition. They can also switch month to month.

In addition, for other low-income beneficiaries, as long as we can identify them, we are going to make sure they get drug coverage by the end of the open enrollment period. The key is getting that low-income subsidy application filled out. For people who we have identified because they are in one of the limited Medicaid benefit programs, the so-called Medicare saving programs, like SLIMB and QMB, we will work with the States to identify those people, enroll them automatically in the low-income subsidy, and get them into drug coverage.

But the other group that we want to reach are those low-income seniors that you mentioned, Senator, who are not getting any help with their drugs or other medical costs. In many cases, we have been able to get them signed up for the drug card and the $600 in assistance and the wrap-around subsidies. Those people we do need to get enrolled in the low-income subsidy so that they can then be subsequently enrolled in the drug card if they do not make a choice on their own.

So, yes, we are planning on enrolling many of these beneficiaries automatically in the drug benefit, and that is why we are starting this process so early this time. This is something that we learned from the drug card experience, that we want to take advantage of all the time we have because these populations can be very challenging to reach.

Senator VOINOVICH. Thank you. Senator Akaka.

Senator AKAKA. Thank you very much, Mr. Chairman.

Dr. McClellan, there are approximately 60,000 dual-eligible HIV/AIDS patients along with 6 million other dual-eligible beneficiaries in the United States. The final regulations have no grandfather clause covering drugs that dual-eligibles have been stabilized on under Medicaid. The question is: How will CMS avoid forcing beneficiaries to change their medications if the drug plans do not provide the same coverage as Medicaid?

Dr. MCCLELLAN. Senator, the first thing we are going to do is require the drug plans to provide beneficiaries access to all medically necessary treatments. And we have worked extensively with advocacy groups for our vulnerable Medicaid beneficiaries who often have illnesses that requires them to depend on particular medicines for AIDS, for mental illnesses, and for other sensitive and complex conditions.

As a result, we issued not only this regulatory requirement for access to medically necessary treatment, but we have backed it up with further regulatory guidances. Let me give you an example of a couple of those.

One of those is our guidance on formulary coverage for the drug benefit, and the formulary coverage is very explicit about——

Senator VOINOVICH. Dr. McClellan, you keep using the word "formulary." Could you explain what a formulary is, please?

Dr. MCCLELLAN. A formulary, Mr. Chairman, is a list of drugs that are covered under a particular drug plan, those drugs get the most favorable subsidies from the drug plan and can be obtained at the lowest cost by the beneficiaries in the plan. Drug plans are also required to have an exceptions and appeals process for access to off-formulary drugs that are medically necessary. And we have tried to make that process quicker, faster and simpler as a result of the regulations and the input that we have received. But the main goal is to have a smooth process for people to get access to the drugs that they need within their drug benefit, and that is why in our formulary guidance, we explicitly said that HIV and AIDS drugs, and other important types of drugs, must be adequately covered. In particular, for the HIV and AIDS drugs, we said that substantially all or all must be covered. That is the test in our CMS formulary review. And we are further requiring that the coverage

reflect the kind of coverage that is widely available in some of the best private plans and Medicaid plans today.

So, for example, the most popular plans in the Federal Employees Health Benefits Program cover typically, on formulary, 25 or more HIV/AIDS drugs because the beneficiaries need access to those particular drugs because of the complexity of their disease. And we are going to require the same kind of oversight for the drugs offered in the Medicare program.

Second, when there are requirements for a drug transition—and I think these are more likely to be when you transition, for example, one cholesterol-lowering drug to another. Beneficiaries can get much lower prices when you can negotiate and get people switched to another drug that meets their needs as effectively. The plans must also meet well-established best practices for any medication transitions. That often involves giving a patient more time on a particular medicine as well as making sure that the medicine that is the subject of the transition is likely to meet the beneficiary's needs. If the beneficiary has already tried a drug and it has not worked, we are not going to make him go back to that.

So there is formulary guidance, there is transition guidance, and there is our regulatory oversight to require plans provide access to needed drugs. And we are relying on the best practices of existing drug plans to do that.

Senator AKAKA. Thank you for your response. My time is almost up. I hope we have another round, Mr. Chairman. Thank you.

Senator VOINOVICH. Senator Levin.

Senator LEVIN. Thank you, Mr. Chairman. Thank you again, Dr. McClellan. I want to talk about the statement that you made that you expect that in all of the regions there will be at least two private plans that will be offered to beneficiaries and, therefore, there will be no fallback triggered, so that there will not be provisions by Medicare itself or the offer of a plan by Medicare itself. That means that you are budgeting next year, I assume, for no costs for that fallback. Is that correct?

Dr. MCCLELLAN. Well, that is correct, but we are planning for all contingencies, and what I can tell you now is that based on the response that we have seen, if we are able to stay on the track that we are on now, we will get those drug plans available everywhere, and we will not need the fallback.

Senator LEVIN. And I take it that is your goal.

Dr. MCCLELLAN. Absolutely, and I think we are on track to achieve that goal.

Senator LEVIN. So the goal is not to trigger a fallback.

Dr. MCCLELLAN. Well, the goal is to trigger access to up-to-date coverage for all of our beneficiaries in all areas.

Senator LEVIN. With private plans?

Dr. MCCLELLAN. And it looks like the health plans are going to be able to deliver that coverage everywhere.

Senator LEVIN. Is the goal to have private plans deliver that type of prescription drug benefit?

Dr. MCCLELLAN. The main goal, Senator, is to get drug costs down for seniors right away and to make sure that their coverage does not fall behind again, like it has over the last several decades. And the health plans are going to enable us to do that.

Senator LEVIN. All right. Now, what are the ways in which you will try to avoid the cherrypicking problem? Since the premium and the co-pay is within the discretion of the company, the private company—there is no limit on those and, therefore, they can have a very high co-pay and cherrypick healthier seniors mainly through using a high co-pay. How are you going to be sure that there are not only two plans or more in each region but that at least one of those plans is an affordable plan for people who are sicker?

Dr. MCCLELLAN. Well, Senator, our main focus is on making sure all of our beneficiaries have access to the drugs they need, and I have already talked about some of the regulatory requirements that we are imposing to make sure that plans provide access to coverage.

Now, I talked about the formulary requirements a minute ago, and I want to make clear that our oversight and our regulatory guidances apply to other tools used by the drug plans, like how they structure their co-pays and which drugs are preferred drugs on their formularies. And we will be enforcing the rules to make sure that there is not discrimination against any particular type of beneficiary.

Once again, there are good examples of how you can do this from the private sector, and we will be looking to make sure that those kind of co-pay structures are used to prevent discrimination against any type of our beneficiary.

Beyond that, there are actuarial requirements that the drug plans have to meet. They cannot require high co-pays on every drug. They must meet the actuarial standards in the law for a 75-percent subsidy between drug spending at $250 and $2,250 where most seniors have much of their drug spending. They must all provide catastrophic coverage for beneficiaries who have high out-of-pocket costs. And they must provide comprehensive benefits to low-income seniors.

So through all of those steps—our regulatory oversight, our requirements that the plans meet the strong benefit intended by the law—we are going to make sure that the plans do not discriminate against any type of beneficiary.

Senator LEVIN. The co-pay, though, is left up to the private company.

Dr. MCCLELLAN. Within our oversight. They can, just like they do now in mainstream health insurance plans, in retiree plans, like for your automakers in the Detroit area, have tiers and have preferred drugs and non-preferred drugs. The requirement, though, is that they cannot discriminate against any types of beneficiaries in the process. We will be comparing the co-pay structure and the other tools used by the drug plans to widely used best practices and retirees plans and the Medicaid plans to make sure that does not happen.

Senator LEVIN. And those regulations have been written?

Dr. MCCLELLAN. The regulations have been written, and not just the regulations but we have issued specific guidances on our formulary oversight, on our oversight of co-pays and other tools used to manage drug costs, on drug transitions. You name it. We are trying to cover comprehensively based on the input we have re-

ceived from a lot of groups who are very concerned about making sure we address this problem effectively.

Senator LEVIN. I am less optimistic than you are about avoiding the cherrypicking problem, but you are telling us that you then are designing your regulations and you will predict for us that problem will be addressed and that there will not be cherrypicking so that all seniors across the level of fragility will be participating, not just being offered plans.

Dr. MCCLELLAN. The intent of the regulations——

Senator LEVIN. If the plans are not affordable for everybody, you are saying that it is your goal—and you predict you will achieve this goal—that seniors of different levels of sickness will participate in these plans. Is that what you are telling us?

Dr. MCCLELLAN. That is right, and we think the plans are going to be particularly attractive to beneficiaries with chronic illnesses where using these drugs can help them avoid other medical complications and costs. So we will be implementing our regulations, we are applying our regulatory guidance now to applications that have come in to make sure that they reflect, again, widely used best practices in formularies and drug benefit management.

Senator LEVIN. I understand. If I could conclude this, Mr. Chairman, with just one more question.

What percentage of seniors do you predict will participate in these plans that will be offered now in every region by the private sector? You said you believe that there will be at least two or more offered in every region. What percentage do you believe will participate? Do you have an estimate of that?

Dr. MCCLELLAN. Well, there are actuarial estimates out from the Congressional Budget Office, from our own independent actuaries, and other sources, and those have projections of very high participation levels.

Senator LEVIN. Give us the percentage that you are predicting.

Dr. MCCLELLAN. I think their participation rates are close to 90 percent, something in that range. I think Senator Carper mentioned the issue of how you think about launching a new product, and this is something that is new. It is new for Medicare. It is new for seniors. And it is a topic that is complicated and that seniors are going to have to spend a little time understanding because it is so important for their health.

What I think that means is that we are not going to see dramatic sign-ups overnight, that over time, by letting seniors know what is coming, by making them aware of the details in ways that are very relevant and understandable to them this fall, by seeing what their experience is in the first months of the program, we will see more and more sign-ups. We are definitely expecting tens of millions of seniors to enroll in this program, to get help. No matter how they get their drug coverage now—through retirement benefits, through State-sponsored plans, through Medicare Advantage plans—we are expecting tens of millions to enroll, and that is the big focus, on making sure that those beneficiaries are informed about their opportunities to save next year.

Senator LEVIN. Thank you. Thank you, Mr. Chairman.

Senator VOINOVICH. Senator Carper.

Senator CARPER. Speaking of product launches, yesterday was the launch of the baseball season, and Senator Levin and I are big Detroit Tigers fans, and we got out of the starting gate in pretty good fashion yesterday, 11–2.

Senator LEVIN. We are in first place.

Senator CARPER. First place. This is the team that, I think, 2 years ago was second to the New York Mets, was the all-time losing baseball team in America. This year we are going to vie with the Cleveland Indians for the Central Division crown in the American League. So we will see how those Indians came out of the starting gate yesterday as well.

I have two questions, Dr. McClellan. I want to go back on one of them to something that Senator Voinovich raised a minute ago, I think. And just take a minute and just talk with us again. How does CMS plan to ensure that, to the best of the ability of the States, they identify all the dual-eligibles? How can you help them do that? It is a tall order.

Dr. MCCLELLAN. This is a very important issue. We want to make sure that there is a smooth transition, and the way to do that is to ensure that it does not happen between December 31 and January 1 but, rather, it begins early and it has a smooth process to get beneficiaries in the new plan in January. There are many facets to this, and in the limited time I am just going to give you a few examples.

One is that we are working with States right now to make sure that we have all of their dual-eligible beneficiaries identified. States are sending us lists of those beneficiaries now, and we are preparing to start contacting them and their caregivers about the changes that are coming.

Second, by early October we are going to let them know what plans are available in their areas that they will be able to choose for free and that they will be able to get access to for no premiums, no gaps in coverage, and, as Senator Voinovich said, just a few dollars in co-pays, we are going to assign them to a plan if they do not choose one on their own by January 1. We are going to do that by early October so that the plan, working with the beneficiary and the beneficiary's caregivers, can start planning for a smooth transition.

Beneficiaries who are dual-eligibles can change anytime. They do not have to stick with the plan that we assign them to. They can go to a different one that is available in their area. In fact, even after the benefit starts, they can change month to month if there is a benefit that they think would be a better fit for their personal needs.

In addition, we have developed a guidance for the transition of beneficiaries in Medicaid programs, and we are working with the States and the health plans to make sure that they follow that guidance. The guidance focuses on issues like medication transitions to make sure that if there are any medication transitions they are handled appropriately, combined with our guidance on access to medically necessary treatments. We think many of the beneficiaries are going to be able to continue the drugs that they are on, especially since many of these formularies are going to be pretty broad and the co-pays for these dual-eligible beneficiaries are

very low, just a few dollars. So those are some of the steps that we are taking.

Another step involves using electronic health systems to help support this effort. We are planning for the contingency that, in spite of all of the effort we undertake, there are going to be people who are on Medicaid who show up at their pharmacy in early January and say, "I want a refill," and are not going to know any of these specific details. We are implementing an electronic coordination of benefits system so that a pharmacist sitting right there at the counter, as long as this person knows their name and their date of birth, just some basic information, they will be able to tell that individual what plan they are in, what their coverage is, and get those prescriptions filled appropriately.

Finally, there are steps that States can take to help make the transition work better. For example, we have notified States that, at their option, if they want, they can fill 3-month prescriptions in December that would effectively extend the transition period through March, and they will get the full Federal match for those provisions. Senator Rockefeller has talked about legislation along these lines, and we can do 3 months administratively at State option.

We are having specific contacts with States about this. We have a major conference sponsored by the National Governors' Association coming up later this month in Chicago to go over the specific transition issues, and we are going to have a specific team in place with each State to make sure that they are keeping up with the checklists of the things that need to be done for a smooth transition.

Senator CARPER. But other than that.

Dr. MCCLELLAN. We are trying to keep busy.

Senator CARPER. Good enough. My second question deals with the number of personnel, the kind of resources, personnel resources you are able to apply to, I guess, reviewing all the plans that are being proposed. I understand as many as a couple thousand are going to be submitted. I have heard that you may have as few as 10 full-time personnel to actually review all of those and I think over maybe a month-and-a-half period, which is not much time and is a lot of work in order to do it well.

First of all, is there any basis to what I have heard?

Dr. MCCLELLAN. Well, I do not know about the couple of thousand plans. We have received a lot of applications, but I think that number is on the high side. And that gets back to the earlier point about the importance of having time to do this effectively. We have divided the process of getting the bids in and getting the plans provided into several steps. We had early notices of intent with the plans back in February. That led to some preliminary discussions to make sure that the plans knew exactly what we were expecting in terms of applications. We had an application deadline on March 23, which included a lot of the details about formularies and where the service areas are going to be. And then the final bids are due in June.

What we have effectively done is have this multiple-step process so that we can spread out the work, deal with issues earlier, and make sure that we can provide some close oversight and coordina-

tion with the plans so that they are meeting our objectives and our requirements for offering a Medicare drug benefit. At the same time not only does the plan have a clear idea about what to expect, we have a smoother workload flow in process. This is the way the FEHB has done business successfully for many years, back and forth a dialogue at each step in the process.

Beyond that, we have a team of individuals assigned to reviewing each and every application. It is not 10 people versus 2,000. We have a lot more staff at CMS that are meeting this workload, and we have been tracking this very closely. We have a very clear idea about the maximum number of bids that we are going to receive because we have all the applications in now. The staff is meeting the workload burden of reviewing the applications, and we are planning ahead for the actuarial, technical, and other reviews that are going to go along with the final bids when they come in.

Senator CARPER. Any idea how many applications you have received?

Dr. MCCLELLAN. I do not have an exact number now. The deadline was just a week and a half ago, and I want to divide the applications into those that look complete and serious and likely to meet all of our requirements and those that may not be so promising. But we will try to get you the numbers on that as soon as we can.

Senator CARPER. All right. And in closing, I would just ask that you keep in mind, whether it is 2,000 or 1,500, whatever, that is a lot, and to make sure that you have the adequate resources to vet it well. Thank you.

Dr. MCCLELLAN. I appreciate that. Thank you, Senator.

Senator VOINOVICH. You talked about the Advantage plans. Could you explain what those plans are. I assume it is something like an HMO where somebody would sign up and that HMO would be given X number of dollars and they would provide services, ordinary Medicare services, and now they would have an additional drug benefit. How would that work? And would they help the individual that was in that Advantage plan to make the right decision in terms of the drugs that they should be—the plan that they should go into or will they have a plan of their own? How does that work?

Dr. MCCLELLAN. That is right. In general, Senator, the Medicare Advantage plans have their own drug benefit as part of the plan, and that is part of the advantage of coordinated care. We are expecting a lot of the Medicare Advantage plans to offer more generous drug benefits beyond just the basic Medicare statutory requirement. The reason for that is that through care coordination they can keep their overall costs down and provide more benefits to seniors. That already happens now. Many Medicare Advantage plans—most of them—are providing some limited drug coverage, and now with the new drug subsidy in 2006, they will be providing much more.

They found that providing effective drug coverage and giving people affordable access to medicines helps them keep costs down in other areas. It helps them keep their patients with heart failure out of the emergency room. It helps them keep their patients with diabetes from experiencing complications that lead to surgery and circulatory problems and the like.

We are also reinforcing this aspect of care coordination by increasingly targeting the money that goes to Medicare Advantage plans to the plans that are taking care of beneficiaries with chronic illnesses. We are doing this through risk adjustment. We are going to 100-percent risk adjust our payments to the plans. That means that if you are a coordinated care plan, you have to attract chronically ill beneficiaries and serve them well in order to make any——

Senator VOINOVICH. How many Medicare-eligible people in this country are in Advantage plans, what percentage?

Dr. MCCLELLAN. We are over 5 million enrollees now, and this has been increasing by 50,000-plus a month in recent months. So that is about 14 percent, and it is growing substantially because these plans are offering better benefits and lower costs and they are more widely available in Medicare than ever before. And this is not just HMOs. That is historically the main kind of coordinated care plan in——

Senator VOINOVICH. In other words, if I am an individual out there and I am on Medicare and I do fee-for-service, I go to see a doctor and I have something wrong with me and they get reimbursed for it, under ordinary circumstances what I would do is I would sign up for Part D separately from that.

Dr. MCCLELLAN. Separately from that.

Senator VOINOVICH. So then I would have my A, B, and D.

Dr. MCCLELLAN. That is right.

Senator VOINOVICH. Right, or I would have the alternative to check around in my community to find out if there is an Advantage plan where I could enter into that plan, they would get the money from CMS, and they would then take care of looking after me in terms of my health care and my prescription drug needs.

Dr. MCCLELLAN. That is right, and they would have a comprehensive set of benefits, and they increasingly cover services beyond the minimum that Medicare offers. So, for example, AltCare is a good example of a coordinated care plan in Ohio that is run by doctors and that focuses on taking this holistic approach to keeping a patient healthy. They do not think about doctor visits separately from drugs, or separately from hospitalizations. They think about the patient. How do you help a patient with heart failure, diabetes, or asthma, or another chronic disease stay well and get the most out of their health care? By combining this new drug coverage with the other coordinated services they provide, including wellness services, or visiting patients in the home when they need help in managing their medications, they can take a lot of steps to keep overall costs down and, most importantly, to keep patients with chronic illnesses healthy.

Senator VOINOVICH. Thank you. Senator Akaka.

Senator AKAKA. Thank you, Mr. Chairman.

Dr. McClellan, I understand that soon seniors will be asked to select a drug plan. CMS will be responsible for counseling and outreach for seniors and vulnerable populations, such as individuals suffering from mental illness.

As you know, the MMA required GAO to examine the accuracy and consistency of answers provided through the Medicare toll-free help line that is supposed to provide answers to questions about

program eligibility, enrollment, and benefits. Unfortunately, GAO's findings were not encouraging. Accurate answers were provided only 61 percent of the time, inaccurate answers were provided 29 percent of the time, and no answer was provided for the remaining 10 percent.

Given these results, what assurances can you provide this Subcommittee that CMS outreach efforts on implementation of the regulations will be more effective?

Dr. MCCLELLAN. Well, let me answer that in two parts. First, we want to make sure that accurate information is available through our 1–800–MEDICARE number.

Second, 1–800–MEDICARE is only one of a number of sources that are going to be available for seniors starting now and throughout the year to help them learn about and get the most help from the drug benefit.

On 1–800–MEDICARE, that GAO survey asked a set of hypothetical questions that are not necessarily what our customer service representatives actually are faced with when beneficiaries call in every day. We have an ongoing independent review process that checks how accurate the information actually provided by our customer service reps are on the calls that come in.

We have been monitoring that very closely, on an ongoing basis. We review a sample of all of the calls in every single month, not just a one-time asking of hypothetical questions. And I am very pleased that we are maintaining accuracy rates—meaning the beneficiary was satisfied with the answer, the answer was independently reviewed and found to be accurate—well over 90 percent of the time. We have a quality control process built in for when the answers are not complete and are not accurate and are not given in a timely fashion to make sure that is the case.

There are several other reasons for the GAO's findings that we pointed out in our response, when you actually interpret it properly, and get the numbers up and in line with what we are seeing in these ongoing independent evaluations of 1–800–MEDICARE. This is very important to get right.

Third, as you mentioned, we need to make sure that we are doing actual outreach at the grass-roots level to a lot of beneficiaries who may not be able to call in or may not be able to use a computer. I was at an event in Philadelphia at a senior center recently where they are organizing grass-roots outreach teams that are using the Internet but in support of beneficiaries—they are not counting on the beneficiaries to use them directly—to get them informed and then signed up for benefits this year, and I had not one, not two, but three translators at that event. They are focusing specifically on their beneficiary populations that do have language barriers or do have cognitive impairments, just as they provide assistance now with helping those beneficiaries get access to the coverage they are eligible for in Medicaid and helping them manage their health costs.

So those grass-roots efforts are very important in addition to making sure we have effective 1–800–MEDICARE answers.

Senator AKAKA. Thank you for that response, Dr. McClellan.

In recent testimony before the Senate Committee on Finance, the HHS Inspector General nominee, Daniel Levinson, testified that

prescription drugs are especially vulnerable to fraud, waste, and abuse. And he said, "It is therefore essential that the CMS build a sound infrastructure for program implementation with strong internal controls, adequate data collection to enable proper oversight, and sound financial management systems."

How has CMS addressed these concerns?

Dr. MCCLELLAN. Well, I agree completely with Mr. Levinson's statement. He is a man of great integrity who is watching closely what we are doing in this area and has had great advice for us. I hope he gets confirmed by the Senate soon.

Here is another case where we have learned a lesson from the drug card. With the drug card, early on we contracted with a program integrity organization that has helped us with monitoring the financial transactions with the drug card, with making sure there was not any bait-and-switch, and keeping a close eye out for exactly the kinds of things that you are worried about. We made that announcement, instituted it in April, 2 months before the drug card started, and we have been monitoring the drug card very closely. We have seen no systematic evidence of any fraud or abuse or even misleading statements by cards, and we have been right on top of any minor violations to get them corrected and to help the program keep working smoothly.

We are going to do the same thing with the drug benefit. We will have program integrity oversight in place, we have special contractors that are making sure that the money is used appropriately, and that the subsidies are spent on their intended purposes of helping seniors get access to affordable medicines. We will be watching that very closely with a lot of help and a lot of tight oversight from the Office of the Inspector General.

This is a very important area for making sure that we continue to have a high level of program integrity. We have also requested additional funds in our fiscal year 2006 budget to help us meet these new responsibilities, which we take very seriously.

Senator AKAKA. Thank you. Thank you, Mr. Chairman.

Senator VOINOVICH. Senator Levin.

Senator LEVIN. Thank you, Mr. Chairman.

The Act that we are talking about contained tax subsidies to encourage employers who keep their retirees covered with prescription drug coverage. The threshold which was used by the bill is called "credible prescription drug coverage," so that if a company maintains that credible prescription drug coverage they will then get a tax subsidy for doing so.

Has the criteria for what is credible been set forth already in the regulations?

Dr. MCCLELLAN. Yes, sir, it has.

Senator LEVIN. OK. And who makes the decision as to whether a particular company meets that criteria? Will that be a Medicare decision, an IRS decision, or a combination?

Dr. MCCLELLAN. It will be a Medicare decision done by our independent actuaries. It is an actuarial test that the coverage is of high quality and that the money we are providing in the subsidy is going to the beneficiaries to support their coverage.

Senator LEVIN. Now, when we were debating the bill, the Budget Office estimated that once it was fully implemented by CMS that

as many as 25 percent of retirees with existing prescription drug coverage would still lose the coverage despite those subsidies. According to one estimate, that would be about 2.5 million retirees who now have good coverage from their former employer who would lose that coverage or have it significantly reduced.

Do you agree with that estimate, first of all?

Dr. MCCLELLAN. No, and this is a good example of why the interaction in our process of developing the regulations and issuing guidances is so important. We have developed a number of steps that employers can take to continue and enhance their drug coverage, and there are lots of ways to do it. The bottom line is that we want to make sure beneficiaries are better off. From what we are seeing in recent surveys, about 90 percent plus of employers are planning to continue their coverage in one way or another, and continue their support for beneficiaries. There are a lot of ways they can do it, not just with this employer subsidy. And I can talk about that if you are interested.

Senator LEVIN. This is for retirees, we are talking about.

Dr. MCCLELLAN. This is for retirees that we are talking about, and then there are some retirees who are just in access-only plans. It is not like the Big Three automakers. This is where the retirees are paying for all their coverage on their own. Those retirees may well be substantially better off in the new highly subsidized Medicare drug coverage. So we are not expecting that kind of drop rate at all.

Senator LEVIN. What is the drop rate you are predicting?

Dr. MCCLELLAN. Well, in our final regulation we talked about approximately 90 percent of beneficiaries having coverage either through continuing the current coverage with the retiree subsidy or through the employer doing what is called a wrap-around. They get the basic Part D benefit, and then they fill in gaps, just like many employers do with retirement benefits. We pointed out that, right now, this other small group of beneficiaries is not getting help from their employer. So they are going to be better off, and they are going to get lot bigger subsidies in Part D, which is subsidized coverage, than they would from any unsubsidized employer coverage. But we are expecting, from what we are hearing and what all the surveys of businesses are showing, that the vast majority of employers are going to take advantage of the new help from Medicare to continue or to improve their coverage.

Senator LEVIN. So is your prediction that 90 percent of employers essentially will maintain their coverage or better for their current retiree——

Dr. MCCLELLAN. Or they will—through one mechanism or another. They can either use the retiree subsidy or they can wrap around the basic benefit. In working with States like Michigan, they may be better off financially doing a wrap-around. But the point is to continue and improve coverage for retirees.

Senator LEVIN. That leaves somewhere around 10 percent who will be worse off?

Dr. MCCLELLAN. I do not think they will be worse off.

Senator LEVIN. Will there be anybody worse off?

Dr. MCCLELLAN. Well, we are obviously trying to minimize that number.

Senator LEVIN. I know what your goal is. Are you projecting that there will be any retirees who will lose their coverage that they now have?

Dr. MCCLELLAN. We have not been able to do specific projections at the level of each and every beneficiaries.

Senator LEVIN. Just a gross number?

Dr. MCCLELLAN. What our actuaries projected was that there was going to be a substantial increase in the total support for retiree coverage. Now, we have the government working with employers to support the coverage, not just the government alone—not just employers alone.

Senator LEVIN. So your actuaries are not projecting that any retirees are going to be worse off.

Dr. MCCLELLAN. They have not done detailed specific estimates at the level of each and every firm. I can tell you that we are working with small employers, large employers, States, all of them, to help make sure they take advantage of the new subsidies to get that——

Senator LEVIN. I understand that. You have said that here. But that means the glass may be 90 percent full. I am just trying to figure out how empty it is.

Dr. MCCLELLAN. Well, the glass is——

Senator LEVIN. It is OK because I am running out of time and you are trying to make sure there are none. But you are not willing to tell us that there is a projection as to how many will be worse off.

Dr. MCCLELLAN. Our projection is that the glass is going to get a lot fuller.

Senator LEVIN. A lot fuller, but you are not willing to tell us how much fuller.

Dr. MCCLELLAN. I cannot give you an exact number for each and every——

Senator LEVIN. Or an approximate number.

Dr. MCCLELLAN. I think it is around 90 percent, and the rest, they are probably better off.

Senator LEVIN. You are not going to give us an approximate number. That is OK. I just want to ask my last question. I give up trying to get the answer to that one.

When the GAO finds, as it has, that the CMS violated the Anti-Deficiency Act by spending appropriated taxpayer dollars on the unallowable activity—we are talking here about those commercials—CMS is required by law to file a report relative to that finding of that violation to the President, Congress, and the GAO, even if it disagrees with the GAO's determination. And I don't doubt that you disagree with the GAO determination. At least I would not be surprised to hear that you do not agree with it.

First, are you going to follow it, even though the Justice Department says you do not have to? And, second, are you going to submit that report, which has to be required, even if you may not agree with the finding of the GAO? This is the area that Senator Lautenberg has been so creative and so determined to explore, not just with CMS but with a number of other agencies which have engaged in the same activity. So that is my specific question. It has to do with that report. First, are you going to file the report re-

quired by law? Second, are you going to follow the GAO's recommendation even though the Justice Department says you do not need to?

Dr. MCCLELLAN. Well, Senator, I am going to make sure we fully comply with the law and that we are transparent with Congress and everyone else in all of these sensitive issues. Now, I am a doctor and not a lawyer, and our main focus is on getting accurate information out to beneficiaries. But we absolutely want to make sure that we do that in full compliance with the law.

As you know, the Department of Justice sets the rules for the Executive Branch for interpreting the law, and they do have a disagreement with the GAO on this particular issue. The Department of Justice's Office of Legal Counsel, which has the binding legal authority for the Executive Branch, says that our interpretation of the law in this case was appropriate. But, more importantly, I will make sure that we comply with the law in providing any information you want. I think the main goal here, which is to get accurate information to beneficiaries, is our foremost goal this year as we try to inform beneficiaries about the facts of the drug benefit. There are a lot of beneficiaries out there who do not have the facts, who do not think this benefit applies to them, who do not realize that it can help them save half or more of their drug costs. There are also low-income beneficiaries who do not realize that there is extra help and a comprehensive benefit for them.

So I want to make sure we are absolutely complying with the law and rely on the experts to make sure we do that, at the same time we really are focusing on getting accurate information out to beneficiaries.

Senator LEVIN. For a non-lawyer, you have been very deft.

Senator VOINOVICH. Senator Lautenberg.

Senator LAUTENBERG. Thanks, Mr. Chairman. Just a few brief things on the news reports.

Dr. McClellan, I heard what you said very clearly, and I just want to confirm it because I thought your statement was very positive in terms of response to what the law requires. I just want to draw this out so that everybody is clear on this.

We have a statement from the Government Accountability Office. They say that it is a violation of law. The Administration says they do not care.

Now, you are in charge here. Will you try to eliminate the distributing of these fake news reports? There is a responsible agency of government that says they are fake. So now the ball is in your hands. Has CMS stopped producing these video releases?

Dr. MCCLELLAN. I think you are referring to this video news release from a year ago. There has not been another one since then. But in terms of the legal authority here, as you know, in the Executive Branch I am bound by the legal interpretations of the Department of Justice, and the Department of Justice and their Office of Legal Counsel sees this issue a little bit differently than the Government Accountability Office.

Regardless of the technical aspects of the legal disagreements here, I want to make sure we get accurate information out about the drug benefit. We have not had any video news release since the one that you are mentioning from over a year ago.

Senator LAUTENBERG. But the declaration of war is already laid down there. The Administration is saying they do not care. I am not sure that those were the precise words, but that was the precise meaning. Are you prepared here and now to say that you will not permit anything in your Department to be prepared that goes out that imitates, that portrays a news release when, in fact, it is not?

Dr. MCCLELLAN. There has been a lot of attention around this issue over the past year. There have been no new video news releases issued since the one you are talking about from over a year ago, at a time when we have been doing an unprecedented amount of outreach and providing information to beneficiaries and working with other groups that do that. I am going to keep following effective approaches and I am going to make sure that we stay within the law in doing it. But the main goal is to make sure that beneficiaries get accurate information.

Senator LAUTENBERG So you are willing to step up and say that your Department, CMS, will absolutely be unwilling to have anything produced with your—that you have knowledge about that isn't factual as we would expect it to be in terms of not using actors, actresses, not using any means of seduction, either compensation or otherwise, to news broadcasters to color the issues?

Dr. MCCLELLAN. We absolutely want to follow the law, and these details happened before I got to the agency a year ago. From what I understand, though, the GAO wasn't issuing a finding relating to the accuracy of the information. They just said that they wanted a clearer identification that this was a produced news release, something that was not attributable to the Federal Government. And in two out of the three segments of that release, it was attributed to the Federal Government. They wanted it in that third segment. And, yes we will make sure we follow the law on——

Senator LAUTENBERG. There is a judgment about the accuracy of these things. I correct you here. There is a judgment about the accuracy. If the process is bad, does that suggest it is bad because those who are producing it want to tell the truth? Or is it bad because people are being given false information?

Dr. MCCLELLAN. Well, I want to make sure we are getting accurate information to beneficiaries. Over the past year, Medicare has developed a lot of materials in close consultation with outside groups, including many groups that did not support the Medicare law. These materials communicate accurately the basic facts about this being a drug benefit available for everyone, that it can provide help for everybody with Medicare regardless of how they get it, what their drug costs, and that the benefit provides extra help to low-income seniors. That is our main goal, and I want to be absolutely in compliance with the law.

Senator LAUTENBERG. So you are willing to say that your agency will not produce or pay for any releases that are sponsored by the government other than just the facts and not used for any coloration of the facts?

Dr. MCCLELLAN. Well, Senator, we are producing an unprecedented amount of information support, working with lots of outside organizations to get beneficiaries informed about the drug benefit accurately. And I absolutely want to make sure that the informa-

tion is not misleading, and obviously we are going to fully follow the law in doing this very important outreach and education effort.

Senator LAUTENBERG. Following the law as defined by government accountability?

Dr. MCCLELLAN. Again, the authority on what the law means for the Executive Branch is the Department of Justice. The authority for the Legislative Branch is the Government Accountability Office. They do differ sometimes in their interpretation of specific provisions of the law. In terms of our overall goal, though, of making sure beneficiaries have exact information, 99 percent of the time they agree, and that is what we are following in our implementation of this law right now. This outreach effort——

Senator LAUTENBERG. OK. So what do you do with the 5 percent that they do not agree on?

Dr. MCCLELLAN. We are bound under the Constitution to follow the Executive Branch legal authorities, and if there are further issues here, I am sure they can get sorted out.

Senator LAUTENBERG. If you were running a company, Dr. McClellan—and you are a very clever fellow, and I always enjoy seeing you——

Dr. MCCLELLAN. Thank you, sir.

Senator LAUTENBERG [continuing]. And talking to you. If you were running a company and the auditor said, look, this accounting statement is 95 percent right, and you say, OK, I am going to listen to the auditors. Now, if you know it is wrong, you are going to have to say it is wrong and that you will not permit it.

Is the $35 monthly premium the correct figure, or is just an estimate?

Dr. MCCLELLAN. It is an approximate estimate. Some may be lower, some may be higher. If beneficiaries get access to extra coverage because that is what they want, they may pay a little bit more for it. But that is the best estimate of the range of premiums. Some beneficiaries are going to pay less. That is the advantage of having choices that let beneficiaries get the care the beneficiaries need.

Senator LAUTENBERG. The regs are out. Don't they say $37?

Dr. MCCLELLAN. It is right around $35 to $37. Again, some plans are going to offer lower-cost coverage; some I expect are going to offer supplemental benefits at a higher cost, and seniors will be able to choose the coverage that is best for them.

Senator LAUTENBERG. Thank you, Mr. Chairman.

Senator VOINOVICH. Thank you, Senator Lautenberg. Senator Pryor.

OPENING STATEMENT OF SENATOR PRYOR

Senator PRYOR. Thank you, Mr. Chairman. Dr. McClellan, I appreciate your time and your patience with our questions.

The first question I have relates to the Medicare Modernization Act, and specifically, I know that several CMS employees have extensive knowledge of pharmaceutical issues given their experience in working with the Medicaid program. To what extent have those people been able to apply their Medicaid expertise implementing what is going on with the MMA?

Dr. MCCLELLAN. Extensive application, Senator. Just to give you an example, Gail Arden, who has been working on Medicaid issues for a long time in our Center for Medicaid and State Operations, is one of the key coordinators of our outreach and transition issues with the State for dual-eligible beneficiaries and also for the State pharmaceutical assistance programs.

You are absolutely right that we have a lot of expertise in the agency on Medicaid issues, and this is an agency-wide effort to implement the Medicare drug law effectively. That is the best way to make sure that States save money as intended, the best way to make sure that we get a smooth transition. So we are absolutely relying on their expertise.

Senator PRYOR. Let me stay with the MMA, if I can. This Subcommittee has jurisdiction over, "the management, efficiency, effectiveness, and economy of all departments, agencies, and programs of the Federal Government, including overlap and duplication of Federal programs." Chairman Voinovich has really been a bulldog on trying to keep the agencies accountable and trying to make sure that Congress exercises its oversight, which we should. One thing I noticed with the Medicare Modernization Act is that the MMA mandates that Medicare Advantage local programs receive an average of 107 to 109 percent of traditional Medicare payment levels, correct? Do you follow me so far?

Dr. MCCLELLAN. I think you are talking about the GAO estimate there.

Senator PRYOR. Right.

Dr. MCCLELLAN. Yes, I think the estimate is 107 percent.

Senator PRYOR. Right. However, experts believe that private plans will actually receive about 116 percent of the cost of the same patients in traditional Medicare because the plans serve healthier than average enrollees. Do you have any comments on that?

Dr. MCCLELLAN. The trend is getting our payments focused on the beneficiaries that have chronic illnesses and have higher costs. I was talking earlier about how we are moving towards more risk adjustment of our payments to private plans. They are at 50 percent this year; they are going to 75 percent next year and 100 percent in 2007. So we are truly accelerating the focus of targeting the payments in Medicare Advantage on the patients who have the most to gain from coordinated care, and that is people with chronic illnesses. They can use drugs in conjunction with the care they get from their doctors, stay out of the hospital to avoid complications, and keep their overall costs down. That is why the Medicare Advantage plans are so important. They are saving beneficiaries now about $100 a month—$100 a month compared to fee-for-service Medicare, and that savings means lower overall health care costs but, most importantly, it means lower health care costs for our beneficiaries who really need help right now and need to be able to take advantage, if they want to, of what care coordination has to offer.

Senator PRYOR. Well, let's talk about our beneficiaries here for just a moment, because I cannot speak for Ohio or other States, but I know in Arkansas our Medicaid program currently provides coverage for prescription drugs. I assume most states do, but probably not all required it. We do and starting on January 1, Medicaid will

not cover any drug covered by Medicare Part D, and the beneficiary must rely on the Federal program exclusively. Many of these beneficiaries, as you can imagine, as you mentioned a moment ago, have multiple and many times chronic conditions.

I am just concerned that there is going to be difficulty in switching to a new formulary overnight. I am concerned there is going to be some needed transition—I hate to use the word "casualties," but there are going to be some folks that miss and fall in the gaps because the formularies are not set up the right way. And, I guess I am just concerned that you all are trying to provide some guidance on this, but I am not sure that we are going to make sure that we get the transition needed, that I think we, in Congress, would like to see. Would you like to comment on that?

Dr. MCCLELLAN. Yes, we would be delighted to work with you and your staff to make sure that you are aware of all the steps that we are taking to make that transition work smoothly, and that means extending it from just December 31 to January 1, early notification of not just the fact that it is coming but which plans people would be going into, transition requirements on the prescription drug plans for handling Medicaid transitions effectively, as well as many other safeguards built into our oversight of the program. We are building electronic data systems that make it possible for someone who just walks into a pharmacy to tell the pharmacist their name, their date of birth, and they will—even if they did not pay any attention to this transition, they will be able to let them know which plan they are in and how they can continue to get the drugs that they need.

This is a very important issue. It requires a lot of ongoing close work with each and every State, including Arkansas, to make sure that people get the full advantage of this comprehensive benefit.

Medicaid drug coverage, Senator, is an optional benefit. Many States have limited their Medicaid coverage to keep costs down. The Medicare drug coverage is going to be comprehensive. It is going to cost Medicaid beneficiaries at most a few dollars a month, and we intend to implement it to get State savings so they can provide even more help for their low-income citizens at the same time. This is very important in Arkansas. You have a lot of low-income beneficiaries, many of whom do not even qualify for Medicaid now, and are getting no help beyond the drug card in the transitional system with their drug costs. And so we would very much like to work closely with you to make sure we get all of those people or as many as possible into effective coverage, and that includes a smooth transition.

Senator PRYOR. Thank you, Mr. Chairman.

Senator VOINOVICH. Doctor, you have done a wonderful job today.

Dr. MCCLELLAN. Thank you.

Senator VOINOVICH. You have been on the grill here for quite some time, but you have really gone into a lot of areas where I am sure that Members of the Subcommittee wanted information, and I am sure that anyone that is having an opportunity to watch us on C–SPAN will be much better informed about this wonderful program.

I just want you to know that as Chairman of this Subcommittee, if there is anything that we can do to be of help to you, if there

is flexibility that you have discovered that you need or anything else, money, whatever, I want you to pick up the phone and call us, and we will do everything we can to help you. You have got a very formidable task ahead of you, but I am encouraged by what I have heard here this morning.

Thank you very much.

Dr. MCCLELLAN. Senator, thank you very much. We truly appreciate your support, and we are looking forward to continuing to work with you to get this help to seniors. Thank you.

Senator VOINOVICH. Thank you.

We will now call on our next two witnesses: Marcia Marsh and Ann Womer Benjamin. I apologize to our two witnesses. I hope that you have learned as much this morning as I have.

Ms. Marsh, thank you for being here today, and we look forward to your testimony.

TESTIMONY OF MARCIA MARSH,[1] VICE PRESIDENT FOR AGENCY PARTNERSHIPS, PARTNERSHIP FOR PUBLIC SERVICE

Ms. MARSH. Thank you. Senator Voinovich and Senator Pryor, I appreciate the opportunity to speak to you today about our partnership with CMS on our Extreme Hiring Makeover. That project was modeled after the popular television series that I am sure the two of you probably do not get to take advantage of watching in the evenings. But it brings together the experts from the private sector in recruiting and assessment with three Federal agencies. And when we first announced this program, the HHS Director called us that afternoon and said, "You really need to meet with the leadership team at CMS." And I stepped up to the plate to take that public challenge right off the bat.

So where are they? Our heavy lifting in the last several months has focused on two key areas. The first is in mapping their hiring process, what they are doing, and the second part is in doing a demonstration project that will show how they might want to model it going forward. And I know when I mention process mapping, your eyes probably glaze over. That is not exactly a sexy topic. But it is the way in which we can really get to the information that will demonstrate how long things are taking, why we cannot have qualified candidates on certificates, and how we can fix the process.

So we worked with the CMS hiring managers, their HR expertise, and with their new hires to really map that process. And when we completed it, we rolled out the map across a conference table like this, and it included 64 steps. And the reaction of the HR managers and the managers has been fairly similar: What can we do to streamline that?

So in the next 2 weeks we will be meeting with the CMS redesign team to work on how we remodel that process, and we are looking for one that has a goal of efficiency and only value-added steps.

Now, the most exciting thing that we have done is in the demonstration project, and here is where I think CMS is really step-

[1] The prepared statement of Ms. Marsh with attachments appears in the Appendix on page 64.

ping out as a great model for government. We have an illustration up here for you of one of those early efforts.

We worked with some volunteers from the Centers for Medicaid and State Operations around the position of a health insurance specialist, a GS–13, and we picked that one because it is fairly common to CMS and cuts across the entire organization. They are going to have multiple openings in the course of the next several months. And what we did with that job was to first start to redefine a new look. And we worked with our partners at Monster Government Solutions in trying to put out a new vacancy announcement, and I know, Senator, you have been very keen on what is happening in recrafting the image of government.

And here is an example of the old vacancy announcement appears on your left, and you will see it is very text heavy, a lot of Federal jargon, and when you read down into it, you have a lot of the "shall not's" and the "no's."

The new vacancy announcement, which appears in the new USAJobs format, appeals to a candidate right off the bat about the mission of CMS and your ability to impact the Nation's health care. We have had a real uptick in response on that basis.

So I know in our detailed testimony we outline for you all the steps that CMS took in this demonstration process. So I would like to use this exhibit to just take you through that fairly quickly.

What we wanted to do because we had multiple openings was to attract as many candidates as possible for this particular announcement. Previously, the same announcement within HHS attracted about an average of 53 applicants. And what we did was to post it on USAJobs and Monster, but we did not want to settle for that. It drove a lot of eyes there. We really wanted to dig deeper into some of those people that sit out in the private sector companies and at the States, with apologies to my colleague over here, who are those sorts of experts and see if they wouldn't want to take a look at that job announcement.

So one of our partners in this process, a company called AIRS, did an Internet targeting campaign for us when in the last few days of this position they went out, they searched candidate resumes from across the country in all sorts of job databases, and sent them all E-mail messages saying, "Wouldn't you like to apply for the CMSO position? You look like you are very qualified."

On that basis, when we concluded that operation, we had 227 applicants for this particular position, and 33 of those came from our target pool. So we proved the fact that with the better advertising and the targeting we can bring a lot of people in the door.

So how do we select from those candidates to pick the very best? And the first thing that a candidate has to do when they apply is to answer some basic questions that are prescreening questions, and they are in the automated tool that CMS uses called Quick Hire.

What we did there was to just ratchet up that performance a little. Previously, that screen would eliminate about 6 percent of the candidates as not minimally qualified. But with sharper questions based on the competencies that the CMSO managers outlined, we were able to take that up to a 15-percent screen. And then for all the people that successfully came to the other side of that, we sent

them an E-mail asking them to take a 45-minute skills assessment test. It tested their knowledge of Medicare, Medicaid, managed care, writing skills, and a variety of other things. We were pleased that of about the 200 applicants that successfully managed the screen, 169 invested the time to take that particular test.

On that basis then, we used category ranking, and 24 candidates floated to the top. Of those 24 candidates, many were invited in for interviews and an additional behavioral interview assessment. And as you see on the results here, we had six candidates who were hired very quickly. I would like to let you know that the top candidate based on just abilities was a disabled veteran who was interviewed, first interview, first job offer, and he reported for duty yesterday with five new colleagues. Two of those came from our targeting campaign.

We are excited about folding this into our new process redesign. We think that CMS would be a model not only for HHS but for the rest of government. And given the fact that every Federal hire is important and really represents a multimillion-dollar investment, if you look at the personnel costs for a single person over the course of their career, we think that managing this kind of process in this kind of time will result in a great benefit not only for CMS but for the rest of government.

I look forward to answering any questions that you have about the project.

Senator VOINOVICH. Thank you very much. I am sure that Dr. McClellan was very appreciative of your being involved. He has to hire 500 people more, or something like that? That is quite a task.

We are so happy that you are here today, Ann, and, again, I apologize that you had to sit around for so long. But you have done an outstanding job in the State of Ohio in terms of being the Director of our Insurance Department, and I cannot thank you enough for the wonderful help that you have given us during this last year or so in trying to sign up as many people in Ohio to take advantage of this new drug benefit. We are anxious to hear your testimony today.

TESTIMONY OF ANN WOMER BENJAMIN,[1] DIRECTOR, OHIO DEPARTMENT OF INSURANCE

Ms. BENJAMIN. Thank you very much, Chairman Voinovich. I appreciate being here. I am Ann Womer Benjamin, the Director of the Ohio Department of Insurance, and I want to thank you, Mr. Chairman and Senator Pryor, for the opportunity to provide this testimony today.

CMS has indeed been a reliable and supportive partner working with the Ohio Department of Insurance and our Ohio Senior Health Insurance Information Program, or OSHIIP, to educate and enroll Ohio seniors and Medicare beneficiaries in the prescription drug program.

The Ohio Department of Insurance regulates and licenses approximately 1,740 insurance companies, 180,000 agents, and more than 13,000 insurance agencies, and monitors the financial solvency of the insurance industry in Ohio.

[1] The prepared statement of Ms. Benjamin appears in the Appendix on page 85.

Another very important facet of our consumer protection mission and of particular relevance today is the Ohio Department of Insurance's OSHIIP Division. OSHIIP was established in 1991 by then-Governor Voinovich and plays an essential role in educating Ohio seniors and others who qualify for Medicare. Through its toll-free help line, 950 volunteers, objective and understandable literature, and speakers' bureau, OSHIIP provides valuable information to Ohio's 1.8 million Medicare beneficiaries.

I would like to take a brief moment to publicly thank Senator Voinovich for his leadership and support of senior and Medicare initiatives, including OSHIIP. Further, I would like to thank Dr. McClellan for his strong commitment to providing the needed resources and information to educate Ohio's Medicare population.

Since the passage of the Medicare Modernization Act of 2003, CMS has been instrumental in helping OSHIIP with information and resources to prepare and respond to the many changes that are coming to Medicare. These efforts could not have been more apparent than last April, when Senator Voinovich and Dr. McClellan joined Governor Taft and me at an OSHIIP volunteer training session to kick off Ohio's introduction of the Medicare prescription drug card program. More than 100 community volunteers participated in the training designed by CMS.

CMS has continued to provide OSHIIP and Ohio consumers with invaluable assistance, including many workshops, publications, and toolkits to update OSHIIP training teams on the many facets of the Medicare program. CMS also seeks the input of all State SHIP programs to ensure that the material is meeting the needs of the consumer and regularly distributes E-mails on critical issues and common problems facing the States.

Outreach and educational efforts have also increased at the State and local levels with the support and coordination of CMS through biweekly and monthly conference calls to keep lines of communications open, allowing OSHIIP to have the most current and pertinent information available. CMS also spearheaded Ohio Medicare Partners to help answer a wide range of health- and health insurance-related questions here in Ohio.

In mid-February of this year, CMS introduced its "2005 REACH National Medicare & You Training Program" focusing on the new prescription drug coverage training module. CMS also facilitated working sessions for each State's Medicare Partners so that coordinated outreach plans could be jointly developed to maximize population penetration and group efficiency.

Later this year, the Ohio Department of Insurance and OSHIIP will be hosting local Medicare prescription drug coverage enrollment and outreach events in each of Ohio's 29 most rural counties. CMS has committed to mailing invitations to these events to the low-income residents of these counties.

The department and OSHIIP have been very pleased with our collaboration with CMS, but there is always room for improvement. We have experienced some delay in getting training materials needed to conduct our volunteer training sessions. We also have experienced delays regarding technical and statistical inquiries we make to CMS. While our impression is that CMS is trying to ensure that the proper individuals respond and provide the most ac-

curate information in a timely fashion, CMS delays sometimes result in gaps in accurate information being available.

This year we have received a substantial increase in our annual Federal grant to help administer OSHIIP, and Ohio and I thank you. We will utilize some of those funds to hire another employee to assist in what we predict will be a dramatic increase in calls. With the expected increase in our workload, the ever-increasing 65-plus population, and the many options consumers face, our challenge will be to continue excellent consumer service to those Ohioans struggling to make informed decisions.

Dr. McClellan has been a real champion of seniors, and his leadership of CMS has reflected this commitment. He and CMS have worked hard to take Medicare benefits and options to seniors and ways to make their choices easier to understand and evaluate. I would like to thank Chairman Voinovich again for the opportunity to share the many positive and exciting things we are doing for seniors in Ohio. From our perspective, we feel the collaboration with CMS has been very beneficial, and we only hope it continues to grow. Thank you.

Senator VOINOVICH. Thank you very much.

Ms. Benjamin, you have worked pretty closely, as you have mentioned in your testimony, with CMS and just mentioned that they have made more money available. Do you feel that the additional money made available to the State of Ohio is adequate to give you the resources you need to be effective in helping them get the job done?

Ms. BENJAMIN. Chairman Voinovich, certainly resources are always an issue, particularly in a program such as this that continues to grow and expand and the beneficiaries continue to expand. With your encouragement and support last year, we had the foresight to continue to develop our volunteer pool, which we have done. Last year, we had about 800 volunteers statewide. Now we have 950, and that number continues to grow. That certainly helps where we have resource shortages because, as I said, we have volunteers who provide information after they are trained freely.

In addition, we are continuing more and more to use the area agencies on aging, senior centers, and other such centers and activities that deal with seniors on a daily basis so that people involved in those programs will also, without direct charge to our OSHIIP program, be able to provide not only contact information but also valuable enrollment information to the seniors they encounter.

Senator VOINOVICH. I know that some of the municipal offices on aging have been participating. I am very familiar with what is happening in Cleveland. Do they get any resources, additional resources, to do the job that they have been asked to do?

Ms. BENJAMIN. Chairman Voinovich, honestly, they don't from us. I don't know if they do from other sources, but they don't come from OSHIIP. The only money that we distribute out from OSHIIP is part of our Federal grant goes to the Ohio Department of Aging, likewise for outreach programs that are complementary to OSHIIP's.

Senator VOINOVICH. Has CMS or have you looked out across the State to look at the various levels of groups that are providing in-

formation to see how it is all coordinated and whether there are any holes in the information system?

Ms. BENJAMIN. That is a continuing challenge, and we have realized, for instance, over the last year that rural counties are a particular outreach challenge. And one of the things that we have done over the past year is reach out in particular to rural counties to develop our volunteer pool as well as to develop our contacts where we perhaps did not have them or did not have as many with local senior agencies and centers so that we would make sure that we reach those seniors in the more outlying areas.

Generally the more urban areas have better outreach systems and information systems in place for seniors.

Senator VOINOVICH. Dr. McClellan talked about the Advantage plans, and it looks like there is a growing number of people taking advantage of them. As part of your responsibilities and information distribution, are you making information available about those Advantage plans also?

Ms. BENJAMIN. Yes. That information is in very comprehensive brochures that the OSHIIP program distributes. In addition, we have been coordinating our brochures and information with the Department of Aging to make sure that we cover all bases, so to speak.

Senator VOINOVICH. One of the things that I am concerned about is that the whole Medicare delivery system to a degree is expensive and in so many instances really does not respond to the needs of our senior citizens; that is, they come in when they are really sick, and too often they do not have a regular physician they go and see and have someone looking after them. And it seems to me that if someone is encouraged to get into one of these Advantage plans, that is a whole lot better way of their getting the kind of medical services that they need, including prescription drug benefits. And I think anything that CMS can do, and you can do, to at least make that information available to people would be very helpful to them. As you remember, my motto when I was governor was "Working harder and smarter, and doing more with less." And the fact is that I think that we would spend less money and we would have better service to our Medicare-eligible individuals.

Ms. BENJAMIN. Chairman Voinovich, if I could expand on what you just said, we do at the department, and in OSHIIP in particular, have trained personnel available to answer the telephone during business hours during the week to respond to seniors' questions as to which plan or plans or drug cards would be most appropriate for them. In fact, we also can run the PDAP right there while the senior is on the telephone and provide a detailed report to that senior within 24 to 48 hours as to what drug card or cards would be more appropriate for that senior's situation.

We have trained personnel who help senior consumers evaluate all their options, and I think that just further adds to the ability of these seniors to make informed decisions and to know what all their options are.

Senator VOINOVICH. Thank you.

Ms. Marsh, during the course of the Extreme Makeover project, the Partnership for Public Service learned much about the inner workings of CMS, and I would like to say publicly that we really

are grateful for the Partnership for Public Service. Many people are not aware that it did not exist several years ago, and that a man named Sam Heyman from New York, who was concerned about the fact that not enough people were going to government service, created this new partnership, and you have been very helpful in encouraging people, particularly on college campuses, to take advantage of the opportunities to come to work for the Federal Government.

How familiar was the Partnership with the department before you began this project? And how did you get into it?

Ms. MARSH. How familiar were we with the department or vice versa?

Senator VOINOVICH. How familiar were you—well, I am interested in how you got together.

Ms. MARSH. We have a monthly meeting with all the HR directors in the major departments in the offices to talk about issues that are key to them. And we made comment about this Extreme Makeover project, and as I mentioned, that very afternoon——

Senator VOINOVICH. In other words, what you are telling me is that the CHICOs—you get together with them once a month, with the partner——

Ms. MARSH. Their operating HR directors typically in some of the CHICOs come and have a conversation about their issues, what they would like to see, and we mentioned the Extreme Makeover project, and that afternoon the HHS HR Director called back and said, "I want you to get on the phone right now with the leadership team at CMS." So we had an initial conversation, and then met virtually everyone in the organization and their senior leadership team, focusing on their key hiring issues and talked about what we are trying to do.

Among the things that we required of an organization was senior leadership commitment and an organization that was in pain. We did not want to have to educate people in this project. And CMS was in pain with the big ramp-up they had, but also their senior leader said this is really important, we will sign on, and they have been at the table with us throughout this process.

Senator VOINOVICH. So, in other words, they found out about you through the meetings that you had once a month.

Ms. MARSH. That is right.

Senator VOINOVICH. And wasn't it the Partnership for Public Service that also brought, was it, Monster to the Department of Personnel?

Ms. MARSH. Well, actually, Monster had responded to the RFP that the OPM had put out to modify USAJobs, and they have been one of our partners in this endeavor and, in fact, had introduced us to many of the other individuals and firms that came together as part of this hiring effort. And I should point out that all the efforts that we have had from all of these firms have been pro bono. So they have dedicated hundreds and hundreds of hours to the effort among three agencies to try and really create a successful model within the Federal Government.

Senator VOINOVICH. It is interesting because when we got started with this human capital challenge that we had to create a situation where we would be able to attract the best and brightest to the

government, we had an executive session that was sponsored by Harvard University, and the folks from Monster were at the table with us. We tried to get the best and brightest people in the country together to talk about how does the Federal Government attract the best people and at the same time have an environment where you keep the best people working for you. And so this has just moved along, hasn't it?

Ms. MARSH. It has, and I think, Senator, it was at one of your hearings where Jeff Taylor, who is the CEO of Monster, rolled out a 47-page job announcement—I think that might have been one of yours—just to say, "How does a candidate plow their way through 47 pages and who is intrepid enough to want to do that?"

Senator VOINOVICH. Well, I have heard complaints for a long time about the fact that they make it difficult for us to go to work for the Federal Government.

Ms. MARSH. And I think in showing the new and improved advertisement—and much credit given to OPM. They have this new five-template format that starts with "What is your mission? What are you really looking for? Let's sell the benefits." There has been a lot of momentum in the last couple of years.

Senator VOINOVICH. Great. And are there any impediments that you have noticed over there that we might try to knock down?

Ms. MARSH. At this point, we do not have any. We are still trying to consider—we are still trying to go through all of the findings. We are completing our 2(b) process. What we are trying to do is to look and see if agencies could make improvements with the existing flexibilities that have been given out in the last couple of years. So we certainly see that we are able to do a lot. That example that I gave you was not a direct hire authority example. It was with the existing flexibilities.

There may well be.

Senator VOINOVICH. Now, they came to—we changed the law to give direct hiring, but they had to come to the Office of Personnel Management to get permission to do the direct hires.

Ms. MARSH. They did, and they have been very successful with those. And part of our endeavor is to look at their ordinary hiring and the non-direct hires to make sure that we can backfill some of those positions that will be subject to the retirements that you mentioned earlier on.

When we finish this project across all three agencies, we are really looking at investments in the HR function. As you well know, that strength has been depleted over the course of the last couple of decades with retirement and downsizing. So one of the things we may want to come back to the Subcommittee with is some observations about some special investments in the HR function across government, sort of Clinger-Cohen-type endeavor for the very important HR assets.

Senator VOINOVICH. Thank you. Do either one of you have anything else, any comments? You have heard the lengthy testimony and the questions to Dr. McClellan. Any comments that you would like to make in conclusion?

Ms. MARSH. The only thing I would say, they have a massive challenge. Having come from a private sector benefits consulting organization, I understand what it is like to roll out on a private

sector company a major endeavor like this. And this is a scale that just boggles the human imagination, what you all have to do collectively over the course of the next couple of years. So it is really a privilege to try and assist that particular organization doing something that is as important.

Senator VOINOVICH. Well, I want to thank you and the Partnership for Public Service for stepping forward and helping us out, and I look forward to your recommendations on how we can help other agencies get the job done. And, Ann, thank you very much for all the good work that you do in Ohio. I think that the partnership that we had between CMS and the Department of Aging and the Department of Insurance is probably one of the best in the country, and I think that had it not been in existence, we wouldn't have had the number of people sign up for the discount drug card. I think there is a tendency out there to kind of feel it is all in the hands of the Federal Government, but I learned when I was governor that when new programs come out, people usually do not call the Federal Government, they call State Government. And I knew that it was coming, and our folks just did a great job, and I am so grateful to you.

Ms. BENJAMIN. Well, I really appreciate that, and I thank you for your help and encouragement along the way, you who are so familiar with the OSHIIP program from its very beginning, and I have to say it indeed has been a challenge and will continue to be a challenge as the program changes to get the information out to the people who need it. But we are doing everything we can at OSHIIP to get that information out, and CMS has truly been a very helpful partner and continues to be so. If we have problems, we call the regional people and they respond generally very quickly.

Senator VOINOVICH. Well, if they don't, you call me.

Ms. MARSH. I will. Thank you. I will take that. [Laughter.]

Senator VOINOVICH. Thank you very much. The hearing is adjourned.

[Whereupon, at 12:13 p.m., the Subcommittee was adjourned.]

APPENDIX

PREPARED STATEMENT OF SENATOR COBURN

On Tuesday, March 23, the Medicare and Social Security Trustees released their annual report on the financial status of the Social Security and Medicare trust funds.

I'd like to just take a minute to go over some of the findings of the Medicare trustees report and the drug benefit.

The Medicare report shows the Hospital Insurance Trust Fund in a deficit state by 2010 (just four years away) and in bankruptcy in 2018. The report also shows a significant unfunded liability for the Medicare program.

From what I understand from reading the report and the laws and regulations, the cost containment provision would be triggered next year. The way I understand the provisions, there is a "cap" on the general revenue amount that can be spent on the total Medicare program—this cap is 45 percent. It is estimated that 45 percent of total Medicare spending will be funded by general revenues within the next 7 years, if this is the case then the cap would have been reached and this would initiate a trigger that would result in either cutting the program benefits or increasing dedicated program revenues either through premium increases or dedicated payroll taxes. If this is the case, then it is my understanding that in next year's report the trustees believe they will issue the warning that the cap will be reached within 7 years and the cost containment process will be activated to implement "corrective action." I find the instability of this system disturbing. I look forward to hearing the testimony of our distinguished witnesses.

Testimony of

Mark B. McClellan, MD, Ph.D.

Administrator, Centers for Medicare & Medicaid Services

Before the Subcommittee on Oversight of Government Management, the Federal Workforce, and the District of Columbia

Of the Senate Committee on Homeland Security and Governmental Affairs

Hearing on

Monitoring CMS' Vital Signs: Implementation of the Medicare Prescription Drug Benefit

April 5, 2005

Chairman Voinovich, Senator Akaka, distinguished members of the Subcommittee, thank you for inviting me here today to discuss CMS' progress in implementing new Medicare prescription drug coverage. Beginning in 2006, the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) provides for new Medicare Advantage (MA) plan options and makes voluntary Medicare prescription drug coverage available to all 43 million Medicare beneficiaries. These important new benefits will provide beneficiaries with additional choices and substantial help in paying for prescription drugs, greatly enhancing their quality of life. The law also gives Medicare the ability, for the first time in the program's 40-year history, to provide additional comprehensive help to those in greatest need—beneficiaries with very high prescription drug costs and people with low incomes. Under the MMA, millions of low-income beneficiaries will receive comprehensive prescription drug coverage at little or no cost.

CMS has already done a significant amount of work to implement all of the provisions of this legislation in a timely manner and in such a way that the new benefits are easily understood and accessed by beneficiaries. And I know, Mr. Chairman, you are particularly interested in how we plan to address the challenges the Agency will face as it rolls out the drug coverage to our Medicare beneficiaries. These new programs will only be successful if we can educate our beneficiaries, providers, and other partners about the impact MMA will have on them. We are developing and implementing a comprehensive education and outreach campaign including grassroots participation to ensure beneficiaries have the information and support they need to select a plan that best fits their needs. We also have worked extensively with potential sponsors

and providers to ensure we are responsive to their concerns in our regulations and guidance and they know what to expect.

In addition, to ensure we have the right people to carry out the new programs required by MMA we have revamped our entire human capital management plans and hiring process. I recognize that this Subcommittee, and you Chairman Voinovich, in particular, have been instrumental in providing CMS with the flexibilities needed to quickly and effectively hire individuals with the skills necessary to implement this important new benefit. I thank you for those efforts and I trust you will be pleased to see how CMS and the millions of Americans we serve have benefited from them.

Expanding the Talent Pool to Meet the Challenges of MMA

We appreciate that Congress recognized CMS would require resources and flexibility to secure new talents to meet the challenges of implementing the MMA. With these resources and flexibilities Congress provided, CMS has hired a significant new talent pool, including individuals with expertise in pharmacy benefits management, clinical matters, disease management and prevention, and retiree benefit package structures. CMS has aggressively recruited IT professionals experienced with the types of payment systems contemplated by the law. We also hired individuals experienced with government contracting, as much of the work under MMA, as with other aspects of Medicare, will be contracted out. In addition, we found it necessary to expand and restructure several organizations within the Agency to fulfill our new responsibilities.

After filling the most critical staffing needs based on the highest priority work, CMS developed a more comprehensive, longer-range hiring plan, covering all our personnel needs for implementing the MMA. This hiring plan played a significant role in helping the Agency ensure that we hired the right people with the right skill sets. Through this plan we especially want to make certain that CMS is doing everything possible to ensure a smooth transition to the new Medicare prescription drug coverage.

CMS Develops Comprehensive MMA Hiring Plan

CMS' new hiring plan incorporates a global Agency vision with a set of precise strategic goals designed to transition CMS from a traditional, bill-paying organization to a modern, patient-centered, competition-driven dynamic entity that works more closely and effectively with our private-sector partners to improve the health of our beneficiaries and the efficiency of our health system. The plan also identifies the need to hire staff with specialized skills and a sound knowledge of our new business partners, which include the pharmacy industry, employer groups, and Medicare prescription drug coverage managers. CMS' MMA hiring plan includes workload analysis and associated staffing requirements broken down by lines of business including the prescription drug coverage; MA; education and outreach; contracting reform; disease management; IT modernization; program integrity; demonstrations; Medicare payment, policy, and systems; and competitive bidding. The plan also includes a two-pronged recruiting strategy that combines the re-deployment of highly skilled CMS employees with the hiring of key external experts with diverse backgrounds. As a result of implementing the various provisions of this hiring plan, CMS has commitments to date for approximately 400 new MMA hires, with 345 highly qualified individuals already on board. We will fill remaining positions over the next several months.

CMS Takes Innovative Steps to Manage the Recruitment and Hiring Process

In addition to developing a comprehensive hiring plan, CMS took the opportunity to dramatically improve the hiring process. Along with two other Federal agencies, CMS is participating in a special initiative with the Partnership for Public Service (PPS) to introduce creative and innovative solutions to the current hiring process. PPS is a nonpartisan, nonprofit organization that works with private and public sector hiring experts to help agencies attract and quickly hire top applicants. This important initiative is referred to as "Extreme Makeover." The objective is to help specific agencies meet their goals and create effective hiring models for the rest of government.

An expert faculty of recruiting consultants is working with CMS to address our hiring needs, including finding talent sources, marketing and branding recruiting efforts, and reducing the time to hire. CMS' Deputy Administrator serves as the Agency's executive sponsor for the Extreme

Makeover. Additionally, the Deputy Chief Operating Officer serves as the project manager, marshalling resources to participate in the diagnostic and solution phases and communicating with the internal leadership team. The CMS team includes human resources staff, hiring managers, the Agency's Chief Administrative Officer, program managers, and the Deputy Chief Financial Officer. The Extreme Makeover project launched on July 22, 2004 and is expected to last through December 2005. Although some solutions will likely go into effect during FY 2005, CMS expects to implement many of the solutions in FY 2006.

To better enable us to recruit and retain talent that is critical to the successful implementation of MMA, CMS has used a number of new approaches to recruiting and managing our talent pool. In September 2004, CMS hosted a targeted, invitation-only, job fair on the CMS campus. To prepare for this critical job fair, we reviewed thousands of resumes and then identified and invited those who appeared to posses the most relevant skills and experience. We developed resource books of impressive resumes for managers to review before the event and provided booths for on-the-spot interviews. We also used this event as an opportunity to make on-the-spot job offers for our positions with Direct Hire Authority (DHA), which the Office of Personnel Management (OPM) provided exclusively for the MMA implementation. DHA allows agencies to make rapid hiring decisions. For example, CMS invited 576 individuals to this job fair, 384 candidates participated, 62 individuals received on-the-spot interviews, and approximately 25 individuals were hired as a direct result of this event. The Agency believes that extensive evaluation and outreach activities like this one are essential to acquiring the highest qualified staff to meet the Agency's vital new challenges.

To monitor and track our progress against our strategic hiring goals, CMS developed a database, referred to as Strategic Tracking Analysis and Report System (STARS). STARS is a planning, evaluation and reporting tool that includes specific information on individuals' job experience, skill grouping, education level and academic discipline, as well as the source of recruitment.

CMS Makes Extensive Use of Valuable Hiring Flexibilities

In addition to the DHA, CMS could not have been successful at hiring critical staff without the use of "Management Staff" authority provided in Section 900 of the MMA. The Management

Staff authority provided CMS with the flexibility to pay key staff with expertise in areas critical to the implementation of the Medicare prescription drug coverage that are in high demand in the private sector at rates more commensurate with their expertise and experience. Although we are being very prudent in using the "Management Staff" authority as strictly as the legislation intended, we have found this authority to be a very valuable tool in the success we have had implementing the MMA.

CMS has also made extensive use of the flexibilities provided by the Federal Career Intern Program (FCIP). The FCIP program is designed to help agencies recruit exceptional individuals into a variety of occupations at the GS-5, 7, and 9 grade levels. It allows appointment of individuals to a 2-year internship that provides formal training and developmental assignments as established by the Agency. Upon successful completion of the program, the interns may be eligible for non-competitive permanent placement within the Agency.

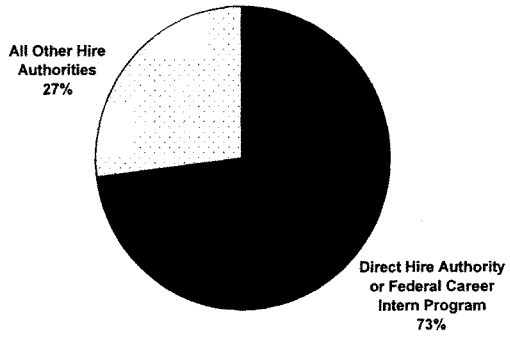
DHA, "Management Staff" authority, and FCIP are simplified and streamlined processes that have enabled the Agency to rapidly identify and hire highly qualified individuals. Furthermore, these authorities have been particularly valuable in helping us meet first and second-year MMA implementation priorities. Table 1 illustrates the number of individuals hired under these authorities (by occupation) through March 30, 2005.

Table 1 – MMA Hires Using Flexible Authorities (By Occupation)

DIRECT HIRE AUTHORITY (DHA) **(CMS-Specific Authority)**		
Health Insurance Specialist (GS-09 thru GS-15)	Actuary (GS-12 thru GS-15)	Economist (GS-12 thru GS-15)
190	3	4
[redacted]		**CMS DHA Total: 197**
DIRECT HIRE AUTHORITY **(Government-Wide Authority)**		
Medical Officer (GS-09 thru GS-15)	Nurse (GS-09 thru GS-15)	Pharmacist (GS-09 thru GS-15)
7	3	10
[redacted]		**Govt.-Wide DHA Total: 20**
FEDERAL CAREER INTERN PROGRAM (FCIP) **(Excepted Service Authority)**		
Health Insurance Specialist (GS-09)	Contract Specialist (GS-09)	Other (GS-09)
20	5	9
[redacted]		**Total FCIP Hires: 34**
[redacted]		**Total (DHA and FCIP): 251**

The 251 hires recruited through the use of DHA and FCIP represent a majority of CMS' MMA hires to date, as outlined in Chart 1. Another 94 individuals have been employed through more typical hiring authorities, for a total of 345 new hires through March 30, 2005. The extensive use of the flexible hiring mechanisms has allowed CMS to fill the bulk of our core MMA positions and allowed us to concentrate our valuable administrative resources on hiring candidates for non-MMA positions simultaneous with MMA recruitment, and without significant delays in the standard hiring process.

Chart 1 – Use of DHA or FCIP vs. Traditional Authorities for MMA Hires



New Employees Have Key Competencies

As a result of the recent MMA hiring process, CMS has acquired employees with a wide range of competencies, skills, and knowledge that will allow us to implement and administer the many facets of the MMA. As a result, we have significantly improved the competence of the entire CMS workforce. In conjunction with our functional reorganization of the Agency, this will enable us to both meet the more immediate MMA needs and enhance CMS' overall ability to work more efficiently with our industry contractor partners and better administer the competitive bidding process. Furthermore, our experience with MMA hiring will help us increase and improve our future outreach and education efforts.

New Key Leaders Enhance Implementation and Administration Initiatives

To date, CMS has hired a total of 20 individuals at the GS-15 level and above. These individuals have been instrumental in leading our MMA implementation and administration initiatives, and have also enhanced the collective knowledge of the Agency's overall leadership cadre. The

following list represents a sampling of the backgrounds and experiences of key leaders that have been added to CMS' workforce as a direct result of the MMA hiring process:

- Formulation and development of the Nation's digital health information infrastructure.
- Leadership of a major university's drug information services, with strong emphasis on women's issues and working with Medicaid-vulnerable populations.
- Management of key information security systems for the Social Security Administration.
- Chief medical officer and senior vice president for a major health care provider.
- Leadership of the medical management, health care spending, credentialing, and pharmacy management functions for a health care utilization management group.
- Senior medical director for a Blue Cross/Blue Shield organization who has implemented quality-based payment systems.
- Management of a group responsible for analyzing individual and industry-wide hospital performance and the modeling of financial implications related to Medicare regulatory change.
- Geriatrics-boarded private physician with extensive experience as a medical director of a nursing facility and as a consultant to the Congressional Budget Office.
- Chief of the hematology and blood bank for a large component of the Veterans Administration; and
- President of a State Board of Pharmacy, with extensive experience in pharmaceutical sales, contracting, and regulatory development.

New Hires Have a Wide Range of Skills

Due in large part to the focus and well-defined goals provided by CMS' MMA hiring plan, the Agency has hired individuals from a wide range of backgrounds. Table 2 depicts the distribution of new hires based on their diverse job experience and educational backgrounds.

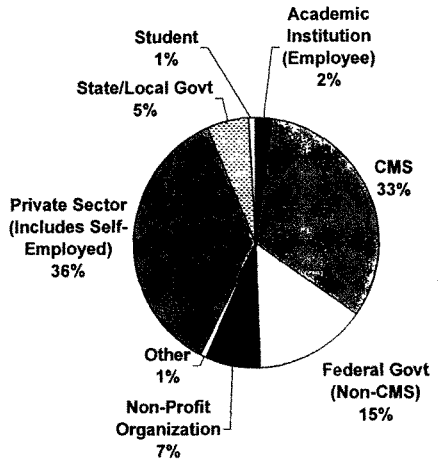
Table 2 – MMA Hires by Skill Grouping

Skill Groupings (Based on Pre-CMS/Pre-MMA Job Experience)	Total Hires
Accountant/Auditor	6
Actuary/Economist	11
Administrative/Clerical Staff	4
Attorney	13
Contract Specialist/Analyst	14
Physician	8
Information Technology Professional	30
Media/Communications Professional	6
Nurse	6
Other Health Care Professional/Employer Plan Manager	109
Other Professional (Interns, Fellows, Statisticians, Researchers, etc.)	119
Pharmacist/Pharmacy Benefit Management	15
Provider/Outreach Professional	4
Total:	**345**

Variety of Recruitment Sources Provide Diverse Backgrounds

We believe that diversity of backgrounds will bring a cadre of staff with fresh perspectives on our MMA implementation initiatives. Therefore, CMS has made a concerted effort to recruit and hire individuals from a wide range of sources. The universe of new MMA hires represents a mixture of individuals with experience in private industry, state and local governments, academia, non-profit organizations, other agencies, and from within CMS itself. Chart 2 illustrates the broad spectrum of recruitment sources for our MMA hires.

Chart 2 - Total MMA Hires (By Recruitment Source)



Well-educated Staff Cover a Broad Range of Disciplines

To meet the demands and challenges of a modern workplace, CMS places considerable value on acquiring, developing, and retaining staff that are well-educated in a broad range of disciplines. We have recruited and appointed a staff that possesses a strong commitment to personal learning and development, and that is well-equipped to handle complex initiatives with innovation, logic, and sound fundamental skills. Table 3 lists MMA hires by type of degree. Almost 90 percent of our MMA hires possess a Bachelors degree or higher, over 40 percent have graduated from a Masters-level program, and nearly 20 percent have attained a doctorate or professional degree.

Table 3 – MMA Hires by Type of Degree

Highest Degree Type	Total Hires	Percentage of Total Hires
High School	33	9.9%
Associate	7	2.1%
Bachelors	94	27.2%
Masters	140	40.6%
Doctorate	25	7.2%
Professional (JD, MD, etc.)	41	11.9%
Totals:	345	100%

Mr. Chairman, as you can see, CMS has put forth great effort into bringing the right people into the Agency to successfully implement the new Medicare prescription drug coverage. These individuals have already made a substantial contribution as we have met with stakeholders, developed and issued proposed and final regulations, and interacted with plans that hope to provide this important new benefit.

Aligning CMS' Organizational Structure to Accomplish MMA Goals and Requirements

In addition to obtaining the right people with the right set of skills to implement MMA, in 2004, we expanded and restructured several components to strengthen the Agency's ability to better meet its programmatic expectations. Three key CMS components were restructured as a result of this effort: The Centers for Beneficiary Choices (CBC), the Office of Information Services (OIS), and the Office of Acquisition and Grants Management (OAGM), formerly the Acquisition and Grants Group (AGG).

The CBC was substantially expanded to include four new group level components, as well as a small ombudsman staff that reports directly to the Center director. This new structure helps CMS exercise appropriate leadership in developing and effectively implementing all aspects of the prescription drug benefit and MA programs.

The four new group level components are: (1) the Medicare Advantage Group, responsible for the administration of the new, enhanced MA program, including the regional PPO program, (2) the Medicare Benefit Drug Group, responsible for the implementation of the Medicare prescription drug program, (3) the Employer Policy and Operations Group, which serves as a focal point for employer operations, including the new MMA retiree drug subsidy program, and (4) the Medicare Plan Accountability Group, which focuses on the performance assessment, plan enrollment, and payment operations for the MA plans and Prescription Drug Plans (PDPs).

In addition, the new ombudsman staff is responsible for ensuring that people with Medicare receive the information they need to exercise their Medicare rights. Also, the ombudsman staff is responsible for ensuring that beneficiary grievances and appeals of a decision or determination made by contractors or MA organizations are handled efficiently and effectively. The ombudsman has an unprecedented ability to review Medicare performance in beneficiary responsiveness and help implement systematic changes to improve responsiveness further.

The OIS was restructured by transferring the CMS information technology architecture planning functions from within a division-level organization to a newly established Information Technology Architecture Planning staff that reports directly to CMS' Chief Information Officer. This new structure helps strengthen CMS' mission functions by fostering a truly enterprise-wide approach to our key information technology planning activities.

The OAGM was recently elevated to an office-level component that reports directly to CMS' Chief Operating Officer. In its new configuration, OAGM will be much better situated to address its greatly expanded MMA-related workload, and will become an even more active participant in helping CMS leadership shape key decisions affecting both MMA implementation and the other core CMS mission functions.

Managing the Agency in such a dynamic environment requires building strong leadership throughout the organization, strengthening the skills base to better support implementation of MMA, and changing the management culture to instill greater accountability. CMS has taken several actions to address these challenges.

- To effectively manage and timely implement the over 200 MMA provisions, the Administrator in July 2004, established the Chief Operating Officer (COO) as a separate position. Previously, the Deputy Administrator also served as the COO. Creating a separate COO who can focus on Agency operations has enhanced CMS' ability to meet its many operational challenges while allowing the Deputy Administrator to work more closely with the Administrator on the many policy decisions that must be made to implement the new MMA legislation as well as lead and direct the important Agency initiatives and issues CMS faces.

- CMS is a matrix organization. To foster greater collaboration, communication and decision making, CMS has created five cross-cutting councils that deal with management, strategic planning, MMA, communications and quality. The councils also serve to ensure that the entire CMS leadership understands our new direction. The Administrator, Deputy Administrator and COO provide executive leadership to these councils.

- To achieve greater workforce accountability, the COO is leading the Agency's efforts to develop performance plans for all employees that cascade from the Agency's senior leadership, through the management ranks, to the general workforce population. Senior leadership and management plans contain specific metrics to which they will be held accountable for achieving. In addition, the COO has instituted a requirement that integrated project plans be developed and tracked for all major initiatives.

As the future aspects of MMA continue to be implemented and integrated into the overall CMS mission environment, we will continue to review our organizational structure and to make the necessary adjustments to ensure that we are well-positioned to meet our program and management objectives in an effective, efficient manner.

Favorable Response from Industry Bodes Well for Beneficiary Choice of Plans

As you know, the new Medicare prescription drug benefit begins January 1, 2006. The first two major steps—selecting the PDP and MA regions and issuing the final regulations—have been

completed. CMS held four conferences for potential PDP and MA sponsors in order to give them the opportunity to interact with CMS experts and ask questions about participation in these new programs. Sponsors appreciated the opportunity to meet with CMS senior leadership and subject area experts and felt that having a forum to ask questions was extremely valuable. March 23, 2005 was the deadline for PDP and MA sponsors to submit applications to participate and CMS has now received numerous applications. We are in the process of reviewing these applications. Based on the strong response to this program, I can tell you that we expect to deliver the drug benefit on schedule, everywhere in the country, on January 1. Seniors will get the medicines they need, and because they can choose their drug coverage competitively, they will have coverage that automatically keeps up with modern medicine and they will get the best possible prices for their medicines. This includes not just "stand alone" prescription drug plans, but also drug coverage available through MA plans, and a broad range of options for employers, unions, and states to continue to provide and to augment drug coverage for our beneficiaries. Based on the high interest level of potential sponsors, CMS is confident that throughout the country, beneficiaries will have multiple plan options for their prescription drug coverage. In fact, at this point, we do not believe that we will need a fallback prescription drug plan, which would require more direct federal intervention in those areas without sufficient private plan participation.

In addition, in 2005 MA plans around the country, recently bolstered by additional payments that have allowed them to significantly expand their services and service areas, will soon be able to provide their valuable health care benefits to even more Medicare beneficiaries. I am pleased to say, we are already seeing the payoff from reforming the MA program to give seniors better, more reliable choices. We're seeing great progress already in 2005. This year, we have received over 130 new MA plan applications, including 50 plans completely new to the Medicare program and around 70 new local Preferred Provider Organizations (PPOs). And some 96 current providers plan to expand their service areas this year. In fact, we expect that MA plans will be available in 47 states in 2005. Based on these applications, we expect over 90 percent of all Medicare beneficiaries will have access to these lower-cost plans this year. And it's not just in the big cities anymore – three-fourths of rural beneficiaries will have access to a MA plan, and one-third of rural beneficiaries will have access to a coordinated care plan.

We're particularly pleased about the emphasis in these plans on improving care for chronically ill beneficiaries. MA plans can offer "Special Needs" plans to our frail and high-cost beneficiaries, including those who are institutionalized, dually eligible for Medicare and Medicaid, or who have other chronic illnesses. Already, more than 40 plans are offering Special Needs plans in 2005, and we expect an even larger number of these plans next year.

On average, individual enrollees of MA plans save nearly $100 in out-of-pocket expenditures each month. This is because plan cost sharing for Medicare-covered services is lower, on average, than in original Medicare. In addition, MA plans provide non-Medicare services that most Medicare beneficiaries would have to pay for out of their own pockets.

This year, we will have broader health plan participation than ever before in Medicare's history. And this includes a completely unprecedented level of PPO participation. It's a tremendous foundation for the additional health plan options – including regional PPOs – that will be available in 2006.

The application and bidding processes for the sponsors are separated to simplify the overall drug coverage program process. CMS learned from the Medicare-Approved Prescription Drug Card that tight time frames for sponsors to submit applications and for CMS to review applications were problematic. CMS maximized the time available for reviews and increased the number of reviewers from the central office and regions to minimize the impact of tight time frames. Bids from PDP and MA sponsors are due June 6, 2005, more than two months after applications, and CMS will review bids as they arrive. CMS will enter into contracts with sponsors by early September.

Outreach, Education, and Enhanced Processes Help Beneficiaries Enroll

CMS' extensive education and outreach campaign to help beneficiaries obtain the personalized assistance they need to enroll and get the most out of Medicare's expanded benefits is critical to our ongoing success. To help beneficiaries choose a plan that is right for them and learn about other new Medicare benefits, CMS is working with a broad array of partners who will help educate beneficiaries, their caregivers, and others at a grassroots level. The Social Security

Administration (SSA), the Administration on Aging (AoA), other Federal agencies, States, State Health Insurance Assistance Programs (SHIPs), employers, unions, national and community-based organizations, and private entities will all participate in this effort. Mr. Chairman, CMS would also welcome any assistance members of Congress can provide. Participating in Town Hall meetings and including information in your newsletters would be a great complement to CMS' outreach activities to help beneficiaries enroll. Beneficiaries can begin enrolling in plans November 15, 2005. Benefits can begin as early as January 1, 2006; however enrollment will remain open until May 15, 2006.

Comprehensive Educational Campaign Begins Now

CMS has an integrated and multi-pronged education effort for beneficiaries that includes media advertising, simple language fact sheets, detailed publications including the annual "Medicare & You" handbook, direct mail, and community-based grassroots efforts to target specific populations. This information will be available in plain English and plain Spanish. Some fact sheets and tip sheets will be available in other languages.

CMS plans to roll out its educational campaign to beneficiaries using a three-phase approach. The first phase, to be implemented through June of this year, is focused initially on making beneficiaries more aware of the MMA's new preventive benefits, on helping low-income beneficiaries take advantage of the prescription drug subsidy, and on providing an extensive foundation for further grassroots education and assistance. We will be working closely with the SSA on this phase of the education program. At the end of this period, the focus will be on educating beneficiaries and others about the sources of information and assistance available to learn about the new Medicare prescription drug coverage, including: the Medicare & You 2006 handbook, community level groups, the 1-800-MEDICARE helpline, and the medicare.gov web site. The second phase, in the last half of this year, will focus on educating beneficiaries to make informed decisions about the new benefits as well as further building up awareness. We will also be helping low-income beneficiaries enroll in the prescription drug program.

The final phase will take place in the first half of 2006 and will be targeted towards beneficiaries who have not yet enrolled to help them understand the benefits and the fact that they will face

higher payments for Medicare prescription drug coverage if they delay enrollment beyond May 15, 2006. This is just like beneficiary payments in Part B, home insurance, and life insurance in other areas.

1-800-MEDICARE Helpline Better Serves Beneficiaries and Caregivers

CMS' 1-800-MEDICARE helpline is an invaluable resource for beneficiaries and their caregivers to access information about the new Medicare prescription drug coverage and MA plans. CMS increased and improved its call center resources to address the higher volume of calls during implementation of the drug card program. Ongoing evaluations of the calls, including independent evaluations, also show accuracy and full responsiveness rates of around 90 percent on calls actually received (i.e., those calls that included actual beneficiary inquiries, not hypothetical topics). This has been achieved by taking various steps, such as conducting additional training sessions at each call center location that focused on accuracy, script navigation, and active listening.

To prepare for the initial open season and for increased informational inquiries, CMS has enhanced the capabilities of our 1-800-MEDICARE call centers so that beneficiaries can get additional support in identifying the drug and health plan options that meet their needs. CMS has substantially increased the number of customer service representatives. CMS will also enhance the capacity and clarity of the other tools available to help beneficiaries get the information they need efficiently and effectively. CMS is working hard to prepare the call center for the significant spike in calls beginning this fall. CMS will provide the best service available while carefully managing the cost of responding to this anticipated increased demand.

State Health Insurance Assistance Programs Provide Personalized Assistance

For beneficiaries who require or prefer personalized assistance, CMS has enhanced its partnership with SHIPs, which were repeatedly identified as a great resource for beneficiary outreach during CMS' drug card implementation. CMS increased SHIP funding in 2004 and will provide $31.7 million to SHIPs in 2005, reflecting the increased emphasis on one-on-one advice and counseling for Medicare beneficiaries. The SHIPs are among the most effective resources in helping beneficiaries learn about the changes to Medicare and will use the additional

funds to equip their local counselors with the tools needed to answer beneficiaries' questions. We view our increase in SHIP funding of more than 100 percent in the past two years as a reflection of the importance of personalized beneficiary support in an era of increasingly personalized health care, in which support for our beneficiaries is a key part of helping them get the most out of our health care system.

Based on the drug card roll-out experience, CMS has engaged the SHIPs by developing new mechanisms of routine communications and training support. In addition, CMS is working with the SHIP network to define the information and materials that will be instrumental to their success and is providing kits tailored to those needs. Moreover, CMS is currently developing a broader outreach and education strategy (described later) based on an extensive analysis of current partner networks. This information will also help shape CMS' efforts to attract some innovative partners, such as alliances developed through our REACH program (discussed below) that will help to enroll beneficiaries who reside in underserved areas. A key factor in the plan is the timely deployment of the partner network and grassroots strategies.

CMS' Regional Offices and Community Organizations Reach Low-Income Beneficiaries

CMS also is conducting the Regional Education About Choices in Health (REACH) Campaign, a nationally coordinated effort to create partnerships with local organizations through CMS' 10 Regional Offices. CMS will work with community-level organizations to ensure that low-income Medicare beneficiaries receive the information they need to take advantage of Medicare's new benefits and options. We also will work closely with community-level organizations to reach those beneficiaries who are also enrolled in Medicaid, known as "full-benefit dual eligibles" who will qualify for Medicare (instead of Medicaid) prescription drug coverage with low or no premiums and co-payments of only a few dollars These beneficiaries may need additional assistance enrolling because they may not (1) have learned about the new benefit and subsidy program because of barriers of location or literacy, (2) know how and where to get their questions answered, (3) receive culturally and linguistically appropriate information, and/or (4) receive accurate and reliable information tailored to meet community needs. We view such outreach as very helpful in assuring a smooth transition for "dual eligibles," however we are

designing our systems and implementation plans to accommodate Medicaid beneficiaries who simply show up at their pharmacy in early January.

In addition, CMS will auto-enroll full-benefit dual eligible beneficiaries and facilitate the enrollment of low-income subsidy qualified populations under the Medicare prescription drug coverage if they do not self-enroll during the open enrollment period. CMS will work with its partner organizations to ensure that individuals with MA plan drug coverage in 2005 will continue to get drug coverage under the new Medicare Advantage-Prescription Drug (MA-PD) plans through the transition into 2006.

Other Outreach to Help Inform Beneficiaries

CMS also will work with providers in nursing homes, pharmacies and other health professions to let them know how to assist beneficiaries. CMS is working with Medicare Today, a partnership of nearly 100 major health care organizations, including providers, advocacy entities, plans and employers to inform beneficiaries about the new Medicare prescription drug coverage by implementing a coast-to-coast grassroots effort of participating organizations. CMS also is working with the Access to Benefits Coalition (ABC), a coalition of almost 100 beneficiary and patient support organizations to target the hard-to-reach low-income population.

Many Federal Agencies Will Help Educate Medicare Beneficiaries

Our plan is to coordinate with other departments and agencies that potentially interact with Medicare beneficiaries, so that they will provide either education materials themselves, or direct beneficiaries to the appropriate resources. The White House is working with the Department of Health and Human Services and other departments to support this inter-departmental and inter-Agency effort.

CMS has worked with other executive branch agencies to identify 21 specific Federal programs that employ 80 different communications resources that can be used to educate Medicare beneficiaries about the new Medicare prescription drug coverage. For example, the national network of community aging services providers, funded by AoA, is an important component of our outreach efforts. As the largest provider of home and community-based care in the country,

the 56 state Agencies on Aging, 655 Area Agencies on Aging and 29,000 community providers interact with seniors, particularly those with low-incomes, on a daily basis at meal sites, senior centers, and in beneficiaries' homes. Examples of other government agencies that work with the Medicare population include:

- The Department of Housing and Urban Development, which provides funding for more than 2,000 service coordinators around the country who interact with seniors on a daily basis.

- The Department of Agriculture's Rural Housing Service, which targets the elderly, people with disabilities, and low-income rural residents.

- The Department of Energy's Weatherization Assistance Program, which also targets low-income Americans, particularly households with elderly residents, individuals with disabilities, and children.

Comprehensive Education and Enrollment Process

Independent surveys show high levels of beneficiary satisfaction with the enrollment process and the savings achieved among almost 6.5 million beneficiaries using the Medicare-Approved Prescription Drug Discount Card. Nonetheless, a commonly raised concern during the Medicare-Approved Prescription Drug enrollment process was that beneficiaries did not recognize they had a choice among a number of drug card sponsors. Further, many beneficiaries incorrectly assumed that their cards were coming directly from Medicare rather than from the health plans providing the new assistance. CMS will take steps during implementation of the Medicare prescription drug benefit to ensure that outreach campaigns and beneficiary materials, including standardized enrollment forms, give all beneficiaries information on the key facts about the coverage available. Additionally, CMS will take steps to ensure that all participating PDPs are announced simultaneously so that beneficiaries receive a consistent message about participating sponsors and can make an informed choice based on complete information. Furthermore, CMS will provide program details to beneficiaries in stages to avoid "information overload."

Internet Comparison Tools Aid Decision Making

CMS will use the Internet to provide comparison information on plans to aid beneficiaries in making a decision about the plan that best meets their needs. Information can be updated frequently and accessed by a broad population including community level organizations, 1-800-MEDICARE Customer Service Representatives, SHIPs, advocates, and our partner organizations in outreach and enrollment, financial service planners, and insurance agents. CMS will draw on our experience in developing the price comparison tool for the Medicare-Approved Prescription Drug Card that was described by sponsors as both a necessary instrument and an important resource for Medicare beneficiaries.

We worked to address concerns expressed early in the drug card program that the web-based pricing tool could be confusing and difficult to navigate. In particular, the large number of approved card sponsors required CMS to reconsider the data presentation. The "Top 5" program display was developed in order to make the initial display of pricing data easier for beneficiaries to understand by limiting the display to the programs that would save them the most money annually. CMS also prominently placed a link at the top of the display page to allow users to easily view all of the available Medicare-Approved Drug Discount Card Programs rather than just the top programs. CMS expects to provide customized support for individual beneficiaries, allowing them to identify key priorities in their drug plan choice (e.g. preferred pharmacy, premium, and out-of-pocket spending) and the amount of information they wish to receive.

Conclusion

CMS employees have made a tremendous effort to move us toward full implementation of the new benefits created under the MMA. As a consequence of our strategic hiring initiatives, organizational alignment, efficient use of resources, extensive education and outreach including national grassroots efforts, we are poised for a successful launch of Medicare prescription drug coverage. We have used our expertise and lessons learned from the Medicare-Approved Prescription Drug Card to design the simplest income and asset testing approach ever and the largest low-income outreach campaign ever. The response we have received from MA sponsors in 2005 and from potential MA and PDP sponsors for 2006 is extremely encouraging. We recognize the challenges yet ahead and there is still much to be done; however, I am confident

that CMS will be able to successfully guide this new program into existence. Furthermore, millions of American citizens will benefit from the new Medicare prescription drug coverage and the additional assistance for low-income beneficiaries.

Thank you, Mr. Chairman, for the opportunity to update you on our progress implementing the Medicare prescription drug coverage. I would be happy to answer any questions you may have.

PARTNERSHIP FOR PUBLIC SERVICE

Testimony of

Marcia Marsh
Vice President for Agency Partnerships
Partnership for Public Service

Before the

Subcommittee on Oversight of Government Management, the Federal Workforce, and the District of Columbia
Committee on Homeland Security and Governmental Affairs
United States Senate

on

Monitoring CMS' Vital Signs: Implementation of the Medicare Prescription Drug Benefit

April 5, 2005

Senator Voinovich, Senator Akaka, Members of the Subcommittee, thank you very much for the opportunity to appear before you today. I am Marcia Marsh, Vice President for Agency Partnerships of the Partnership for Public Service, a non-partisan, nonprofit organization dedicated to revitalizing the federal civil service. We appreciate your invitation to discuss our partnership with the Centers for Medicare & Medicaid Services (CMS) in reforming its human capital strategies and specifically our work with them on the Extreme Hiring Makeover. This Subcommittee continues to recognize that a skilled and dedicated workforce is absolutely essential to meeting an agency's mission, and we are honored to share with you our perspective on CMS's efforts to recruit and retain the workforce it needs to succeed.

The Partnership has two principal areas of focus. First, we work to inspire a new generation to federal service. Second, we work with government leaders to help transform the business of government so that the best and brightest will enter, stay and succeed in meeting the challenges of our nation. That includes all aspects of how we manage people, from attracting them to government, leading them, supporting their development, and managing performance. In short, all the essential ingredients for forming and keeping a winning team. Given those objectives, fixing the federal hiring process tops the list in terms of our priorities. We welcomed the chance to work with the leaders at CMS to develop a new model for government.

EXTREME HIRING MAKEOVER

Current events have raised the stakes on government's success -- and to perform effectively, government needs top talent. But the federal government is in double jeopardy: More than half of all federal employees will be eligible to retire within the next five years, and there is a very

thin pipeline of talent waiting in the wings to replace the skilled and experienced workers who will walk out the door. Worse yet, the way the federal government hires is often inadequate - it takes too long, is cumbersome, and may fail to produce quality results.

The federal hiring process is one of the biggest impediments to attracting new employees to government service. In some cases, federal job application instructions run 35 pages long – and applicants often have to wait six months to a year before getting a federal job offer, sometimes with little or no communication from agencies. This situation is further complicated by today's competitive market. According to research conducted by Penn, Schoen, Berland & Associates, Inc., 69 percent of college juniors and seniors said they are not willing to wait over four weeks for a job offer. If it takes federal agencies a year to hire, they will lose the most highly qualified applicants to other, more nimble organizations.

There is also growing concern that federal methods for assessing the skills of potential employees are among the least effective available. According to a recent report published by the Partnership entitled, *Asking the Wrong Questions: A Look at How the Federal Government Assesses and Selects Its Workforce*, many agencies use the training and experience point method to assess their applicants. Among the common selection procedures available to federal agencies, this approach is the least valid predictor of success on the job.

Finally, and perhaps most disheartening, is that after all that time and effort, managers are often not satisfied with the final candidate(s) that result from the hiring process.

Project Overview

The Extreme Hiring Makeover project has shown that change is possible. Modeled after the popular *Extreme Makeover* television shows, this project united some of the nation's premier experts on recruiting and assessment with three federal agencies to implement some of the most effective hiring practices in the federal government. Together, these agencies are paving the way for better hiring.

Like the television shows, participating agencies boldly and bravely came forward with a simple desire to improve. But unlike the TV show participants, their measure of success is not cosmetic, but something far more important: bringing the best talent into the federal government by improving the way the government works.

We had three objectives for this project:

- Demonstrate that the federal hiring process can be fixed and *without extraordinary measures*
- Create a "do it yourself" toolkit for success that other agencies can use
- Launch a campaign for change across government through our Makeover stories

Agencies

The three participating agencies are CMS, within the Department of Health and Human Services (HHS); the Department of Education (ED); and the National Nuclear Security Administration (NNSA), within the Department of Energy.

It was important to us to have three agencies participate. If we worked with only one agency, it was likely others could dismiss any success as an anomaly. With three agencies of varying mission and need, we hoped to identify the practical issues encountered by our participants, the commonality of challenges, and the effectiveness of shared solutions.

Partners

The Extreme Hiring Makeover project is enhanced by the participation of world-class experts in the area of recruiting and hiring. The Partnership for Public Service has united a number of private and public sector organizations to help CMS, ED and NNSA. These organizations, who have donated their products and services, are providing the tools and expertise necessary to assist the agencies in their specific areas of need. Whether the issue is planning, marketing, assessment, selection, or making an offer, the Extreme Hiring Makeover team has the skills and knowledge to help participating agencies improve their practices and enhance their workforce.

Combined, these project partners form a "Dream Team" to tackle the specific hiring challenges of our three participating agencies. In addition to the Partnership, this team includes: Monster Government Solutions, ePredix, CPS Human Resource Services, AIRS, Brainbench, the Human Capital Institute and Korn/Ferry International. The project offers them a great opportunity to demonstrate how their tools and services can be used effectively to better recruit and retain talent.

Approach

We launched this project in September 2004 with a phased approach. From September to January, we helped agencies diagnose the key issues they face through a series of interviews and

by mapping the hiring process. We also implemented "quick wins" to demonstrate immediate success. Those included creating new looks and marketing appeal for vacancy announcements, targeting passive candidates for existing positions, helping to script communications for job fairs, and providing interview guides for managers. From January through the end of April, we are constructing the short term fixes – designing the new hiring process, creating a new front end toolkit to facilitate better planning for managers and HR teams, tightening up the pre-screening and assessment process, designing new recruiting materials, and training the agency recruiting experts. From May through the end of this calendar year, we will help the agencies with long-term planning for building on and sustaining change. This will involve an organization-wide campaign to train managers on the new system and culminate with implementing management performance measures for the future.

We launched this project with the premise that the agency challenges and solutions would overlap enough to produce a government-wide change toolkit. Although we are still in the solutions phase, that premise seems right on target. Major segments of the hiring process lend themselves to common solutions. Several of the key elements in our future toolkit were developed and piloted by the CMS team.

CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS)

We did not lack for volunteers for our makeover process, but CMS, along with the other participants, impressed us early on as ideal candidates for our efforts. CMS demonstrated:

- *Leadership commitment* – From the initial interest of the HHS HR team through the ongoing attention of the senior leadership at CMS, we have been impressed with the commitment of their leaders and managers to this project. That was an essential ingredient for success.

- *Strategic need* – As this committee knows better than others, CMS had a pressing need for change in staffing to meet the requirements of the Medicare Modernization Act (MMA). MMA implementation demanded significantly increased hiring, growing the size of the workforce by approximately 500 professionals within two years. This constitutes 10% of the existing workforce and double their normal annual hiring. Such changes involved not only consideration of new lines of business but also new skills and competencies. As an example, individuals with expertise in pharmaceutical contracting, clinical matters, disease management and prevention, nursing home formulary needs, retiree benefit package structures and marketing skills will be key to successful rollout of the MMA provisions.

  The agency's hiring challenges did not begin, nor do they end, with MMA. Like the rest of government, CMS has an aging workforce and will likely face significant retirements in coming years. They must attract and retain a highly skilled workforce to meet the increasing pressures of America's aging population.

- *Recognition that the current process is broken* - Both HHS and CMS were already engaging in efforts to "fix" the hiring process. Managers were concerned with both the length of time it took to hire and the quality of applicants that emerged through the

certification process. Given volume hiring and retirement turnover anticipated in the near term, the old system would not meet the needs of the new CMS.

- *Talented multi-functional project team* – We asked for a commitment of resources that would draw from the best in their HR, finance, and hiring management teams. We have been privileged to work with a dedicated team of people who are genuinely interested in making a difference for CMS and others. In our last testimony on this subject, we stressed that leaders and managers must accept accountability for this project. At CMS, they have demonstrated leadership accountability for change across many offices and functions. CMS' Deputy Chief Operating Officer has been our project leader and enthusiastic driver for this project. The Chief Information Officer and his team helped shaped the organization sales pitch and managers from the Center for Medicaid and State Operations (CMSO) rolled up their sleeves and built and test drove the model for the rest of the organization. The HHS HR shared services team members continue to be enthusiastic proponents for change.

What was the targeted strategy for Extreme Hiring Makeover at CMS?

All of our Makeover efforts would include an "end to end" mapping of the hiring process and identification of short term and long term fixes. But, in deference to the priorities and current issues of each Makeover agency, we tailored our workplan to areas of emphasis that they identified as critical to their ongoing success.

For CMS, *focus on effective selection and assessment processes was central.* They wanted to ensure that the CMS of the future would have top talent from across America to meet changing circumstances and their increasing mission requirements. Given the volumes of applicants typically received for their jobs, effectively screening and assessing candidates for quality can be a challenge. Additionally, HHS was encouraging the use of category ranking and this provided an opportunity to use that flexibility effectively at CMS.

Concurrent with our process mapping and diagnosis, we decided to conduct a demonstration hiring process for a CMS group. This demonstration process would use some of the successful targeting, pre-screening and assessment processes from best practice organizations, thereby establishing a successful model on which other CMS groups could base their practices.

MMA hiring activities were already in full swing when we arrived at CMS. Given the critical hiring targets and milestones they faced, the team determined that our data gathering, process mapping and experimentation and innovation efforts should not slow that process. To heed their concerns, we planned to conduct our activities around that effort in a way that would ultimately contribute to the timeliness and quality of their hiring and that of the entire agency. Managers within CMSO volunteered to test drive our demonstration process.

What the team has accomplished to date?

We met the enemy head on – mapping the hiring process

Working with resources from across the agency and our Dream Team partners at CPS Human Resources Services, we mapped the hiring process from end to end. We define this to start when a manager identifies their need and to conclude when the person reports for duty. That is notable

because the effort extends well beyond the traditional HR functions that have received the most comment and attention in typical improvement initiatives.

The timing of this exercise was perfect for CMS. They were already in the process of revamping their HR service delivery model through the HHS' shared service initiative. So, documenting hiring from end to end would help all the players realign their activities. The CMS end to end process entailed 64 steps. Those steps represented a series of actions that involve the hiring manager, their executive officers, budget resources, agency and HHS executives, and multiple HR resources.

At all three organizations, the end to end look allowed them to gain a realistic and practical understanding of their hiring issues. While it is difficult to prescribe the optimal number of steps for any given agency, this exercise highlighted areas where non-value added steps had crept into the process over a period of years. Many of those steps were not generated by statute or regulation, but through a layered history of Department, agency, and functional practice. Most importantly, it allowed the collective leadership of the organization to understand each others' activities and where to hunt for real process improvements. The simple visual of this multi-step process evoked enthusiastic commitments for change from all the Makeover teams.

It also led to a focus on accountability. When a process crosses so many organizational functions, who owns it? It would be impossible to fix it without an owner. At CMS, the Deputy COO has enthusiastically embraced responsibility for the process and the fix.

The key learning from all three organizations was that the *front end of the process was THE problem*. For decades, walls had been built between the hiring managers and HR teams. Invoking the Merit Principles, we had carved off hiring activities as sacrosanct processes that were conducted by third parties twice removed. And, restricting manager involvement in the process became the norm along with the creation and use of super-technical HR specialists in components of hiring.

Over the last ten years as authorities have been delegated back to agencies, some relief and improvements have occurred – but re-engaging managers effectively has not happened the way it should. Managers are not primarily accountable for hiring the way they are in best practice organizations. Nor have we invested in strategic HR recruiting partners for those managers – people who understand the end to end process, have the most innovative practices at their fingertips and can deliver the best in customer service to the management team. Based on our discussions with our Office of Personnel Management (OPM) colleagues, our findings at these three organizations are right in line with what the OPM teams have learned through their own makeover efforts.

At all three participating agencies, we have been working together to recreate the front end of the hiring process. The critical element of this is a strategic conversation between the hiring manager and their expert HR partner. That conversation should be the comprehensive source of information for:

- Developing a comprehensive candidate profile;
- Job analysis including critical competencies;
- Budget/FTE justifications;

- Candidate sourcing/targeting ideas;
- Recruiting strategies;
- Marketing/sales pitches for the position;
- Effective assessment approaches;
- And, *finally* the vacancy announcement.

We are currently working with the Makeover agencies and OPM to create a new front end tool kit that will ensure hiring success, aid in streamlining the process, provide great service to managers and reinforce their strategic partnership with their HR teams. This toolkit should be complete for implementation across each organization by the end of the second calendar quarter.

Demonstrating success

The managers of CMSO's Families and Children's Health Programs Group bravely raised their hands and volunteered for duty in test driving new processes that might be used more broadly in the organization. Designing and implementing that test required significant time commitment on their part. CMS identified the position of health insurance specialist as the best candidate for the test process for several reasons:

1. It was the most common occupation series across the organization. There will always be hiring needs in this area.
2. There were immediate hiring needs for multiple positions.
3. Many of their projected retirements are expected to deplete these positions going forward, so the work done in this area could benefit future hiring.
4. There were no special flexibilities or direct hiring authorities for these positions, so positive results might be even more significant for MMA positions.

5. We could conduct this demonstration outside the current MMA hiring efforts to avoid slowing that process, even temporarily.

All of our Dream Team partners participated in this demonstration effort. The process included:

Demonstration Efforts	**Output/Results**
Testing a new front end conversation – Given that this was a critical volume hiring position, the team and managers invested considerable time in the front end set up which included a detailed job analysis workshop.	• Detailed validated candidate profile. • Comprehensive recruiting strategies. • Questions for pre-screening.
Creating a new look vacancy announcement using the new OPM/USA Jobs five tab format (See Appendix I)	• A marketing piece that "sells" the position and provides the candidate with real insight into what is required to be successful in that job.
Spreading the word broadly – Posting the announcement on both USAJobs and Monster's job board.	Round One Results – o Over 15,000 hits at USAjobs. o 704 hits on Monster. ▪ 210 visited USAJobs. o 227 applications.
Targeting passive candidates – Using the Internet to identify candidates from multiple job boards to introduce to the CMS opportunity. • Automated search for interesting resumes • Email to candidates with sales pitch and link to job announcement	Round One Results - Launched in only the last week of the effort. o Located 276 qualified candidates o We could identify 33 targets who applied for the position o 32 passed the first screen o 5 were in the well qualified group o 2 of the six job offers in the first round were extended to those candidates.
Using automation to pre-screen volume applications - Enhancing the questions to which candidates respond to identify those potentially qualified for further screening.	Round One Results – o Moved from minimal screening with questions to 15% selected out.
Testing knowledge, skills and abilities - Automated testing of successfully screened applicants in areas of Medicare and Managed Care knowledge, and writing skills.	Round One Results – o Of the applicants that passed the screening process 169 invested the 45 minutes it took to take the automated skills test via the Internet.
Developing the pool of best qualified candidates – Using the results of pre-	Round One Results – o A field of 24 candidates emerged

screening, automated testing and resume reviews to produce a field of best qualified candidates.	from the blend of scores as well qualified.
Testing behavioral competencies and cognitive abilities - Supplementing the manager interview process with an automated, proctored test of cognitive abilities to help gauge potential success on the job.	Round One Results – o Interesting consensus between these tests and feedback from interviews. Validated decisions made.
Conducting a well informed management interview	Round One Results – o A job offer followed the very first interview – the top scored candidate via screen and skills assessment who just happened to be a disabled veteran.

The hiring process continues in this demonstration. To date, six offers have been made and the manager involved is pleased with the payoff. According to one CMS manager, "The process produced great candidates and was well worth the effort!" Our next steps in the demonstration will include conducting a side by side review of what the testing taught us as compared with resume screening, calculating the Return on Investment (ROI) of our efforts and finalizing the recommendations for the broader organization.

What's next for CMS?

In the next few weeks, a multi-functional team will meet for 2 ½ days to re-engineer the hiring process. Working with the knowledge of the as-is process and our new front end tool kit, the managers and HR resources will build the recommended process of the future for CMS. That process will be vetted with agency leadership and HHS.

Once approved, we will conduct a one day on-site training session for the change leaders within CMS who will drive this effort forward and a subsequent two day "boot camp" for all three teams on common tools and practices.

Following those sessions, we will work with the Deputy COO and HR leadership to develop the longer term change and communications plan. We intend to both coach and monitor success until the end year, but will revisit with these organizations in the years to come. Our colleagues at OPM have graciously agreed to lend whatever support is necessary in making this effort a success.

SUMMARY

This is a makeover that matters. It's one that affects the health of our citizens, the performance of our schools and the safety of our nuclear systems. We have witnessed cross-cutting challenges, crafted shared solutions, and demonstrated how these lessons can be applied across government.

****

On July 20, we will be hosting a public close to the project. In that session, our agency project leaders and Dream Team partners will share their lesson learned and the tools and processes that we have used to enhance their efforts. In the TV vernacular, we will be unveiling our "before and after" results. All of the lessons and tools will be made available to any interested parties in the hopes that this will help fuel change across government.

Appendix

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FAQs | PRIVACY POLICY | HELP | SITE MAP

[illegible] RESEARCH JOBS | MY USAJOBS | [illegible] EMPLOYER SERVICES

United States Department of Health & Human Services

Department: Department Of Health And Human Services
Agency: Centers for Medicare & Medicaid Services
Job Announcement Number: HHS-CMSO-2005-0054

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Health Insurance Specialist

SALARY RANGE: 74782 - 97213 USD per year

SERIES & GRADE: GS-0107-13/13

OPEN PERIOD: Friday, February 11, 2005 to Friday, February 25, 2005

POSITION INFORMATION: Full-Time Permanent

DUTY LOCATIONS: Few vacancies - Baltimore, MD (Woodlawn Area)

WHO MAY BE CONSIDERED:
Applications will be accepted from United States citizens and nationals.
Applicants who applied under Announcement Number HHS-CMSO-2005-0039 NEED NOT REAPPLY.

JOB SUMMARY:

INFLUENCE SOLUTIONS TO ONE OF THE NATION'S TOUGHEST CHALLENGES

Help shape America's health care agenda. Ensure the uninsured are covered. Touch the lives of 82 million individuals by giving them access to health care. These are the challenges we face every day at the Centers for Medicare and Medicaid Services (CMS) - the largest single purchaser of health care in the world. To accomplish our mission, we need people like you, who share our vision to improve the quality and efficiency of an evolving health care system on a national level. You can be part of the changes we are making as a Health Insurance Specialist in our Family and Children's Health Programs Group (FCHPG), taking responsibility for a wide variety of our program initiatives.

IMPACT HEALTH CARE POLICY FROM THE TOP DOWN

Working directly with States and other Federal partners, your innovative thinking and cutting-edge ideas will be the key to effectively coordinating, developing, evaluating and implementing program initiatives that ensure health care for those in need. You will help us accomplish our goals by assisting States to shape and implement policy that affects millions of people through Medicaid and the State Children Health Insurance Program (SCHIP). Your responsibilities will also involve advising on laws, regulations and policy, monitoring and evaluating the work of organizations that contract with Medicaid, and identifying and developing ways to resolve problems or issues that directly affect the accomplishment of our Group objectives.

If you're ready to make significant positive changes in the administration and execution of American health care, send us your application today.

KEY REQUIREMENTS:

- U.S. Citizenship

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United States Department of Health & Human Services

Department: Department Of Health And Human Services
Agency: Centers for Medicare & Medicaid Services
Job Announcement Number: HHS-CMSO-2005-0054

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Health Insurance Specialist

Additional Duty Location Info:
Few vacancies - Baltimore, MD (Woodlawn Area)

MAJOR DUTIES:
As a Health Insurance Specialist, you will provide Federal oversight of State Medicaid operations by:

- Advising on the legal requirements of the program and ensuring compliance with Medicaid/SCHIP programs;
- Analyzing policy/regulations and advising on their implementation;
- Analyzing proposals for demonstration projects so that decision-makers understand their potential impact;
- Ensuring that States are working to improve the delivery of health care to those who are uninsured; and
- Facilitating the sharing of state quality initiatives to improve quality outcomes.

You will work independently under the supervision of the Division Director, the scope of your projects and studies will include analyzing the effectiveness of State waiver programs. A substantial amount of your time will be spent working with public and private-sector entities to exchange information, coordinate work, develop goals, resolve operational problems and negotiate the acceptance of controversial recommendations.

You will also study an extensive range of complex and diversified subjects addressing conflicting goals, priorities and services while developing and applying new methods and techniques to resolve problems that ultimately result in positive changes to health care administration and operations.

In this capacity you will:

- Plan, coordinate and direct special studies, assignments and projects often involving issues of a sensitive or critical nature to develop, analyze, implement and modify operating policy and procedures.
- Prepare briefings and reports for the Director/Deputy Director to present at executive meetings.
- Represent the Group at inter/intra-agency meetings to justify and approve specific Group initiatives, and to provide authoritative information on various aspects of FCHPG functions.
- Maintain working relationships with customers and serve as a member of various ad hoc workgroups.

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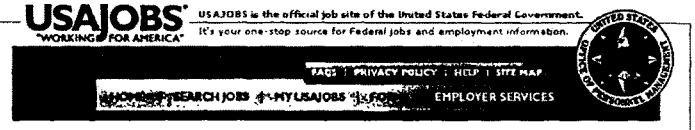

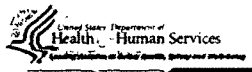

Department: Department Of Health And Human Services
Agency: Centers for Medicare & Medicaid Services
Job Announcement Number: HHS-CMSO-2005-0054

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Health Insurance Specialist

QUALIFICATIONS REQUIRED:
To be successful you must have demonstrated experience utilizing strong analytical and negotiating skills along with solid research skills. You must possess a knowledge of public health programs, such as Medicaid law and policy, and be able to translate complex laws into clear, understandable language. You must be data savvy and have a strong math ability particularly in dealing with complex financial data and review of Federal and State health grant appropriations. You must have strong oral and writing skills.

A background in handling health care issues, such as with a managed care or health insurance company or State Medicaid operations, is also required--particularly experience at the programmatic or administrative level that demonstrates the ability to negotiate and administer contracts with States or other entities. Research experience or a background in working with a think tank or advocacy group would be useful.

Additionally, you must have a comprehensive knowledge of laws, policies, regulations and precedents that apply to the administration of family and children's health; and the ability to apply a wide range of quantitative/qualitative methods to assess and improve program effectiveness, management processes and systems.

A talent for planning, developing and conducting comprehensive studies and projects is also needed, in order to detect problem areas and formulate solutions. The ability to build and maintain effective working relationships with others and to develop formal reports, position papers and oral presentations will ensure your effectiveness in this role.

Your previous work experience must meet the level of difficulty and complexity of the GS-12 grade level in the Federal service and you must have performed at this level for at least one year.

HOW YOU WILL BE EVALUATED:

You will be evaluated based upon the experience reflected in your resume and responses to the questionnaire. All qualified applicants will then be asked to complete an on line skills test for which a link will be provided. Based on your final score, you will be placed in one of the following categories - Superior, Highly Qualified or Qualified.

PRIORITY SELECTION:

DEPARTMENT OF HEALTH AND HUMAN SERVICES SURPLUS OR DISPLACED EMPLOYEES REQUESTING SPECIAL SELECTION PRIORITY CONSIDERATION

If you are currently a DHHS employee who has received a Reduction in Force (RIF) separation notice or a Certification of Expected Separation (CES), you may be entitled to special priority selection under the DHHS Career Transition Assistance Program (CTAP).

(click here for CTAP qualifications: http://career.psc.gov/choublic/ctap.html)

DISPLACED EMPLOYEES REQUESTING SPECIAL SELECTION PRIORITY CONSIDERATION UNDER THE INTERAGENCY CAREER TRANSITION ASSISTANCE PROGRAM (ICTAP)

If you are a displaced employee you may be entitled to receive special priority selection under the ICTAP.

(click here for ICTAP qualifications: http://career.psc.gov/choublic/ictap.html)

HHS, CMS is an Equal Opportunity Employer. Selection for this position will be based solely on merit, without discrimination for non-merit reasons such as race, color, religion, sex, national origin, politics, marital status, physical or mental disability, age or membership or non-membership in an employee organization.

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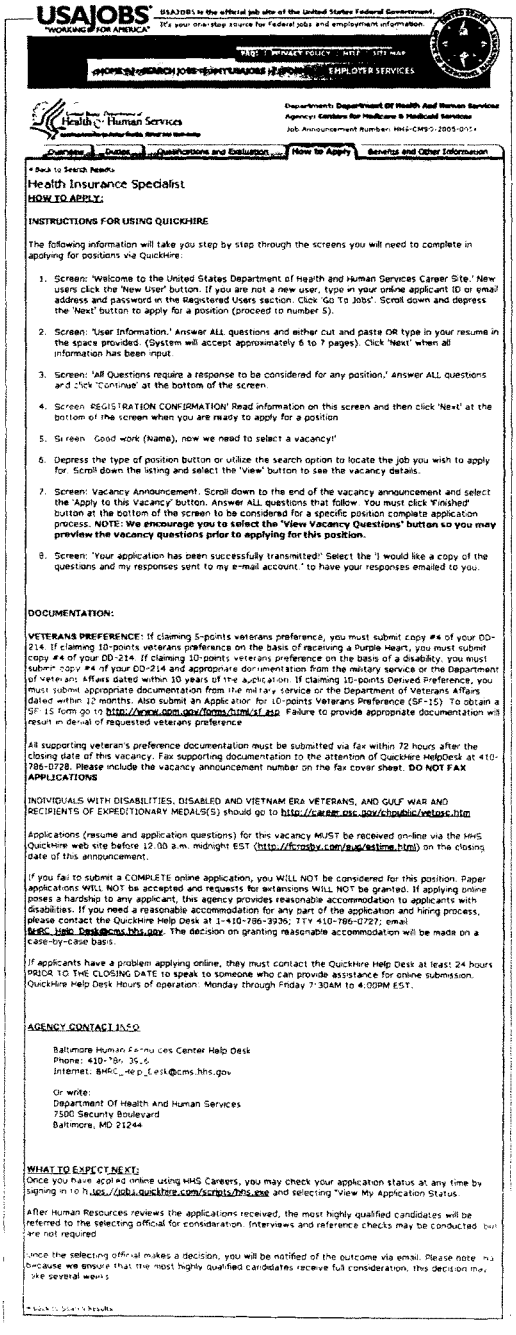

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EMPLOYER SERVICES

Department of Health and Human Services

Department: Department Of Health And Human Services
Agency: Centers for Medicare & Medicaid Services
Job Announcement Number: HHS-CMS-2005-0[illegible]

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Health Insurance Specialist

HOW TO APPLY:

INSTRUCTIONS FOR USING QUICKHIRE

The following information will take you step by step through the screens you will need to complete in applying for positions via QuickHire.

1. Screen: 'Welcome to the United States Department of Health and Human Services Career Site.' New users click the 'New User' button. If you are not a new user, type in your online applicant ID or email address and password in the Registered Users section. Click 'Go To Jobs'. Scroll down and depress the 'Next' button to apply for a position (proceed to number 5).
2. Screen: 'User Information.' Answer ALL questions and either cut and paste OR type in your resume in the space provided. (System will accept approximately 6 to 7 pages). Click 'Next' when all information has been input.
3. Screen: 'All Questions require a response to be considered for any position.' Answer ALL questions and click 'Continue' at the bottom of the screen.
4. Screen: 'REGISTRATION CONFIRMATION' Read information on this screen and then click 'Next' at the bottom of the screen when you are ready to apply for a position.
5. Screen: 'Good work (Name), now we need to select a vacancy!'
6. Depress the type of position button or utilize the search option to locate the job you wish to apply for. Scroll down the listing and select the 'View' button to see the vacancy details.
7. Screen: Vacancy Announcement. Scroll down to the end of the vacancy announcement and select the 'Apply to this Vacancy' button. Answer ALL questions that follow. You must click 'Finished' button at the bottom of the screen to be considered for a specific position complete application process. **NOTE: We encourage you to select the "View Vacancy Questions" button so you may preview the vacancy questions prior to applying for this position.**
8. Screen: 'Your application has been successfully transmitted!' Select the 'I would like a copy of the questions and my responses sent to my e-mail account.' to have your responses emailed to you.

DOCUMENTATION:

VETERANS PREFERENCE: If claiming 5-points veterans preference, you must submit copy #4 of your DD-214. If claiming 10-points veterans preference on the basis of receiving a Purple Heart, you must submit copy #4 of your DD-214. If claiming 10-points veterans preference on the basis of a disability, you must submit copy #4 of your DD-214 and appropriate documentation from the military service or the Department of Veterans Affairs dated within 10 years of the application. If claiming 10-points Derived Preference, you must submit appropriate documentation from the military service or the Department of Veterans Affairs dated within 12 months. Also submit an Application for 10-points Veterans Preference (SF-15). To obtain a SF-15 form go to http://www.opm.gov/forms/html/sf.asp. Failure to provide appropriate documentation will result in denial of requested veterans preference.

All supporting veteran's preference documentation must be submitted via fax within 72 hours after the closing date of this vacancy. Fax supporting documentation to the attention of QuickHire HelpDesk at 410-786-0728. Please include the vacancy announcement number on the fax cover sheet. **DO NOT FAX APPLICATIONS**

INDIVIDUALS WITH DISABILITIES, DISABLED AND VIETNAM ERA VETERANS, AND GULF WAR AND RECIPIENTS OF EXPEDITIONARY MEDALS(S) should go to http://career.osc.gov/chpublic/vetosc.htm

Applications (resume and application questions) for this vacancy MUST be received on-line via the HHS QuickHire web site before 12:00 a.m. midnight EST (http://fcrosby.com/sug/estime.html) on the closing date of this announcement.

If you fail to submit a COMPLETE online application, you WILL NOT be considered for this position. Paper applications WILL NOT be accepted and requests for extensions WILL NOT be granted. If applying online poses a hardship to any applicant, this agency provides reasonable accommodation to applicants with disabilities. If you need a reasonable accommodation for any part of the application and hiring process, please contact the QuickHire Help Desk at 1-410-786-3936; TTY 410-786-0727; email BHRC_HHS_Desk@cms.hhs.gov. The decision on granting reasonable accommodation will be made on a case-by-case basis.

If applicants have a problem applying online, they must contact the QuickHire Help Desk at least 24 hours PRIOR TO THE CLOSING DATE to speak to someone who can provide assistance for online submission. QuickHire Help Desk Hours of operation: Monday through Friday 7:30AM to 4:00PM EST.

AGENCY CONTACT INFO

Baltimore Human Resources Center Help Desk
Phone: 410-786-3936
Internet: BHRC_Help_Desk@cms.hhs.gov

Or write:
Department Of Health And Human Services
7500 Security Boulevard
Baltimore, MD 21244

WHAT TO EXPECT NEXT:

Once you have applied online using HHS Careers, you may check your application status at any time by signing in to https://jobs.quickhire.com/scripts/hhs.exe and selecting "View My Application Status."

After Human Resources reviews the applications received, the most highly qualified candidates will be referred to the selecting official for consideration. Interviews and reference checks may be conducted, but are not required.

Once the selecting official makes a decision, you will be notified of the outcome via email. Please note that because we ensure that the most highly qualified candidates receive full consideration, this decision may take several weeks.

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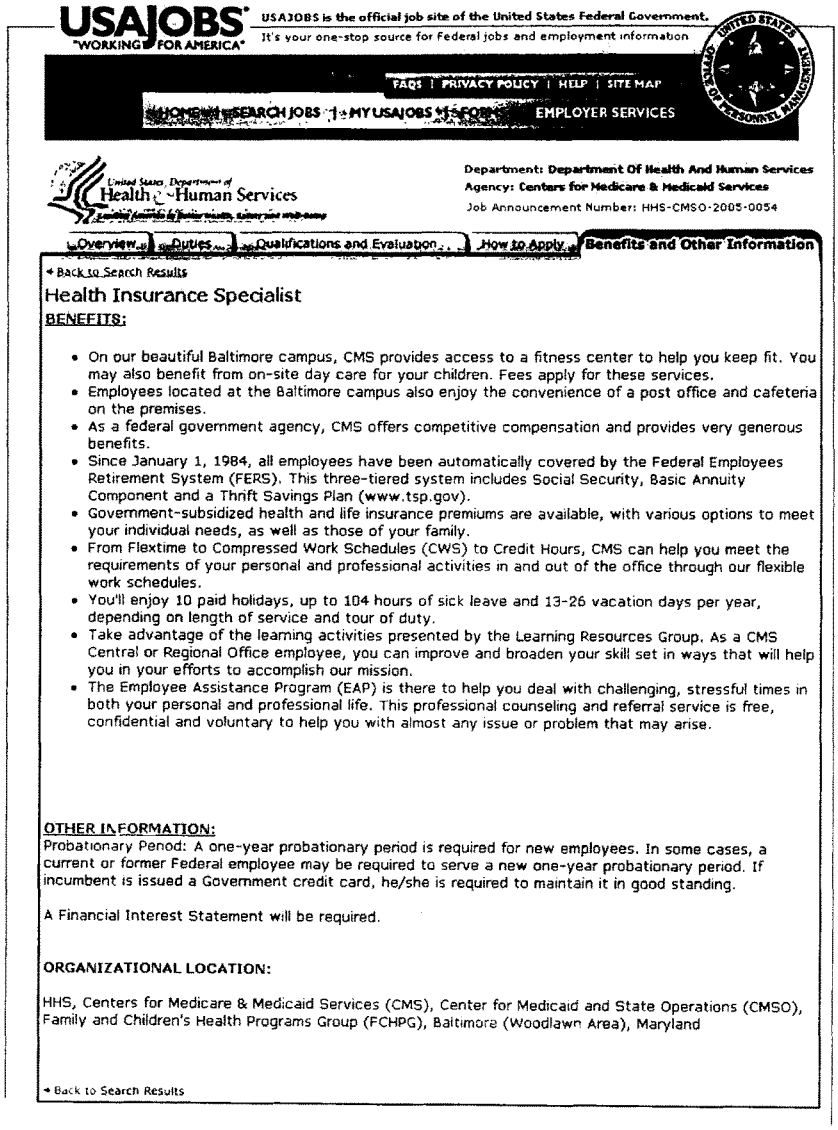

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United States Department of Health & Human Services

Department: Department Of Health And Human Services
Agency: Centers for Medicare & Medicaid Services
Job Announcement Number: HHS-CMSO-2005-0054

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Health Insurance Specialist

BENEFITS:

- On our beautiful Baltimore campus, CMS provides access to a fitness center to help you keep fit. You may also benefit from on-site day care for your children. Fees apply for these services.
- Employees located at the Baltimore campus also enjoy the convenience of a post office and cafeteria on the premises.
- As a federal government agency, CMS offers competitive compensation and provides very generous benefits.
- Since January 1, 1984, all employees have been automatically covered by the Federal Employees Retirement System (FERS). This three-tiered system includes Social Security, Basic Annuity Component and a Thrift Savings Plan (www.tsp.gov).
- Government-subsidized health and life insurance premiums are available, with various options to meet your individual needs, as well as those of your family.
- From Flextime to Compressed Work Schedules (CWS) to Credit Hours, CMS can help you meet the requirements of your personal and professional activities in and out of the office through our flexible work schedules.
- You'll enjoy 10 paid holidays, up to 104 hours of sick leave and 13-26 vacation days per year, depending on length of service and tour of duty.
- Take advantage of the learning activities presented by the Learning Resources Group. As a CMS Central or Regional Office employee, you can improve and broaden your skill set in ways that will help you in your efforts to accomplish our mission.
- The Employee Assistance Program (EAP) is there to help you deal with challenging, stressful times in both your personal and professional life. This professional counseling and referral service is free, confidential and voluntary to help you with almost any issue or problem that may arise.

OTHER INFORMATION:

Probationary Period: A one-year probationary period is required for new employees. In some cases, a current or former Federal employee may be required to serve a new one-year probationary period. If incumbent is issued a Government credit card, he/she is required to maintain it in good standing.

A Financial Interest Statement will be required.

ORGANIZATIONAL LOCATION:

HHS, Centers for Medicare & Medicaid Services (CMS), Center for Medicaid and State Operations (CMSO), Family and Children's Health Programs Group (FCHPG), Baltimore (Woodlawn Area), Maryland

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United States Senate Subcommittee on Oversight of Government Management, the Federal Workforce and the District of Columbia.
Ann Womer Benjamin, Director, Ohio Department of Insurance
Testimony on Centers for Medicare and Medicaid Services
Chairman George Voinovich, Ohio
April 5, 2005

Good Morning. I am Ann Womer Benjamin, Director of the Ohio Department of Insurance.

Thank you Chairman Voinovich and distinguished senators for the opportunity to provide testimony on the education, resources, and outreach efforts of the Centers for Medicare and Medicaid Services (CMS) specifically as they relate to the Medicare prescription drug program. CMS has been a reliable and supportive partner in working with the Ohio Department of Insurance and our Ohio Senior Health Insurance Information Program (OSHIIP) section to educate and enroll Ohio seniors and Medicare beneficiaries in the prescription drug program. With any working partnership, opportunities exist to strengthen and improve delivery of this critical assistance to Ohio's beneficiaries.

Overview

The Ohio Department of Insurance ("Department") is committed to providing consumer protection through fair but vigilant regulation while promoting a competitive environment for insurers. The Department regulates and licenses approximately 1,740 insurance companies, nearly 180,000 agents, and more than 13,000 insurance agencies, and monitors the financial solvency of the insurance industry in Ohio.

Another very important facet of our consumer protection mission, and of relevance to the hearing today, is the Ohio Department of Insurance's OSHIIP, headed by Gretchen Margraf. OSHIIP was established in 1991 by then Governor Voinovich, and plays an essential role in educating Ohio seniors and others who qualify for Medicare. Through its toll-free help line, 950 volunteers, objective and understandable literature, and speakers' bureau, OSHIIP provides valuable information to many of Ohio's 1.8 million Medicare beneficiaries. The number of beneficiaries continues to grow rapidly with approximately 12,000 Ohioans turning 65 each month. Our population is aging quickly, so we need to ensure that seniors are educated about their health insurance and Medicare options.

In addition to assistance with Medicare, OSHIIP also provides planning for long-term care expenses. Part of that planning includes outreach to large employers. This initiative is geared to educate employers and their employees about the options available for long-term care costs. Workshops offer information on various financing options such as (1) long-term care insurance, (2) accelerated death benefits on life insurance, (3) long-term care riders on life insurance products, (4) annuities, and (5) HUD reverse mortgages. The

Department's guides on annuities, life insurance and long-term care insurance are also distributed.

I would like to take a brief moment to publicly thank Senator Voinovich for his leadership and support of senior issues including but not limited to Medicare and his launching of OSHIIP. Further, I would like to thank Governor Bob Taft for his ongoing support of our programs. Finally, I would like to thank Dr. McClellan for his strong commitment to provide the needed resources and information to educate Ohio's Medicare population.

The Ohio Department of Insurance and OSHIIP have always been very aggressive in our efforts to assist and educate Medicare recipients on the many intricacies of the program. OSHIIP is an invaluable resource for Ohio seniors and has some very impressive results that I would like to point out: OSHIIP personnel have counseled more than 395,000 people, saved Ohio consumers $3.6 million, distributed more than 1,000,000 publications, trained and certified more than 1,926 community-based volunteers and established more than 250 information sites since 1992.

While these general efforts continue, we have also been increasing the scope of our work and outreach in preparation for the full implementation of Medicare's new prescription drug coverage, as well as the increasing numbers of Ohioans who each day move closer to Medicare eligibility. In calendar year 2004, OSHIIP assisted 57,197 consumers, recovered nearly one million dollars for consumers, recertified 367 volunteers and trained 281 new volunteers, bringing the total number of currently trained and certified volunteers to over 950.

These accomplishments I have just highlighted would not be possible without the dedication of OSHIIP's 13 employees and volunteers serving all 88 of Ohio's counties, and CMS. Their hard work and willingness to invest the needed time and energy for the consumers of Ohio should be commended.

CMS Collaboration

Since the passage of the Medicare Modernization Act of 2003 (MMA), CMS has been instrumental in helping us with information and resources to prepare and respond to the many changes that are coming to Medicare. These efforts could not have been more apparent than last April when Senator Voinovich and Dr. McClellan joined Governor Taft and me at an OSHIIP volunteer training session. We kicked off Ohio's introduction of the Medicare prescription drug card program with more than 100 community volunteers participating in the training, designed by CMS to provide the critical program information they needed. The Ohio Department of Insurance and OSHIIP staff and volunteers also aggressively spread the word and were available on a state holiday to assist seniors with enrolling in the discount drug card program and the $600 credit associated with it. On December 31, 2005, the last day to register for the $600 credit for 2004, our OSHIIP employees enrolled 115 low-income Ohioans and helped them save over $138,000 on much needed prescription drugs.

CMS has continued to provide OSHIIP and Ohio consumers with invaluable assistance, such as annual train-the-trainer workshops which allow our training teams to keep updated on the many facets of the Medicare program. CMS also facilitates and produces helpful training toolkits and numerous publications. CMS seeks the input of all state SHIP programs to ensure the material is meeting the needs of the consumer, and regularly distributes e-mails on critical issues and common problems facing states.

Outreach and educational efforts have increased at the state and local levels with the support and coordination of CMS. CMS has facilitated bi-weekly conference calls on all aspects of the MMA. This opportunity to keep lines of communication open has allowed OSHIIP to have the most current and pertinent information available. CMS has also facilitated monthly conference calls with the Ohio Medicare Partners. This partnership was established to help answer a wide range of health and health insurance related questions here in Ohio. This partnership is made up of the Ohio Department of Insurance, the Medicare Part A and Part B contractors, the Medicare Durable Medical Equipment Carrier, the Ohio Department of Aging, Ohio Department of Health, Ohio Department of Job and Family Services, and the Social Security Administration.

In mid-February of this year, CMS hosted a train-the-trainer and Medicare Partners strategic planning session in Chicago. CMS introduced its "2005 REACH National Medicare & You Training Program" focusing on the new prescription drug coverage training module. CMS also facilitated working sessions for each state's Medicare Partners (e.g. the Part A , Part B, and DMERC contractors and others) so that coordinated outreach plans could be jointly developed to maximize population penetration and group efficiency.

Later this year, the Ohio Department of Insurance and OSHIIP will be hosting local Medicare Prescription Drug Coverage enrollment events in each of Ohio's 29 most rural counties. These day-long events will include educational presentations on the new prescription drug option, individual counseling to assist people in making informed decisions and, in most cases, online enrollment opportunities. CMS has committed to mailing invitations to these events to the low-income residents of these counties.

The Department and OSHIIP have been very pleased with our collaboration with CMS, but there is always room for improvement and increased efficiencies. We have experienced some delay in getting training materials needed to conduct our volunteer training sessions. While this delay was only a couple of weeks, it has compressed the time we have to conduct the training of our volunteers, particularly since CMS has established a deadline of July 1, 2005, for training all SHIP volunteers. OSHIIP anticipates meeting this requirement by June 1, 2005. We also have experienced delays regarding technical and statistical inquiries we make to CMS. While our impression is that CMS is trying to ensure that the proper individuals respond and provide the most accurate information in a timely fashion, CMS delays sometimes result in gaps in accurate information.

The process of selecting the appropriate Medicare program and benefit plan is not a choice that seniors should make quickly without assessing all of their needs. OSHIIP provides free accurate, objective, and personal assistance to each consumer we encounter. By providing individualized prescription drug comparison reports and a willingness to spend whatever time is required, OSHIIP staff and volunteers continue where the 1-800-MEDICARE hotline stops. The nationwide hotline is a great resource and starting point, but responders do not have the ability to spend an extraordinary amount of time with callers nor do they have the ability to meet face-to-face as our volunteers do.

Conclusion

This year we have received a substantial increase in our annual federal grant to help administer OSHIIP, and Ohio and I thank you. We will utilize some of those additional resources to hire another employee to assist in what we predict will be a dramatic increase in calls. The initial open-enrollment period for the Medicare prescription drug coverage is November 15, 2005 thru May 15, 2006. With the expected increase in our workload, the ever-increasing 65-plus population, and the many options consumers face, our challenge will be to continue excellent consumer service to those Ohioans struggling to make an informed decision.

Dr. McClellan has been a real champion of seniors and his leadership of CMS has reflected this commitment. He and CMS have worked hard to take Medicare benefits and options to seniors in ways to make their choices easier to understand and evaluate. Strong partnering with SHIP initiatives has made the CMS effort all the more helpful to seniors everywhere.

I would like to thank Chairman Voinovich again for the opportunity to share the many positive and exciting things we are doing for seniors in Ohio. From our perspective we feel the collaboration with CMS has been very beneficial, and we hope it only grows stronger.

Homeland Security and Governmental Affairs
Subcommittee on Oversight of Government Management and the Federal Workforce

Monitoring CMS' Vital Signs:
Implementation of the Medicare Prescription Drug Program
April 5, 2005

Questions for the Record
Senator Frank R. Lautenberg

1. **Under the Bush Medicare law, "dual eligibles" in my state will go from having no copayments to having a drug plan with a strict formulary and copayments of up to five dollars per medication. Most of these people have five and 10 prescriptions — so this adds up to a serious cost for low-income people. Are you going to warn dual eligibles about these changes before 2006?**

Answer:

As you know, starting in 2006, the new Medicare drug benefit makes prescription drug coverage available to all 43 million Medicare beneficiaries, providing them with substantial federal help in paying for their prescription drugs and improving their quality of life. For the first time in Medicare, additional comprehensive help will be available to those who need it most – people with very high prescription drug costs and people with low incomes. Millions of low-income beneficiaries will receive comprehensive coverage at little or no cost. Dual eligibles and millions more low-income beneficiaries will have comprehensive coverage for little or no cost.

Under the new drug benefit, about 6.3 million full-benefit dual eligible low-income beneficiaries will have no premium or deductible and nominal co-pays of as little as $1 or $3 per prescription. For these beneficiaries, the Medicare benefit will pay, on average, 98 percent of their drug costs. Of the dual eligible beneficiaries, about 1.5 million who are institutionalized are totally exempt from cost sharing. They pay no premiums, no deductibles, no coinsurance, and no co-payments.

CMS is working diligently to ensure a smooth transition process for dual-eligible beneficiaries. In May 2005, CMS will mail a letter notifying full-benefit dual eligible beneficiaries that they automatically qualify for the low-income subsidy and do not need to apply. In October, CMS will mail a letter to these beneficiaries identifying the plan in which Medicare will enroll them, effective January 1, 2006, if they do not choose a plan on their own by December 31, 2005. Medicare prescription drug plans will mail enrollment materials to the beneficiaries assigned to their plan that includes the list of covered drugs and pharmacy network. The beneficiary will then have the opportunity to review the plan materials available to him or her to make an informed choice of a drug

plan. If the beneficiary does not make a choice, CMS will enroll him or her in a Medicare prescription drug plan with an effective date of January 1, 2006. Full-benefit dual eligible beneficiaries will have the opportunity to switch plans at any time.

2. What will happen to the dual eligibles at the pharmacy when one or more of their prescriptions are not on the formulary and therefore not covered by their plan?

Answer:

CMS recognizes the enormity of the transition from Medicaid drug coverage to Medicare and is working diligently to ensure the process for beneficiaries is as quick and efficient as possible. Protections are in place to help ensure that no full-benefit dual eligible beneficiary will go without coverage when the new Medicare prescription drug benefit starts on January 1, 2006.

CMS has developed a set of checks and oversight activities to ensure that prescription drug plans offer a comprehensive benefit that reflects best practices in the pharmacy industry as well as current treatment standards.

Additionally, CMS has developed appeals procedures that ensure that enrollees quickly receive decisions regarding medically necessary medications. Because most enrollees will receive information about the amount of cost-sharing for a requested drug at pharmacy counters, CMS is requiring plans to arrange with their network pharmacies to distribute or post notices that instruct enrollees to contact their Medicare prescription drug plans to obtain a coverage determination or to request an exception to the plan's formulary if they disagree with the information provided by their pharmacists. If an enrollee would like to receive a requested drug before a decision on a coverage determination or appeal has been made, he or she may choose to pay for the prescription and then request a written coverage determination or an exception from the plan. If an enrollee requests a coverage determination or exception, the plan must make its decision as expeditiously as the enrollee's health condition requires after it receives the request, but no later than 24 hours for an expedited coverage determination or 72 hours for a standard coverage determination. If an enrollee has already purchased a drug and, for example, an off-formulary exceptions request is later approved by the plan, the enrollee should submit the receipt for the purchase to the plan to obtain reimbursement. If an enrollee cannot afford to purchase the entire prescription before requesting an exception from the plan, pharmacies typically have procedures for dispensing a few doses of a prescribed drug (for which the beneficiary may have to pay). Medicare prescription drug plans must comply with the provisions related to making arrangements for their network pharmacies to distribute or post the notice that instructs enrollees to contact their plans to obtain a coverage determination or an exception. Medicare prescription drug plans may also establish additional contractual arrangements with their network pharmacies to address situations where an enrollee has an immediate need for a non-formulary drug.

3. **What would the impact be on the program's deficit if we could safely re-import drugs from Canada and Mexico?**

Answer:

Currently, the only types of legally imported drugs are: 1) those that are manufactured in foreign FDA-inspected facilities that adhere to FDA-approval standards, or 2) those that are U.S.-approved and manufactured in the U.S., sent abroad, then imported back into the U.S. by the manufacturer under proper controls and in compliance with federal law. In this bill, Congress decided to uphold the law unless the Secretary of Health and Human Services determines that importation can be done safely, and can actually save consumers money.

The HHS Task Force on Prescription Drug Importation reported in 2004 that there are significant risks associated with the way individuals are currently importing drugs, and that the public expectation that most imported drugs are less expensive than American drugs is not generally true.

4. **Dr. McClellan, your agency has a tough implementation schedule it is trying to meet. I understand that Plans will bid by June of this year and be selected in order in time to begin to be marketed by October and that the beneficiary can select by January. Is this correct?**

Answer:

CMS is working diligently to ensure full implementation by January 1, 2006. We are issuing operational guidance regularly and are engaged in an ongoing dialogue with plans, providers and other organizations. In fact, the final marketing guidelines will be released in August so that plans can begin their marketing efforts to beneficiaries in October 2005.

Plans will submit their bids in June 2005. Contracts will be signed and plans announced in mid-September. Plan marketing will begin in October. CMS and its partners across the US have reached out to educate seniors and people with disabilities about the new Medicare drug benefit. The initial enrollment period will begin November 15, 2005 and continue through May 15, 2006. Coverage for those who have signed up by December 31, 2005, will begin January 1, 2006.

CMS is committed to making sure that Medicare beneficiaries have the information they need to make informed decisions about their health care and will continue working with Plans and our partners to make this happen.

5. Will individual drug plans and the Medicare Advantage plans both be priced at the same cost to the consumer or will the Medicare Advantage be truly preferable due to cost savings over the average drug plan?

Answer:

Premiums for prescription drug coverage in Medicare Advantage health plans are expected to be even lower than in the stand-alone prescription drug plans on average. Medicare Advantage plans will frequently offer additional drug coverage beyond the basic Medicare benefit for no additional premium.

On average, premiums for prescription drug coverage in Medicare Advantage Prescription Drug Plans (MA-PDPs are expected to be even lower than in stand-alone Prescription Drug Plans (PDPs). MA-PDPs will frequently provide non-Medicare benefits that enhance and improve upon the Medicare package. Examples of these improved benefits include preventive care, disease management for chronic illnesses, dental and vision care, and other services. Additionally, MA-PDPs that bid lower than the benchmark for regular Medicare Part A and Part B coverage can use 75 percent of the difference between their bids and the benchmark to reduce their prescription drug plan premium, offer supplemental benefits or reduced beneficiary cost sharing, or reduce Part B premiums paid by enrollees.

MA plans have been preferred by millions of seniors because they offer lower costs (during 2004, this amounted to overall savings for the Medicare and non-Medicare benefits of over $700 per year in out-of-pocket costs for the average beneficiary and nearly $2,000 in savings for those beneficiaries in poor health) compared with traditional Medicare for beneficiaries who do not have supplemental coverage from an employer or Medicaid. For Medicare-covered benefits and the out-of-pocket costs that individuals typically have for such benefits, savings in MA are increasing with an average of $34 in out-of-pocket costs per month for covered services in 2005 for MA enrollees, compared with an average of $119 in monthly out-of-pocket costs for fee-for-service Medicare.

6. What is the number of Medicare beneficiaries who have drug coverage through an employer today?

Answer:

CMS estimated in the Impact Analysis included in the final Title II regulation released in January 2005 that 11.4 million Medicare beneficiaries would have had retiree drug coverage in 2006 had the MMA not been enacted.

7. **What percent of those drug plans would you estimate -- and I know you're not an actuary so I would just like a ball park estimate so I can get my arms around the idea-- what percent of those drug plans would you estimate are about the same or close to the Medicare drug benefit?**

Answer:

CMS estimated in the Impact Analysis included in the final Title II regulation that 9.8 million of the total 11.4 million retirees who would have had retiree drug coverage in 2006 had the MMA not been enacted would have coverage that is creditable. Creditable coverage means coverage that pays out on average benefits equal to or greater than the benefits provided by the standard Part D plan. If an employer plan is deemed to be creditable coverage, that employer is eligible for the 28% retiree drug subsidy, which will be paid by CMS to employers to help cover retiree drug costs between $250 and $5000.

8. **Do you believe as many labor economists do, that employees pay either directly or through forgone wages for their employer paid benefits?**

Answer:

The widely accepted economic theory of compensating wage differentials argues that workers make tradeoffs between wages and benefits, and that employees (not their employers) pay for health insurance in the form of lower wages or reductions in other forms of compensation. This economic theory also extends to retirees, assuming that they pay for their retiree health benefits in the form of foregone wages while they were active workers and/or retiree health insurance premium contributions.

However, the relationship between retiree health benefits and foregone wages is not a perfect one, given the uncertainty that exists about future health expenditures. The theory that active workers pay for their future retiree health benefits in the form of foregone wages assumes that employers are able to accurately measure the present discounted value of their employees' future retiree health costs, and adjust their employees' wages accordingly. However, estimates of the value of future retiree health benefits are dependent on assumptions about a variety of factors that could change considerably over time, including health care cost inflation rates and life expectancy.

Thus employers could potentially be faced with unfunded liabilities for postretirement health benefits if they underestimated the future cost of providing these benefits. In an effort to reduce their retiree health liabilities, many employers have made changes in the eligibility criteria for receiving retiree health benefits (for example, based on age and service requirements) and in their retiree health benefit packages (for example, reducing or capping the benefit that is offered and/or increasing the amount that the retiree has to pay).

9. **Now I understand that the Federal government is going to give these employers who are now providing drug benefits 28% of the drug costs between $250 and $5000 in 2006 for each qualifying covered retiree. Isn't this akin to paying the employer twice for those benefits from an economists' point of view?**

   Once by the employee and once again by the Federal government not to mention the original tax break the business received for the business expense in the first place.

Answer:

Economic theory suggests that employers adjust their employees' wages to reflect the cost of retiree health benefits. However, the net cost of retiree health benefits to the employer may exceed the combined value of their retirees' foregone wages and premium contributions, even when the tax-favored status of these benefits is taken into account.

Given the uncertainty that exists in estimating future health expenditures, employers can potentially be faced with significant unfunded liabilities for retiree health benefits. Although employers' payments for health insurance are deducted in determining the employer's corporate income tax liability and share of payroll taxes for Medicare and Social Security (through reductions in their gross revenues and base payroll, respectively), the incremental savings related to the tax-favored status of these benefits may not be sufficient to compensate for increases in health care cost inflation and changes in life expectancy.

Thus, the net cost of retiree health benefits to the employer may exceed the combined value of their retirees' foregone wages and premium contributions, even with the tax-favored status of these benefits, which could put additional financial pressures on employers to reduce the cost of these benefits. Indeed, the availability and generosity of retiree health coverage had been declining for more than a decade prior to enactment of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), particularly for future retirees. Available evidence suggests that this erosion is continuing to occur due to ongoing financial pressures on employers. Some employers currently make little or no contribution toward the cost of their retirees' health coverage.

The options available to employers and unions under the MMA for continuing to provide assistance with their retirees' prescription drug costs – such as receiving tax-free payments for a portion of drug costs, or incorporating the Part D benefits into their retiree health programs –provide additional financial resources to offset some of the sponsors' net costs in furnishing such coverage. All of these options will make it far more affordable for employers and unions to continue to provide and support high quality retiree drug coverage for Medicare-eligible retirees.

For example, by making a tax-free subsidy for 28 percent of allowable prescription drug costs available to qualified retiree prescription drug plans that meet the two-prong actuarial equivalence standard, the Medicare retiree drug subsidy significantly reduces the financial liabilities associated with employers' retiree drug coverage and thereby encourages employers to continue assisting their retirees with prescription drug coverage.

- The tax-free retiree drug subsidy enables employers and unions to receive assistance while maintaining their current benefit designs, thus minimizing disruptions for beneficiaries who are currently enrolled in those retiree health plans.

- Additionally, the retiree drug subsidy saves both the Medicare program and taxpayers money because the estimated average per capita retiree subsidy payment that an employer/union would receive for a qualifying retiree ($668 in 2006) is less than the estimated cost to the Medicare program (and thus the taxpayers) of enrolling the same beneficiary in the Medicare prescription drug benefit ($891 in 2006, excluding reinsurance payments).

All of the options that are available to employers and unions under the MMA make it possible for retirees to receive drug coverage at a lower cost than employers and unions are paying today, regardless of whether they receive this coverage through an employer or union-sponsored retiree plan that is eligible for the retiree drug subsidy, or by enrolling in a Part D plan and receiving additional coverage that complements the standard Part D benefit from their former employer or union. Ultimately, we believe that the implementation of Medicare Part D, including the Medicare retiree drug subsidy and the other opportunities it affords employers and unions for providing continued prescription drug assistance to their Medicare retirees, will result in combined aggregate payments by employers/unions and Medicare for retiree drug coverage generally being greater – and frequently significantly greater – than they otherwise would have been without the enactment of the MMA. The MMA provisions will help to counteract some of the financial pressures that have been contributing to the trends toward erosion in retiree health benefits by making it more affordable for employers and unions to continue providing high quality retiree drug coverage.

10. **Finally, will you please compare the prices anticipated will be paid for the top fifty prescription drugs under the Medicare program compared to the prices for the same drugs paid by the Veterans Administration and Medicaid program?**

Answer:

The new Medicare drug benefit will utilize the power of the market to negotiate low prices for prescription drugs and save money for both Medicare beneficiaries and the taxpayers. We have every reason to believe that this proven approach is the best way to provide Medicare beneficiaries with the best prices on the prescription drugs they need.

We are unable to make this type of comparison at this time. According to the statute, the negotiated prices reported to CMS by a prescription drug plan or Medicare Advantage Prescription drug plan are subject to the Confidentiality of Information provision in 1927 (b) (3) (D), which generally prohibits the disclosure of the identity of a specific manufacturer or wholesaler and prices charged for drugs by the manufacturer or wholesaler. Moreover, while negotiated prices offered by a plan in a particular region will be consistent, cost-sharing arrangements may differ. However, once enrollment begins, beneficiaries will be able to use an online tool to compare the price of their drugs across plans in their particular service area, as well as obtain that information directly from plans.

Homeland Security and Governmental Affairs
Subcommittee on Oversight of Government Management and the Federal Workforce

Monitoring CMS' Vital Signs:
Implementation of the Medicare Prescription Drug Program
April 5, 2005

Questions for the Record
Submitted by Senator Tom Carper

Questions for Dr. Mark McClellan, Director, Center for Medicare and Medicaid Services

1. **I have heard reports that CMS has received an incredibly large number of applications from organizations that would like to offer a prescription drug benefit under the new Medicare drug program or through the Medicare Advantage program. In fact, CMS has stated that there is so much interest in providing the benefit that they do not expect to have "fallback" plans in any area of the country. While it is encouraging to hear that there is so much interest in delivering drug coverage to seniors, I have several concerns regarding the information that has been reported to me. I would appreciate clarification from CMS regarding the following questions:**

   a) **The deadline to submit applications to provide drug coverage as an MA-PD or stand alone PDP was March 23, 2005. It has been reported to me that as many as 2500 different benefit packages were submitted for approval. How many different organizations submitted applications to CMS? Each organization may have submitted multiple benefit designs — how many total benefit designs were submitted to CMS? Please include the number of MA-PD packages and PDP packages separately.**

      Answer:

      [***This answer is out-of-date***] The new prescription drug coverage has resulted in a robust response from the industry. CMS will carefully review each bid for important factors such as whether plans can ensure that beneficiaries are able to get their drugs at pharmacies close to their homes.

      CMS is unable to release the number of bids submitted and types of proposed benefit packages, as releasing that information might adversely affect the competitive nature of the bidding process. Once CMS finalizes the negotiations between CMS and the plan sponsors and signs contracts in mid-September, we will announce the approved bids.

b) One reason cited for low enrollment in the drug discount card was the availability of too many card options. Is CMS concerned that seniors in some areas of the country will in fact have too many drug benefit options as well? Does CMS plan to limit the number of plans in certain regions, and if so, how will CMS decide which plans to approve and which to reject.

Answer:

CMS will not limit the number of plans in a region. As stated in 1860D-11(f)(3) of the Social Security Act, there shall be no limit on the number of full risk plans that are approved. Thus, CMS may approve all bid submissions as long as they meet all of the requirements as laid out in the statute, final rule, and guidance. Limiting the number of plans in a region would amount to imposing additional government involvement and requirements on a program which was intended to use the private market to provide a prescription drug benefit to people with Medicare.

The intent of Congress in creating the new prescription drug benefit was to establish a program that would provide beneficiaries with the ability to choose a prescription drug plan that best meets their needs. CMS is aware that the variety of plan options in a region may be confusing to seniors. However, CMS is working hard to develop materials for beneficiaries and people who love them and care for them to be able to understand the new drug coverage and enroll in a drug plan that meets their needs. To ensure that beneficiaries will have the information necessary to select the plan that is right for them, CMS has been working with a variety of partners, information intermediaries and community-based organizations to educate people with Medicare and Medicare providers on the new Medicare preventive benefits, including the Medicare prescription drug coverage.

Beginning in 2005, CMS began implementing a three-phase education and outreach campaign to help people with Medicare understand the new prescription drug coverage and get the maximum help from Medicare's new programs and services. The first "awareness" phase of the campaign was implemented through June of 2005, and was focused on introducing the new benefits and options available under MMA, with special emphasis on the Medicare prescription drug coverage coming in 2006. During the second "decision" phase, education and outreach will inform people with Medicare about their drug plan options and let them know they can choose a Medicare prescription drug plan in fall 2005. Beginning in January 2006, the third "urgency" phase will highlight the importance of making a decision about drug coverage by May 15, 2006 and encourage people with Medicare to make a decision about their drug coverage because if they wait they may have to pay more for the coverage.

A variety of information tools and tactics will be employed to make the drug benefit understandable to beneficiaries and to provide specific information about

locally-available Medicare prescription drug plans. These tools include the following:

- Publications and print materials will provide detailed information about Medicare prescription drug coverage and will include a direct mailer, targeted and tailored fact sheets and tip sheets, more detailed consumer booklets, and the *Medicare & You 2006* handbook. All materials will be available in plain English and plain Spanish. Many fact sheets and tip sheets will be also be available in Chinese, Russian, Korean and Vietnamese.

- The www.medicare.gov web site will be a comprehensive information resource providing current, accurate and relevant information about Medicare prescription drug plans. Users can compare benefits and pricing of locally available plans and then enroll in a plan.

- The 1-800-MEDICARE helpline will provide 24 hour-a-day, 7 days a week reference and assistance. English and Spanish speaking customer service representatives will answer questions about the benefits and costs of locally-available drug plans, take orders for consumer publications, mail out applications for extra help paying for Medicare prescription drug plans, let beneficiaries know their eligibility status for the extra help, and access tools on www.medicare.gov to help callers get the information they need to compare and enroll in prescription drug plans.

c) **What criteria will CMS use to evaluate applications and benefit packages to ensure that plans do not discriminate in any way against beneficiaries, for example, by designing benefit packages that would discourage sicker beneficiaries from participating? How will CMS consider a plan's pharmacy network adequacy standards and beneficiary appeals process in making this determination? Will CMS use the same criteria to evaluate both MA-PD and PDP plans? Ensuring that plans are properly designed and do not utilize discriminatory practices is a vitally important aspect of the implementation of the new drug benefit. I voted in favor of the MMA with the understanding that private organizations would only be allowed to participate in the delivery of prescription drugs after a careful, thorough review and approval by CMS.**

Answer:

As provided in §423.272(b)(2) of the final Part D rule, CMS will not approve a bid if it finds that the design of the plan and its benefits are likely to substantially discourage enrollment by certain Part D eligible individuals under the plan. This is important to ensure that Medicare beneficiaries, regardless of their health status, geographic location or income have access to the drugs they need most.

Specific aspects of the bid that fall under close review include the formulary submitted by the plan to CMS. The MMA requires CMS to review Plan formularies to ensure that beneficiaries have access to a broad range of medically appropriate drugs to treat all disease states and that formulary design does not discriminate or substantially discourage enrollment of certain groups. Guiding principles in conducting the formulary review include ensuring the inclusion of a broad distribution of therapeutic categories and classes; utilizing reasonable benchmarks to check that drug lists are robust, review of tiering strategies and utilization management; identifying potential outliers (i.e., bids that significantly diverge from other bids) at each step of the review; and obtaining clinical justification when outliers appear to create access problems. One of the key criteria in the CMS formulary review is the drug list review in which reviewers will look for the inclusion of things like at least two drugs in each category and class of drugs and the most commonly prescribed drugs to the Medicare population in terms of cost and utilization. In addition, while the use of a tiering structure is allowed, a plan may be found to be discriminatory based on its allocation of drugs among the tiers. For example, not all drugs in a particular category and/or class can be placed on a high cost tier. CMS will also review certain drug classes to ensure that beneficiaries being treated with drugs within these classes have uninterrupted access to "all or substantially all" drugs in that class via formulary inclusion, utilization management tools, or exceptions processes. Those categories and classes include antidepressants, antiretrovirals, antipsychotics, anticonvulsants, antineoplastics and immunosuppressants.

CMS is also closely reviewing a plan's pharmacy network to confirm that the plan is providing potential enrollees with convenient access to covered Part D drugs.

The standards in the MMA require that each Plan sponsor must secure participation in their pharmacy networks of a sufficient number of pharmacies that dispense drugs directly to patients (other than by mail order). Furthermore, §423.120 requires that Plans must provide adequate access to home infusion, long-term care and I/T/U pharmacies.

The final marketing guidelines prohibit anti-discrimination in marketing materials and other marketing activities. Specifically, organizations cannot discriminate based on race, ethnicity, religion, gender, health status or geographic location within their plan's service area. Plans may not target marketing to beneficiaries in higher-income areas or imply in any of their materials that the plan is available to some and not all Medicare beneficiaries in the service area. CMS will be conducting ongoing oversight of plans to ensure their compliance with these beneficiary protections. Medicare beneficiaries and other organizations should contact 1-800-MEDICARE with any complaints.

d) **It has been reported to me that CMS has as few as 10 staff members to perform the incredibly important task of evaluating all of the submitted benefit packages. Further, I understand that only a limited amount of time is available to accomplish the evaluations. How many staff members has CMS assigned to evaluate the applications submitted to ensure that they represent comprehensive, nondiscriminatory coverage? How much time will CMS staff have to complete the evaluation of all plans and benefit designs? Does CMS intend to complete this process before the submission of bids in June 2005 or will CMS continue to negotiate formularies and benefit designs after the submission of bids? It is vital that CMS devote the proper resources to evaluating each and every application submitted for providing the new prescription drug benefit.**

Answer:

Numerous CMS staff have been participating in the review of the plan bids and benefit packages. In addition to CMS staff, contractors hired for this purpose are reviewing the bids to determine whether there are any outliers.

CMS learned from the Medicare-Approved Prescription Drug Card program that tight time frames for sponsors to submit applications and for CMS to review applications were problematic. CMS maximized the time available for reviews and increased the number of reviewers from the central office and regions to minimize the impact of tight time frames. Plans were required to submit their formularies to CMS for review by April 18, 2005. Final plan bids are due to CMS on June 6, 2005, and CMS contractors and staff will be working very hard to review bids and negotiate with plans. CMS expects to finalize the negotiation process and sign contracts with the plans by mid-September.

2. **I understand that earlier this year CMS made public nationwide drug spending data which would allow plans to see the level of drug spending in all regions of**

the country. It is my understanding that this could lead plans to submit higher or lower bids in various parts of the country based on information about higher or lower drug spending. I am concerned that this could lead to geographic variations in the Part D premium. How will CMS address large variations in premiums to ensure that seniors in certain parts of the country don't have to pay more than their fair share? Will CMS consider a risk adjustment or geographic adjustment to ensure that premiums nationwide are relatively level and to ensure that seniors in Delaware, for example, do not have to pay more than seniors in other parts of the country.

Answer:

While a plan may submit a bid that reflects the level of drug spending in a particular region, CMS believes that drug costs do not vary substantially by region. It is also difficult to say whether plans will have taken into account local price variation when making theirs bids. Finally, the bid amount is not entirely based on drug prices, as plans must take into account risk factors, costs of care, and utilization in estimating their costs of providing this benefit.

Some difference in premiums between regions would not be unexpected. The intent of Congress in creating the drug benefit was to foster competition between private plans, and as such regional differences in the costs of conducting business would have to be reflected in a plan's bid. As mentioned above, any differences in premium amounts between regions would be a reflection of plans' expected variation in terms of demographics, utilization, and costs of care as part of the competitive bidding process in each region. The law requires private plans to take into account regional variations in numerous factors as a part of submitting bids based on their expected costs, and it is important for the payments to the plans and the beneficiary premiums to be in line with local markets. Part D was designed to foster competition among plans, and not allowing regional variation would stifle this competition.

The statute requires CMS to calculate the national average monthly bid amount for the entire United States on a yearly basis. While it also directs CMS to develop a methodology for incorporating regional variation in drug prices into the calculation of the national average monthly bid amount, CMS is not authorized to adjust beneficiary premiums on a regional basis. However, the law requires risk adjustment as a factor in a plan's bid; as a result, risk factors for beneficiaries in a particular region are used to calculate a plan's expected costs.

Homeland Security and Governmental Affairs
Subcommittee on Oversight of Government Management and the Federal Workforce

Monitoring CMS' Vital Signs:
Implementation of the Medicare Prescription Drug Program
April 5, 2005

Questions for the Record
Questions of Senator Pete V. Domenici

For: The Honorable Mark McClellan, Administrator Centers for Medicare and Medicaid Services

Subject: Section 1011 of the Medicare Prescription Drug, Improvement and Modernization Act

For many years, local communities have been forced to shoulder the burden of providing emergency medical care for those who are living in the U.S. illegally. The issue of illegal immigration is a problem that affects communities across the nation. However, this issue affects my home state of New Mexico disproportionately because of its proximity to the border.

Section 1011 of the Medicare Prescription Drug, Improvement and Modernization Act established a program that provides $250 million per year for fiscal years (FY) 2005-2008 for payments to eligible providers for emergency health services provided to undocumented aliens and other specified aliens. Two-thirds of the funds are divided among all 50 states and the District of Columbia based on their relative percentages of undocumented aliens. One-third is divided among the six states with the largest number of undocumented alien apprehensions. Using apprehension data from DHS for FY 2003, it was determined that the six states with the highest number of undocumented alien apprehensions were Arizona, California, Florida, New Mexico, New York, and Texas.

1. When Congress passed the Medicare Prescription Drug, Improvement and Modernization Act, we mandated that this program be in place by September 1, 2004, with payments beginning in December 2004. However, at this time, CMS has acknowledged that they have not yet set a starting date for the program. This is despite the fact that healthcare providers are incurring substantial costs as the delay continues. These health care providers deserve timely action on a program already passed by Congress and signed by the President and I ask at this time when can they expect the program to be implemented?

Answer:

As you know, section 1011 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) provides $250 million per year for fiscal years (FY) 2005-2008 to reimburse eligible health care providers for emergency health services furnished to undocumented and other specified immigrants. As required by the Emergency Medical Treatment and Labor Act (EMTALA), hospitals participating in Medicare must medically screen all persons seeking care in hospital emergency departments, and provide the treatment necessary to stabilize those determined to have an emergency condition, regardless of income, insurance, or immigration status. In providing this medical screening and treatment for emergency services for undocumented immigrants, health care providers often must absorb the costs of this care. Section 1011 is intended to provide relief to these health care providers, and we intend to implement it in a way that maximizes support for this critical health care.

Section 1011 is the first program of its kind, and it requires payments to hospitals, physicians, or ambulance services that provide substantial uncompensated care to undocumented immigrants and avoids any substantial new burdens. We received many thoughtful and valuable comments about our proposed implementation plan issued last July. Based on these comments, we are currently finalizing our guidance to health care providers. We intend to accept the public comments that suggested the use of non-burdensome eligibility methods to target the funds to the providers who are actually providing care to undocumented immigrants, using methods that do not require providers to obtain direct evidence of a patient's immigration status. We expect to publish the final implementation plan within the next few weeks.

Subject: Section 1016 of the Medicare Prescription Drug, Improvement and Modernization Act

The Medicare Prescription Drug, Improvement and Modernization Act demonstrated our commitment to building the public health infrastructure in order to make sure that our citizens have access to quality medical care. In furtherance of that goal, Section 1016 of the bill established a loan program to provide qualifying hospitals with money for the payment of the capital costs. This loan program is available to hospitals is engaged in research related to the causes, prevention, and treatment of cancer.

2. **When Congress passed the Medicare Prescription Drug, Improvement and Modernization Act, we stated that "amounts appropriated under this section shall be available for obligation on July 1, 2004." However, at this time, CMS has acknowledged that they have not yet set a starting date for the program. When can qualifying hospitals expect the program to be implemented?**

Answer:

As you know, section 1016 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) establishes Section 1897 of the Social Security Act, "the Health Care Infrastructure Improvement Program," whereby the Secretary of Health and Human Services is

authorized to "establish a loan program that provides loans to qualifying hospitals for payment of the capital costs of projects."

The statute dictates that qualifying hospitals must be engaged in research in the causes, prevention, and treatment of cancer. Qualifying hospitals must also be designated as a cancer center by the National Cancer Institute or designated by the State legislature as the official cancer institute of the State and such designation must have occurred prior to December 8, 2003.

The statute specifies that the Secretary is authorized to forgive such loans if the hospital establishes an outreach program for cancer prevention, early diagnosis and treatment for a substantial majority of the residents of the state, a similar outreach program for multiple Indian tribes, and either unique research resources or an affiliation with an entity that has unique research resources.

The Centers for Medicare & Medicaid Services (CMS) is working diligently to construct the policy and implement section 1016. We recognize the importance of this program and hope to issue a notice in the Federal Register in the very near future.

Homeland Security and Governmental Affairs
Subcommittee on Oversight of Government Management and the Federal Workforce

Monitoring CMS' Vital Signs:
Implementation of the Medicare Prescription Drug Program
April 5, 2005

Questions for the Record
Submitted by Senator Tom Coburn

Questions for Dr. Mark McClellan, Director, Center for Medicare and Medicaid Services

1. **Dr. McClellan, don't you think that Medicare trustees report indicates that the Medicare program, particularly the Drug program, is fragile?**

Answer:

The financial projections shown in the 2005 Medicare Trustees Report clearly show that the program faces major challenges in the long range:

• The total cost of the Medicare program is projected to increase from 2.7 percent of gross domestic product (GDP) currently to 3.3 percent in 2006 (when the full Part D benefit is implemented), to 6.8 percent in 2030 (when the last of the "baby boom" generation reaches age 65), and to 13.8 percent by the end of the Trustees' 75-year projection period. For comparison, the total cost of the Federal government in 2004 was about 19.8 percent of GDP.

• At the end of the Board of Trustees' 75-year projection period, scheduled Part A tax revenues would be sufficient to cover only one-fourth of projected Part A expenditures.

• The Federal general revenues required under current law to help finance Parts B and D are projected to increase from 14 percent of total Federal income taxes in 2010 to 57 percent by the end of the 75-year period (assuming that income taxes maintain about the same share of gross domestic product as they have over the last 50 years).

• The average beneficiary premiums and cost-sharing requirements for Parts B and D are expected to increase at a significantly faster rate than beneficiaries' incomes. Thus, over time, beneficiary out-of-pocket costs for Medicare would require a rapidly growing share of their incomes. (To the extent that such costs for low-income beneficiaries are paid by Medicaid and/or the Part D low-income subsidy, Federal and State general revenues would be required to cover the growing amounts.)

Each of these measures of Medicare's long-range future sustainability raises serious questions about the affordability of Medicare to society, generally, or to the Federal Budget and beneficiaries, specifically. These financial pressures, while not immediate, reinforce the need to plan and act now to strengthen Medicare's future and enable the program to continue to fulfill its purpose--to help seniors and people with disabilities obtain high-quality, affordable health care, and at a cost that the nation can afford.

As noted in my testimony, there are some promising ways to help achieve these results. It is our joint responsibility to determine and implement such solutions.

2. Dr. McClellan, what would means testing the entire Medicare drug program do towards addressing this program's becoming insolvent?

Answer:

While means testing would certainly reduce program outlays, CMS does not believe that its application in this instance would be appropriate. The intent in the development of the original Medicare program was to offer health care coverage to our nation's seniors and people with disabilities regardless of their income. That same intent holds true today under the new Medicare drug benefit. CMS is committed to ensuring a wide range of plans to meet the needs of all Medicare beneficiaries. The new Medicare drug benefit program will utilize the power of the private market to negotiate low prices for prescription drugs and save money for both Medicare beneficiaries and the taxpayers. Competition among private plans to secure favorable drug pricing has been a successful model for other public and private programs, including the Federal Employees Health Benefits Plan (FEHBP). Under FEHBP, the health plans and PBMs that provide coverage for all enrollees, including federal retirees, negotiate prices for their enrollees. We have every reason to believe that this proven approach is the best way to provide Medicare beneficiaries with the best prices on the prescription drugs they need.

CMS is in the process of implementing the new prescription drug benefit program based on the MMA. We believe that Congress intended to provide a basic level of drug coverage for Medicare beneficiaries and envisioned extra help (i.e., a more comprehensive benefit) for those with limited incomes and assets. We believe this framework achieves the necessary fiscal balance between offering a comprehensive benefit to our most vulnerable beneficiaries while providing substantial help to others.

Senate Committee on Homeland Security and Governmental Affairs
Subcommittee on Oversight of Government Management and the Federal Workforce

Monitoring CMS' Vital Signs: Implementation of the Medicare Prescription Drug Program
April 5, 2005

Questions for the Record
Submitted by Senator Tom Coburn

Questions for Ms. Marcia Marsh, Partnership for Public Service

1.) Your program intrigues me, Ms. Marsh, with your Extreme Hiring Makeover. You are right that our workforce is aging and record numbers of Federal employees will be able to retire – it is estimated that CMS will need more than 500 new highly skilled employees in the next 2 years (about 10 percent of the CMS workforce) if the MMA is to be implemented correctly. Given what you know of the Agency, and the bureaucracy that exists there, will your extreme makeover program be enough to hire and retain these 500 needed workers?

While we believe that the Extreme Hiring Makeover program will help our three pilot Agencies, including CMS, in re-engineering and improving their hiring process, that is only one element of what they need to do to attract and retain the very best.

The most critical element of success is leadership commitment to human capital management – setting objectives, leading by example, coaching employees, dealing with performance issues as they arise and creating an environment that truly engages people day in day out.

Our "Best Places to Work in the Federal Government" research reinforces this point. Based on results of the U.S. Office of Personnel Management's survey of job satisfaction among more than 100,000 executive branch employees, we know that leadership, teamwork and employees skills and mission lead the list of things that drive employee engagement and help create the environment that makes people want to work for the federal government. (To learn more about our Best Places research, please visit www.bestplacestowork.org).

We have benefited from top leadership commitment in this project and are impressed by the priority that CMS has given to human capital issues. Given the action we are seeing around the hiring process and discussions that we have had about other human capital issues, we are very hopeful that CMS will meet their current and future talent challenges.

We are also very encouraged by the time and attention that your Subcommittee has dedicated to the management challenges that CMS faces with their general operations and the Medicare Modernization Act implementation. Your leadership and continued interest will help to keep everyone focused and striving for excellence.

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