Final Report of the Study Panel on

Medicare's Governance and Management

Matching Problems with Solutions

Improving Management

July 2002





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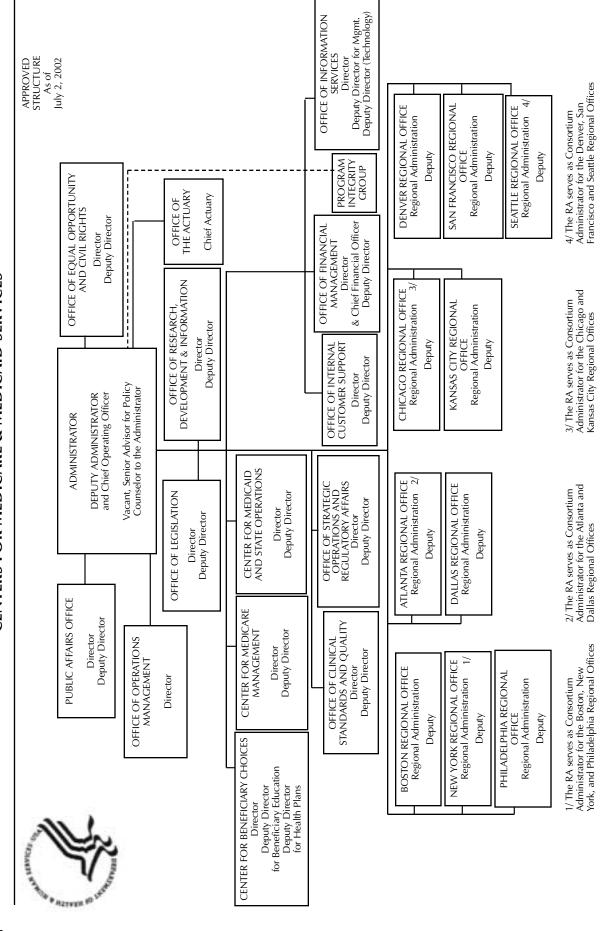
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Introduction

The National Academy of Social Insurance (NASI) convened a study panel in 2000 on Medicare governance and management as part of its project to examine key issues policymakers face in preparing Medicare for the future. Members of the study panel were selected for their recognized expertise and experience with Medicare and public administration. Their views do not represent the official position of NASI, which does not take positions on policy issues.

The study panel had two tasks: examining whether a different governance structure might help the federal agency that runs Medicare, the Centers for Medicare and Medicaid Services (CMS), be more effective and identifying ways in which current Medicare management could be improved. In part because some panel members had different views on whether Medicare should be restructured, the panel concentrated its focus on making the current Medicare program work better.

In its work, the panel was struck by Medicare's size, scope, and complexity and its importance to beneficiaries, the federal government, the health care system, and the national economy. Virtually the entire population over age 65 (97 percent) is insured by Medicare, as well as 5 million people with disabilities. The program is enormously important to both the economic security and health status of elderly Americans, and also plays a substantial role in improving the health care system. Before Medicare, nearly

one-third of senior citizens were poor and more than 50 percent paid their health care costs out of pocket. Today, the proportion of seniors living in poverty mirrors the younger population—about 10 percent. Medicare has dramatically increased access to health care, particularly for minorities, and has contributed to significant increases in life expectancy for the elderly. In 2001, Medicare spending was estimated at \$238.2 billion and accounted for 19.3 percent of national spending for personal health care and for 11.7 percent of all federal spending (CMS 2002a). More than 6,000 hospitals; 41,800 health plans, long-term care facilities, and other providers; 861,800 physicians and other practitioners; and 168,300 clinical laboratories participate in Medicare. Its size, breadth, and complexity make the task of administering it exceptionally difficult. While the study panel identified a number of weaknesses in current program management, it wants to emphasize that Medicare has been, and continues to be, a very successful program and its shortcomings should be construed as opportunities for improvement, rather than indications of failure.

GOVERNANCE

The study panel examined four different models of governance as possible alternatives to the current structure: an agency that is independent of the Department of Health and Human Services (HHS), a multimember board, a performance-based organization, and a government corporation. In order to

In some proposals, the board would be independent of the executive branch, while other proposals would place the board inside HHS.

recommend a different governance structure, the panel would have to judge it clearly superior to the current structure for the longterm. Based on these considerations, the study panel did not reach consensus that the current governance structure is fatally flawed or that one of the alternative models should be adopted in its purest form. It did, however, think that further consideration of the independent agency model, as typified by the Social Security Administration (SSA), is merited. Thus far, no comprehensive evaluation of SSA's move from an operating agency in the Department of Health and Human Services (HHS) to an independent agency has been undertaken. However, some members believed that an independent agency could be detrimental to Medicare because CMS would lose the support and protection of a cabinet official.

Some panel members think that the board model merited further consideration. In their view, an independent board could improve capacity and flexibility, particularly if the board were independent of any executive agency. Others argue that Congress would not be able to hold a board accountable for sound decision-making, and that a program as large and critical as Medicare must be directly accountable to the Congress and the President.

The two other models were not judged to be viable alternatives for Medicare. The panel thinks, however, that some variant of the independent agency or board models might be worthy of further consideration, although this was beyond the scope of their work.

MANAGEMENT

The study panel identified a number of criticisms regarding the management of Medicare, including: insufficient resources to fulfill the responsibilities Congress has given it, an inability to implement laws on a timely basis, Congressional micromanagement, inadequate oversight of contractors, outdated information systems, inadequate communications with beneficiaries, a sometimes heavyhanded approach to fraud and abuse prevention and detection, and an inability to recruit and retain qualified staff. In the study panel's view, many of CMS' management problems stem from two factors: a pervasive and persistent shortage of resources to meet the greatly increased responsibilities Congress has given it and the extent of Congressional involvement in the management of Medicare. In recent years, Congress has enacted increasingly specific laws that limit the agency's flexibility in administering the program, and also has become much more involved in overseeing ongoing management.

Over three years ago, a distinguished panel of health policy and management experts wrote an open letter to Congress and the Executive that called upon Congress and the administration to "provide the agency the resources and the administrative flexibility necessary to carry out its mammoth assignment..." (Butler 1999). Since that time, the agency has not received substantially more resources and has faced increasingly harsh criticism for failing to meet all the demands placed on it. Unless the resource issue is addressed in the near future, without waiting for Congress to decide whether or how to restructure Medicare, the study panel fears that inade-

quate resources will begin to erode CMS' ability to keep the program operating at the level upon which beneficiaries and providers depend. Therefore, the panel recommends that Congress act now to increase resources to CMS so that they are commen-

to CMS so that they are commensurate with the responsibilities with which CMS is entrusted. The study panel also recommends that Congress consider removing from CMS some responsibilities not directly related to Medicare and Medicaid, such as oversight of the Clinical Laboratory Improvement Act (CLIA) and responsibility for the Health Insurance Portability and Accountability Act (HIPAA). Concentrating the agency's focus

on its central missions should assist CMS in better meeting its core responsibilities. Greater resources should allow CMS to provide contractors with the resources they need to function and to exercise proper administrative oversight. It should also allow the agency to recruit and retain staff with the appropriate expertise to manage such a complex program and to design and implement information systems adequate to that task.

While the study panel believes that Congressional oversight of Medicare is crucial, given its share of the federal budget and its importance to beneficiaries and the health care sys-

tem, it thinks that both the number and the highly specific content of laws passed in recent years have severely taxed the agency's ability to comply with the requirements imposed on it. In addition to enacting

detailed legislation, Congress is also very involved in agency matters on an ongoing basis.

Congressional committees, including not just authorizing and appropriating committees, but also oversight committees, have held scores of hearings, which require significant preparation on the part of administration witnesses. Congress has also requested a great many GAO reports on Medicare, to which the agency

typically issues a formal response. Moreover, the volume of telephone calls and letters to the agency from members of Congress has increased over time; responding to them on a timely basis has proved to be a significant challenge for the agency.

In the panel's view, the agency would benefit from some respite in implementing new laws and from greater administrative flexibility. Perhaps even more importantly, the study panel believes that both Congress and CMS would benefit from a greater sense of trust and comity, and urges a public dialogue on how that might be accomplished.

Executive Summary

In 2000, the National Academy of Social Insurance (NASI) convened a study panel on Medicare governance and management as part of its project to examine key issues policymakers face in preparing Medicare for the influx of the baby boom generation. The study panel met seven times to examine the issue, and this is their final report.

In its work, the panel used three criteria to evaluate Medicare's governance and management:

- Does it have the **capacity** to accomplish its functions including the resources (financial, human, technological, and organizational) to fulfill the responsibilities Congress has given it? Does it have the technical expertise it needs? Does it have the flexibility needed to adapt to changes in the environment in which it operates, or is it too constrained by Congressional directives?
- Is it accountable for the decisions it makes? How is oversight furnished? Is it responsive to the beneficiaries it serves and stakeholders?
- Is the Medicare program administration viewed as **credible**?

The study panel began its work with an important premise. It evaluated Medicare's current governance and management, without making assumptions about ways in which Medicare might be restructured. Its recommendations are designed to make the current Medicare program work better, not to change the governance or management to accommodate a restructured Medicare program.

OVERVIEW OF MEDICARE

In order to inform its work, the panel examined Medicare's history, mission, responsibilities, and current operations. Medicare is the second largest domestic social program; it provides health insurance to more than 39 million individuals, including more than 5 million disabled people and almost all Americans over age 65. Since its inception, Medicare has made enormous contributions to the health and economic status of the elderly and to the U.S. health care system. Medicare is responsible for enforcing health and safety standards in hospitals, nursing homes, and other health care facilities. It also makes direct financial contributions to the training of new physicians and other health care providers.

Over time, Congress has expanded Medicare's scope, mission, and responsibilities substantially. For example, Congress included disabled people and those with end stage renal disease (ESRD) in Medicare in 1972. In 1985, it established direct subsidy payments to hospitals that serve a disproportionate share of low-income and uninsured people. These payments are not linked to providing care for Medicare beneficiaries, but serve a broader social goal of providing a financial safety net for vulnerable hospitals.

Over the years, Congress has attempted to redress deficiencies in the health care system and improve the quality of health care through greater federal oversight and regulation. In many instances, these responsibilities were assigned to the Health Care Financing Administration (HCFA, now called the Centers for Medicare and Medicaid Services

(CMS)), the federal agency responsible for administering Medicare.² Examples include: regulation of Medicare supplemental (Medigap) insurance, oversight of clinical laboratories, oversight of private health insurance, responsibility for administrative simplification of health care transactions, and responsibility (with the states) for the State Child Health Insurance Program.

Today, Medicare is a vastly more complex and larger program than envisioned at its enactment. Some of the increased complexity stems from the additional responsibilities Congress has given it over the years, but unprecedented advances in technology and medical science have also greatly complicated the administration of Medicare. Taken together, all these actions have combined to make Medicare a formidable presence in both the nation's health care delivery system and the federal budget. In FY 2001, Medicare spending was estimated at \$238 billion, accounting for 11.7 percent of all federal spending.

ADMINISTRATIVE HISTORY

The way that Medicare was designed in 1965 continues to have important implications even today. Congress established Medicare as an entitlement program, which means that all those who meet the eligibility criteria established in law are eligible to receive Medicare benefits, without regard to the annual appropriation of funds from Congress.

In 1965, Congress put Medicare's operations largely in the hands of private insurers to avoid federal intrusion into the practice of

medicine. Under contract to the federal government, private insurers continue to perform many functions, including processing claims, reimbursing providers for services, performing audits, and reviewing claims to determine medical necessity. Today, 48 insurers have contracts with Medicare, 28 for Part A and 20 for Part B.

Medicare was administered by a bureau of the Social Security Administration (SSA) until 1977, when HCFA was created as a new agency in the Department of Health, Education and Welfare (now Health and Human Services (HHS)). HCFA was given responsibility for administering both the Medicare and Medicaid programs.

GOVERNANCE

Multiple Congressional committees have jurisdiction over Medicare: the House Committee on Ways and Means, the House Committee on Energy and Commerce, and the Senate Committee on Finance. These committees are considered the authorizing committees, and are responsible for legislative oversight, which includes holding hearings and proposing changes to Medicare eligibility, benefits, payment, and coverage. The Appropriations Committees in the House and the Senate are responsible for appropriating funds for the administration of Medicare. Although Medicare's situation is no different from many other federal programs, the fact that the authorizing committees control the program, while the appropriating committees control the funds to administer the program, causes a mismatch between responsibilities and resources

² The name of the agency that runs Medicare was changed from the Health Care Financing Administration (HCFA) to the Centers for Medicare and Medicaid Services (CMS) in 2001. In this report, the agency is referred to as either HCFA or CMS, depending on the date.

to fulfill those responsibilities. The House and Senate Budget Committees also have a role in Medicare. Through an annual budget resolution, they recommend the overall level of Medicare spending for the following year. In crafting the budget resolution, the Budget Committees may influence substantive Medicare policy. Other committees in both the House and Senate, including the Senate Special Committee on Aging, the Oversight Subcommittee of the House Committee on Commerce, and the Small Business Administration Committee and the Government Reform Committee in the House, are involved in Medicare oversight, but have no authority to legislate with respect to Medicare. The General Accounting Office (GAO), under Congress' direction, is also very involved in Medicare oversight.

In the executive branch, CMS is an operating agency of HHS whose administrator reports directly to the Secretary of HHS. The Office of the Inspector General (OIG) in HHS also has a very strong role in Medicare oversight, and some independent authority on fraud and abuse matters. As a practical matter, other divisions in HHS are frequently involved in reviewing and approving proposed CMS actions. For example, they typically review and approve proposed regulations and other significant actions. While some maintain that the oversight these other HHS agencies furnish is invaluable, others argue that their involvement just adds layers of bureaucracy and unnecessarily slows down the agency's actions.

GROWTH IN RESPONSIBILITIES SINCE 1996

The study panel was struck by how much CMS' responsibilities have increased in recent

years. Since 1996, Congress has enacted four major pieces of legislation that dramaticaly increased the agency's responsibilities.

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 gave CMS three very significant tasks: oversight of state regulation of private health insurance plans to ensure availability and portability of private health insurance, responsibility for administrative simplification for all electronic health care transactions, and greatly expanded responsibility for Medicare fraud and abuse. Notably, the first two responsibilities are not directly related to Medicare.

In 1997, Congress enacted the Balanced Budget Act (BBA), which made sweeping changes to Medicare law. It created Medicare Part C, which offers a broader range of health plan choices to beneficiaries, and directed CMS to mount a comprehensive campaign to educate beneficiaries about Medicare and their new health plan choices. In addition, the BBA created four new prospective payment systems (for skilled nursing facilities, home health agencies, outpatient hospital departments, and rehabilitation hospitals). Sophisticated design and analytic work must precede implementation of prospective payment systems, and implementation itself is complicated and laborintensive. Other new responsibilities created by the BBA include establishing coverage and payment policies for several new preventive health benefits. Although not Medicare-related, the BBA also gave the implementation of the new State Child Health Insurance Program (SCHIP) to CMS, which required a substantial commitment of agency time and resources. In all, the BBA had 359 provisions that required agency action to implement. Many of the provisions, particularly those

involving information systems changes at CMS or the contractors, were not implemented on the date Congress set because the agency delayed all systems work to prepare its legacy information and claims processing systems for the transition to Year 2000.

The Balanced Budget Refinement Act (BBRA) of 1999 was less far-reaching in scope and contained only 126 provisions to implement. Although the BBRA did not contain any major new initiatives, its "give back" provisions touched most aspects of Medicare, including significant

changes in newly implemented prospective payment systems, and required agency regulatory action.

Congress enacted another bill in 2000—the Medicare, Medicaid and SCHIP Benefits
Improvement Act (BIPA) of 2000—that further rolled back many of the deficit reduction features of the BBA. CMS reported that it contained 152 provisions to implement.

Management Issues

Over the years, CMS has been criticized for poor management of Medicare. This criticism has intensified in the last several years, partly because the agency was slow to implement some provisions of law, and partly because of philosophical differences about what type of program Medicare should become in the future. Some believe that Medicare is an antiquated fee-for-service (FFS) program. Others believe that its leadership and staff have been too vested in maintaining the status quo to adapt to a different program structure. While the study panel acknowledges that these pre-

dispositions have colored evaluations of CMS' performance, it focused its work on determining whether the agency was performing current responsibilities well and recommending changes or alternative structures that could improve the agency's performance.

Resources not Commensurate with Responsibilities

The panel found a serious mismatch between the agency's responsibilities and its resources.

This mismatch has grown worse in recent years as CMS' responsibilities have increased dramatically. From FY 1992 to 2002, in inflation-adjusted (real) dollars, benefit outlays have increased 97 percent and claims volume has increased 50 percent, while program management appropriations have increased only 26 percent and the number of full time equivalent employees (FTEs) 12 percent. Growth in the number of contractor staff has been even slower, at six percent, during this period.

Beginning in 1996 with the enactment of HIPAA, both the magnitude and the scope of responsibilities given to CMS have

grown enormously, while the size of the staff has increased only modestly. The breadth of those new responsibilities, especially those unrelated to Medicare, such as the health insurance and administrative simplification provisions of HIPAA and the State Child Health Insurance Program in the BBA, have posed exceptional challenges to the agency. Some of the new Medicare tasks, such as the Medicare Education Program and the new provider types in the BBA have been very

resource-intensive. In addition, funding to contractors, who are responsible for implementing new provisions through changes to information systems and instructions to providers, has not kept pace with the additional work given to them.

Congressional Micromanagement

The study panel also considered the question of whether Congress is too involved in the details of CMS. Although Congress is responsible for the Medicare statute and giving direction to the agency, the sheer number and highly specific content of laws passed in recent years have severely taxed the agency's ability to comply with the requirements imposed on it. In addition, Congressional committees and individual members have become increasingly involved in program operations.

The panel found that a primary contributor to the increased specificity in law derives from the role of "scoring" in the budget process. In budget reconciliation, Congress passes a budget resolution to determine government spending for the next fiscal year, and committees are directed to report bills that are within budget targets. The Congressional Budget Office (CBO) plays an important role because it assigns a savings or cost estimate (called a score) to every legislative provision. CBO is increasingly reluctant to assign a score to a provision unless it is fairly specific, and Congress has responded by enacting laws that are very detailed.

Other reasons contributing to increased specificity include mistrust between the Congress and the administration. Congress has not always trusted the administration—particularly when one party controls the

Congress and the other the White House—to implement provisions in accordance with its wishes, and has dealt with that by making the law very specific. Health care providers and others in the industry have also lobbied for great specificity.

The study panel concurs with the views expressed by some that Congress has been too prescriptive in statute. Detailed legislation impedes agency discretion and requires Congress to make changes that should be within the agency's authority. However, given the requirements of the budget process, the degree of specificity seems unlikely to diminish significantly. What seems to be needed is a greater sense of trust and comity between the agency and Congress. In the study panel's view, the agency would also benefit from a respite in implementing new laws and in greater administrative flexibility.

Inability to Implement Laws on Time

CMS has been roundly criticized for falling behind in implementing provisions of HIPAA, the BBA, the BBRA, and BIPA. CMS did not keep track of HIPAA implementation, but reported in its 2002 strategic plan that it had implemented 75 percent of the BBA, 80 percent of the BBRA, and 15 percent of BIPA. Unquestionably, CMS' decision to delay implementing key provisions of the BBA in order to assure that its information systems could function in year 2000 was a key reason for the backlog in implementing the BBA, and had a rippling effect on later laws. The study panel notes, however, that the sheer volume of changes in the BBA, BBRA, and BIPA and tight implementation timelines would have presented a daunting challenge to any agency, even with adequate resources.

Oversight of Contractors

Another area of vulnerability for CMS is management of its contractors. GAO and the OIG have produced numerous reports documenting shortcomings in the agency's accounting procedures and oversight of contractors. One of the frequently cited statistics is the error rate—the percentage of claims paid improperly because the services were medically unnecessary, documentation was insufficient, the claims had coding errors, or Medicare did not cover the services. In 1996, the OIG estimated the error rate at 14 percent. The error rate has sometimes been used incorrectly as a measure of fraud and abuse. It is important to note that not all of the errors represent efforts to defraud or abuse the program. For example, some of what is counted in the error rate reflects coding errors or lack of documentation for appropriate services. In any event, the error rate reflects inaccurate or incomplete billing or documentation and measures claims that were paid when they should not have been. While equating the error rate with fraud and abuse is too simplistic, it is appropriate to consider the error rate as a reflection of inadequate oversight by the contractors and CMS.

Other indicators of poor oversight of contractors include legal settlements with contractors following allegations of improper or illegal actions. Since 1993, CMS has entered into settlements with 14 contractors, with settlements exceeding \$350 million.

In 2001, the OIG reported that it had 24 former or current contractors under investigation.

Despite continuing problems, both GAO and OIG credit CMS with improved contractor oversight in the last few years. The error rate declined to 6.8 percent in 2000 and the agency received a "clean" audit opinion for the first time. CMS has appointed a management board to oversee contractors, separated contractor management from contractor evaluation, and assigned additional staff to monitor contractors. However, both GAO and OIG still find problems with management and accounting.

Numerous provisions in Medicare law limit CMS' ability to effectively manage the contractors, or to expand an ever-shrinking pool of contractors. Each year since 1993, the agency has asked Congress to enact contractor reform legislation.³ Both GAO and OIG have consistently testified in support of this legislation, but Congress did not seriously consider it until 2001. The Medicare Regulatory Relief and Contractor Reform Act passed the House of Representatives on December 4, 2001 by a vote of 408-0 and is currently pending in the Senate.

Both the contractor management function at CMS and the administration of the program by contractors have suffered from resource limitations. In addition to paying claims, contractors have primary responsibility for informing and educating providers about changes in law and policy, and the passage of the BBA, BBRA, and BIPA have seriously strained contractors' ability to perform all required functions. In particular, provider education and customer service to providers have suffered in recent years.

³ The Reagan administration also sent contracting reform legislation to Congress.

Information Systems

CMS and its contractors have hundreds of information systems, most of which were not designed to communicate with each other and are seriously outdated. In 1994, CMS undertook a sweeping systems modernization project called the Medicare Transaction System (MTS). Design and implementation of this system did not proceed smoothly, and CMS abandoned the project in 1997 in favor of a more incremental approach.

However, work on Year 2000 conversion delayed the agency's work on new systems. GAO has issued several reports on the agency's information systems plan, and is concerned that resource limitations, including both lack of funding and staff expertise, pose threats to the success of the agency's plan.

Fraud and Abuse

In the late 1990s, complaints surfaced that CMS was too aggressive in investigating fraud and abuse and had unfairly accused providers of misconduct when they have made innocent billing errors. The climate has changed dramatically since the early 1990s, when fraud and abuse detection efforts were relatively lax, to a zero tolerance policy in the Clinton administration. The passage of HIPAA in 1996 was a landmark event, although its significance was not widely recognized at the time. HIPAA dramatically increased funding for fraud and abuse, and gave investigative and law enforcement agencies a much more prominent role and greater independence than they had before.

Prior to HIPAA's enactment, fraud and abuse activities (also known as program safeguards) were funded primarily from CMS'

contractor budgets, and competed with other contractor functions, including paying claims. Over time, the funding for program safeguards eroded. HIPAA changed that by giving CMS funding for special program integrity contracts, and providing substantial funding to OIG in HHS, the Department of Justice (DOJ), and the Federal Bureau of Investigation (FBI) for enforcement actions. Predictably, these agencies used these funds

to pursue health care fraud and abuse vigorously, and the level of law enforcement activities increased substantially. The DOJ also began to use the False Claims Act (FCA) more aggressively to pursue health care fraud and abuse.

A backlash resulted, leading to proposals to limit enforcement actions. Legislation was introduced in Congress to limit DOJ's ability to use the FCA. The pro-

posal did not become law, but its consideration led DOI to take actions on its own to limit situations in which the FCA could be used. Resentment also grew about CMS' administrative actions to detect fraud and abuse, and encourage providers to enter into settlements. Another bill, the Medicare Regulatory and Contracting Reform Act of 2001, would limit CMS' authority in several ways to review claims for fraud and abuse and revise procedures for collecting overpayments. It would also give providers more information about fraud and abuse detection and prevention activities. It passed the House of Representatives in 2001, and is currently pending in the Senate.

The study panel views effective fraud and abuse prevention and detection efforts as

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essential to protecting the integrity of Medicare. Getting the right balance between effective fraud and abuse detection and enforcement and maintaining a positive relationship with the provider community is a delicate matter. Public sentiment and policy have vacillated between aggressive enforcement and complaints that aggressive fraud and abuse detection efforts were unfairly frightening and penalizing honest providers. The study panel believes that CMS and law enforcement agencies probably pursued fraud and abuse too aggressively at times in the past, especially since CMS and its contractors frequently have not given providers clear and concise explanations of coding and billing requirements. More resources and attention should be devoted to assuring that providers have the right information to code and bill correctly.

Communications with Beneficiaries

CMS has also been criticized for its communications with beneficiaries. The BBA directed CMS to conduct a comprehensive campaign to educate beneficiaries about Medicare and about expanded Medicare+ Choice (M+C) benefits in particular. Under specific instructions from Congress, CMS was directed to provide beneficiaries with detailed information about benefits and health plan options, establish a toll-free telephone line to answer beneficiary questions, and maintain an Internet site. About 75 percent of the National Medicare Education Program (NMEP) was funded through a user fee on M+C plans, with the balance from the Medicare general administrative account and the Quality Improvement Organizations (QIOs, formerly called the Peer Review Organizations (PROs)) account. CMS spent an average of \$107.8 million a year from FY 1998-2000 on the NMEP.

From the start, the funding mechanism was controversial. The M+C plans argued that they should only have to pay their proportionate share of the education campaign, not the bulk of it. They also maintained that they could do a better and less costly job than CMS, and that CMS' presentation was slanted toward traditional Medicare. Congress responded to their complaints in the BBRA by scaling back the user fees from \$95 million to \$17 million for 2001. CMS adjusted to the loss of the approximately \$78 million in user fees by drawing down unspent funds for 2001. However, beginning in 2002, the full impact of the reduction will be felt, requiring either additional funds or a scaling back of the program.

In the BBRA, Congress directed GAO to study the NMEP and report back periodically. In its first report, issued in September 2001, GAO said that beneficiaries and their advocates generally gave the program high marks, but the M+C plans were more critical. Overall, GAO reported that the NMEP increased the amount and type of information regarding Medicare and M+C plans. However, it was unable to evaluate whether the NMEP persuaded beneficiaries to actively consider health plan choices.

The study panel believes that the controversy about the funding source of the NMEP probably influenced some organizations' views. The panel believes that a strong education campaign is essential, particularly given Medicare's complexity. While it believes that more education efforts would be beneficial, it commends CMS for the progress it has made so far. The *Medicare and You* handbook, the toll-free line, the internet site (including comparative information about nursing homes, health plans, and

Medigap insurance) have clearly given beneficiaries far more access to objective information than they had before.

Leadership and Staffing Issues

The study panel also looked at concerns about lack of continuity in leadership, too few senior executives to manage the agency's workload, an impending "brain drain" as senior managers approach retirement, and an overly insulated staff that does not have the appropriate skill set to manage such a complex program.

The study panel is concerned about the length of time acting administrators have led the agency and about the average tenure of the administrator, and believes that steps should be taken to encourage greater longevity. The panel also believes that the salary of the administrator ought to be increased to reflect the stature of the position and the scope and depth of the administrator's responsibilities. Similarly, the panel is concerned that CMS has far fewer senior executives than other agencies with significantly smaller budgets. Additionally, many senior executives are either approaching retirement or considering other offers because the demands on them are too great and the resources too few. The agency also needs to recruit and retain staff with some highly technical skills, such as information systems specialists and actuaries, and staff with significant private sector experience, if it is to meet its responsibilities. The study panel believes that giving the agency some targeted flexibility from the civil service personnel rules and hiring caps would assist in such recruitment and retention.

ALTERNATIVE GOVERNANCE MODELS

While the panel

believes that more

education efforts

would be benefi-

cial, it commends

CMS for the

progress it has

made so far.

In addition to examining the existing CMS governance structure, the study panel looked at alternative structures to determine whether

a different structure might help the agency better accomplish its mission. The models included: the independent agency model (e.g. Social Security), the independent board model (e.g. the Federal Trade Commission), the performance-based organization model (e.g. the Office of Student Financial Assistance in the Department of Education and the Patent and Trademark Office in

the Department of Commerce), and the government corporation model (e.g., the United States Post Office).

In considering whether a different governance structure might help Medicare run more efficiently, the study panel considered the words of Hippocrates, "First, do no harm." In order to recommend a different governance structure, the panel would have to judge it clearly superior to the current structure for the long-term. In addition, the benefits of adopting an alternative structure would have to outweigh the costs (both fiscal and psychic) of implementing it. Adopting a different governance structure would require consensus, entail considerable use of resources, and slow down, at least for a time, the work of the agency. Research also shows that externally imposed reorganizations are less likely to succeed than internally driven reorganizations, because they are less likely to take organizational culture into account, less likely to be rooted in sound policy theory, and more likely to trigger bureaucratic resistance (Gormley 2000).

Based on these considerations, the study panel did not reach consensus that the current governance structure is fatally flawed or that one of the alternative models should be adopted in its purest form. The panel members held widely divergent views about whether other governance structures would be preferable. Some panel members thought that one or more of the governance models could be customized to fit the particular circumstances of CMS. A number of members found promise in the model of Social Security as an independent agency and suggested that the Social Security Administration's experience in moving to independent agency status and its track record since independence be studied further to see if CMS could benefit by becoming an independent agency. However, other members cautioned against the independent agency approach because CMS would lose the advocacy and protection of the Secretary. In their view, the current governance structure is appropriate, although some structural separation of FFS and M+C within CMS would help allay concerns about inherent conflicts of interest between the two. The panel also discussed the merits of streamlining the HHS departmental review process, so that CMS can operate more efficiently. Such an approach might relieve some of the most critical problems CMS has as an operating agency of HHS without the disadvantages of independence.

Some panel members viewed the board model, in which CMS would report directly to Congress and thus not be accountable to the President, as a desirable model for governing Medicare + Choice. They said it could improve administrative capacity and offer increased flexibility, if the board were structured to be independent of any executive

agency. Some panel members also urged consideration of a board that would be located within HHS and thus accountable to the Secretary and the President. Other panel members, who opposed the board, expressed concerns about Congress' ability to hold the board accountable for sound decision-making and the constitutionality of an independent board. Further, they said that a program as large and vital as Medicare ought to be accountable to the President.

Some panel members expressed the view that the fundamental problem stems more from the detailed nature of the statute than the governance structure. One possible remedy for that would be changing Medicare to be more like FEHPB so that Congress would not have to be nearly as involved as they are now. The FEHPB statute is much less prescriptive in terms of benefits and reimbursement.

Two of the models were judged not suitable for CMS. The study panel concluded that the PBO model was probably not appropriate for CMS as a whole, although the concept might be useful in managing contractors. While its administrative flexibilities would be advantageous to CMS, they also have the potential to make the relationship between HHS and CMS counter-productive. Moreover, the study panel believes the PBO model would not work well for CMS. In their view, many of the advantages of being a PBO could be conferred on CMS through specific changes in legislation, without actually changing its governance structure. The precedents for performance-based organizations also seem to be for organizations with a narrower mission and not nearly the same scope in policy-making.

The study panel also viewed the government corporation model as not well suited to

Medicare program administration. Successful examples of this model normally have a defined way of generating revenue to become financially self-sustaining. Since CMS offers few business-type services to the public, this model does not seem to be applicable.

RECOMMENDATIONS

Recommendation 1

Medicare policymakers should act now to address administrative and management problems in CMS regardless of whether Congress takes action on broader Medicare reform.

Recommendation 2

A panel of independent experts should be appointed to prepare an analysis of the impact on Social Security and its stakeholders of its transition from an operating agency within the Department of Health and Human Services to a free-standing agency. Such a report should also include an analysis of the implications of such a change for CMS.

Recommendation 3

In order to enable CMS to fulfill its responsibilities, Congress should increase administrative funding for the agency.

Recommendation 4

In the absence of a decision by Congress to fundamentally reform Medicare, or provide substantial new investment of resources, both financial and human, the study panel urges Congress not to enact major changes to the program in the near term because CMS does not currently have either the resources or the capacity to implement such changes in a timely fashion while managing the existing

program and the changes enacted in the last few years. The study panel also urges Congress to shift its focus from micromanaging CMS to giving the agency more administrative latitude to accomplish the goals Congress sets for it.

Recommendation 5

Congress should consider removing from CMS some functions not directly related to Medicare or Medicaid so that the agency can focus more on its core missions. Some functions that might be removed from CMS include oversight of the Clinical Laboratory Improvement Act (CLIA) and responsibilities in the Health Insurance Portability and Accountability Act for oversight of private health insurance and administrative simplification of health business transactions.

Recommendation 6

Congress should furnish CMS with new multi-year funding to develop and implement improved information systems. CMS should seek expert guidance and assistance in implementing these systems.

Recommendation 7

Congress should authorize the President to appoint, subject to Congressional approval, the administrator of CMS to a fixed term and furnish protection against arbitrary removal. Congress should increase the salary of the administrator to better reflect the stature and responsibilities of the position. The CMS administrator's salary should be commensurate with the Commissioner of the Social Security Administration.

Recommendation 8

Congress should grant CMS some relief from both limitations on salary and civil service personnel rules to recruit and retain staff with technical skills (such as actuaries or information systems experts) or highly sought-after expertise.

Recommendation 9

In order to recognize Medicare's economic, social, and budgetary impact, as well as its role in the nation's health care system, Congress should create a joint committee to serve as a central source of information and analysis. Membership of the committee should be comprised of members from the House Ways and Means Committee, the House Commerce Committee, and the Senate Committee on Finance.

Recommendation 10

Congress should enact legislation that gives CMS more flexibility to contract with new organizations to process Medicare claims. Additional resources should be provided to contractors to better help them meet the responsibilities with which they are entrusted.

CMS should build service standards for customer service in contractor contracts and devote more attention to assuring that information supplied to health care providers is timely, accurate, and easily understandable.

Recommendation 11

Congress should provide resources to CMS to provide more real-time assistance to beneficiaries with Medicare-related problems by telephone, via the internet, or by establishing Medicare help desks in Social Security field offices. Regardless of the method, those helping beneficiaries should have access to beneficiary claims records.

Recommendation 12

To ensure that beneficiaries and their families have the information they need to make informed choices about the Medicare program, Congress should provide adequate funding for the National Medicare Education Program.

Chapter 1: Introduction

The National Academy of Social Insurance (NASI) convened a study panel on Medicare governance and management as part of its project to examine the key issues policymakers face in structuring Medicare for the long-term. As with other study panels convened by the Academy, this panel aimed to provide an objective, evidence-based analysis of the need for change and the options at hand. This is the panel's final report.

THE CONTEXT FOR CONSIDERING CHANGES IN MEDICARE'S GOVERNANCE AND ADMINISTRATION

Ideas for changing how Medicare is governed and administered have engaged policymakers for the past several years. Proposals to redesign the program's systems and structures for governance and management have figured prominently in Congressional hearings and have been the subject of substantial discussion in Washington's leading think tanks, advisory agencies, and advocacy groups. When this panel began its work, Medicare restructuring was often mentioned as a key Congressional priority. Since then, the terrorist acts of September 11 have dramatically altered priorities, with much greater attention to homeland security and national defense. However, while Medicare restructuring may not be the top priority of either the Administration or Congress in 2002, the sheer size of Medicare's budget and the number of Americans' lives it touches inevitably give it a prominent place on the national agenda.

Definition of terms used in this report

Governance refers to the organization that has legal authority for the administration of Medicare and whether that authority is perceived to be effective.

Management refers to a structure and a set of systems and processes by which the program is managed.

Three motives underlie proposals for changing how Medicare is run:

- a desire to fix problems in the way Medicare is currently governed and managed,
- a concern that the existing governance and management structures and systems cannot be adapted to suit potential changes in the Medicare program, and
- a belief that Medicare's governance and management is not designed to facilitate the program's objectives.

The first type of call for change has been issued by the stakeholder community, comprised of the various groups with a vested and direct interest in the successful accomplishment of various functions of the Medicare program, such as making accurate and timely payments to providers or ensuring that beneficiaries have access to quality health care services. Nearly every interest group affected by the program has raised concerns about how Medicare is run.

A second source of concern about Medicare governance and management comes from Medicare policy analysts, and others engaged

in a discussion of whether and how to undertake restructuring the program. Some believe that fundamental changes in Medicare must be undertaken if the program is to survive in the long run. Such changes may result in a different set of functional responsibilities for the program. As they consider such fundamental changes, policymakers also must consider whether the program may benefit from or require a complementary change in governance or management.

Finally, some political scientists, economists, experts in public administration, and others who approach Medicare governance and management from an academic perspective are concerned that the current structure—irrespective of any future program changes—is imbued with incentives that conflict with the goals of running the program efficiently and effectively.

Although today's calls for reform spring from different sources, they tend to reinforce one another. It is in this context that the Academy's study panel on Medicare management and governance was charged with examining the need for changing Medicare's structures and systems, and potential prescriptions for doing so.

THE STUDY PANEL APPROACH

In summer 2000, NASI convened a group of experts to examine Medicare's governance and management. The panel was not charged with evaluating the need for changing Medicare's mission or the ways in which core responsibilities associated with program management might be altered to address cost containment or program modernization goals. Other panels and commissions have taken on those questions. Rather, the panel focused on whether the program's gover-

nance and management support the successful accomplishment of Medicare's mission.

The panel includes experts on the Medicare program and its history and experts on the design of effective organizations and oversight of large public and private programs. Among the panelists are two former Administrators of HCFA, former Congressional staff members, and others who work on Medicare policy as representatives of physicians, hospitals, and health plans. Panelists also brought to bear their experience as researchers, analysts, and legal scholars, and their expertise in public administration and program management.

The panel met seven times over eighteen months to assess the nature and extent of the problems driving administrative reform discussions and to evaluate potential solutions. In the course of its work, the panel heard testimony from many of those in leading roles in program administration and governance, and engaged in discussion with expert observers from a variety of vantage points. The panel discussed reports, articles, and policy proposals, including work it commissioned to explore aspects of existing problems not well documented elsewhere. In some of the most challenging aspects of its work, the panel examined the experience of other organizations, agencies, and programs whose governance and management models might offer lessons for Medicare.

In the end, the panel found much common ground, although consensus was not possible in all areas. This report synthesizes the findings from research and analyses that the study panel conducted, commissioned, and reviewed to address the policy-issues regarding Medicare's governance and management. It also presents the panel's findings and rec-

ommendations and describes issues on which members' views diverged.

A FRAMEWORK FOR EVALUATING MEDICARE'S GOVERNANCE AND MANAGEMENT

In the ideal world, a program's governance and management would be designed to foster the best performance of the tasks that must be accomplished to meet the program's objectives. To assess whether a particular structure works, policymakers can look at whether the program's objectives are being met. To assess options for change, policymakers can use established criteria to evaluate components of the alternative models.

CRITERIA FOR EVALUATING MEDICARE'S GOVERNANCE AND MANAGEMENT

To provide a framework for assessing Medicare's current governance and management, as well as alternative structures that could be considered, the panel developed a set of evaluation criteria. The criteria put forward by the study panel are: capacity, accountability, and credibility.

Capacity refers to the organization's ability to accomplish its required functions and achieve its programmatic objectives, while optimizing efficiency, effectiveness, comportment with legal and ethical standards, and other implicit guidelines. Evaluating capacity requires considering issues such as: Does the structure have the level of resources (financial, human, technological, and organizational) required to do its job? Does it have the amount of technical expertise needed? Can it access and utilize the information relevant to the work? Does it have flexibility needed to

adapt to changes in the environment in which it operates?

Accountability is the extent to which program administration is liable for making decisions and taking actions consistent with its mandate. What mechanisms are in place to ensure that administrative actions and decisions are legal, ethical, and appropriate? Under what authority is oversight furnished? What redress is available for remedying errors? Is it responsive to constituents and stakeholders? Do they have ways to provide input on the rules, structures, processes, and outcomes that result from management decisions?

Credibility is largely dictated by how observers perceive an organization's capacity to accomplish its mission and its accountability to authority. Because such perceptions reflect individual judgments, credibility does not necessarily correlate completely with capacity and accountability. Determinants of credibility include sufficient and transparent sources of authority. A credible organization is characterized by robustness against rivals for authority that is adequate to dissuade frequent challenges.

GUIDELINES FOR APPLYING THE CRITERIA

Applying these criteria to the evaluation of a program's governance and administration is not simple because not all of the attributes can be achieved simultaneously, and all governance models fall short of the ideal. In practice, policymakers should determine which criteria are most important to them, and then choose a model that comes closest to maximizing their priorities.

When a program's mission changes in important respects, new technology allows for a

new method of accomplishing the mission, or public expectations have changed significantly, changes to the governance and management should be considered. The notion that form should follow function is a critical principle that suggests the need for changes in governance and management when the functional activities associated with running a program change. Given an impetus for change, whether to try to redesign the former structures or start anew is an important decision. Designing a new governance structure to accommodate new functional requirements of a program has appeal, in that such a structure could be custommade to meet the challenges at hand. However, the motivation to start over must

be balanced against the fact that

accommodate to new structures

there are unknown, but lurking, The motivation to flaws in any new alternative. start over must be Furthermore, there are usually balanced against considerable costs and risks in the fact that there making a transition in either govare unknown, ernance or management. Program but lurking, flaws beneficiaries, for example, value in any new stability in the program. They and alternative. other stakeholders are invested in the status quo and would have to

and systems. These costs and risks suggest a bias toward the status quo, absent compelling and demonstrated need to start fresh or the certainty of significant improvement. However, there are also risks to inaction that must be weighed.

Chapter 2: An Overview of Medicare

MEDICARE'S CONTRIBUTIONS TO THE HEALTH OF THE ELDERLY AND DISABLED

Any thoughtful consideration of changing Medicare's governance or management should begin with a thorough understanding of its history, mission, responsibilities, and current operations. Medicare was enacted into law in 1965, after decades of debate about how best to meet the health care needs of elderly Americans. At its enactment, it was modeled after the existing employer health insurance market, with benefits, administration, and payment methods based on Blue Cross and Blue Shield plans then prevalent. It is an entitlement program, meaning that it is available to all elderly and disabled persons who meet the eligibility requirements.

Prior to enactment, about half of all senior citizens were uninsured. Today, Medicare provides health insurance to more than 39 million people, including more than 5 million disabled people under age 65.4 Virtually the entire population over age 65 (97 percent) is insured by Medicare. The program is enormously important to both the economic security and health-status of elderly Americans, and it also plays a substantial role in improving the health care system. Before Medicare, nearly one-third of senior citizens were poor, and paid more than 50 percent of their health care costs out of pocket. Today, the proportion of seniors living in poverty mirrors the younger population—about 10

percent. Medicare has dramatically increased access to health care, particularly for minorities, and has contributed to significant increases in life expectancy for the elderly. In 1960, a 65-year-old American woman could expect to live an additional 15.9 years to reach the age of 80.9. That same year, a 65year-old man could expect to live an additional 12.9 years to the age of 77.9. Today, the average life expectancy of a 65-year-old woman has increased nearly 20 percent to 84.2 years, and the average 65-year-old man can expect to live to the age of 80.9. While Medicare has given minority beneficiaries increased access to health care services, there are still significant differences between the health status and life expectancy of minority and white beneficiaries. For example, twenty six percent of white beneficiaries viewed themselves as being in poor health, compared to 45 percent of African American beneficiaries and 42 percent of Hispanic beneficiaries (Henry J. Kaiser Family Foundation, 2001).

Medicare also plays a key role in the U.S. health care system. In 2000, Medicare covered about 14 percent of the U.S. population and financed 19 percent of the nation's health care spending. By virtue of its size, Medicare has an enormous effect on the entire health care system. And as baby boomers age into Medicare, its size and influence will continue to grow.

⁴ Unless otherwise noted, the data in this section are derived from (DHHS 2000).

In addition to its role of financing health care for the elderly, Medicare has, since its inception, made important contributions to health and safety standards in hospitals, nursing homes, and other health care facilities, and to the training of health care professionals. As a condition of receiving Medicare funds, these facilities must meet certain quality and safety standards ("conditions of participation") that apply to all patients served, not just those on Medicare. More than 6,000 hospitals now participate in Medicare, along with 41,800 health plans and long-term care and other facilities, 861,800 physicians and other practitioners and 168,300 laboratories (DHHS 2001a). Medicare also makes direct financial contributions to the training of new physicians and other health care providers. In 2000, Medicare paid nearly \$8 billion to U.S. hospitals to help train new health care providers.

Over time, Congress has expanded Medicare's scope, mission, and responsibilities substantially. In 1972, Congress expanded Medicare's scope by adding two eligibility categories: disabled people under age 65 and those with end stage renal disease. In 1985, Congress expanded Medicare's mission by authorizing subsidy payments to hospitals that serve a disproportionate share of low income Medicare and Medicaid beneficiaries. These payments are not linked to providing care to Medicare beneficiaries, but serve a broader goal of protecting vulnerable hospitals. They provide an important financial "safety net" for these hospitals, many of which could not provide care to poor and uninsured people without these subsidies. In 2000, Medicare paid \$4.6 billion to these hospitals.

Over the years, Congress has attempted to redress deficiencies in the health care system, and improve the quality of health care through greater federal oversight or regulation. In large part, these regulatory responsibilities have been assigned directly to Medicare or to the federal agency that administers Medicare, CMS. For example, in 1980, Congress required federal oversight of Medicare supplemental (Medigap) insurance to address marketing abuses. In 1988, in response to allegations of poor quality in clinical laboratories, Congress established federal quality standards for all clinical laboratories. In 1996, Congress passed the Health Insurance Portability and Accountability Act (HIPAA), to give Medicare a much stronger role in preventing and detecting fraud and abuse, to give the Secretary of Health and Human Services (HHS) broad authority to oversee portability in private health insurance plans and greater authority to regulate the format and electronic submission of health care transactions.⁵

Medicare has frequently been on the leading edge of developing innovative payment systems subsequently adopted by many other payers. Medicare was the first to use prospective payment systems for inpatient hospital services, a new resource-based payment system for physician services, and prospective payment systems for outpatient hospital services, home health agencies, skilled nursing facilities, and rehabilitation hospitals.

Today, Medicare is an infinitely more complex and larger program than envisioned at its enactment. In part, increased complexity stems from these expansions in its mission, scope, and responsibilities. But it is also important to remember how vastly the prac-

⁵ The Secretary subsequently delegated the health insurance portability provisions to CMS.

tice of medicine has changed since 1965.
Unprecedented advances in technology and medical science, such as CAT,
MRL and PET scans: organ trans-

MRI, and PET scans; organ transplants, and laparoscopic surgery, to name just a few, have resulted in quantum improvements in health care. At the same time, the pace of change in diagnostic and clinical care has increased the complexity of administering Medicare an enormous degree.

ment, the panel thought it would be useful to understand why Medicare was designed

the way it was. To this end, it commissioned a review of the administrative history of Medicare. This section provides a brief overview of some of the important developments in Medicare's administrative history and describes the impact of critical design decisions on the program's evolution.⁶

Today, Medicare is an infinitely more complex and larger program than envisioned at its enactment.

Taken together, all these forces have combined to make Medicare a formidable presence both in the nation's health care delivery system and the federal budget. Medicare is the second largest social program (after Social Security), and surely one of the most, if not the most, complex. While most observers would agree that Medicare has been highly successful in meeting its mission of providing health care to elderly Americans, any program of this magnitude is inevitably subject to criticism and calls for reform, particularly since the demographics of the baby boom generation will cause increasing budget pressures.

MEDICARE'S ADMINISTRATIVE HISTORY

Key decisions that were made in establishing the Medicare program continue to affect its administration today. To better understand Medicare's current governance and manageWhen Medicare was enacted in 1965, policymakers envisioned Medicare as another component of the nation's social insurance system for the elderly. (This distinguished it from the Medicaid program, seen as part of the welfare safety net.) This distinction, as well as the decision to link Medicare eligibility to Social Security eligibility, resulted in the responsibility for Medicare being given to SSA, an agency widely respected for its efficient administration of payments to beneficiaries and its talented staff. SSA's role in administering Medicare had a profound impact on the program. The agency's orientation toward beneficiaries, its commitment to social insurance, and expertise in making timely and correct payments to beneficiaries contributed to the initial success of the program in many respects.

At Medicare's inception, a key decision about who would administer the program was

Much of this overview was distilled from a report by Jonathan Oberlander commissioned by the study panel to aid in its understanding of why Medicare administration and governance structures were designed as they were, and how they have evolved over time. In addition to original interviews conducted for this study, Oberlander drew upon sources such as A Report on the Implementation of the Social Security Amendments of 1965, by Robert Ball, November 15, 1965, reproduced in Reflections on Implementing Medicare (Washington, DC: National Academy of Social Insurance, 2001); The Politics of Medicare by Theodore Marmor (Chicago: Aldine, 1973); and Medicare: The Politics of Federal Hospital Insurance by Judith Feder (Lexington, MA: Health, 1977).

made. In response to fears articulated by the American Medical Association and others that federal administrative control of Medicare would be tantamount to socialized medicine, the day-to-day administration of the program was given to private insurance companies, primarily Blue Cross and Blue Shield plans. Under contract to the federal government, they were authorized to handle many duties - processing claims, reimbursing providers for services, making local coverage and medical necessity decisions, and other administrative tasks. To this day, private health insurers are responsible for most Medicare administration; twenty-eight intermediaries administer Medicare Part A and twenty carriers administer Medicare Part B.⁷

In addition to blunting criticism of government intrusion into private health care, the decision to have private insurance companies administer Medicare was perceived to have other important advantages. Private health insurers could implement Medicare rapidly, while the federal government had no existing administrative apparatus to get the job done. Moreover, having Blue Cross and Blue Shield plans administer the program meant that the program would be based on local practices and customs, rather than under uniform standards. At the time, that was thought to be an advantage, because Medicare would not cause dislocations in local medical practice patterns. Local administration of Medicare remains one of its defining characteristics. While some believe that local administration is still preferable, others believe that its advantages are offset by fragmented information systems and inconsistent oversight of medical services and payments.

Taken together, these decisions were made primarily to assure a successful and rapid implementation of Medicare. And they were largely successful. As President Lyndon Johnson predicted, "[Medicare] will take its place beside Social Security, and together they will form the twin pillars of protection upon which all our people can safely build their lives and their hopes," (DHHS 2000).

Over the years, however, as Medicare spending grew, concerns were voiced about whether SSA was the appropriate administrative home. Some thought that SSA lacked the cost containment focus necessary to control rising health spending. Suggestions about merging Medicare and Medicaid administration also began to surface, in part because having two different federal agencies administer health programs (particularly since some people are enrolled in both programs) seemed increasingly less prudent. In addition, critics of the way Medicaid was administered thought that it would benefit from the management talent in SSA. In 1977, these discussions culminated in an executive branch decision to take Medicare out of SSA, combine it with Medicaid, and create a new agency in the Department of Health, Education, and Welfare. The new agency was called the Health Care Financing Administration (HCFA).

Medicare Part A is financed by a payroll tax and covers inpatient hospital services, skilled nursing facility care, home health care, and hospice care. Part B is financed 75 percent from general revenues and 25 percent by premiums paid by beneficiaries. It covers physicians' services, laboratory services, durable medical equipment, other medical services, and a portion of home health care. Medicare Part C covers managed care and other health plan choices. Part C does not have a separate revenue source; services furnished under Part C are funded by transfers from the Medicare trust funds in proportion to the percentages of services covered by Parts A and B.

The creation of HCFA influenced Medicare's evolution in several important respects. Perhaps most importantly, it shifted Medicare's focus from management of a social insurance program more to health care financing, raising the mission of cost containment as another goal. In one area, however, creation of HCFA did not accomplish an intended objective. Full coordination between Medicare and Medicaid did not occur, despite the overlap in beneficiary population and administrative functions.

The next structural event of real significance came in 1997, when Administrator Bruce Vladeck implemented a large-scale reorganization. The primary thrust of the reorganization was to change the agency from a functional orientation to be client- or customer-focused. with three discrete divisions: the Center for Beneficiary Services, the Center for Health Plans and Providers, and the Center for Medicaid and State Operations. Some of the key reasons for the reorganization were: to increase emphasis on beneficiaries as clients, to unify Medicaid and State Operations in one unit, to provide a coherent structure to replace one that had evolved without a central plan, to meet administrative challenges associated with evolution of the program such as increased managed care, and to achieve a more integrated staff with greater collaboration across functional responsibilities.

The reorganization increased HCFA's capability to take on the new administrative responsibilities given to it in the Balanced Budget Act of 1997, including administration of the Medicare+Choice program and the State Children's Health Insurance Program (SCHIP). It also assisted the agency in becoming more responsive to beneficiary interests. As with any reorganization, it was

costly in terms of the disruptions and delays at a time when the agency's workload was increasing dramatically. During the three years following the reorganization, dissatisfaction about the agency's overall performance persisted in the Congress and among stakeholders, particularly providers. In general, complaints about the reorganization centered on confusion in identifying those with responsibility in a given area, diffusion of decision-making, and transfer of staff members with particular expertise to other jobs.

The new Bush administration quickly undertook another internal reorganization and renamed the agency the Centers for Medicare and Medicaid Services (CMS). The rationale for the name change was to better reflect the mission of the agency and a renewed commitment to responsiveness to health care consumers and providers (DHHS 2001b). The reorganization was made largely on functional grounds, creating three centers designed to reflect the agency's three lines of work: the Center for Beneficiary Choices, which is responsible for the Medicare+Choice program and beneficiary education; the Center for Medicare Management, which manages traditional FFS Medicare; and the Center for Medicaid and State Operations, which handles all state-related programs and activities run by the agency. One of the key effects of the reorganization was uniting all the functions of Medicare+Choice, including beneficiary education, in one center. Because this reorganization was just implemented in June 2001, it is too early to evaluate its performance.

MEDICARE'S GOVERNANCE

CMS is the administrative home of the Medicare program. The Medicare program is in the jurisdiction of two committees in the House of Representatives, and one in the Senate, with administrative funding under the purview of appropriations committees. Other committees also hold oversight hearings, and Medicare is a frequent target of study for GAO and the OIG in HHS.

Department of Health and Human Services

CMS is an operating agency in HHS. It has

approximately 4,500 employees, about half of whom are located in the agency's Baltimore headquarters. A relatively small number of staff is located in Washington, D.C. with the balance in ten regional offices. The President nominates the head of the agency, the administrator, who is confirmed by the Senate. The administrator's salary is established as

level IV of the Executive Pay

Scale, which is \$130,000 for

2002.

On paper, the relationship of the agency to the Secretary appears simple. However, the operational reality is much more complex.

On paper, the relationship of the agency to the Secretary appears simple: the CMS administrator reports directly to the Secretary. However, the operational reality is much more complex. Although each Secretary can organize the department and use staff as he or she wishes, typically other agencies are involved in decisions made by CMS. This is mainly because the agency's scope is so broad and affects so many other people and programs. The Secretary has a number of staff divisions (defined as those without responsibility for running programs) that advise the Secretary and usually play a significant role in reviewing and approving proposed actions by operating agencies, including CMS and other agencies. These staff agencies include the Offices of the Assistant Secretaries for: Planning and Evaluation; Budget, Technology, and

Finance; Administration and Management; Public Affairs; Legislation; and Civil Rights.

Other agencies, such as the Office of the General Counsel and the Surgeon General, also advise the Secretary. In addition, when proposed actions affect other operating agencies, such as the Agency for Health Care Research and Quality, the National Institutes for Health, the Administration for Families and Children, and the Centers for Disease Control, they frequently participate in advising the Secretary and "clearing" the pro-

posed action. While staff and operating agencies within HHS often render sage advice and frequently improve CMS's decision-making, their involvement inevitably complicates and slows down the process.

In addition to review within the Department, most significant proposed actions by CMS, including testimony, legislative proposals,

and regulations, are reviewed by the President's Office of Management and Budget (OMB) and by policy officials in the White House. Ultimately, the Secretary is accountable to the President for all of CMS' actions. Given the visibility and importance of health issues in the last decade, White House staff have taken the lead on many new proposals, and participated actively in most major CMS actions.

Congress

Congress created Medicare in 1965 in Title XVIII of the Social Security Act, and has amended the law multiple times since then. In the House of Representatives, the Committee on Ways and Means has jurisdiction over Medicare revenues and the

Medicare program.⁸ The House Committee on Commerce has shared jurisdiction with the Ways and Means Committee over Medicare Part B, the parts of Medicare where Parts A and B overlap, and Part C. In the Senate, the Committee on Finance has sole jurisdiction for the Medicare program and revenues. These committees are known as the "authorizing" committees and are responsible for legislative oversight of Medicare. They hold hearings and propose changes to Medicare eligibility, benefits, payments, and coverage.

The House and Senate Budget Committees, through an annual budget resolution that covers all federal spending, recommend the overall level of spending in the Medicare program for the following year. Through the budget resolution, the Budget Committees may influence substantive Medicare policy. In both the House and the Senate, other committees frequently hold hearings on Medicare issues, although they do not have legislative jurisdiction. In the Senate, these committees include the Committees on: Aging; Health, Education, Labor and Pensions; and Governmental Affairs. In the House, the Committees on Government Reform and Small Business, as well as the Subcommittee on Oversight and Investigations of the Committee on Commerce have all held hearings on Medicare. When these committees hold hearings, agency officials are typically asked to testify and to produce information for the committee's use. In particular, the Senate Special Committee on Aging has had

a strong interest in overseeing the Medicare program.

In addition to the committees that have jurisdiction over the Medicare program, the Appropriations Committees in both the House and Senate have jurisdiction over the administrative budget of CMS. Through the appropriations process, they enact legislation that funds the operating costs of CMS. They do not have jurisdiction over the Medicare program itself, but they have occasionally reported legislation on program issues.9 Although not unique to Medicare, the fact that the authorizing Committees enact changes in the Medicare program, and the Appropriations Committees set the level of funding provided to carry out the tasks of administering the program, frequently causes a mismatch between the responsibilities assigned to CMS and the funds allocated to perform these duties.

Other Advisory or Oversight Agencies

In the 1980s, Congress created two non-partisan commissions to advise it on Medicare issues: the Prospective Payment Assessment Commission on hospital and other institutional services, and later, the Physician Payment Review Commission on physician issues. In 1997, the two commissions were combined to form the Medicare Payment Advisory Commission (MedPAC). Through their work, Congress has directed in-depth research and analyses of Medicare issues. Each year, Congress receives recommendations from MedPAC on various Medicare

Having jurisdiction over a program means that a committee is authorized to report out legislation affecting the program. Committees without jurisdiction may hold hearings regarding a program over which they do not have jurisdiction, but cannot report out a bill.

Another way the Appropriations Committees have become involved in Medicare is by providing earmarked funds in the appropriations process for specific activities or projects.

payment and policy issues, some of which they have relied on to enact changes in Medicare law.

In addition to MedPAC and its precusors, Congress makes frequent use of its investigative arm, the GAO, to examine a wide range of policy and management issues in Medicare governance.

GAO initiates its work in response to requests from Congressional committees or individual members. Since 1995, GAO has published nearly 200 documents (investigations, reports, or testimony before Congress) dealing with

Medicare program or administration issues.

In the executive branch, the OIG plays a very influential role in overseeing Medicare and CMS. Established by law in 1976, the HHS OIG has a great deal of authority and autonomy to audit, investigate, and supervise oversight of HHS programs. Its mission is to detect and prevent waste, fraud, and abuse, and to assure that beneficiaries receive highquality services at appropriate payment levels. The OIG reports to the Secretary of HHS, but the Secretary is specifically prohibited from preventing the OIG from "initiating, carrying out, or completing any audit or investigation" (DHHS 2000a). In addition to its general authority, HIPAA gave the OIG authority to conduct investigations, audits, and evaluations about health care fraud, and to coordinate Federal, State, and local enforcement efforts targeting health care fraud. The OIG takes a very active role in overseeing CMS. For example, it has a comprehensive work plan for 2002, under which it will evaluate or audit most aspects of the Medicare program (DHHS 2002).

As of October 2000, 1,006 pages of law in the Social Security Act and 1,978 pages of regulation in the Code of Federal Regulations governed Medicare.

RESPONSIBILITIES OF CMS

Medicare

Administering the second largest U.S. social program is an immense task. As of October 2000, 1,006 pages of law in the Social Security Act and 1,978 pages of regulation in the Code of Federal Regulations governed Medicare (CMS 2002b). In addition, the agency issues decisions and guidance through a wide variety of

documents: program memoranda, national coverage decisions, operational policy letters (OPLs), and other letters.

Broadly, CMS' key responsibilities in managing the Medicare program include:

- setting prices for what Medicare will pay for all services provided under the program;
- managing approximately 50 contractors who pay nearly one billion fee-for-service claims a year and perform other administrative tasks;
- determining whether providers meet the qualifications for participating in Medicare, and taking actions against providers who fail to meet standards;
- determining which new services and technologies Medicare should cover;
- conducting quality control and program integrity assurance activities;
- providing information about Medicare to beneficiaries;
- working with states to coordinate administration of Medicare for beneficiaries also eligible for Medicaid; and
- overseeing the 150 plans participating in the Medicare+Choice program.

Within the scope of each of these broad responsibilities, there are hundreds of tasks to be performed. For example, each year CMS updates the fees it pays to hospitals and other institutions, physicians and other practitioners, home health agencies, durable medical equipment suppliers, community health centers, rural health clinics, and managed care plans, among others. Medicare law generally specifies a different payment methodology and methods for calculating payment updates for each type of provider.

Procedural requirements also play an important role in regulatory complexity. The need to comply with the Administrative Procedure Act (APA) and other requirements established to ensure transparency in program decision-making results not only in slow promulgation of rules, but also the issuance of regulations that are overly long, convoluted, and obscure in interpretation (Berenson 2001). For example, the APA requires the agency to establish, in advance of making a decision, the criteria and standards by which an administrative decision is to be made and to obtain comments on the specified factors in advance. The end result of this is to effectively tie the agency's hands in incorporating new information in the final rule or if it did not anticipate key concerns prior to their being raised in comments.

The purpose of the APA is to ensure that the government does not act in an arbitrary and capricious way, and that the public has an opportunity to participate in government. It is one of the hallmarks of democracy. While few would want to alter fundamentally the nature of our democracy, these processes do slow government agencies down. Unlike the private sector, government agencies are limit-

ed in the extent to which they can be nimble and quickly respond to changes.

Responsibilities Not Related to Medicare

In addition to administering Medicare, CMS has a host of other significant responsibilities, including:

- working with the states to administer
 Medicaid and the SCHIP;
- enforcing the Clinical Laboratory
 Improvement Act (CLIA); and
- implementing the non-Medicare parts of HIPAA, including health insurance portability and administrative simplification.

GROWTH IN RESPONSIBILITIES SINCE 1996

Since 1996, Congress has increased dramatically both CMS' responsibilities and workload, starting with the enactment of HIPAA. Since this time, Congress has enacted four significant pieces of legislation which have had a profound effect on Medicare: HIPAA; the BBA of 1997; the BBRA of 1999; and the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000.

The Health Insurance Portability and Accountability Act (HIPAA) of 1996

HIPAA is best known for its provisions to guarantee the availability and renewability of private health insurance, and its elimination of pre-existing condition limitations for those with continuous health insurance coverage. But the law also had far-reaching effects on Medicare's fraud and abuse prevention efforts, and on revising electronic health information transactions standards.

Under the health insurance portability provisions, states were given the primary responsibility for enforcing requirements on insurers that issue group and individual health insurance, but the Secretary of HHS was given "fallback" enforcement authority if the states fail to act. Following the Medigap model, HCFA was given enforcement responsibility. This is noteworthy because this enforcement responsibility expanded the agency's responsibilities to matters unrelated to Medicare or Medicaid. At the time, the agency had virtually no experience in this arena, and had to train staff for these additional responsibilities without new funding. In conjunction with the Departments of Labor and Treasury, CMS published an enforcement regulation, and is currently enforcing all the HIPAA standards in one state, and individual requirements in six states. 10

In HIPAA, Congress also dramatically increased attention to, and funding for, fraud and abuse prevention activities, both in HCFA and in investigative and law enforcement agencies. Within HCFA, it created the Medicare Integrity Program, and directed HCFA to contract with special program safeguard contractors to reduce fraud, waste, and abuse. In an unusual move, Congress directed mandatory appropriations from the Part A trust fund for these contractors. Congress also directed mandatory appropriations from the trust fund to the HHS Inspector General and the Department of Justice to investigate and prosecute Medicare fraud and abuse.

In addition, HIPAA contained a number of provisions broadly described as "Administra-

tive Simplification." The goal of these provisions was to improve and standardize all electronic health transactions by:

- requiring a uniform format and coding for submission of health claims information;
- establishing unique identifiers for individuals, employers, health plans, and health care providers; and
- establishing standards for both the security and privacy of personal health information.¹¹

Within HHS, CMS has the lead responsibility for working with industry groups to develop and implement the administrative simplification requirements, except the privacy rule. The agency has published four proposed or final regulations, and five remain. When these provisions were enacted, few appreciated their breadth, scope, and the myriad and complex issues that would arise in developing and implementing these standards. When fully implemented, they will have far-reaching effects on all payers and providers in how health care business transactions are conducted.

The Balanced Budget Act of 1997 (BBA)

In 1997, Congress enacted the BBA, whose main purpose and accomplishment was eliminating the federal deficit for the first time since 1969. Medicare's contribution to balancing the budget was substantial. From FY 1998-2002, Medicare spending was reduced by an estimated \$115 billion, which CBO estimated would reduce the rate of growth in Medicare spending from 8.8 percent a year

¹⁰ The individual requirements were enacted in a later amendment to HIPAA, the Women's Health and Cancer Act.

II The individual identifier rule was put "on hold" because it evoked too much controversy.

to 5.5 percent. Most of the reductions were achieved by reducing the rate of increase in payments for almost every type of Medicare service.

The BBA was enacted after more than two years of intense debate in Congress about whether Medicare should be reformed, and whether HCFA should be restructured. In the end, Congress decided that its first priority was balancing the budget. Thus, the BBA did not include the fundamental reform of Medicare that some had advocated, nor did it restructure HCFA, although both issues remained on the Congressional agenda. Nonetheless, BI

the Congressional agenda. Nonetheless, BBA made significant changes to Medicare law and expanded HCFA's responsibilities. More importantly, the size and scope of the changes Congress passed dramatically increased HCFA's workload. In terms of increased responsibilities, the implementation of the SCHIP, while not a Medicare program, posed significant challenges for the agency.

For Medicare, the biggest change was the creation of Medicare Part C: Medicare+ Choice (M+C). Congress added four new options to the existing array of qualified Medicare managed care plans: providersponsored organizations (PSOs), preferred provider organizations (PPOs), private feefor-service plans (private FFS), and a medical savings account (MSA) demonstration combined with a high deductible insurance plan. Each new type of plan required implementing instructions and rules. Moreover, the BBA substantially revised the operating rules for managed care plans. Medicare Part C also charged HCFA with creating a comprehensive beneficiary education campaign, including a handbook, annual health fair, toll-free telephone number, and comparisons of M+C plans by service area.

The new tasks for the FFS (traditional) Medicare were also formidable. BBA directed HCFA to implement four new prospective

payment systems (for skilled nursing facilities, home health agencies, outpatient hospital departments, and rehabilitation hospitals), and implement or expand coverage for several preventive benefits (including prostate cancer screening tests, mammography, screening pelvic exams, colorectal screening, bone

mass measurement, and diabetes self-management training).

Both from analytic and operational perspectives, implementing the BBA was a daunting task. By CMS' count, the BBA contained 359 provisions that required agency action. While HCFA had considerable expertise with payment rate reductions, it still had to issue regulations and write and transmit implementing instructions to intermediaries and carriers, who, in turn, would reprogram systems and inform providers of the changes.

Implementing new prospective payment systems was a far more complex task than reducing payment updates, and was made more difficult by the fact that four new payment systems were mandated at the same time. Sophisticated design and analytic work, typically occurring over several years, are the foundations for any new payment system. HCFA had laid the groundwork for most of the payment systems, but intensive work was still needed on the design phases. On the operational side, implementing a new payment system requires giving detailed instruc-

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tions to the intermediaries or carriers, and making multi-faceted changes to claims processing systems.

Complicating the implementation of the new systems were hundreds of archaic information systems. Readying these "legacy" systems to operate after 2000 caused a major disruption in HCFA's implementation of the BBA. After an analysis of risks and benefits, the agency decided that it had to postpone all information systems changes in order to ensure that claims could be paid after January 2000. As a result, the skilled nursing facility payment system was the only one of the four implemented as scheduled on July 1, 1998. Implementation of the other three payment systems, as well as a number of other FFS provisions of the BBA, was delayed.

The Balanced Budget Refinement Act of 1999 (BBRA)

The primary purpose of the Medicare BBA provisions was to slow the rate of growth in Medicare spending in order to help balance the federal budget. But in the two years following its enactment, Medicare spending was sharply lower than predicted. In FY 1998, Medicare spending grew by only 1.5 percent. In FY 1999, Medicare spending actually declined for the first time in its history. Medicare outlays were almost 1 percent lower than the previous year. In March 1999, CBO revised its budget projections, and lowered its estimates of Medicare spending by \$80 billion over 5 years. And, in July 1999, CBO projected further reductions in Medicare spending (CRS 2001). Most stakeholders, citing a record surplus, argued that Congress had actually made cuts in Medicare spending far deeper than necessary to balance the budget. While most analysts pointed to contributory effects of other factors, such as changes in CBO's economic estimates and the effects of increased fraud and abuse prevention and detection efforts, the precipitous decline in spending was cause for concern (CRS 2001). Most providers lobbied Congress for increased payments, maintaining that their ability to continue providing care was threatened. While GAO could find little conclusive evidence that Medicare beneficiaries' access to care was eroding, Congress took the fall-off in Medicare spending seriously.

In 1999, it enacted the BBRA, primarily to partially restore some BBA reductions, but also to refine some of the BBA's provisions relating to prospective payment systems. CBO estimated that the BBRA would increase Medicare spending by \$16 billion over 5 years, with about seventy-five percent of the additional spending targeted to hospitals, skilled nursing facilities, home health agencies, and M+C plans (CRS 2001). While the BBRA contained fewer changes in law than the BBA (126 in the BBRA, compared to 359 in the BBA), implementation still posed real operational challenges to HCFA, especially in light of delays caused by Year 2000 systems issues (GAO 2000). For example, the Blue Cross and Blue Shield Association reported that Medicare contractors received 719 formal instructions ("change orders") from HCFA for systems changes in 2000, more than 2.5 times as many as in 1998, before the Year 2000 systems moratorium was imposed. While the 1999 moratorium on systems changes probably made the 2000 number higher than it otherwise would have been, it nonetheless indicates the workload that both the agency

and the contractors faced in implementing the BBA and the BBRA (GAO 2001a).

The Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA)

After the enactment of the BBRA, CBO's projections showed much slower rates of growth in Medicare spending than previously projected. In July 2000, CBO's

estimate of Medicare spending was more than 20 percent lower than it had projected prior to enactment of the BBA. CBO now projected that Medicare spending would grow at an average annual rate of 7.5 percent from 2001 to 2005, compared to 9.4 percent prior to the BBA. These projec-

tions fueled an ongoing debate that the BBA Medicare reductions were too deep. In response, Congress enacted the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA). CBO estimated the cost of the legislation at \$32.3

billion over 5 years. Most of the bill's proviappeals process, and required the Secretary to

> After enactment, HCFA determined that BIPA had 152 provisions requiring agency action to implement.

Taken together, the range and scope of the new responsibilities given to CMS since 1996 are extraordinary. While many have been critical of the agency's inabil-

ity to implement all these changes quickly, the study panel thinks it is important to remember that all of these tasks were given to an agency already charged with managing an already exceedingly complex program in a fluid and rapidly changing health care system.

sions further increased payments to Medicare providers, with the largest increase, \$11.2 billion over 5 years, going to M+C in an attempt to stem plan withdrawals from the program. BIPA also expedited the Medicare conduct outreach activities to inform beneficiaries, providers, and others of their rights.

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Chapter 3: Issues in Medicare Management

By virtue of its size, complexity, and importance, Medicare commands the attention of Congress and policy-makers. In the last several years, Medicare has faced even more scrutiny as the baby boom generation approaches Medicare eligibility. The impending and steep increase in the number of beneficiaries has led to a serious debate about whether the current Medicare program is financially sustainable in the long run. The question at the heart of that debate is whether Medicare should continue as a social insurance program with defined benefits. Some have proposed means testing, while others have proposed moving toward a premium support or defined contribution strategy. Greater use of managed care for Medicare beneficiaries would be an integral part of such reform proposals. In some people's view, the current governance and management structure has a bias toward the traditional fee-for-service program and does not encourage enrollment in managed care plans.

Philosophical differences about what kind of program Medicare should be inevitably color considerations about how well the program is currently administered. The panel understands that Medicare governance and management may need to change substantially if the program is restructured and that the current structure might not be well-suited to an organization with a different mission. But since Congress has not yet acted to restructure Medicare, the panel focused on making the current Medicare program work better, rather than speculate about what type of governance structure might be best suited to a different type of Medicare program.

SOME GENERAL OBSERVATIONS

Most discussion about Medicare's governance and management focuses on its shortcomings or perceived failures. While much of the criticism has a basis in fact, the panel is keenly aware of how important Medicare is in the lives of elderly and disabled Americans, and emphasizes that its intent is not to undermine Medicare, but only to make it stronger.

The panel also recognizes Medicare's achievements. By any measure, Medicare must be judged successful in accomplishing its core mission: providing health insurance to elderly and disabled Americans. It is the most cost-effective health insurer in the country. Medicare processes nearly a billion claims a year, and pays its claims faster than any other insurer, and at a lower cost. The costs for processing Medicare claims is approximately \$1 to \$2 per claim, far lower than the \$6 to \$10 costs per claim for private insurers (GAO 2001b). Furthermore, Medicare administrative costs are far lower than those of private insurers. In fiscal year 2000, HCFA's administrative costs were less than 1 percent of benefits paid for Part A and 2 percent for Part B. By comparison, Blue Cross/Blue Shield Association plans' administrative costs were about 12.2 percent in 1998 and other commercial insurers' costs can be as much as 25 percent of benefit costs (GAO 2000).

Other aspects of the program must be considered strengths as well. Medicare generates a great deal of data that provide the basis for important health services research. Such data

include information on beneficiary access to care, service use, and out-of-pocket spending, derived from the annual Medicare Current Beneficiary Survey (Adler 1994). Studies conducted by health services researchers and policy analysts using these data are used to help improve the financing and delivery of care for all Americans. For example, Medicare data served as the main source of information used in groundbreaking research on variations in medical practice and health outcomes. Similarly, research, demonstrations, and evaluations that are conducted as a part of Medicare program management provide information used to improve care for privately insured and uninsured Americans. Also, the program stands as a model of integrity in important respects. Despite hundreds of billions of dollars paid by the program since its inception, no evidence of corruption internal to the agency has ever been produced.

Although the panel recognizes Medicare's success in accomplishing its core mission, it also explored areas in which management of the program has been found wanting. Critics have charged that the agency does not implement new provisions of law in a timely fashion, adequately oversee its contractors, manage its information systems well, use a measured approach in pursuing fraud and abuse, communicate well or simply with beneficiaries, or respond quickly to changing market conditions. The agency is also thought to suffer from a lack of continuity in leadership and an overly insulated staff that does not have adequate experience or training to administer such a complex program. Others have said that Congressional micromanagement, in the form of overly specific

laws and conflicting priorities, has kept CMS from functioning as effectively as it could.

While each of these issues will be discussed, the panel generally concludes that many of Medicare's shortcomings stem from insufficient resources.

RESOURCES NOT COMMENSURATE WITH RESPONSIBILITIES

Table 1 shows Medicare's appropriations to CMS for program management, benefit outlays, claims volume, FTEs, and contract employees from FY 1992 through 2002.12 Figure 1 shows the same data. In inflationadjusted (real) dollars, benefit outlays have increased 97 percent and claims volume has increased 50 percent. However, program management appropriations have increased only 26 percent, while the number of FTEs has increased 12 percent. Growth in the number of contractor employers has been even smaller, at 6 percent. During that period, great efficiencies were achieved through automation of claims, but these data reveal a serious mismatch between the agency's responsibilities and the resources allocated to fulfill them. The mismatch has been particularly acute since the passage of HIPAA. As shown in Figure 1 and discussed earlier, both the magnitude and scope of responsibilities given to CMS have grown enormously, while the size of the staff has increased only modestly. The breadth of those new responsibilities, especially those totally unrelated to Medicare, such as the health insurance and administrative simplification provisions of HIPAA and the State Child Health Insurance Program in the BBA, have posed exceptional challenges to the agency. Some of the new

¹² FTEs include all agency employees; approximately 400 employees are assigned to Medicaid.

Table 1

		Progra	ram Grow	ım Growth vs. Change in Administrative Resources	nge in Ac	lministrat	ive Resour	ces			
Fiscal Year	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002
Total Administrative Funding (Real \$ in mil.) 1,941.0	1,941.0	1,746.6	1,799.2	1,787.1	1,728.0	1,734.4	1,788.9	1,945.1	1,996.3	2,241.6	2,437.1
Cumulative % Change (Since FY 1992)	0.0%	-10.0%	-7.3%	%6''-	-11.0%	-10.6%	-7.8%	0.5%	2.8%	15.5%	25.6%
Medicare Operations (Real \$ in mil.)	1,380.9	1,196.3	1,224.5	1,213.3	1,201.4	1,207.2	1,216.1	1,265.1	1,239.0	1,356.4	1,534.0
Cumulative % Change (Since FY 1992)	0.0%	-13.4%	2.4%	-1.0%	-1.0%	0.5%	1.0%	4.0%	-2.0%	9.5%	13.0%
Program Mgmt. Approp. (Real \$ in mil.)	560.1	550.3	574.7	573.8	526.6	527.2	572.8	680.0	757.4	885.1	903.1
Cumulative % Change (Since FY 1992)	0.0%	-1.7%	4.4%	0.2%	-8.2%	0.1%	8.6%	18.7%	11.4%	16.9%	2.0%
Benefits Outlays (Real \$ in millions) 19	96,400.0	196,400.0 217,300.0 2	238,100.0	262,300.0 279,300.0		298,300.0	306,500.0	311,500.0	311,500.0 327,900.0 364,742.0 386,069.0	64,742.03	0.690,98
Cumulative % Change (Since FY 1992)	0.0%	10.6%	21.2%	33.6%	42.2%	51.9%	56.1%	58.6%	%0′29	85.7%	%9.96
Medicare Claims Volume (in millions)	e 647.9	684.5	735.7	779.6	807.7	842.7	859.8	867.4	891	930.6	970
Cumulative % Change (Since FY 1992)	%0.0	2.6%	13.6%	20.3%	24.7%	30.1%	32.7%	33.9%	37.5%	43.6%	49.7%
FTE Consumption	4,147	4,236	4,119	4,099	4,081	3,979	3,942	4,219	4,446	4,583	4,632
Cumulative % Change (Since FY 1992)	%0.0	2.1%	-0.7%	-1.2%	-1.6%	-4.1%	-4.9%	1.7%	7.2%	10.5%	11.7%

Note: Total administrative funding is the sum of Medicare Operations (the vast majority of which is for contractor management) and Program Management Funds.

Source: Office of Financial Management Centers for Medicare and Medicaid Services, 2002.

GROWTH IN CMS RESPONSIBILITIES

HIPAA - 1996

- "Fallback" enforcement of private health insurance provisions
- Medicare Integrity Program, including new program safeguard contracts
- Administrative Simplification to improve and standardize all electronic health transactions (9 regulations in all) including:
 - Uniform formats for coding of health claims information
 - Unique identifiers for individuals, employers, health plans, and health care providers
 - Standards for the security and privacy of personal health information

BBA - 1997

- Medicare+Choice, including four new options (PSOs, PPOs, Private FFS, and MSA demonstration)
- Medicare Education Program, including handbook with local comparative information, 1-800-MEDICARE phone line, www.Medicare.gov, and regional health fairs about Medicare choices
- State Child Health Insurance Program
- Four new prospective payment systems (skilled nursing facilities, home health agencies, hospital outpatient services, and rehabilitation hospitals)
- Payment reductions (requiring regulations) for almost all Medicare providers

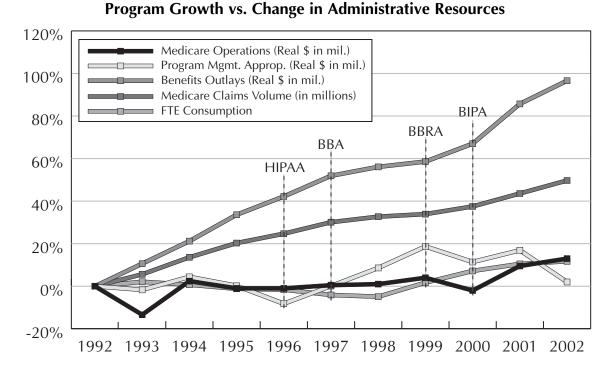
BBRA - 1999

- Refinement of prospective payment systems
- Partial restoration of BBA payment reductions for most Medicare providers

BIPA - 2000

- Further changes to payment systems for most Medicare providers
- Changes to Medicare appeals process and outreach activities

Figure 1



Source: Office of Financial Management, Centers for Medicare and Medicaid Services, 2002.

tasks related to Medicare, such as the Medicare Education Program and the new provider types in the BBA have been very resource-intensive. In addition, funding to contractors, who implement changes through information systems changes and instructions to providers, has not nearly kept pace with the additional work given them.

In January 1999, three former administrators (Leonard Schaeffer, William Roper, and Gail Wilensky) joined a number of health policy experts and advocates in writing an open letter to Congress and the Executive about a looming crisis at HCFA due to insufficient human and financial resources. They said, "Over the past decade Congress has directed the agency to implement, administer, and regulate an increasing number of programs that derive from highly complex legislation.

While vast new responsibilities have been added to its workload, some of its most capable administrative talent has departed or retired...At the same time, neither Democratic or Republican administrations have requested administrative budgets of a size that were in any way commensurate with HCFA's growing challenge...no private insurer would ever attempt to manage such large and complex insurance programs with so small an administrative budget" (Butler 1999).

CONGRESSIONAL MICROMANAGEMENT

Over time, Congress has become increasingly involved in Medicare. In the 1970s, the number of Congressional staff working on Medicare began to grow, signaling growing

Congressional interest. In 1974, the enactment of the Congressional Budget and Impoundment Control Act of 1974 was a pivotal event, increasing Congressional power over the budget. Prior to its enactment, Congress had no overall framework to develop its own spending priorities and had to rely on the Office of Management and Budget (OMB) for budget information, cost estimates, and forecasts. The 1974 Act established procedures for Congress to develop an annual Congressional budget. It established Budget Committees in the House and Senate, gave them authority to draft Congress' budget, and created the Congressional Budget Office (CBO), which gave Congress an independent and influential source of information on budget issues and the ability to generate its own cost estimates.13

In the 1980s, Congress began to write more detailed laws, beginning with the passage of the prospective payment system for inpatient hospital services in 1983. However, prior to the early 1990s, health care policy did not occupy as prominent a position in the Congressional agenda, and was not foremost in the minds of most Americans. The presidential campaign of 1992 and the Clinton health care reform plan brought Medicare and health care issues to center stage in both the Congress and the minds of the American people. Since that time, Congress has been much more involved in Medicare, although its focus has shifted from comprehensive health system reform, first to deficit reduction, and then to restructuring Medicare. In 1995, Congress passed a balanced budget bill that would have reduced Medicare spending

by \$270 billion over 5 years and added new health plan options to the program. President Clinton vetoed that bill. Since that time, Congress has passed four significant pieces of health care legislation and has also considered Medicare reform and prescription drug coverage. Enactment of these laws placed a heavy burden on CMS. Many provisions contained very detailed specifications that required extensive action to implement. The BBA had 359 provisions to implement, BBRA 126, and BIPA 152.

In addition to enacting detailed legislation, Congress is also very involved in agency matters on an ongoing basis. Congressional committees, including not just authorizing and appropriating committees, but also oversight committees, have held scores of hearings, which require significant preparation on the part of administration witnesses. Congress has also requested a very large number of GAO reports on Medicare, to which the agency typically issues a formal response. Moreover, the volume of telephone calls and letters to the agency from members of Congress has increased over time; responding to them on a timely basis has proved to be a significant challenge for the agency. In 2000, the HCFA Administrator told the Senate Finance Committee that the agency received an average of 700 letters a month from members of Congress, not including letters that go directly to Medicare contractors (DeParle 2000).

Both the amount and specificity of Congressional action have raised questions about whether Congress is micromanaging Medicare. Even some members of Congress

¹³ The Act also limited the President's authority to impound (or withhold from federal agencies) funds appropriated by Congress.

believe that they have become too involved in Medicare issues. Senators Breaux and Frist have offered legislation to "depoliticize" Medicare by creating a Medicare Board to resolve contentious issues, in the hope that the Board would allow members of Congress to refer some controversial issues, such as Medicare benefits and coverage, to the board, rather than becoming directly involved. However, some doubt that such an approach would be Both the amount successful because members will and specificity of always be called upon to intercede in matters affecting their district. action have raised

questions about Keeping in mind Medicare's whether Congress importance, a fairly high level of is micromanaging Congressional involvement seems Medicare. appropriate. In the study panel's view, Congressional oversight of Medicare is part of their fiduciary responsibility to both taxpayers and beneficiaries. However, the panel also wanted to understand why Congres-sional involvement in Medicare has grown so much in recent years in order to assess whether their involvement is hindering effective management of the program or draining agency resources that would better be spent on program management.

The Budget Reconciliation Process

Over the years, Medicare law has become increasingly specific. A critical contributor to increased specificity is the role of "scoring" in the budget reconciliation process. In that process, Congress passes a budget resolution to determine government revenue and spending for the next fiscal year. The budget resolution establishes budget targets for committees, and directs the committees to report back legislation meeting those targets. After the committees report their respective bills,

the budget committees combine all the provisions into an omnibus reconciliation bill. These bills cover a multi-year period, although typically Congress intervenes by enacting legislation in the intervening years.

CBO plays a critical role in this process. It assigns a cost estimate or savings estimate (called the score) to each provision. CBO is

unwilling to score provisions

unless they specify how savings (or spending) will be achieved. The result is that Medicare law has become very detailed. Unless the budget reconciliation process is changed or CBO changes its scoring conventions, both of which seem unlikely, future laws are likely to be just as specific, since they typically amend existing law.

Further, for the degree of specificity to diminish markedly in the future, Congress would probably have to repeal, or at least reduce, some of the specificity in existing law.

Other Reasons for Increased **Specificity in Law**

In addition to the budget scoring rules, other factors affect how deeply Congress gets involved in Medicare law and administration. Congress has not always trusted the administration to implement the law in accordance with its wishes. Sometimes, but not always, the mistrust has been partisan, when one party controls the White House and the other one, or both, Houses of Congress. Making the law more specific gives the administration less latitude to exercise discretion in implementation and gives Congress greater assurance that its intent will be implemented. However, Congress is not the only actor driving greater specificity in the law. Given the importance of Medicare to health

Congressional

care industry and the national economy, health care providers have also lobbied Congress to enact laws with greater specificity.

The study panel concurs with the view that laws passed in recent years have been too prescriptive. On occasion, members of Congress have even asked the administration not to implement the law exactly the way it was written because of unforeseen consequences. For example, the Bush administration recently tried to change some elements of the Medicare beneficiary education program to conform to changes in the M+C program, but was prevented from doing so. The court ruled that the education campaign had to be conducted in accordance with the law, which was very specific about both the content and timing of the campaign (Gray Panthers v. Thompson 2001). In another example, the administration was required to implement a 5.4 percent reduction in payments to physicians for 2002 because it had no flexibility to alter the formula in law. Many members of Congress, as well as physician organizations, asked the administration to interpret the law differently, so that the reduction would not be implemented, but the law was written in such a way that the administration felt no other interpretation would be legally sustainable.

The study panel believes that Congress should be involved in oversight of Medicare by setting priorities for Medicare, determining its future, overseeing its operations, and holding CMS accountable for performance objectives. The panel does not subscribe to the view that Congress should not be involved in Medicare oversight. However, it is clear that both the number and highly specific content of laws passed in recent years have severely taxed the agency's ability to comply with the

requirements imposed on it. The study panel thinks that the agency would benefit from some respite in implementing new laws and from greater administrative flexibility. Perhaps even more importantly, the study panel believes that both the agency and Congress would benefit from a greater sense of trust and comity, and urges a public dialogue on how that might be accomplished.

INABILITY TO IMPLEMENT LAWS ON TIME

Beginning with the passage of HIPAA, enactment of major pieces of legislation in most of the ensuing years has severely taxed the agency, compromising its ability to perform ongoing work while implementing the new provisions. Even without the additional responsibilities in recent years, Medicare is an exceedingly complex program with equally complex administrative tasks. Not including the provisions of HIPAA, the agency reported that these laws included 637 provisions that required agency action. Some of these provisions, such as the reductions in payments to providers, were routine or relatively simple. Even so, the agency is required to publish regulations, which are timeconsuming, to implement provisions of law. Other provisions in these laws, such as implementing new prospective payment systems, required extensive design and analytic work, followed by the regulatory process. In addition, some of the new responsibilities, such as the health insurance portability and administrative simplification provisions of HIPAA and the new SCHIP in the BBA were not directly related to Medicare and required extensive agency resources to implement.

In its strategic plan for 2002, the agency reported that it had implemented 75 percent of the BBA, 80 percent of the BBRA, and 15

percent of the BIPA.¹⁴ While other factors, such as the Year 2000-related delay, clearly impeded the agency's ability to implement these laws in the timeframes required by Congress, the panel notes that the sheer volume of changes would have presented a daunting challenge to any agency, even with resources adequate to the task.

POOR OVERSIGHT OF CONTRACTORS

Contractors perform most of the actual work of administering Medicare. There are 28 intermediaries for Part A, 20 carriers for Part B, and 19 program safeguard contractors. The contractors currently employ approximately 22,500 employees, nearly five times as many as CMS. Contractor duties include the following:

- claims processing (receiving claims and making decisions about which services should be covered, paying appropriate claims, taking action to identify inappropriate or fraudulent claims, and withholding payment or collecting overpayments);
- payment safeguards (additional activities to ensure that payments are proper, including medical review, audits, and investigations by fraud units);
- fiscal responsibility (actions to ensure a full and accurate reporting of Medicare accounts receivable);
- services to beneficiaries (including resolution of claims disputes);
- services to providers, including providing them information about payment

- and coverage system changes, instructing them how to submit claims, and customer service in resolving billing and other problems; and,
- administrative duties. 15

Over the years, both OIG and the GAO have been particularly critical of the agency's oversight of contractors. Since 1996, the OIG has conducted annual audits of FFS claims to estimate the extent to which payments did not comply with Medicare laws and regulations. For FY 2000, the latest year for which data are available, the OIG estimated that about 6.8 percent, or \$11.9 billion, of the \$173.6 in FFS claims processed was improper (Mangano 2001). These improper payments, referred to as the error rate, consist of:

- medically unnecessary services;
- unsupported services (those for which insufficient documentation is found in the medical records);
- coding errors (services or procedures for which lower reimbursement should have been paid); and
- non-covered services (payment was made for services that do not comply with Medicare law or regulation).

The error rate has sometimes been misidentified as a measure of fraud and abuse. It is important to note that not all of the errors represent efforts to defraud or abuse the program. For example, what is included in the error rate reflects simple coding errors or lack of documentation for appropriate services. In

¹⁴ The agency did not keep records of the number of provisions in HIPAA.

¹⁵ The description of these duties is derived from testimony delivered by Michael Mangano, Acting Inspector General, to the House Ways and Means Committee on June 28, 2001.

any event, the error rate reflects inaccurate or incomplete billing or documentation, and measures claims that were paid when they should not have been. While equating the error rate with fraud and abuse is too simplistic; it is appropriate to consider the error rate as a reflection of inadequate oversight by the contractors and CMS.

In the OIG's estimation, contractors' claims systems were generally adequate to determine both beneficiary and provider Medicare eligibility, price claims correctly, and ensure that the services billed were allowed under Medicare rules. However, the OIG said that the contractors' controls were inadequate to detect the types of errors described above, which were detected by having medical professionals review beneficiary medical records. While the OIG views the error rate as an indicator that CMS needs to strengthen its oversight and control over contractors, it credits CMS for cutting the error rate by about half, from 14 percent in 1996 to 7 percent in 2000.

Besides the error rate, there are other indicators of poor contractor oversight. Several contractors defrauded the government or settled cases alleging fraud for hundreds of millions of dollars in the 1990s (GAO 2001c). The allegations included deleting or destroying claims, failing to conduct proper audits, falsifying documentation for medical claims, falsifying performance measures to evaluate their performance, and switching off toll-free phone lines designed to assist beneficiaries. What made these circumstances more troubling, according to the GAO, is that they were not discovered by the agency

during routine oversight, but were reported by whistleblowers.

Since 1993, CMS has entered into settlements with 14 Medicare contractors, with settlements exceeding \$350 million. In conjunction with some of these settlements, the OIG has imposed eight corporate integrity agreements, which stipulate mandatory compliance and reporting requirements agreed to by the contractors to avoid exclusion or debarment from Medicare. Two other contractors have pled guilty to obstructing federal audits. In June 2001, the OIG reported that it had 24 former or current contractors under active investigation.

GAO has also studied contractor performance in providing information and services to health care providers (GAO 2001c). In reviewing ten contractor-issued bulletins (letters to physicians informing them of changes in national and local Medicare policy), GAO found that some of the bulletins contained overly technical and legalistic language and omitted some information about mandatory billing procedures. GAO also found that 85 percent of the calls to the telephone call centers were answered either incompletely or inaccurately.

Despite continuing problems, both the OIG and GAO credit the agency with improved oversight of contractors in the last few years. CMS has appointed a management board comprised of senior executives to oversee contractor performance. It has also separated contractor management from contractor evaluation functions, and assigned additional staff to monitor and oversee contractors. However, both OIG and GAO still find

¹⁶ This discussion is derived from the June 28, 2001 testimony of Acting Inspector General Michael Mangano.

problems with financial management and accounting procedures.

In part, the difficulties CMS has in overseeing contractors stem from legal restrictions in its contracting authority.¹⁷ Under the Competition in Contracting Act and its implementing regulations, known as the Federal Acquisition In part, the Regulation (FAR), most federal difficulties CMS agencies can contract with any has in overseeing entity as long as that entity has contractors stem not been debarred from federal from legal restriccontracting and the contract is not tions in its confor what is essentially a governtracting authority. mental function. However, when Medicare was enacted, the Social Security Act established somewhat different contracting requirements, which are still in effect. For example, there is no fair and open competition for selection of Medicare intermediaries and carriers. For Part A, the Secretary is directed to enter into contracts with fiscal intermediaries nominated by different provider associations. When Medicare was enacted, the intent of this provision was to encourage hospitals to participate by giving them a voice in the selection of claims processors. There are currently three intermediary contracts, one of which is with the National Blue Cross and Blue Shield Association. When one of the local Blue plans declines to renew its contract, the national association nominates another Blue Cross plan. The nomination process has resulted in a dwindling pool of contractors.

dropped by half, and contractors seem to be less interested in Medicare business than in the past. On occasion, the agency has had difficulty finding qualified contractors.

Other restrictions in Social Security law also limit the agency's ability to manage its con-

tractors effectively. In addition to being awarded without full and open competition, the contracts must be with health insurers and must cover the entire range of claims processing and related activities (with specific exceptions) and cannot be terminated without cause and without giving the contractor an opportunity for a public hearing. The contracts must also

be cost-based, not performance-based, and cannot provide incentive bonuses.

Each year since 1993, the agency has asked Congress to enact contracting reform legislation that would allow it considerably more flexibility in its contracting arrangements. 18 Both the GAO and the OIG have consistently testified that such legislation would greatly enhance CMS' ability to manage its contractors. However, Congress never seriously considered contracting reform legislation until 2001. The Medicare Regulatory Relief and Contracting Reform Act of 2001 (H.R. 3391) passed the House of Representatives on December 4, 2001 by a vote of 408-0, and was referred to the Senate Committee on Finance. As passed by the House, the bill gives the agency much of the flexibility it has

Since 1980, the number of contractors has gives the agency much of the flexibility it

17 This discussion is derived from the testimony of Leslie Aronovitz, Director of Program Administration and

Integrity Issues, GAO, before the Subcommittee on Health and the Subcommittee on Oversight and Investigations, Committee on Commerce, June 28, 2001.

¹⁸ Previous administrations, beginning with President Reagan, had also requested contractor reform legislation, although not every year.

sought, including: allowing the Secretary to contract with any qualified entity, not just health insurers; permitting the Secretary to enter into functional contracts for part of the Medicare scope of work; applying the FAR to Medicare contracts; requiring the Secretary to use competitive procedures in Medicare administrative contracting; and permitting the use of performance, quality, price, and other factors, thus allowing contractors to make a profit.

Passage of contracting reform legislation should help the agency manage its contractors better, but contractor reform is not a panacea for all the agency's problems with contractors. Some of the contractor management problems probably result from poor management practices, but in the panel's view, insufficient resources for contractor oversight have been a significant contributing factor. Over the years, the budget for contractor management has remained relatively flat, while the complexity of the program increased, as did the number of claims.

The contractors themselves have also suffered from resource limitations. When most contractors switched to electronic processing of claims during the 1990s, their budget was effectively increased because the costs of processing claims were lower. However, these savings eroded relatively quickly because of higher claims volumes and greatly increased responsibilities. When Medicare law and policy change, the contractors are responsible for writing and implementing instructions, and informing and educating providers about the changes. The passage of the BBA, BBRA, and BIPA meant both sizable increases in

workload for the contractors, as well as much higher levels of confusion among providers, creating a greater demand for customer service from the contractors. In particular, provider education has suffered because of resource limitations.

In the panel's view, both the contractor management function at CMS and the work performed by contractors, particularly in provider education and customer service, have suffered from lack of resources.

Increased funding for both contractor oversight at CMS and administration of the program by contractors is critical to improving their performance.

OUTDATED INFORMATION SYSTEMS

Medicare administration requires an array of detailed information on beneficiary enrollment, use of services, provider payments, quality of care, contractor performance, and numerous other components. To meet the need for this information, CMS relies on hundreds of data collection and management information systems. Many of these systems were not designed to communicate with each other, and most of them are outdated. Further complications stem from the fact that Medicare's 48 contractors use six different standard systems to process claims. The Medicare Part A contractors use two systems, and the Part B contractors use four standard systems.

As detailed in a recent report by GAO, Medicare's information system deficits are evident in many respects. ¹⁹ At present, Medicare relies on multiple information systems that cannot speak to one another, limit-

¹⁹ This discussion is largely derived from GAO's Report, Medicare: Information Systems Modernization Needs Stronger Management, September 2001.

ing the ability to combine data from various sources to create enhanced information. The information systems do not assemble or maintain data in an easily accessible format, meaning that some of the information that exists cannot easily be used in program management. Furthermore, data submission requirements are not always well coordinated, limiting the ability to combine data from different sources to improve analytic capabili-

ty. For example, linking skilled nursing facility claims with patient assessment data has proven very challenging, although the assessments are used in determining payment amounts.

In addition, these systems are modified frequently to reflect changes in law, annual payment updates, and changes in policies.

Since the enactment of the BBA, the number of systems modifications has been much more frequent, which has placed considerable stress on already outdated systems.

In early 1994, HCFA undertook a sweeping systems modernization project, called the Medicare Transaction System (MTS), to replace the multiple contractor-operated claims systems with a single, standard operating system. Originally, HCFA planned to implement all the elements of the MTS simultaneously. However, the agency had difficulty defining the systems requirements, and decided to phase-in the MTS over time in order to minimize risk. Still, GAO was highly critical of the agency's management of MTS development, faulting the agency for not developing adequate cost-benefit analyses, and underestimating the risks of developing and implementing a comprehensive

solution. Estimates of the project's costs also grew substantially over time. In part, the agency responded to GAO's criticism of poor management by citing lack of resources to properly develop and manage such a large-scale project. Ultimately, under pressure, HCFA abandoned MTS in August 1997 in favor of a more incremental approach to systems redesign. However, design and implementation of these plans were delayed for

approximately 18 months while the agency and its contractors prepared all systems for conversion to Year 2000. HCFA, along with many other agencies, devoted considerable effort and resources to assuring that its payment systems could process claims after January 1, 2000. After this conversion was accomplished successfully, the agency once again turned to system redesign issues. The current plan is much more modest than MTS. It calls for

reducing the number of standard systems from six to three, and developing a new financial management reporting system, called HCFA's Integrated General Ledger Accounting System (HIGLAS), that will be designed to connect with the agency's other financial and claims processing systems.

At the request of Representative Pete Stark, ranking member of the Subcommittee on Health of the House Ways and Means Committee, GAO reviewed the agency's revised information system modernization plans. One of their key findings is that resource gaps in the agency—both funding and staff expertise—pose threats to the success of the agency's plans. GAO recommended that Congress consider enhancing resources for information system moderniza-

tion contingent upon CMS demonstrating progress in providing appropriate technical foundations and management capacity. GAO also recommended that Congress provide multi-year funding for the project to provide CMS with the stability and flexibility it needs to maintain and modify some systems while gradually redesigning or replacing others.

While the study panel did not independently evaluate Medicare's information systems, it believes that prompt improvement in Medicare's information systems is critical, and supports GAO's recommendations. Improvements in such systems are an essential part of any effort to increase administrative efficiency, reduce the need to rely on retrospective fraud enforcement, and minimize the regulatory burden of providers.²⁰

FRAUD AND ABUSE

In the mid 1990s, complaints began surfacing that HCFA was too aggressive in fighting fraud and abuse and had unfairly accused providers of misconduct when they had made innocent billing mistakes. The climate regarding fraud and abuse has changed dramatically since the early 1990s. As described by former Administrator Nancy-Ann Min DeParle, the government moved from relatively lax efforts to a zero tolerance policy on fraud, waste, and abuse in just a few years (DeParle 2000). In retrospect, the changing climate on fraud and abuse began with a 1995 demonstration project by the Clinton Administration, Operation Restore Trust (ORT), to reduce fraud and abuse in three areas (nursing homes, home health agencies,

and durable medical equipment) where Medicare spending was rising rapidly. The demonstration had several goals, including: identifying and penalizing those who willfully defrauded Medicare and Medicaid, identifying systematic problems and special vulnerabilities to fraud and abuse in Medicare and Medicaid, alerting the public and the health care sector to fraud schemes, and demonstrating new efforts to provide for voluntary disclosure of evidence of fraud. By one account, ORT saved \$23 for every dollar it spent (Stanton 2001).

The Clinton administration's desire to pursue fraud and abuse more aggressively was bolstered by public opinion. In 1996, AARP conducted a consumer telephone study to assess public attitudes toward health care fraud and found that 93 percent of the respondents believed that health care fraud was either somewhat or extremely widespread (DHHS 2001d). The GAO and the OIG also pressed for increased attention to fraud and abuse through audits and reports to Congress.

In 1996, Congress enacted HIPAA, fundamentally altering the landscape in the fight against fraud and abuse. It dramatically increased funding and also gave investigative and law enforcement agencies a much more prominent role, signaling a shift away from dealing with fraud and abuse in a low-key way. Prior to HIPAA, fraud and abuse activities, also known as program safeguard activities, were funded primarily from the HCFA contractors' (intermediaries and carriers) budgets, and competed with other contractor

²⁰ In order to examine this issue more carefully, the study panel commissioned a paper written by Thomas Stanton, "Fraud and Abuse in the Medicare Program: Evolving Issues and Relationships," that forms much of the basis of the following discussion. The paper led to the article published in *Health Affairs* and cited at the end of this report.

functions, including paying claims. Over time, funding for program safeguard activities eroded. GAO has reported that the number of Medicare claims grew by 70 percent from 1989 to 1996, while funding for program safeguards grew by only 11 percent (GAO 1998). HIPAA changed this by establishing a dedicated funding stream for program safeguard activities, with substantially more funding. In 1995 (prior to HIPAA), an estimated \$428 million was spent on program safeguards. HIPAA appropriated \$440 million for FY 1997, rising to \$720 million in FY 2003 and subsequent years. Congress also created a broad-based Medicare Integrity Program (MIP) led by the Secretary of HHS, through the Inspector General and the Attorney General. Funds were specifically directed to the HHS OIG, the Department of Justice, and the FBI, among other agencies.

The infusion of funds had very tangible effects on these agencies. The Inspector General used MIP funds to increase the number of states with IG offices from twenty-one, in 1996, to all fifty, in 2002. OIG staffing also nearly doubled from about 900 in 1997 to almost 1,500 in 2001 (DHHS 2001c). Similarly, the DOJ created the position of Special Counsel for Health Care Fraud to coordinate the work of its criminal and civil divisions, the FBI, and the 93 United States Attorneys who have independent authority to bring cases in their own jurisdictions (Stanton 2001). The FBI also added several health care fraud units and a number of agents. Predictably, these agencies pursued health care fraud vigorously, and the number of enforcement actions increased substantially. In their 2000 annual report on

HIPAA actions, the Attorney General and the Secretary of HHS reported that federal prosecutors filed 457 criminal indictments in health care fraud cases, an increase of 23 percent over the previous year. That year, there were also 1,995 civil matters pending, with 233 civil cases filed in 2000 alone. The OIG excluded 3,350 individuals or health care entities from Medicare, mostly as the result of criminal convictions. They also reported that the federal government won more than \$1.2 billion in judgments, settlements, and imposition of civil penalties for health care fraud and abuse.

HIPAA also appropriated more funds to HCFA for fraud and abuse and, for the first time, provided HCFA with dedicated funding for fraud and abuse. HIPAA authorized HCFA to enter into specialized contracts for fraud and abuse detection and prevention. These activities include: review of medical claims (both pre and post payment), Medicare secondary payer reviews (which determine whether other payers are liable for services provided to Medicare beneficiaries), audits of provider cost reports, fraud unit investigations, and provider education.²¹ Nancy-Ann Min DeParle cited fraud and abuse detection and prevention as one of her top priorities when she became administrator in 1997. Subsequently, the agency reorganized to focus more attention on these issues, and issued its first comprehensive plan for program integrity. From 1996, when the error rate was about 14 percent of FFS payments, or \$23 billion, the agency reduced improper payments to about \$12 billion, or 7 percent in 2000 (Morris 2001).

²¹ All claims are reviewed through an automated process, but fewer than five percent are actually reviewed by a person.

By most measures, the fight against fraud and abuse would be considered a success. However, many provider groups have been harsh critics. Their criticism stems largely from three sources: use of the False Claims Act (FCA) in health care fraud cases; a charge of inconsistent, confusing, and voluminous instructions from HCFA and its contractors that make it difficult for providers to understand what is required of them; and audit or sampling practices.

The False Claims Act

The DOJ's use of the FCA in fraud and abuse cases has been particularly contentious, especially for hospitals. Under the FCA, providers are liable for treble damages and penalties of up to \$1,000 for each false claim if convicted. For Medicare, a false claim has been defined as each individual billing for a particular item or service. From providers' perspectives, DOJ has been overly aggressive in demanding large penalties under the FCA for largely unintentional billing errors. Some providers feel that the penalties under the FCA are so large that they are coerced into settlements. Hospitals were especially aggrieved by the 1995 "PATH" audits of claims by physicians at teaching hospitals. By 1998, DOJ had obtained \$67 million in settlements from prestigious teaching hospitals.

In response to perceived abuses of the FCA, legislation was introduced in Congress that would have limited DOJ's authority to use the FCA in health fraud and abuse cases. Although the bill did not pass, it led Deputy Attorney General Eric Holder to issue guidance essentially limiting use of the FCA in health care matters in June 1998. The guidance directs both DOJ and U.S. Attorneys to determine, before they allege violations of the FCA, that the facts and the law sufficient-

ly establish that the provider knowingly submitted false claims. In 1999 and 2000 appropriations acts, Congress directed the GAO to monitor and report on whether DOJ properly enforced the guidance (GAO 2001d). In August 1999, GAO reported that DOJ's process for reviewing implementation of the guidelines was superficial, and that U.S. Attorneys did not consistently apply the guidance. By August 2001, however, GAO reported that DOJ had taken steps to strengthen its oversight of compliance, and that DOJ and the U.S. Attorneys were operating in compliance with the guidance. Still, the FCA remains potent. In 2000, DOJ reported that it had recovered over \$840 million in civil health care fraud, much of it related to the FCA.

Inconsistent and Burdensome Guidance

Providers have long complained that Medicare issues too many rules and instructions, many of which are contradictory or confusing. They also complain about the paperwork burden. Some say that they cannot comply with all of Medicare's requirements because they don't fully understand them. As a result, they feel that they are unfairly accused of fraud or abuse.

The Bush administration has implemented several initiatives to improve provider relations. Secretary Thompson has chartered a regulatory reform task force and asked it to identify regulations that prevent providers from serving Medicare beneficiaries effectively. The task force will determine what rules need to be better explained, streamlined, or eliminated (Scully 2001). CMS Administrator Thomas Scully has also taken several steps to improve provider relationships, including: creating open door policy forums to strengthen communications with pro-

efforts to improve their consistency; expanding the provider education website, www.hcfa.gov/medlearn; providing free computer and web-based training courses for providers; expanding the toll free hotline to twenty-four hours a day, seven days a week; and establishing a quarterly compendium of all changes to

Medicare so that providers will have an easier time understanding and complying with Medicare

Claims

Another provider technic to the draw so that providers are sults

The study panel views effective fraud and abuse

requirements.

The House of Representatives has ment as essential also passed a bill, the Medicare to protecting the Regulatory and Contracting integrity of Reform Act of 2001, which is Medicare. pending in the Senate. In addition to the contracting reform provisions discussed above, the bill streamlines the regulatory process and imposes new requirements for provider education. In recognition that some of the shortcomings in provider education are due to insufficient funding, the bill authorizes an additional \$25 million in FY 2003 and 2004 to increase provider education and training and improve the accuracy and quality of provider responses.

To respond to some of the providers' strongest complaints about the regulatory process, the bill permits the Secretary to issue rules only one business day per month, requires the Secretary to study the collective impact of a new regulation on providers, generally limits the retroactive application of rules, provides for a 30-day grace period before a rule becomes effective, and absolves providers from liability and the duty to make repayments if they relied on inaccurate instructions from CMS or contractors.

Claims Reviews and Sampling

Another point of contention between providers and CMS is the use of sampling techniques to determine whether providers have billed improperly. Currently, contractors draw samples of claims and then extrapolate results to a provider's entire practice to issue

a demand for repayment. The agency has long maintained that it does not have the ability to survey a provider's entire practice, and that extrapolation is an important and legitimate tool in program integrity efforts, while providers have viewed it as somewhat extortionist.

In general, the regulatory reform bill diminishes the Secretary's ability to review claims and collect

overpayments by imposing new requirements in areas where CMS previously had administrative latitude. The bill requires the Secretary to consult with providers to develop protocols for random prepayment reviews of claims, and limits his authority to conduct non-random prepayment reviews unless there is a likelihood of sustained- or high-level payment error. The Secretary would also be prohibited from using extrapolation to collect overpayments unless there is a sustained- or high-level of payment error or the provider did not correct a payment error after being notified of it and being given an opportunity to correct it. In addition, the bill requires the Secretary to establish a process, in consultation with providers, to notify them when a Medicare contractor has identified overuse of specific billing codes.

To improve communications, the bill requires central coordination of provider education efforts through the contractors. It

prevention, detec-

tion, and enforce-

also requires Medicare contractors to: provide general written responses in a "clear, concise, and accurate" manner within 45 business days; provide a toll-free line to answer questions; keep records identifying which employees responded to which questions; and monitor the accuracy, consistency, and timeliness of information provided. The bill also establishes a Medicare Provider and Beneficiary Ombudsman.

The study panel views effective fraud and abuse prevention, detection, and enforcement as Getting the right essential to protecting the integrity of Medicare. Getting the right balance between effective fraud and abuse enforcement and maintaining a positive relationship with the provider community is a delicate matter. In the early 1990s, fraud and abuse matters were largely handled administratively, with relatively little focus on enforcement, or creating a sentinel effect. Spurred by public perceptions of widespread fraud, and fueled by GAO and OIG reports about lax program integrity efforts, both the executive branch and Congress responded with strong actions.

The enactment of HIPAA was a watershed event, dramatically increasing the funding for fraud and abuse and shifting the emphasis from administrative resolutions to investigative and law enforcement agencies. Congress clearly expected increased recoveries and more prosecutions from its HIPAA investment, but the response was probably greater than intended. By most accounts, the DOJ used the FCA with more vigor than the facts warranted, and the provider community reacted with predictable fear and anger, especially since many also faced increased scrutiny and demands for repayment from HCFA and the OIG on other fronts. They felt beleaguered and took their case to Congress, arguing for relief on many fronts. Now Congress is considering regulatory relief legislation that would limit some of the tools that CMS uses to detect fraud and abuse.

Although there are several other agencies involved in fraud and abuse efforts, the study panel focused most of its attention on CMS.

> In its view, CMS' focus on fraud and abuse prevention and detection is appropriate. The agency is responsible for ensuring that Medicare funds are spent properly, and must be vigilant if it is to fulfill its responsibilities. Critics of the agency have a legitimate point, however, when it comes to instructions issued by CMS. They are frequently voluminous and sometimes contradictory. The study panel supports the agency's recent actions to streamline the

regulatory process and improve its provider education efforts. Greater consistency, particularly in instructions and communications from Medicare's contractors, is critical in helping providers comply with the rules. Better responsiveness to provider questions and concerns is just as important. The agency and its contractors need more resources to achieve these goals, as Congress has recognized in the pending regulatory relief bill.

COMMUNICATIONS WITH BENEFICIARIES

Communicating with beneficiaries has at least two aspects. The first is ensuring that beneficiaries are given enough information and the right information to understand Medicare and to make informed choices about their

health care. The second is ensuring that Medicare responds appropriately and quickly when beneficiaries have problems.

In the BBA, Congress directed HCFA to establish a new beneficiary education program as part of its effort to help beneficiaries understand the new plan options in the BBA and promote informed choices. Congress spelled-out the components of the education program in substantial detail. Required elements include providing:

- notice to beneficiaries at least 15 days prior to an open enrollment period containing a general description of the benefits under traditional Medicare, including covered items and services:
 - □ information about beneficiary cost sharing such as deductibles, coinsurance, and co-payment amounts,
 - information about beneficiary liability for balance billing;
- notice of procedural rights (including grievance and appeals) and the right to be protected against discrimination based on health-status-related factors;
- a description of the benefits, enrollment rights, and other requirements of Medigap and Medicare Select policies;
- information about an M+C plan's right to terminate its contract, and the effects of termination, non-renewal, or reduction in areas served upon beneficiaries;
- information comparing M+C plans, including:
 - covered items and services,
 - □ cost-sharing,
 - □ limitations on out-of-pocket expenses,

- differences in cost-sharing, premiums, and balance billing for private FFS plans and MSA plans,
- the extent to which enrollees may obtain benefits through in-network and out-of-network providers, and
- coverage of emergency and urgently needed care;
- information about the M+C premium;
- the service area of the M+C plan;
- to the extent available, quality and performance indicators for M+C plans, and how they compare to indicators for traditional Medicare, including information on disenrollment rates, enrollee satisfaction, health outcomes, and the recent record of compliance with the Secretary's requirements;
- information about whether the M+C plan includes mandatory supplemental benefits in its base benefit package or offers optional supplemental benefits; and
- establishment of a toll-free telephone line and Internet site.

Congress funded about 75 percent of the education program from a user fee imposed on M+C plans (GAO 2001b). User fees of \$95 million per year were collected from the plans, with the balance from the Medicare general administrative account, and the peer review organization (PRO) account. HCFA spent an average of \$107.8 million a year from FY 1998-2000 on the education program.

From the start, the funding mechanism was very controversial. The M+C plans argued that they should have to only pay their proportionate share of the education program's cost. They also argued that they could do a

better job than HCFA, and that HCFA's presentation of the material was slanted toward traditional FFS Medicare. In the BBRA, Congress scaled back the user fees to approximately \$17 million (down from \$95 million) for 2001. To adjust to the loss of approximately \$78 million in user fees, HCFA drew on unspent funds from previous years to fund the program. Beginning in 2002, however, the full impact of the reduction will be felt, requiring HCFA to either spend an additional \$46 million to maintain the current program, or scale it back.

The National Medicare Education Program

HCFA established the National Medicare Education Program (NMEP) to implement the BBA. The NMEP has the following components:

- 1-800-MEDICARE, a toll-free telephone line;
- Medicare and You (the Medicare handbook) and approximately two dozen other education booklets and brochures;
- www.Medicare.gov, the Internet site;
- Health Insurance Counseling programs, funded by \$15 million in grants; and
- Regional Education about Choices in Medicare (REACH) campaign, which consists of local health fairs and media campaigns.

In the BBRA, Congress directed GAO to study the NMEP and periodically report on it. In GAO's first report, issued in September 2001, beneficiaries and beneficiary advocates generally gave the program high marks, but the M+C plans were more critical.²² Beneficiaries and their advocates were pleased with

1-800-MEDICARE. More than 80 percent said they were satisfied with it, and call volume has increased dramatically since the line was introduced, from an average of 27,000 calls per month shortly after its introduction to 326,000 calls per month in 2000. Both the timeliness of answering the calls and the information provided appear to be appropriate. According to a CMS-sponsored study, 92 percent of calls were answered within 30 seconds. About 60 percent of callers speak directly to a customer service representative, while the remaining 40 percent obtain assistance through an automated system. The most common reasons beneficiaries call is to request a publication; the most frequently requested are Medicare and You and the Guide to Health Insurance. Beneficiaries also ask how to apply for Medicare, how to get a replacement Medicare card, or ask questions about Medicare, Medicaid, and claims payment. About half of the calls are transferred to a third party to answer. Of those, about 18 percent go to a contractor (which probably indicates that these questions pertain to problems or questions callers have about their own health care), about 9 percent go to a State Medicaid agency, about 9 percent to the Social Security Administration, about 4 percent to State Health Insurance Programs (SHIPS), and the remainder to other entities, such as M+C plans.

Reaction to *Medicare and You* has been more mixed. Focus groups sponsored by HCFA reported that the handbook is comprehensive, understandable, and a good reference. However, most beneficiaries use the handbook as a quick reference, rather than reading it all the way through. M+C plan representatives reported that it was too long

²² The following discussion is largely derived from that GAO report.

and over-emphasized traditional FFS
Medicare at the expense of the plans. HCFA
has had difficulty meeting some of the BBA
requirements to provide comparative information about M+C plans in the handbook.
In the last few years, a number of plans have
dropped out of Medicare or reduced their
service areas after *Medicare and You* had
already gone to print. In view of the lead
time required to get 40 million copies of *Medicare and You* printed and mailed to beneficiaries in time for the open enrollment season, HCFA decided to provide less detailed
information about M+C plans in

the handbook. More recently, CMS postponed the date for M+C plans to report their premium and benefits information from July 1 to September 15, 2001, making it impossible to include this information in the handbook.

Reaction to the Internet site has also been relatively positive; about 85 percent of users found it helpful. Most beneficiary advocates said that they think that the site is used more by family members than beneficiaries. Since its inception, HCFA has added comparative information about M+C plans, nursing homes, and Medigap insurance. M+C plan representatives reported that the standardized descriptions of M+C plans could confuse beneficiaries.

Most beneficiary advocates said that the REACH campaign was an essential part of the NMEP, and were generally positive about it, particularly the work of the SHIPs, which provide beneficiaries with individual assistance. While health plan representatives were supportive of local outreach efforts, they complained that they were not included in them often enough.

Overall, GAO reported, the NMEP has increased the amount and type of information regarding Medicare and M+C plans. However, it was unable to evaluate whether the NMEP persuaded beneficiaries to actively consider their health plan choices. In the fall of 2001, the Bush Administration strengthened the NMEP by expanding 1-800-MEDICARE to twenty-four hours a day, seven days a week and conducting a \$30 million media campaign to provide beneficiaries with more information about their choices.

After reviewing the evidence about the NMEP, the study panel did not concur with the assessment that Medicare has done a poor job communicating with beneficiaries, or that HCFA has not tried to foster more choice. Some of the criticism of the NMEP was probably related to the user fees, and M+C organizations had a legitimate complaint

that they were bearing more than their fair share of the costs. Prior to the BBA, Medicare was already a very complex program. The new types of plans created in the BBA and the confusion resulting from M+C plans that have withdrawn from Medicare in the last few years have made Medicare even more complex, challenging the ability of most beneficiaries to understand everything they need to know. While more education efforts would be beneficial, the panel commends the agency for the progress it has made since the BBA. Beneficiaries clearly have far more access to information than they did several years ago. GAO also recommended that CMS be given more latitude in conducting the NMEP, especially in regard to the content, format, medium, and timing of the information that the agency distributes to

Reaction to the Internet site has also been relatively positive; about 85 percent of users found it helpful.

beneficiaries. The study panel concurs with GAO's recommendation, so that the agency can have the flexibility it needs to respond to changing circumstances and implement recommendations to improve the education program.

The study panel thinks that a strong public information campaign is essential to help beneficiaries understand their choices, answer questions, and resolve problems. While the NMEP and the expansion of 1-800-

MEDICARE are positive steps, there are still

longstanding issues about whether beneficiaries get sufficient and timely help in resolving problems.

Providing assistance to beneficiaries has been a responsibility of the contractors and of the SHIPs, with CMS itself providing relatively little direct assistance. However, providing assistance to beneficiaries (and to providers) has probably not received either the attention or the funding needed to provide

customer services comparable to those in the private sector, particularly in the last several years, when contractor budgets have become increasingly tight.

The study panel thinks that providing more personalized assistance to beneficiaries is important. This assistance could take place via the internet, the telephone, or by establishing a local presence in Social Security offices.

LACK OF CONTINUITY IN LEADERSHIP AND STAFFING ISSUES

Over time, several issues have been raised about whether CMS is appropriately staffed. Observers have said that the agency suffers from a lack of continuity in leadership, too

few senior staff to manage the agency's complex responsibilities, an impending "brain drain" as senior managers approach retirement, and an overly insulated staff that does not have the appropriate skill set or training to manage such a complex program.

Tenure of the Administrator

Like GAO, the

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The Administrator is a presidential appointee, confirmed by the Senate, who reports to the Secretary of HHS. Thus, an administrator may only serve as long as the president who

appointed that administrator is in office. The salary of the administrator is set by law by Section 5315, Title 5 of the Executive Pay Schedule. For 2002, the administrator's salary is \$130,000. The administrator does not have the highest salary in the agency. In 2002, 35 employees are being paid more than the administrator; some because they are receiving salary adjustments and some

because they are at the top of the Senior Executive Service (SES) pay scale, \$138,200.

Since the creation of HCFA in 1977, the agency has had 22 administrators or acting administrators (GAO 2001e). For about 15 percent of the time, acting administrators have led the agency, sometimes for lengthy periods. The average tenure of administrators confirmed by the Senate is 2.5 years. Given the degree of turnover at the top of the agency, and the leadership void caused by acting administrators, GAO and others have questioned whether the lack of continuity has deleterious effects on the agency's work. Some have questioned also whether the demands on the administrator are too great, and whether narrowing the agency's mission

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might help both the administrator and the agency become more successful.

Like GAO, the study panel believes that increasing the tenure of the Administrator would be advantageous. One possible alternative is appointing the administrator to a fixed term, rather than serving at the pleasure of the president. The director of the FBI and the Surgeon General both have fixed terms that do not coincide with the length of the president's term. In the case of the FBI, that

has given the director considerable autonomy, credibility, and latitude to enforce the law without political interference. While Presidents and the Attorneys execution General have sometimes wished for more control over the FBI director, the director's autonomy has generally been viewed positively. FBI directors also have generally served fairly long terms. In the case of the Surgeon General, the evidence is some-

the Surgeon General, the evidence is somewhat mixed about whether a fixed term contributes to longevity and autonomy. For example, the first Surgeon General in the Clinton Administration, Joycelyn Elders, was pressured into resigning when she voiced an opinion not consonant with the Administration's views. Other Surgeons General have served the full length of their term, but their visibility and influence greatly declined when a new administration took

office. While the study panel recognizes that the evidence about whether a fixed term increases longevity is inconclusive, it believes that proposals that might lead to increased longevity warrant consideration.

Increasing the administrator's salary might also improve retention. The study panel believes that the administrator's salary ought

to reflect the stature and responsibilities of the job, and suggests that it be commensurate with that of the Commissioner of Social Security, whose salary is \$166,700.

Insufficient Number of Senior Managers and **Impending Retirements**

GAO has testified that the agency has fewer senior executives (members of SES) than other agencies with significantly smaller budgets and responsibilities. Currently, CMS has 54 SES positions, of which 10 are non-career

(or political) appointments. The study panel believes that increasing the number of senior executives would help the agency better fulfill its responsibilities.

A significant percentage of the current SES corps is approaching retirement eligibility. In 2002, eight members will be eligible,

increasing to 23 by 2006. Unless the agency retains some of those eligible for retirement, and recruits and trains new leaders in the next few years, it will lose about 50 percent of its most experienced managers. In addition, the agency has recently lost some of its most senior managers to other government agencies or the private sector, in part because the demands upon them were too great and the resources too few.

Inappropriate Skills and Training

GAO and OIG have reported that the agency lacks staff with the right skills to fulfill some of its more complex responsibilities. In particular, they said, the agency did not have staff with expertise in implementing the new plan options in the BBA – PPOs, PSOs, and MSAs (GAO 2001f). In a review of the agency's regional offices, OIG reported that half of the regions' managed care staff did

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not have the clinical knowledge and background to assess quality of care, and that few managed care staff had data analysis skills critical to assessing plan performance (DHHS 1998). CMS has also had problems recruiting and retaining qualified information systems staff.

The agency is cognizant of these issues, and is conducting a four-phase workforce planning process to identify skills and competencies that it needs in order to carry out the agency's mission. In recent years, CMS has also provided more opportunities for training through the Federal Executive Institute (FEI) sponsored by the OPM. The FEI provides a highly regarded, month-long management training program in Charlottesville, Virginia, for members of the SES and SES candidates. CMS managers also participate in year-long training programs with the Council on Excellence in Government, and in seminars with the National Health Care Purchasing Institute, sponsored by the Robert Wood Johnson Foundation.

On hiring, the agency must comply with civil service personnel requirements in Title 5 of the U.S. Code. Under those provisions, federal agencies must post jobs for a specified length of time, establish a panel to review all applications to determine the three best qualified applicants, give preference to veterans, select from among the three best qualified applicants, and hire citizens. Complying with these requirements is time-consuming; CMS estimates that it takes an average of three months from the time a position is posted until a job offer is made.

Federal agencies also must pay according to the civil service pay scales. For 2002, the top federal salary (excluding the SES pay scale) is \$119,682. The civil service requirements can limit agencies' abilities to hire qualified applicants. Sometimes, qualified applicants take other positions because the hiring process takes too long. The federal pay scale is also not competitive with the private sector for some types of positions, such as actuaries, information systems professionals, clinicians, and others. Even for the SES, where the top salary is \$138,200 in 2002, agencies frequently have difficulty recruiting executives with appropriate technical and management expertise.

CMS currently has flexibility to pay more than the civil service pay scale in some situations, but does not have authority to circumvent the hiring rules. For example, under the Physician Comparability Allowance (PCA), which is available to any federal agency, physicians in medical officer positions can be paid between \$10,000 and \$30,000 more than others in the same pay grade. Of the 32 physicians currently employed at CMS, 24 receive a PCA allowance, and three receive a similar exception called physician special pay (PSP), leaving only five who do not receive any salary differential. The agency also uses relocation allowances when appropriate and retention bonuses, which allow up to a 25 percent increase in salary for one year, to retain valued employees who have received private sector job offers. Currently, nine employees are receiving a retention bonus.

CMS does not have the same flexibility as some other federal agencies to exceed the salary cap or hire outside the civil service process. For example, Public Health Service (PHS) agencies were granted authority in law to hire "special experts," who are not subject to the civil service pay scale. Agencies hiring special experts also are not required to honor the veterans' preference. The special expert

designation was designed with researchers in mind, and special experts are not permitted in supervisory positions. Special experts are appointed for a two-year period, with annual renewals thereafter. They are considered federal employees for purposes of benefits, but do not have civil service employment protections.

The National Institutes of Health (NIH) and other PHS agencies have additional hiring flexibility that CMS does not. In the Senior Biomedical Research Service (SBRS), designed for biomedical researchers at NIH, non-managers may be paid at the SES level, which is otherwise restricted to management jobs.

ed program, and While some HHS agencies have that some targeted more flexibility regarding the Title relief from both 5 requirements, all HHS agencies the salary limitaare still generally subject to Title 5 tions and civil serrequirements. However, Congress vice personnel has enacted legislation that rules would be exempts three federal agencies beneficial. from Title 5 requirements to allow them to meet specific needs.²³ In 1996, Congress enacted a law that allowed the Federal Aviation Administration (FAA) to establish its own personnel system to address the unique demands of its workforce. Among other things, the FAA's system streamlined hiring through authority for "on the spot" hiring for special needs and hard to fill positions, provided for recruitment bonuses, reduced the number of steps needed to make a hiring decision, and reduced other rules to

allow for faster hiring. FAA human resource managers have expressed "strong conviction" that the new system has allowed them to develop innovative executive and professional recruiting processes and use recruiting firms more effectively to bring in the right talent. As evidence of success, FAA pointed to the fact that 17 percent of newly hired executives have come from outside the agency, and that

more than 90 percent of senior executive positions in research and development have come from outside the agency.

Congress took a more limited approach for the U.S. Patent and Trademark Office (USPTO). It established the USPTO as a "performance-based" organization (PBO), which typically means that the agency head and senior managers work under contract, with performance goals. Because unions representing USTPO personnel objected to proposals to exempt the agency from Title 5 requirements, Congress did not do so. However, Congress did make one change that USTPO officials viewed as crucial. It gave

the USTPO independence from its parent agency, the Department of Commerce, in personnel matters. Previously, USTPO had to compete with other agencies in the Commerce Department for SES positions. Under the new system, USTPO can work directly with OPM to get new SES positions and thinks this flexibility gives them a better opportunity to get the executive resources they need.

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²³ The discussion of these three agencies is based on "A Weapon in the War for Talent: Using Special Authorities to Recruit Crucial Personnel," Hal Rainey, School of Public and International Affairs, University of Georgia, Price WaterhouseCoopers Endowment for the Business of Government, December, 2001.

Congress also made the Office of Student Financial Assistance Programs (OSFAP) in the Department of Education a PBO. In this instance, Congress gave OSFAP several forms of personnel flexibility including exemption from limits on the numbers and grades of employees and authority to hire up to 25 technical and professional employees who would not be subject to Title 5 restrictions. OSFAP has not established a systematic way of paying these 25 employees. Instead, they have based salary on what the person was making in his or her previous position, what the person's supervisor thought justified and necessary, and the apparent value of the person's skills, credentials, and services. OSFAP has reported that these flexibilities have

enabled the agency to get the people it wants much faster than before. They said that these authorities have particularly helped them attract excellent employees in information technology, financial management, and other areas.

The study panel believes that CMS' work is hampered by its inability to recruit and retain staff with the expertise and experience needed to run such a complicated program, and that some targeted relief from both the salary limitations and civil service personnel rules would be beneficial. As with other agencies that have been granted such exceptions, employees hired under these exceptions would be civil servants.

Chapter 4: Consideration of Other Governance Structures

In addition to looking closely at CMS' current governance and management to evaluate strengths and weaknesses, the study panel evaluated other potential governance structures to determine whether they might be more suitable for Medicare. During this process, the study panel heard from policymakers, administrators, and others with first-hand experience in Medicare governance.

The Office of Personnel Management's administration of FEHBP is sometimes put forward as an example of successful government management of a program comparable to Medicare+Choice (see for example, Butler and Moffit 1995). Among the key differences between the programs is a much less detailed and specific legislative mandate for administering FEHBP, compared with Medicare, which allows OPM greater administrative flexibility and discretion in making program management decisions. Also important is that the FEHBP entails a much less complex set of administrative requirements (for example, FEHBP does not risk-adjust payments to plans). The size of FEHBP administration is minuscule compared with Medicare staff and resources. Medicare's administration of health plans could be simplified in many respects, allowing it a number of administrative efficiencies enjoyed by OPM. However, Medicare's status as an entitlement program adds administrative complexities that OPM does not face in managing an employee benefits program. In addition, complications presented by the need to serve an elderly and disabled population will always present challenges in Medicare that the FEHBP does not face. For

example, a higher proportion of the Medicare population has cognitive impairments. This presents challenges for the program in communicating with beneficiaries and ensuring that the health system is comprehensible and negotiable.

The panel reviewed a variety of alternatives to the current Medicare governance structure. Four alternative models were examined: creating an independent agency that is not part of any cabinet department, changing the governance structure to an independent administrative board, converting CMS to a performance-based organization, and switching to a wholly owned government corporation model of administration.

THE INDEPENDENT AGENCY MODEL

Making CMS independent of HHS could reduce some layers of bureaucracy that impede administrative flexibility and efficiency, and reduce accountability. As part of HHS, CMS' proposals must be reviewed and approved by other agencies in the department and the Secretary before CMS can act. Although many have argued that extensive review improves the final product, it also slows down the agency's work. CMS also must compete for the Secretary's attention with other large agencies such as the NIH, CDC, and the FDA. Particularly since September 11, 2001, the Secretary has devoted a considerable amount of attention to bio-terrorism issues.

Large, complex administrative agencies can function well and with considerable autonomy within departments, but also can be effectively managed without being part of a department (NAPA 1984). The choice of whether to place an agency within a cabinet department or to make it independent relates to the tension in government between the President as a centralizing focus and the myriad of constituencies that represents particular interests. As a general rule, it is preferable to link a government agency to a cabinet department. Without a member of the cabinet to defend it, an independent agency tends to be at the mercy of narrow interests that may influence relevant Congressional committees. By contrast, a cabinet secretary is better positioned to defend his or her department against encroachment.

In considering the desirability of making CMS independent of HHS, policymakers must consider several factors. One is the importance of the roles played by HHS in Medicare administration and whether CMS could be expected to fill those roles as well if made independent. Another is the potential benefit of making the CMS administrator directly and fully accountable to the President for the performance of the agency. This must be counterbalanced, however, against the value of the political buffer from the influence of constituencies and the additional layer of oversight and input into decisions and actions that the Secretary furnishes.

The panel considered the example of the Social Security Administration (SSA). In 1935, when the Social Security program was created, it was run by an independent agency, but President Franklin Roosevelt brought it into a larger agency as part of a reorganization of the executive branch shortly before the U.S. entered World War II. Debates about whether SSA should be an independent agency began anew in 1981, when the

National Commission on Social Security strongly recommended that SSA become independent again. Congress debated the issue for almost 15 years, until it passed legislation in 1994 that made SSA an independent agency. When the bill was enacted, members of Congress maintained that it would increase SSA's stature, promote long-term stability of the Social Security program, increase the public's confidence in the program, and protect SSA from the cross-fire of partisan politics (Conference Report on H.R. 4277 1994) (Social Security Administration Reform Act 1999).

The SSA example is instructive because SSA and CMS have some similarities. Both administer programs that help vulnerable people meet critical needs, and both disburse funds. Key differences are in agency size (approximately 65,000 SSA employees, which makes it comparable to the entire staff of HHS, compared with only about 4,500 employees at CMS and 22,500 contractor staff) and in program complexity. SSA's basic function is to determine eligibility and provide monthly benefits, but CMS' work is infinitely more complex, and involves a much broader array of stakeholders. SSA also has a direct relationship with its beneficiaries because it makes payments to them every month. In contrast, CMS makes payments to providers on behalf of beneficiaries, which may weaken beneficiaries' identification of CMS as the source of Medicare benefits. Another key difference is that CMS directly affects a significant sector of the economy, while SSA does not.

There have been no formal studies of SSA's independence, although most observers seem to think it has generally had a positive effect. However, the SSA's effectiveness was proba-

bly compromised to a certain degree initially because its first Commissioner failed to win Senate confirmation.

One former Administrator, Bruce Vladeck, and a colleague, Barbara Cooper, surveyed more than 25 experts on Medicare, including representatives of providers and beneficiaries, Congres-sional staff, and current and former CMS executives to determine what could be done to make Medicare better (Vladeck 2001). They recommended that CMS be made an independent agency, similar to SSA, to increase its responsiveness and flexibility.

THE INDEPENDENT BOARD MODEL

Establishing an independent board to manage the participation of private health plans in Medicare is an important component of some Medicare reform plans. These proposals stem from two sources: a desire to remove Congress from the details of Medicare by giving the board authority to deal with matters that currently come to Congress; and a belief that an inherent conflict exists between administering a government-run fee-for-service system and a system of private managed care plans in the same agency.

Under one proposal, Congress would establish a board appointed by the President, but operating independently of the executive branch and, thus, not accountable to the President. The board would report directly to Congress, set program policy, and manage a staff responsible for administering a system of competing plans. CMS would continue to administer one of the plans, i.e. the existing FFS program, but would report to the board. In a variant of that proposal, the

board would be responsible for only some functions, including beneficiary education and the M+C program, while CMS would continue to administer FFS Medicare, and would report to the Secretary.

One advantage of a Medicare board would be greater administrative flexibility in managing the M+C program. The board would have greater independence from the executive branch. The Federal Reserve Board, for example, is capable of choosing whether to coordinate its economic policies with those of the Treasury Department; because of its independence from the executive branch, it is free to do otherwise (Merlis 2000). Potential disadvantages of a board include: a lack of coordination between the FFS and M+C programs, absence of accountability to the executive branch or Congress, and a weakening of leadership. Questions have also been raised, but not resolved, about whether this type of board violates the separation of powers clause in the Constitution. The DOI argued that at least two aspects of the board model could be unconstitutional, while the American Law Division of the CRS argued that Congress has broad and far-reaching authority over how executive branch agencies are structured (Raben 2000).24

Some critics of the Medicare board model maintain that creating an independent Medicare board could result in inconsistent treatment of Medicare beneficiaries (depending on which entity was responsible for their care), confusion among beneficiaries and providers, conflicting regulations, and potentially duplicative staff functions (CRS 2001). For example, beneficiaries switching back and forth between traditional FFS Medicare and

Other proposals, including one passed by the House of Representative in the 106th Congress, and now being considered again, would obviate this problem by placing the board under the direct authority of the Secretary.

M+C would be served by different agencies. This would create an extra burden for beneficiaries dropped by their M+C plan and who live in an area not served by another M+C plan. Since 1999, 327,000 beneficiaries have found themselves in this situation (CRS 2001).

Some have questioned whether an independent Medicare board would be sufficiently accountable. Under some proposals, the Medicare board is not designed to be accountable to the President or the executive branch. In testimony before the Senate Finance Committee, HCFA Administrator Nancy-Ann Min DeParle pointed out that the President would have virtually no authority over one of the most important federal programs (DeParle 2000). Questions have also been raised about whether the board would be accountable to Congress.

The third issue relates to the relative value of moving from a single administrator to a multimember board. With some exceptions, such as SSA and the Small Business Administration, Congress tends to place a board structure at the top of independent agencies. From a public administration perspective, the value of a board depends largely on whether the independent agency has operational or regulatory responsibilities.

In most cases, the creation of a board detracts from, rather than enhances, the capacity and accountability of a government agency with operational responsibilities, like CMS. Examples of independent agencies with operating responsibilities that are governed by boards of directors include the Export-Import Bank of the United States, the Tennessee Valley Authority, the Pension Benefit Guaranty Corporation, and the Federal Retirement Thrift Investment Board.

The diversity of viewpoints on a board and the lack of a single locus for accountability tend to impede the organization's ability to undertake effective administration.

Multimember boards are often found in regulatory agencies with quasi-legislative or quasi-judicial responsibilities. In regulatory agencies, and in contrast to operating agencies, divergent opinions among board members are considered helpful for assuring the fairness of a decision. Multimember boards also are helpful in insulating some agencies from potential political interference in their operations, as is the case with the Board of Governors of the United States Postal Service (USPS) and the Federal Retirement Thrift Investment Board. In both cases, the board is charged with appointing the chief executive of the agency. The insertion of a multimember board between the chief executive and the political process is considered valuable in protecting the agency's operations from the kind of untoward political intervention that characterized USPS before its reorganization in 1971. Finally, the Congress may place an independent board at the top of an agency as a way to promote responsiveness to stakeholders. This happened recently with the Internal Revenue Service (IRS) after allegations of unduly harsh IRS collection practices.

THE PERFORMANCE-BASED ORGANIZATION MODEL

Increasing accountability for performance has been a goal in government program administration in recent years. In 1993, the Congress enacted the Government Performance and Results Act, which requires government agencies, including CMS, to develop performance goals and strategic plans for meeting them. Under the law,

agencies must define performance measures to assess their progress in meeting selected goals. Some indications suggest that Medicare's administrative agency lags behind others in adopting a performance-based orientation. For example, GAO recently reported findings from a survey of federal managers showing that CMS' managers were among the least likely to say they were held accountable for results to at least a great extent (GAO 2001e).

The performance-based organization model takes the movement one step further by granting an agency a significant degree of administrative flexibility in meeting established goals. In the 1990s, the Vice President's National Performance Review proposed creation of a new organizational form, known as the Performance Based Organization (PBO). In its pure form, the PBO involves the design of an organization, often located within a larger department, to include a Chief Operating Officer who serves a five-year term. The Chief Operating Officer negotiates a performance contract with his or her superior and is compensated in proportion to the achievement of the annual goals in that contract. In addition, the PBO itself is subject to performance goals. In practical effect, the consideration of PBO status has provided agencies with an opportunity to seek needed management flexibilities, especially in personnel actions and contracting, in return for a commitment to achieving performance goals.

Only two PBOs have been created to date: OSFAP in the Department of Education, and USPTO in the Department of Commerce. The study panel considered the experience of the OSFAP as an example of how PBO status can affect an administrative entity's perfor-

mance, although the OSFAP does not share with CMS a comparable mission in terms of complexity or scope. In general, the panel found that the administrative flexibilities granted to OSFAP have been instrumental in allowing the office to achieve its administrative goals. However, the office's status as a PBO may also have created administrative friction within the department that has undesirable costs.

THE GOVERNMENT CORPORATION MODEL

Another model for Medicare administration and governance that was examined by the panel is the government corporation model. The U.S. Postal Service (USPS) provides an example of this type of structure. Like many, but not all government corporations, it is characterized by considerable potential freedom in personnel management, contracting, and purchasing.

The government corporation is an organizational form that can be quite helpful in supporting the operations of an agency that funds itself by providing business-type services. The corporate form of organization is particularly suited to the administration of government programs which are predominately of a commercial character—those which are revenue producing, are at least potentially self-sustaining, and involve a large number of business-type transactions with the public. In their business operations, such programs require greater flexibility than the customary annual appropriations budget ordinarily permits.

In contrast to PBOs and most other forms of government organization, the government corporation gains the authority to keep its accounts and manage its affairs on a multiyear basis. This can provide considerable flexibility in managing the organization's affairs and permits a business-like approach to making investments. In other words, a government corporation that is financially self-sustaining does not need annual appropriations; it funds itself, instead, from revenues that it generates. For example, the USPS sells mail delivery services, the Tennessee Valley Authority sells power, and the Government National Mortgage Association (Ginnie Mae) charges a fee for guaranteeing mortgage-backed securities.

EVALUATION OF ALTERNATIVE GOVERNANCE MODELS

In considering whether a different governance structure might help Medicare run more efficiently, the study panel considered the words of Hippocrates, "First, do no harm." In order to recommend a different governance structure, the panel would have to judge it clearly superior to the current structure for the long term. In addition, the benefits of adopting an alternative structure would have to outweigh the costs (both fiscal and psychic) of implementing it. Adopting a different governance structure would require consensus, entail considerable use of resources, and slow down, at least for a time, the work of the agency. Research also shows that externally imposed reorganizations are less likely to succeed than internally driven reorganizations because they are less likely to take organizational culture into account, less likely to be rooted in sound policy theory, and more likely to trigger bureaucratic resistance (Gormley 2000).

The study panel also thought it important to consider whether a different governance structure would help lessen Congress's micromanagement of CMS, and the effect of

new structure on the now suboptimal coordination between Medicare and Medicaid. In the study panel's view, a governance model that would weaken coordination between the two programs would be detrimental. In the case of the independent agency model, coordination would be weakened if Medicaid remained a part of HHS, but could be maintained if Medicaid were part of the new agency. The board model, especially a board independent of the executive branch, would likely increase the coordination problems between the two programs.

Based on these considerations, the study panel did not reach consensus that the current governance structure is fatally flawed or that one of the alternative models should be adopted in its purest form. The panel members held widely divergent views about whether other governance structures would be preferable. Some panel members thought that one or more of the governance models could be customized to fit the particular circumstances of CMS. A number of members found promise in the model of Social Security as an independent agency and suggested that the Social Security Administration's experience in moving to independent agency status and its track record since independence be studied further to see if CMS could benefit by becoming an independent agency. However, other members cautioned against the independent agency approach because CMS would lose the advocacy and protection of the Secretary. In their view, the current governance structure is appropriate, although some structural separation of FFS and M+C within CMS would help allay concerns about inherent conflicts of interest between the two. The panel also discussed the merits of streamlining the HHS departmental review process, so that CMS can

operate more efficiently. Such an approach might relieve some of the most critical problems CMS has as an operating agency of HHS without the disadvantages of independence.

Some panel members viewed the board model, which would report directly to Congress and, thus, not be accountable to the President, as a desirable model for governing Medicare+Choice. They said it could improve administrative capacity and offer increased flexibility, if the board were structured to be independent of any executive agency. Some panel members also urged consideration of a board that would be located within HHS and thus accountable to the Secretary and the President. Other panel members, who opposed the board, expressed concerns about Congress' ability to hold the board accountable for sound decision-making and the constitutionality of an independent board. Further, they said that a program as large and vital as Medicare ought to be accountable to the President.

Some panel members expressed the view that the fundamental problem stems more from the detailed nature of the statute than the governance structure. One possible remedy for that would be changing Medicare to be more like FEHPB so that Congress would not have to be nearly as involved as they are now.

Two of the models were judged not suitable for CMS. The study panel concluded that the PBO model was probably not appropriate for CMS as a whole, although the concept might be useful in managing contractors. While its administrative flexibilities would be advantageous to CMS, they also have the potential to make the relationship between HHS and CMS counter-productive. In their view, many of the advantages of being a PBO could be conferred on CMS through specific changes in legislation, without actually changing its governance structure. The precedents for PBOs also seem to be for organizations with a narrower mission and not nearly the same scope in policy-making.

The study panel also viewed the government corporation model as not well suited to Medicare program administration. Successful examples of this model normally have a defined way of generating revenue to become financially self-sustaining. Since CMS offers few business-type services to the public, this model does not seem to be applicable.

Chapter 5: Conclusions and Recommendations

The study panel used its framework (capacity, accountability, and credibility) to evaluate how well the governance and administration of Medicare is serving beneficiaries and taxpayers. In the study panel's view, many of the agency's problems are reaching a critical level. In an open letter to Congress and the Executive more than three years ago, three former administrators, health policy experts, and advocates warned of an impending management crisis that threatened to cripple the agency (Butler 1999). Lack of resources, both human and financial, and insufficient administrative flexibility are the primary problems. GAO said, "Relative to the size of private health insurers and their administrative budgets, HCFA runs Medicare on a shoestring. As we and others have reported, too great a mismatch between the agency's administrative capacity and its designated mandate could leave HCFA unprepared to handle Medicare's future population growth and medical technology advances" (Scanlon 2000).

Recommendation 1

Medicare policy makers should act now to address administrative and management issues in CMS, regardless of whether Congress takes action on broader Medicare reform.

Despite an apparent consensus and a growing sense of urgency that CMS cannot fulfill all of its responsibilities, neither the administration (under both Presidents Clinton and Bush) nor Congress has proposed actions to strengthen the agency. To be fair, several members of Congress have offered Medicare

reform proposals that would restructure CMS, and most discussion has been focused on Medicare reform, with administrative and management issues subsumed in that debate. But Congress appears further from enacting Medicare reform now than it was three years ago, while pressure on CMS continues to grow. The study panel believes these problems are threatening to imperil the work of the agency, especially if no relief is in sight. Therefore, the study panel recommends that Medicare policymakers act now to alleviate the administrative and management issues that keep CMS from functioning more effectively.

Recommendation 2

A panel of independent experts should be appointed to prepare an analysis of the impact on Social Security and its stakeholders of the transition from an operating agency of HHS to an independent agency, as well as its ongoing performance. The report should include an analysis of the implications of such a change for CMS.

In its evaluation of alternative governance models, the study panel did not find one so clearly superior that it would recommend its adoption. However, the panel was intrigued by the independent agency model, and thinks that it could have considerable promise for CMS. While the SSA's move to independent agency status seems to be regarded favorably, no formal evaluation has been conducted, or commissioned. In addition to shedding light on the performance of the new agency, such a study would be helpful to policy-makers in

understanding what the change entailed, and whether any problems arose during implementation. The study panels recommends that such an evaluation be undertaken to determine whether moving to independent agency status would help CMS better accomplish its work.

CAPACITY ISSUES

Recommendation 3

In order to enable CMS to fulfill its responsibilities, Congress should increase administrative funding for the agency.

In the study panel's view, many of the agency's shortcomings can be attributed to a lack of resources to fulfill all of the responsibilities it has been given. Medicare is a very complex program to administer, and has become more difficult with the passage of several major pieces of Medicare legislation in recent years. Congress has also given CMS major new responsibilities outside of Medicare, including oversight of private health insurance and administrative simplification in HIPAA and the SCHIP in BBA.

In the study panel's estimation, CMS simply does not have the capacity to meet all of the demands on it. This shortage of resources manifests itself throughout the agency in many ways: inability to implement laws on the timetable required, uneven oversight and management of the contractors that pay Medicare claims, and archaic information systems. While not all the agency's problems can be attributed to resource constraints, the study panel thinks that many problems could be alleviated by giving the agency more resources.

Recommendation 4

In the absence of a decision by Congress to fundamentally reform Medicare or provide substantial new investment of resources, both financial and human, the study panel urges Congress not to enact major changes to the program in the near term because CMS does not currently have either the resources or the capacity to implement such changes in a timely fashion while managing the existing program and the changes enacted in the last few years. The study panel also urges Congress to shift its focus from micromanaging CMS to giving the agency more administrative latitude to accomplish the goals Congress sets for it.

While the study panel believes that Congressional oversight of Medicare is crucial, given its share of the federal budget and its importance to beneficiaries and the health care system, it thinks that both the number and the highly specific content of laws passed in recent years have severely taxed the agency's ability to comply with the requirements imposed on it. In addition to enacting detailed legislation, Congress is also very involved in agency matters on an ongoing basis. Congressional committees, including not just authorizing and appropriating committees, but also oversight committees, have held scores of hearings, which require significant preparation on the part of administration witnesses. Congress has also requested a large number of GAO reports on Medicare, to which the agency typically issues a formal response. Moreover, the volume of telephone calls and letters to the agency from members of Congress has increased over time; responding to them on a timely basis has proved to be a significant challenge for the agency.

In the panel's view, the agency would benefit from some respite in implementing new laws and in greater administrative flexibility. Perhaps even more importantly, the study panel believes that both the Congress and CMS would benefit from a greater sense of trust and comity, and urges a public dialogue on how that might be accomplished.

Recommendation 5

Congress should consider removing from CMS some functions not directly related to Medicare or Medicaid so that the agency can focus more on its core missions. Some functions that might be removed from CMS include oversight of the Clinical Laboratory Improvement Act (CLIA) and responsibilities in the Health Insurance Portability and Accountability Act for oversight of private health insurance and simplification of health business transactions.

To reduce CMS' responsibilities, policymakers could consider removing some of CMS' current functions that do not pertain directly to Medicare or Medicaid or some functions that could be performed by other organizations. It is important to recognize that if functions were removed from CMS, another agency would require funding to perform those tasks. Transferring funding along with the functions would defeat the goal of making more resources available to CMS. In that case, the only goal that might be served is allowing CMS to concentrate on fewer responsibilities.

Functions that could be moved out of CMS include any of the following:

 oversight of private health insurance plans under HIPAA,

- responsibility for administrative simplification under HIPAA, and
- **a** administration of the CLIA.

Some functions, such as administrative simplification, oversight of private health insurance plans, and enforcement of CLIA, do not relate directly to Medicare's central mission, and could probably be moved to another agency without jeopardizing either those functions or Medicare itself. Some would argue that giving CMS responsibilities that are not part of its core mission has undermined its ability to effectively administer Medicare.

The issue of moving Medicaid and SCHIP out of CMS is complicated because many beneficiaries are dually eligible for both programs. Coordination between Medicare and Medicaid (primarily through state governments) has long been sub-optimal. Many Medicare beneficiaries, particularly those who live in the community, do not know that they may also be eligible for Medicaid or for assistance in paying Medicare premiums. They do not receive the additional benefits offered by Medicaid, including the prescription drug benefit that so many beneficiaries need. Better coordination of benefits between the States and the federal government is also needed to ensure that Medicaid is the payer of last resort. Because putting Medicaid and SCHIP under a different agency would probably further erode the coordination of the two programs, the study panel does not recommend it.

Some have proposed moving M+C outside of CMS to an independent board or to OPM. However, these proposals appear to stem more from a belief that CMS either does not have the appropriate expertise in contracting with health plans or has a bias

against managed care than from a belief that the agency has too many responsibilities. If M+C administration were moved to another agency, a great deal of thought would be required so that beneficiaries would not be confused, or have to deal with two separate Medicare agencies. These could be particularly problematic for beneficiaries who switch back and forth between traditional Medicare and M+C.

Recommendation 6

Congress should furnish CMS with multiyear funding to develop and implement improved information systems. CMS should seek expert guidance and assistance in implementing these systems.

The study panel is concerned that CMS is operating hundreds of archaic information systems that are sorely in need of replacement. Modern information systems are vital to helping Medicare accomplish its core mission. Since its successful Year 2000 conversion, the agency has made good progress in developing new information systems architecture, but much work remains. The year-toyear nature of appropriations has hampered the agency's development of long-term plans because funding is only assured for one year at a time. More stable and predictable funding would help CMS to implement a longterm plan for information systems, as would recruitment of staff with expertise in designing and implementing highly complex systems.

Recommendation 7

Congress should authorize the President to appoint, subject to Congressional

approval, the Administrator of CMS to a fixed term and furnish protection against arbitrary removal. Congress should increase the salary of the administrator to reflect better the stature and responsibilities of the position. The CMS administrator's salary should be commensurate with the Commissioner of the Social Security Administration.

In an effort to create more stability in Medicare program administration, the study panel supports the notion of giving the CMS Administrator additional authority and political insulation by appointing the Administrator to a fixed term.²⁵ This approach maintains accountability to the President but provides the Administrator with greater independence. GAO has reported that the experience of other agencies whose heads have been given fixed-term appointments suggests that this action will result in longer administrative tenure, but will not prevent a President from removing an Administrator when necessary (Scanlon 2000). While the study panel recognizes that the evidence about whether a fixed term increases longevity is inconclusive, particularly with respect to the Surgeon General, it believes that proposals that might lead to increased longevity warrant consideration.

The administrator's job, as director of the second largest domestic program, is surely one of the most demanding in government. The study panel thinks it would be appropriate to increase the administrator's compensation to reflect better the demands and responsibilities of the position. As a benchmark, the salary of the Commissioner of the Social Security Administration (\$166,700) seems appropriate.

²⁵ This policy option was presented by William Scanlon of the U.S. General Accounting Office in testimony before the Senate Finance Committee on May 4, 2000.

Recommendation 8

Congress should grant CMS some relief from both limitations on salary and civil service personnel rules to recruit and retain staff with technical skills (such as actuaries or information systems experts) or highly sought-after expertise.

Since its inception, Medicare has grown dramatically in size and complexity, but its staff has not grown at nearly the same rate. In addition to needing more staff, the agency also needs staff with more complex technical skills. The agency also would benefit from staff with more private sector and clinical experience. However, both salary limitations and the civil service personnel requirements hinder the agency in recruiting and retaining staff with the skill mix and expertise it needs to manage such a complex program. Some relief from these requirements would be beneficial to CMS, particularly in recruiting staff with technical or other highly sought-after expertise.

ACCOUNTABILITY AND RESPONSIVENESS

Recommendation 9

To recognize Medicare's economic, social, and budgetary impact, as well as its role in the nation's health care system,

Congress should establish a joint committee, without legislative authority, to serve as a source of information and analysis.

In the study panel's estimation, CMS is sufficiently accountable to the Congress, GAO, and the OIG. The program is subject to considerable Congressional scrutiny and oversight, from the authorizing and appropriations committees, oversight committees (including the Senate Special Committee on

Aging), and individual members of Congress. At Congress' behest, the GAO is also very involved in Medicare oversight. It has issued numerous reports on Medicare in the last several years that include numerous recommendations. From the agency's perspective, it expends considerable resources in fulfilling the increasing number of requests it gets from multiple Congressional committees, members of Congress, and the GAO.

The study panel thinks that both Congress and the agency might benefit if a special joint committee of the House and Senate were established to coordinate Congressional oversight of Medicare and give Congress independent technical expertise on Medicare. The committee could help Congress overcome the lack of institutional knowledge and expertise that has resulted from a high rate of Congressional staff turnover. The joint committee could be modeled on the existing Joint Committee on Taxation, which consists of five members each from the House Ways and Means Committee and the Senate Finance Committee, which have jurisdiction over taxation and revenue. The Joint Committee on Taxation does not have authority to legislate on revenue and tax matters; it exists to gather data, conduct research and investigations, and provide estimates of proposed tax or revenue bills. It is widely respected as a repository of information about tax policy, and Congress relies extensively on its work.

If the Medicare joint committee were structured in the same way, it would include members from the House Committee on Ways and Means, The House Committee on Energy and Commerce and the Senate Committee on Finance. The joint Medicare committee could advise the committees on

how to align better the requirements in Medicare law with the resources available to fulfill these duties. The joint committee also could work with CMS to explore the feasibility of various policy options being considered in Congress and advise Congress on whether they could be implemented in accordance with Congress' wishes. The committee could also examine ways in which Medicare law and regulations could be streamlined.

On the issue of responsiveness, the study panel's view is that CMS attempts to be responsive to Congress in most matters, but is not fully successful. CMS works closely with Congress and its staff, and the administrator and other senior executives testify frequently before Congressional committees. The administrator and other staff also meet often with members of Congress and staff. On that level, the agency is very responsive to Congress.

In terms of implementing provisions according to the timelines set forth in law, the agency has been less successful. Some of the delays related to the BBA were caused by an explicit agency decision to postpone implementation of some provisions until the agency was certain that its information systems were Year 2000 compliant. In other cases, the agency simply has not been able to meet the time frames specified in law, although some have questioned whether Congress set realistic implementation dates. And, despite several attempts to redesign its correspondence to produce more timely answers to members of Congress and key stakeholders, CMS has not yet been able to demonstrably increase its response time. It should be noted, however, that the volume of correspondence, particularly from members of Congress, has increased dramatically

over the last several years. Some of the letters relate to Medicare policy options being debated in Congress, but a considerable number pertain to highly technical matters, sometimes involving specific health care providers, making it more difficult to respond quickly.

The agency has recently taken some steps to improve its responsiveness. Under Administrator Thomas Scully's leadership, CMS has created a number of industry forums to listen to key stakeholders and has announced its intent to publish regulations on only one day per month to make it easier for stakeholders to identify relevant regulations. Mr. Scully has also instituted measures to improve the timeliness of responses to correspondence.

Recommendation 10

Congress should enact legislation that gives CMS more flexibility to contract with new organizations to process Medicare claims. Additional resources should be provided to contractors to enable them to meet the responsibilities with which they are entrusted. CMS should build service standards for customer service in contracts and devote more attention to assuring that information supplied to health care providers is timely, accurate, and easily understandable.

Until recently, CMS has not made providing timely, accurate, and appropriate assistance to health care providers a priority for Medicare contractors. Emphasis had been placed, instead, on paying claims on a timely basis and on payment safeguards. As a result, customer service and provider education have been inconsistent and of uneven quality. In large measure, lack of focus on provider education has been the byproduct of extremely

scarce resources and more pressing demands to focus on payment safeguard activities. Because of legal constraints in contracting authority, CMS also has had limited flexibility to take work away from poorly performing contractors.

Recommendation 11

Congress should provide resources to CMS to provide more assistance to beneficiaries with Medicare-related problems by telephone, via the internet, or by establishing Medicare help desks in Social Security field offices. In any case, those helping beneficiaries should have access to beneficiaries' claims records.

CMS has made substantial progress in improving both the quality and the quantity of educational materials to beneficiaries. The Medicare and You handbook has been improved; a 24 hour-a-day telephone call center is available to beneficiaries; the Medicare website provides comparative information for local areas on Medicare +Choice plans, nursing homes, ESRD facilities, and Medigap plans; and CMS regional offices hold numerous outreach activities to help beneficiaries understand their health choices. Still, Medicare is an exceedingly complex program and many Medicare beneficiaries do not understand the program sufficiently to make informed choices. In addition, most beneficiaries and their families do not have access to assistance to resolve problems relating to their own care. The study panel thinks that CMS should devote more resources to beneficiary education and problem resolution. In their view, it would be particularly

useful if those helping beneficiaries had immediate (on-line) access to their health records, and if beneficiaries could obtain assistance in person.²⁶ The study panel believes that CMS should consider establishing beneficiary assistance centers in some Social Security field offices.²⁷

Recommendation 12

To assure that beneficiaries and their families have the information they need to make informed choices about Medicare, Congress should provide adequate funding for the National Medicare Education Program.

The study panel views an effective education program for beneficiaries and their families as essential to helping them understand a complicated program and make informed choices. The National Medicare Education Program has accomplished much since its creation, and needs to be funded adequately in the future.

CREDIBILITY

In the study panel's view, CMS faces enormous challenges to its credibility. Critics of the agency vastly outnumber its supporters. While the study panel's review of Medicare found significant shortcomings in the agency's management of Medicare, it also found real strengths. Medicare is a functioning program that pays its bills on a timely basis. As the largest single purchaser of health care in the U.S., its payment systems and coverage policies are widely emulated in the private sector. Most Medicare beneficiaries

Access to medical records would be contingent upon compliance with privacy regulations that require approval from a beneficiary or the beneficiary's designated representative.

²⁷ Vladeck and Cooper recommended this in Making Medicare Better.

also report that they are happy with the care they get through Medicare.

Many of the problems identified in Medicare management stem from a lack of resources to administer the program appropriately. Some of the criticism levied against CMS stems from philosophical differences about the structure of Medicare as a defined benefit program operating primarily in a fee-for-

service environment. While Congress and others continue to debate the future of Medicare, the study panel urges Congress to take action now to strengthen one of America's most important programs. The study panel also urges CMS to focus on providing better services to its business partners by reducing inappropriate bureaucratic obstacles wherever possible.

References

Adler, Gerald S., "A Profile of the Medicare Current Beneficiary Survey," *Health Care Financing Review* 15 (4): 152-163, 1994.

Berenson, Robert A., Director of the Center for Health Plans and Providers, Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services, "Regulatory Complexity in Medicare and Comparisons to the Private Sector," written statement to the Medicare Payment Advisory Commission, Washington, DC, September 13, 2001.

Butler, Stuart M., and Moffit, Robert E., "The FEHBP as a Model for a New Medicare Program," *Health Affairs* 14 (4): 47-61, 1995.

Butler, Stuart M., et al., "Open Letter to Congress and the Executive: Crisis Facing HCFA and Millions of Americans," *Health Affairs* 18 (1): 7-10, 1999.

Centers for Medicare and Medicaid Services, Office of the Actuary, Baltimore, MD, personal communication based on Budget of the United States, Spring 2002a.

Centers for Medicare and Medicaid Services, Baltimore, MD, personal communication, Spring 2002b.

"Conference Report on H.R.4277, Social Security Administrative Reform Act of 1994 (House of Representatives-August 11, 1994)," Congressional Record H7915-H7925, August 11, 1994.

DeParle, Nancy-Ann, Administrator, Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services, testimony before the U.S. Senate Committee on Finance, Washington, DC, May 4, 2000.

Gormley, William T, Professor, Department of Public Policy, Georgetown University, "Medicare, Accountability, and Structural Reform: Final Report to the Assistant Secretary for Planning and Evaluation," unpublished report prepared for the U.S. Department of Health and Human Services, Washington, DC, September 5, 2000.

Gray Panthers v. Thompson, 139 F. Supp. 2nd 66, 76 (D.D.C. 2001).

Henry J. Kaiser Family Foundation, *Medicare Chart Book* (Washington, DC: Kaiser, 2001).

Mangano, Michael, Acting Inspector General, U.S. Department of Health and Human Services, testimony before the U.S. Senate Committee on Finance, Washington, DC, April 25, 2001.

Merlis, Mark, "Administration of a Medicare Premium Support Program," *Competition with Constraints: Challenges Facing Medicare Reform* (Washington, DC: Urban Institute, 2000).

Morris, Lewis, Assistant Inspector General for Legal Affairs, U.S. Department of Health and Human Services, testimony before the U.S. Senate Special Committee on Aging, Washington, DC, July 26, 2001.

National Academy of Public Administration, *The Social Security Administration:*Management Reforms as a Part of Organizational Independence, (Washington, DC: NAPA, May 1984).

Raben, Robert, Assistant Attorney General, Office of Legislative Affairs, letter to Senator Jay Rockefeller, U.S. Congress, Washington, DC, April 20, 2000.

Scanlon, William J., Director, Health Care Issues, U.S. General Accounting Office, "21st Century Challenges Prompt Fresh Thinking About Program's Administrative Structure," testimony before the U.S. Senate Committee on Finance, Washington, DC, May 4, 2000.

Scully, Thomas, Administrator, Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services, testimony before the Health Subcommittee of the U.S. House Committee on Ways and Means, Washington, DC, September 25, 2001.

"Social Security Administrative Reform Act of 1994-Conference Report (Senate-August 5, 1994)," Congressional Record S10875-S10877, August 5, 1994.

Stanton, Thomas H, "Fraud-and-Abuse Enforcement in Medicare: Finding Middle Ground." *Health Affairs* 20 (July/August): 28-42, 2001. Note: This article is based on a study conducted for NASI in January 2001.

- U.S. Congress, Congressional Research Service, *Medicare Structural Reform: Background and Options*, prepared by Jennifer O'Sullivan, Hinda Chaikind, and Sibyl Tilson (Washington, DC: July 24, 2001).
- U.S. Congress, General Accounting Office, Medicare: HCFA's Use of Anti-Fraud and Abuse Funding and Authorities, GAO/HEHS-98-160 (Washington, DC: 1998).
- U.S. Congress, General Accounting Office, Medicare: 21st Century Challenges Prompt Fresh Thinking About Program's Administrative Structure, T-HEHS-00-108 (Washington, DC: May 4, 2000).
- U.S. Congress, General Accounting Office, *Medicare Information Systems Modernization Needs Stronger Management and Support*, GAO-01-824 (Washington, DC: September 2001a).

- U.S. Congress, General Accounting Office, Medicare Management: CMS Faces Challenges to Sustain Progress and Address Weaknesses, GAO-01-817 (Washington, DC: July 2001b).
- U.S. Congress, General Accounting Office, Medicare Management: CMS Faces Challenges in Safeguarding Payments While Addressing Provider Needs, GAO-01-1014T (Washington, DC: July 26, 2001c).
- U.S. Congress, General Accounting Office, Medicare Fraud and Abuse: DOJ HAS Improved Oversight of False Claims Act Guidance, GAO-01-506 (Washington, DC: March 2001d).
- U.S. Congress, General Accounting Office, *Medicare Management: Current and Future Challenges*, GAO-01-878T (Washington, DC: June 19, 2001e).
- U.S. Congress, General Accounting Office, Medicare: Successful Reform Requires Meeting Key Management Challenges, GAO-01-1006T (Washington, DC: July 25, 2001f).
- U.S. Department of Health and Human Services, Office of the Inspector General, *Medicare's Oversight of Managed Care: Implications for Regional Staffing*, HHS IOG (Washington, DC: April 1998).
- U.S. Department of Health and Human Services, Health Care Financing Administration, *Medicare 2000: 35 Years of Improving Americans' Health and Security*, (Washington, DC: July 2000).
- U.S. Department of Health and Human Services, Health Care Financing Administration, *The Health Care Financing Administration & Its Programs*, (Washington, DC: April 24, 2001a).
- U.S. Department of Health and Human Services, CMS Press Office, *The New Centers for Medicare and Medicaid Services (CMS)*, (Washington, DC: June 14, 2001b).
- U.S. Department of Health and Human Services, Office of Evaluation and Inspections, *A Brief History of the HHS Office of Inspector General*, prepared by Genevieve Nowolinski, (Washington, DC: HHS, June 2001c).
- U.S. Department of Health and Human Services, Office of the Inspector General, *Beneficiary Awareness of Medicare Fraud: A Follow-up*, prepared by Janet Rehnquist, OEI-09-00-00590 (Washington, DC: November 2001d).
- U.S. Department of Health and Human Services, Office of Inspector General, Fiscal Year 2002 Work Plan-Centers for Medicare and Medicaid Services, (Washington, DC: 2002).

Vladeck, Bruce C. and Cooper, Barbara S., *Making Medicare Work Better* (New York, NY: Institute for Medicare Practice, 2001).

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