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Administrative Challenges in Managing the Medicare Program

by
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FOREWORD

Since its inception in 1965, Medicare has helped improve the health of millions of individuals and has protected them from being impoverished by their medical expenses. However, as the federal health care program for over 40 million older Americans and certain persons with disabilities, Medicare is a large and complicated program, and effective management is critical to its success. Policymakers discussing whether and how Medicare should be reformed to continue meeting the needs of its beneficiaries would be well served by recognizing the range of responsibilities that are involved in administering the program.

This paper describes the scope of activities necessary to manage the Medicare program and identifies challenges faced by federal administrators in performing these tasks. The study was conducted by Michael E. Gluck, Ph.D.[1] and Richard Sorian[2] while at Georgetown University's Health Policy Institute. For the purposes of this study, the authors performed a review of existing literature as of the spring of 2002 and conducted extensive interviews in the fall of 2001 with individuals knowledgeable about Medicare management and policy. Thus, the scope of activities involved in administering the Medicare program which is addressed in this paper generally excludes prescription drug-related activities and other administrative requirements resulting from the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. In addition, the impact of recently enacted legislation increasing funding to State Health Insurance Assistance Programs (SHIPs) is not addressed.

The authors focus on administrative tasks that are of particular importance to beneficiaries. These include: (1) educating and informing Medicare beneficiaries; (2) using information technology as a tool in performing functions such as paying claims; (3) making national coverage determinations for Medicare; and (4) administering private health plans. The paper also highlights other administrative tasks, including combating waste, fraud, and abuse in Medicare and ensuring that Medicare beneficiaries receive high quality care.

The paper does not present recommendations but, rather, describes challenges and cross-cutting issues the federal government faces in performing the range of Medicare administrative tasks. This analysis provides valuable information to policymakers and policy researchers about ongoing issues that need to be considered in administering the Medicare program.

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Executive Summary

Medicare was enacted by Congress in 1965 to give America's older adults access to comprehensive, affordable health insurance. At the time, nearly half of Americans age 65 and older had inadequate health insurance coverage. Since 1965, Medicare has helped improve the health and extended the lives of millions of elderly Americans. Furthermore, it has protected a generation of elderly Americans from being impoverished by their medical bills.

For most of Medicare's history, Congress and the executive branch have wrestled with potential reforms of the program, and there remain fundamental divisions about what shape the Medicare program should ultimately take. In addition, continuing concerns about the cost of the Medicare program, its ability to meet the health care needs of current and future beneficiaries, and heightened criticism from providers have led policymakers to pay attention to another very important question: What management infrastructure is necessary to administer this program? Medicare is an enormous and complicated program, and effective management is critical to its success.[3]

Most Medicare policies are set by the U.S. Congress and implemented by the executive branch of the federal government. Currently, the federal agency with primary responsibility for managing Medicare is the Centers for Medicare and Medicaid Services (CMS) — until July 2001 known as the Health Care Financing Administration (HCFA) — within the U.S. Department of Health and Human Services (HHS). CMS is also the lead federal agency for Medicaid, a federal-state program that has provided health insurance to very low-income people since 1965; and the State Children's Health Insurance Program created in 1997 to expand health insurance coverage for low-income children.

This paper describes the scope of activities necessary to manage the Medicare program and identifies several challenges federal administrators face in performing these tasks. Because research for this paper was completed prior to the passage of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), new responsibilities and resources created by this and subsequent legislation are generally not included in the analysis.[4] Few observers or analysts would disagree that the MMA

[3] By management, the authors refer to the overall administration of the Medicare program including processing and paying claims, developing payment methodologies, implementing legislation, interacting with various contractors, combating fraud and abuse, monitoring and assuring quality of care, and providing information to beneficiaries and others about the program and its operation.

[4] For example, changes to Medicare include: establishing a new Medicare Part D for outpatient prescription drug coverage, effective in 2006, and a discount card program that operates in 2004 and 2005; renaming Medicare+Choice (Medicare Part C) as Medicare Advantage; establishing new preventive benefits; consolidating the functions of fiscal intermediaries and carriers into a single category of Medicare Administrative Contractors (MACs) as of October 2005 and requiring CMS to contract with MACs through a competitive bidding process subject to standard federal rules; adding $1 billion for administration of the Medicare program (a relatively small amount given the additional responsibilities the legislation entails); income-relating the Medicare Part B premium (i.e., charging additional premiums to those with higher incomes) starting in 2007; indexing the Part B deductible to the annual increase in Part B costs starting in 2006 after increasing the deductible from $100 in 2004 to $110 in 2005; instituting a demonstration program for beneficiaries requiring chronic care; implementing a competitive system between Medicare Advantage plans and original Medicare starting in 2010; providing hospitals with financial incentives to submit data on quality of

creates additional administrative challenges for the Medicare program and CMS. In fact, some interviewees for this study expressed the concern that, if Congress enacted a benefit in an area of health care with which CMS has little experience, CMS might not have the flexibility, time, or money to obtain the expertise needed to implement the law successfully.

The analysis concludes that resources for Medicare's burgeoning administrative and management tasks are woefully inadequate; that Medicare officials are torn by conflicting roles and demands; that congressional involvement in Medicare management has been increasing; that relations between Medicare and health providers have been strained; that there are uncertainties about the functions of CMS and its regional offices; and that questions remain about the role of CMS itself.

Background

The Medicare program serves about 40 million older Americans and persons with disabilities (about 12 percent of the U.S. population), pays more than 900 million claims each year, and contracts with more than 1 million health care providers. In FY 2003, Medicare's budget was $273 billion, making the program the second largest component of the U.S. domestic budget. Because Medicare is the largest single payer of health care costs, its practices and policies affect the activities of thousands of private health insurance plans, health plans, and medical facilities. The program also plays a critical role in the economy of communities, states, regions, and the nation as a whole.

The original Medicare program established by Title XVIII of the Social Security Act in July 1965 had two parts, which remain today:

- **Medicare Part A (hospital insurance)** covers inpatient hospital services, skilled nursing facility care, hospice care, and some home health care. All people (1) age 65 or older who have paid Social Security taxes for at least 40 quarters or (2) under age 65 and eligible for Social Security Disability Insurance cash benefits qualify for Medicare Part A benefits.[5] Part A is primarily financed through mandatory payroll contributions to the hospital insurance trust fund maintained by the U.S. Treasury.
- **Medicare Part B (supplementary medical insurance**) covers physician services, lab services, medical equipment, outpatient hospital care, and home health care services not covered by Part A. Unlike Part A, Part B is voluntary for elderly and disabled people eligible for Social Security cash benefits. Part B is mostly financed through premiums and general revenue subsidies, which are paid to the supplementary medical insurance trust fund maintained by the U.S. Treasury.

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care; and enacting certain other provider payment changes. The MMA also included a three-year demonstration program in which Medicare specialists will provide assistance to beneficiaries in at least six Social Security Administration (SSA) offices that have a high volume of beneficiary visits. Congress added a payment option for Medicare Advantage plans in 2004 and 2005: 100 percent of the Medicare fee-for-service payment.

[5] Individuals under age 65 with end-stage renal disease (ESRD) who paid Social Security taxes for at least 40 quarters are also eligible for Medicare.

The Social Security Amendments of 1972 (Public Law 92-336) broadened Medicare to provide health insurance coverage to two other population groups that were having difficulty obtaining such coverage: people under age 65 who receive Social Security disability cash payments for at least 24 months and people with end-stage renal disease who require maintenance dialysis or a kidney transplant.

The Balanced Budget Act of 1997 (Public Law 105-33) established a third part of Medicare: **Medicare Part C (Medicare+Choice).** This program, which became effective January 1, 1999, expanded Medicare beneficiaries' options beyond the traditional fee-for-service Medicare program to include managed care plans such as health maintenance organizations (HMOs), private fee-for-service health plans, and Medical Savings Accounts.[6] Individuals enrolled in a private Medicare plan are entitled to the same items and services for which benefits are available under Part A or B. A private Medicare plan may also provide its enrollees with additional health care items and services not covered under the traditional Medicare program.[7]

Scope and Methods of the Study

Managing a program as large and complex as Medicare entails the performance of several important administrative tasks by the federal government and its contractors. This paper describes a number of those tasks and identifies some of the challenges involved in their performance.

Four tasks of particular interest to Medicare beneficiaries and providers are focused on in depth:

- Educating and informing Medicare beneficiaries about their benefits, rights, and options;
- Using information technology as a tool for Medicare administrative tasks such as processing claims; combating waste, fraud, and abuse; and maintaining and improving quality;
- Making national coverage decisions for medical services, procedures, and technologies provided to beneficiaries; and
- Administering private Medicare plans.

In addition, the paper discusses several other administrative tasks that are essential to Medicare management: (1) determining eligibility and collecting premiums; (2) implementing Medicare payment systems; (3) selecting and managing Medicare contractors (e.g., contractors that process Medicare claims); (4) combating waste, fraud, and abuse in Medicare; (5) ensuring the quality of health care services provided to Medicare beneficiaries; and (6) supporting research and demonstration projects pertaining to Medicare. The concluding chapter of the paper highlights several cross-cutting issues and challenges for the federal government in performing these tasks.

[6] As of December 31, 2002, no Medical Savings Accounts were participating in Medicare.

[7] Many people in the traditional Medicare program also have a Medigap (Medicare supplemental insurance) policy or supplemental coverage provided by their former employer to help pay health care costs that Part A and Part B do not cover.

For the purpose of this study, the authors performed a review of existing literature as of the spring of 2002, including oral and written histories of the program, reports and government documents, news accounts, and congressional testimony. To supplement the literature review, the authors conducted 37 structured telephone interviews with national experts in Medicare management and policy in the fall of 2001. Interviewees represented a wide range of relevant experiences, philosophies, and political parties. In order to evoke candid responses, interviewees were promised that they would not be quoted directly.

Key Findings

The central findings of this study are as follows:

Diversity and complexity of administrative tasks involved in managing Medicare. The tasks involved in managing Medicare include (1) determining eligibility for Medicare; (2) collecting Part B premiums from beneficiaries; (3) educating and informing Medicare beneficiaries about their benefits, rights, and options; (4) processing and paying Medicare claims; (5) implementing Medicare payment policies (i.e., developing and implementing payment methodologies, and setting and updating Medicare payment rates); (6) administering private Medicare plans; (7) selecting and managing Medicare contractors; (8) rendering coverage determinations for medical services, procedures, and technologies; (9) combating fraud and abuse in Medicare; (10) ensuring the quality of services provided to Medicare beneficiaries (i.e., setting standards for health care facilities and other providers to participate in Medicare, and overseeing quality improvement efforts); and (11) supporting Medicare research and demonstration projects. In recent decades, the administrative tasks have become increasingly diverse and complex.

Adequate performance by CMS and its contractors of their core responsibilities. CMS and its contractors perform many of their core responsibilities well. CMS has developed new and innovative payment mechanisms, complied with often difficult statutory deadlines for implementing congressionally mandated reforms, and, of late, worked effectively to reduce Medicare payment error rates and overpayments. The Medicare contractors that process claims usually do so in a timely manner.

Grossly inadequate funding for Medicare administration and management. The overwhelming conclusion of this paper, like that of other assessments, is that federal funding for the administration and management of Medicare is grossly inadequate. In recent decades, the need for administrative resources to manage Medicare in the best interests of Medicare beneficiaries, health care providers, and U.S. taxpayers has been increased by several developments. Congressionally mandated Medicare payment reforms, for example, have moved Medicare from a system of reimbursement based on providers' own costs or charges to a system of administered prices. In addition, Congress assigned CMS several new responsibilities for Medicare and other programs in the Balanced Budget Act of 1997 and other laws.

While the task of managing Medicare has grown more complex, real expenditures for Medicare management activities have declined. In FY 2003, an estimated $3.7 billion was spent on Medicare administration and management activities.[8] From FY 1979 to 2003, administrative spending as a percentage of Medicare benefit payments declined from 3.1 percent of Medicare benefit payments in 1979 to 1 percent in 2003.[9] By comparison, administrative expenses as a percentage of benefit payments in 1998 represented, on average, 5 percent for Medicaid, 12.2 percent for Blue Cross/Blue Shield plans, and 25 percent for commercial insurance plans (which have to spend money on marketing and sales) (Tilson, January 2001).

Insufficient personnel for Medicare administration and management. Medicare's administrative resource problems also include inadequate numbers of skilled personnel. In 1999, CMS employed 4,139 full-time equivalent employees (nearly 600 fewer than it employed in 1979). Given the size and complexity of Medicare and the other programs CMS oversees, the number of people employed by CMS has been relatively small. In 1999, almost a third of the CMS employees worked in the agency's 10 regional offices and another 385 worked exclusively on Medicaid. By comparison, the Social Security Administration, with an overall budget of $402 billion in 1999, employed about 60,000 full-time equivalent employees.

Furthermore, CMS has had trouble attracting individuals with certain types of training and expertise, particularly medicine and information technology. In addition, CMS has had little success in hiring individuals with experience in managed care or other parts of the private health insurance industry. Because salary restrictions make it difficult for CMS to compete with the private sector for the best and brightest, the agency often has been left without enough professional staff with experience and skills in medicine, statistics and related disciplines, information technology, and private health insurance.

Inadequacy of Medicare's information technology. CMS uses or has the potential to use computers and other information technology as a tool for more effectively and efficiently performing several Medicare administrative tasks:

- Processing Medicare claims;
- Educating and informing Medicare beneficiaries about their benefits, rights, and options;
- Combating fraud and abuse in the Medicare program;
- Supporting Medicare quality assurance and improvement activities; and
- Providing data on the Medicare program needed for analysis and policymaking.

[8] The figure was $4.4 billion if one includes payments to health care quality improvement organizations (QIOs).
[9] Excluding payments to QIOs. The percentage is slightly higher, 1.4 percent, if one includes expenditures for the Health Care Fraud and Abuse Control Account created in 1997. Funds for the Health Care Fraud and Abuse Control Account go to CMS contractors and to parts of the federal government other than CMS.

Interviews conducted for this study, as well as other analyses, suggested that CMS's computer systems were antiquated, inadequate to do their tasks, and without sufficient funding for improvement.

Medicare officials torn by competing roles and demands. Medicare managers reported that they are often torn by competing roles and demands. Medicare managers must attempt to meet the needs of Medicare beneficiaries. They must ensure adequate participation in Medicare by health care providers, but also see to it that providers meet performance and quality standards. To ensure that the program will be available to future Medicare beneficiaries, they must maintain the financial viability of Medicare and the Medicare trust funds, which means, among other things, that they must guard against waste, fraud, and abuse in the Medicare program. Some of these missions are complementary, but others sometimes conflict. Compounding the situation is the fact, that because of Medicare's enormous size, its impact on the health of elderly and disabled beneficiaries, and its potentially huge effect on local and national economies, Medicare managers are often placed under an unforgiving microscope.

Increasing congressional involvement in Medicare policies. In recent years, Congress has sharply increased its level of involvement in Medicare payment and other policies. In the 1990s, Congress enacted six major pieces of legislation affecting Medicare policy, including the far-reaching Balanced Budget Act of 1997, which established the Medicare+Choice program, created prospective payment systems for outpatient hospital departments, home health services, and skilled nursing facilities; created a new cost-containment system for physician fees; and instituted a new Medicare beneficiary education program. And while lawmakers have added to CMS's responsibilities by adding other new programs and responsibilities, they have frequently balked at adding resources to enable CMS to perform these responsibilities.

Strained relations between Medicare and health care providers. In Medicare's early years, lawmakers were criticized for being too deferential to providers in setting payment policies. In recent decades, however, Medicare payment policies have become increasingly restrictive, and CMS has been criticized for being too tough on providers. The federal government's increased focus in recent years on combating health care fraud and abuse has also strained relations between Medicare and health care providers. Many providers believed they have been unfairly targeted for investigation and penalized for errors that are more likely due to unclear guidance from CMS, its regional offices, and its contractors. Cutbacks in contractor funds to educate providers and respond to their inquiries about correct billing practices exacerbated tensions between Medicare and providers.

Ambiguities with respect to the functions of CMS and its regional offices. CMS has 10 regional offices. Although Medicare was designed as a national program with uniform benefits and eligibility rules, these regional offices and Medicare contractors have been permitted considerable leeway in making decisions about what is covered, how contracts are established and managed, and how facilities are inspected and certified.

This somewhat decentralized approach allows Medicare to recognize the regional and local variations in the practice of medicine and delivery of health care, but it can result in a widely varying Medicare program for beneficiaries and providers. Furthermore, beneficiaries and providers complain that they often get conflicting information from the national and regional offices. Recent indications are that CMS is moving toward a more centralized approach to management.

Questions remaining about the role of CMS itself. Given the many challenges faced by CMS, serious questions have been raised about whether the agency should have fewer responsibilities. Should CMS be an agency devoted to the management of Medicare? Or should it have other health policy responsibilities, as it does now?

Conclusion

This paper underscores the magnitude and complexity of responsibilities in managing the Medicare program and identifies several challenges federal administrators face in performing these tasks. These challenges have made it difficult to develop solutions that support the program's ability to make high quality, affordable care available to older Americans and those with disabilities. Furthermore, the challenges outlined in this paper do not even begin to include those that emerge as a result of the nation adopting substantial changes in Medicare's benefits and basic structure.

Chapter 1. Introduction

In many ways, the Medicare program is one of the great success stories of American social policy. Founded on a social insurance model,[10] the program has helped improve both the length and the quality of the lives of the people it serves. Since Medicare's enactment in 1965, elderly Americans have moved from being the least likely to have health insurance to the most likely. Average additional life expectancy at age 65 has increased by nearly 20 percent or three years. The number of older individuals in poverty has declined from 35.2 percent in 1959 to 17 percent in 2000 (U.S. DHHS, HCFA, 2000). Medicare is among the most highly valued public programs in America (National Academy of Social Insurance, Study Panel on Medicare's Larger Role, 1999).

Most Medicare policies are set by the U.S. Congress and implemented by the executive branch of the federal government. The federal agency with primary responsibility for managing Medicare is the Centers for Medicare and Medicaid Services (CMS) — until July 2001 known as the Health Care Financing Administration (HCFA) — within the U.S. Department of Health and Human Services (HHS). CMS is also the lead federal agency for Medicaid (a joint federal-state program for low-income people who cannot afford health insurance) and the State Children's Health Insurance Program established in 1997.

Medicare is an enormous and complicated program that plays a critical role in the health of older Americans and certain individuals with disabilities, and effective management is critical to its success.[11] Recently, continuing concerns about the cost of the Medicare program, its ability to meet the health care needs of current and future beneficiaries, and heightened criticism from providers have led policymakers to pay attention to another very important question: What management infrastructure is necessary to administer this program? Because Medicare is an enormous and complicated program, effective management is critical to its success.

Medicare's management has been an issue of great importance for older persons and those with disabilities, their advocates, public policymakers, and health care providers since the program's inception in 1965. As discussed in Chapter 2, in fact,

[10] Social insurance refers to government-established systems for insuring workers and their families against economic insecurity caused by the cost of health care and the loss of income from work. Social insurance programs (1) are paid for, at least in part, through mandatory contributions, usually from workers and employers, (2) provide benefits from a fund earmarked for the program, and (3) provide benefits defined in law under a single set of rules to all eligible individuals as an earned right (National Academy of Social Insurance, 2001; National Academy of Social Insurance, Study Panel on Medicare's Larger Role, 1999). Social insurance programs in the United States are Social Security (Old Age, Disability, and Survivors' Programs), Medicare, and unemployment insurance.

[11] By management, the authors refer to the overall administration of the Medicare program including processing and paying claims, developing payment methodologies, implementing legislation, interacting with various contractors, combating fraud and abuse, monitoring and assuring quality of care, and providing information to beneficiaries and others about the program and its operation.

questions about the optimal way to administer the new program occupied members of Congress right up until the moment Medicare was enacted and signed.

In recent years, much of the discussion about Medicare's management has focused on the federal agency with primary responsibility for managing Medicare: CMS and its predecessor HCFA. Critics have questioned the agency's ability to perform its Medicare responsibilities. Some of the criticisms and their implications were highlighted in a 2001 report by the U.S. General Accounting Office:

> The agency's [CMS] responsibilities for other programs and activities and its new Medicare responsibilities emanating from recent statutory changes are substantial. Its capacity to carry out these responsibilities has not kept pace. Notably, the agency faces staff shortages in both skills and numbers and is operating Medicare with archaic information technology systems that are unsuited to meet requests for basic management information within reasonable time periods. At the same time, HCFA faltered in adopting a results-based approach to agency management. In addition, constraints exist on the agency's contracting authority, limiting its use of full and open competition to choose claims administration contractors and assign administrative tasks (Scanlon, July 2001).

That the management of the Medicare program continues to be a topic of debate today is perhaps not surprising. With an annual budget of $273 billion in FY 2003, the program serves about 40 million beneficiaries (about 12 percent of the U.S. population), contracts with more than 1 million providers, and processes more than 148 million claims a year (U.S. DHHS, HCFA, 2000). Medicare is one of the nation's largest payers of health care costs, and its practices or policies affect the activities of thousands of private insurance plans, health plans, and medical facilities. Medicare also plays a critical role in the economy of communities, states, regions, and the nation as a whole (Vladeck, 1999). This paper describes the scope of activities necessary to manage Medicare and identifies several challenges federal administrators face in performing these activities. Because research for this paper was completed prior to the passage of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, new responsibilities and resources created by this and subsequent legislation are generally not included in the analysis.[12]

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[12] For example, changes to Medicare include: establishing a new Medicare Part D for outpatient prescription drug coverage, effective in 2006, and a discount card program that operates in 2004 and 2005; renaming Medicare+Choice (Medicare Part C) as Medicare Advantage; establishing new preventive benefits; consolidating the functions of fiscal intermediaries and carriers into a single category of Medicare Administrative Contractors (MACs) as of October 2005 and requiring CMS to contract with MACs through a competitive bidding process subject to standard federal rules; adding $1 billion for administration of the Medicare program (a relatively small amount given the additional responsibilities the legislation entails); income-relating the Medicare Part B premium (i.e., charging additional premiums to those with higher incomes) starting in 2007; indexing the Part B deductible to the annual increase in Part B costs starting in 2006 after increasing the deductible from $100 in 2004 to $110 in 2005; instituting a demonstration program for beneficiaries requiring chronic care; implementing a competitive system between Medicare Advantage plans and original Medicare starting in 2010; providing hospitals with financial incentives to submit data on quality of care; and enacting certain other provider payment changes. The MMA also included a three-year demonstration program in which Medicare specialists will provide assistance to beneficiaries in at least six Social Security (SSA) offices that have a high volume of beneficiary visits. Congress added a payment option for Medicare Advantage plans in 2004 and 2005: 100 percent of the Medicare fee-for-service payment.

[12] Individuals under age 65 with end-stage renal disease (ESRD) who paid Social Security taxes for at least 40 quarters are also eligible for Medicare.

1A. Method of the Study

In preparing this paper, the authors performed a review of existing literature as of the spring of 2002, including oral and written histories of the program, reports and government documents, news accounts, and congressional testimony.

In addition, in the fall of 2001, the authors conducted 37 structured telephone interviews with national experts in Medicare management and policy. Appendix A presents short biographies for all the individuals interviewed for this study as of the time of interview. As the biographies suggest, the interviewees represented a wide range of relevant experiences, philosophies, and political parties. Appendix B presents the instrument used to guide the interviews. In order to evoke candid responses, interviewees were promised that they would not be quoted directly.

1B. Organization of the Paper

The rest of this paper is organized in the following chapters:

- **Chapter 2** provides background on the history of Medicare's administrative structure, noting past decisions that are relevant to the issues before policymakers today.
- **Chapter 3** presents an in-depth discussion of four Medicare administrative tasks of particular interest to beneficiaries and providers: (1) educating and informing Medicare beneficiaries about their benefits, rights, and options; (2) using information technology as a tool for administrative tasks such as processing claims, combating fraud and abuse, and improving quality; (3) rendering coverage determinations for medical services, procedures, and technologies; and (4) administering private Medicare plans.
- **Chapter 4** discusses other Medicare administrative functions: (1) determining eligibility and collecting premiums; (2) implementing Medicare payment systems; (3) selecting and managing Medicare contractors; (4) combating, waste, fraud, and abuse; (5) overseeing quality assurance and improvement activities; and (6) supporting Medicare research and demonstration projects.
- **Chapter 5** concludes by identifying and discussing several issues and challenges that cut across Medicare's administrative functions.

Chapter 2. Historical Background: The Evolution of Medicare Management Since 1965

The law establishing Medicare — Title XVIII of the Social Security Act —was enacted by the U.S. Congress in July 1965. Since then, Medicare's management structure has been shaped by a variety of forces, including decisions made at the time of its enactment, changes in the federal bureaucracy, the introduction of new populations to be served by Medicare, congressionally mandated changes in hospital and provider payment mechanisms, the introduction of managed care plans, and numerous other factors and developments. A timeline of some of the important events in Medicare's history through 2003 is presented in Box 2-A.

The 1965 enactment of the Medicare law followed a decades-long national debate over the appropriate role of government in providing health care coverage to all or part of its citizenry. In creating Medicare, U.S. lawmakers chose to focus on addressing the health insurance needs of people age 65 and older, a segment of the population that the private insurance industry was not serving well (National Academy of Social Insurance, Study Panel on Medicare's Larger Role, 1999). Many of the other compromises that enabled the Medicare law to win its much-delayed victory focused on the management of the program and the role of the federal government in that process. Some of these compromises have had a long-lasting impact on the management of the Medicare program and are discussed further in this chapter.

As background, this chapter also provides a brief overview of the three major periods of Medicare management since the program's inception:

- The early years of Medicare, when it was administered by the Social Security Administration (SSA) within the U.S. Department of Health, Education, and Welfare (HEW) (1965-77)[13];
- The Health Care Financing Administration (HCFA) years of managing Medicare, at first within HEW and then within HEW's successor, the U.S. Department of Health and Human Services (HHS) (1977-2001); and
- The administration of Medicare under the Centers for Medicare and Medicaid Services (CMS), HCFA's successor, which was created administratively within HHS in July 2001.

[13] The Social Security Administration became an independent agency on March 31, 1995.

Box 2-A—Evolution of Medicare Management 1965-2003

1965-1977: The Early Years of Medicare Administration by the Social Security Administration (SSA)

1965: Medicare, extending health insurance coverage to Americans age 65 and over, is enacted by the U.S. Congress and signed into law. The program has two parts: Part A (hospital insurance) and Part B (supplementary medical insurance). Responsibility for managing Medicare is assigned to the U.S. Department of Health, Education, and Welfare (HEW).

1966: HEW assigns Medicare's administration to the Social Security Administration (SSA), an HEW agency with responsibility for administering the Social Security program.

1972: Congress broadens Medicare to cover Americans under 65 with disabilities and end-stage renal disease and takes steps to rein in Medicare spending and improve quality oversight.

1977-2001: The Health Care Financing Administration (HCFA) Era of Medicare Administration

1977: HEW Secretary Califano administratively creates the federal Health Care Financing Administration (HCFA) to oversee Medicare and Medicaid.

1980: HEW is split into two agencies; the U.S. Department of Health and Human Services (HHS) and a separate U.S. Department of Education.

1983: Congress, facing pressures to contain Medicare rising costs, enacts the Social Security Amendments of 1983, replacing Medicare's cost-based hospital reimbursement system with a prospective payment system based on diagnostic-related groups (DRGs).

1996: Congress enacts a major welfare reform act (with implications for Medicaid) and the Health Insurance Portability and Accountability Act of 1996.

1989: Congress enacts a law replacing cost-based reimbursement for physicians with a national fee schedule using a resource-based relative value scale.

1995: SSA becomes in independent federal agency.

1997: Congress enacts the Balanced Budget Act of 1997. In Medicare, the Balanced Budget Act creates Medicare+Choice, giving Medicare beneficiaries a choice of health plans, including managed care plans, private fee-for-service plans, and Medical Savings Accounts; the law also creates prospective payment systems for outpatient hospital departments, home health services, and skilled nursing facilities; creates a new cost-containment system for physician fees; and establishes a new Medicare beneficiary education program. Under HCFA Administrator Vladeck, HCFA is transformed into an organization with major centers for each of the agency's major groups of customers: (1) the HCFA Center for Health Plans and Providers, (2) the HCFA Center for Beneficiary Services, and (3) the HCFA Center for Medicaid and State Operations**.**

1999: Medicare+Choice becomes effective in January. HCFA deals with the Y2K computer system crisis, diverting resources from the implementation of the Balanced Budget Act of 1997. Congress softens or reverses some payment decreases of the Balanced Budget Act.

2000: Congress continues to soften the impact of payment decreases of the Balanced Budget Act.

2001- 2003: Medicare Administration by the Centers for Medicare and Medicaid Services (CMS)

2001: Health and Human Services Secretary Thompson announces in July that HCFA's name is being changed to the Centers for Medicare and Medicaid Services (CMS). The new agency is restructured around (1) the CMS Center for Medicare Management, (2) the CMS Center for Beneficiary Choices, and (3) the CMS Center for Medicaid and State Operations.

2003: Congress enacts the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). One of the most significant features of the law is that it establishes a new Medicare Part D for outpatient prescription drug coverage, effective in 2006, and a discount card program that operates in 2004 and 2005.

2A. Key Decisions Made When Medicare Was Enacted (1965)

Prior to Medicare's enactment, a decades-long national debate over the appropriate role of government in providing health care coverage to all or part of its citizenry pitted numerous political and ideological forces against one another. The American Medical Association, for example, spent years and millions of dollars fighting the Medicare law's enactment. As the congressional debate over creation of the Medicare program neared its end, concerns continued to be expressed about the potential for government intrusion into the practice of medicine. To reassure the medical profession, the hospital industry, and others that the government's role would be minimized and to ensure a smooth startup for the new program, legislators made several compromises with respect to Medicare reimbursement and other matters. The objective was "not to rock the boat and to pay full costs" (Ball, 1995).

Several key decisions made at the time of Medicare's enactment continue to affect the way Medicare is governed today and shape the ongoing debate about how Medicare should be managed:

- **Division of Medicare into Part A and Part B.** The original Medicare program had two parts. The administrative divide between Parts A and B continues today. Medicare Part A (hospital insurance) helps pay for care in a hospital and skilled nursing facility, some home health care, and hospice care. Part A was designed as a social insurance program like Social Security and is financed primarily through mandatory payroll contributions. Medicare Part B (medical insurance), with benefits patterned after the predominant Blue Cross/Blue Shield major medical plan of the day, helps pay for doctors, outpatient hospital care, home health care not covered by Part A, and other medical services. Participation in Part B is voluntary for Medicare beneficiaries. Part B is financed through premiums and general revenue subsidies.
- **Noninterference with the practice of medicine.** The Medicare statute prohibits against any federal interference with the practice of medicine or the provision of medical services (42 U.S.C. § 1395). Although courts have generally upheld this provision,[14] some of the interviewees believed that it has sometimes conflicted with subsequent policy decisions. An example is a 1983 decision by Congress to mandate that Medicare move from a retrospective cost-based hospital reimbursement system to a new prospective payment system for inpatient hospital services; the new payment system, based on diagnosis-related groups (DRGs),[15] has created

[14] *See, e.g., Home Health Care, Inc. v. Heckler*, 717 F.2d 587 (D.C. Cir. 1983) (The imposition of cost limitation mechanisms on Medicare providers is not within the ambit of § 1395). "[I]f . . . [Medicare Approved Charge] program has the effect of introducing financial considerations into the physician's decision concerning the course of treatment to recommend to his patients, the Congress will have achieved it purpose." *Pharmacist Political Action Committee v. Harris*, 502 F. Supp. 1235, 1244 (D. Md. 1980).

[15] Prospective payment is a general term for methods of payment in which the amount of payment for health services is set prior to the delivery of those services. Medicare's diagnosis-related group (DRG) based prospective payment system for inpatient hospital services relies on a mechanism under which Medicare pays hospitals a flat rate per case that varies depending on the patient's diagnosis and other factors.

strong incentives for hospitals to reduce lengths of stay and move care to outpatient settings.

- **Criteria for provider participation in Medicare.** Under the original Medicare program, a beneficiary may obtain health services from any institution, agency, or person qualified to participate in the Medicare program. Language included in the original Medicare statute specified that Medicare would accept any provider willing to participate and meet some minimum standards, an arrangement that now makes Medicare different from most private sector health insurance. Hospitals were allowed to participate in Medicare if they were certified as providing quality health care by a private organization founded by the American Hospital Association known as the Joint Commission on Accreditation of Hospitals, now known as the Joint Commission on the Accreditation of Healthcare Organizations. This process, called "deeming," remains in effect today. Furthermore, the same concept has been extended to other accrediting bodies and other types of health care providers, including health maintenance organizations (HMOs).
- **Reliance on Medicare contractors to process claims.** When Medicare was created, its designers decided to build upon the claims processing expertise of commercial insurers and have these private organizations pay claims for Medicare under contract. A decision was made to utilize private insurance companies — primarily Blue Cross/Blue Shield plans — for claims processing. The use of local Medicare contractors to process Medicare claims in each state continues to this day. When a qualified health care provider or supplier provides medical care to a Medicare beneficiary, the provider or supplier, or in some cases, the beneficiary, submits a claim for Medicare benefits to a local Medicare contractor. In the original Medicare law, the federal government was precluded from using competitive bidding to select contractors to process Medicare hospital claims; hospitals were permitted to nominate the contractor of their choice.
- **Reliance on state-level mechanisms for quality assurance.** Responsibility for the certification of health care facilities to participate in Medicare remained largely with state agencies in 1965, and this arrangement has continued. Responsibility for monitoring the quality of care provided to Medicare beneficiaries remained with physicians and hospitals at the state level. State agencies survey and certify nursing homes, home health agencies, and other health care facilities. As federal quality initiatives have evolved from quality assurance to quality improvement over Medicare's history, the federal government has assumed greater responsibility for the direction and oversight of quality reviews. Nevertheless, the federal government contracts with local organizations called health care quality improvement organizations (QIOs) in each state to carry out those activities.

- **Hospital and physician reimbursement**. In 1965, Congress adopted the private health insurance sector's retrospective cost-based reimbursement system to pay for hospital services provided to Medicare beneficiaries. Compared to hospital reimbursement, Medicare's hospital reimbursement was modeled on the Blue Cross/Blue Shield's "cost-plus" payment system, which initially built a 2 percent "profit" into all Medicare reimbursements. Medicare's initial system of payments to physicians was even more generous, based not on costs but on each doctor's "usual, customary, and reasonable" fees. Although Medicare's early approaches to hospital and physician payment were later abandoned, they contributed to many of the historic inflationary patterns of Medicare spending.
- **Balance billing by physicians.** In 1965, physicians who were not satisfied with the amount Medicare paid were allowed to bill their patients for any additional amount they chose under a practice known as "balance billing." Congress later placed strict limits on the amount physicians can charge their patients, and, now, more than 95 percent of claims are reimbursed on "assignment," with no balance billing.

2B. The Early Years: Medicare Under the Social Security Administration (SSA) (1965-77)

The original Medicare statute assigned responsibility for managing the Medicare program to the U.S. Department of Health, Education and Welfare (HEW). In 1966, HEW Secretary John W. Gardner assigned the administration of Medicare to the Social Security Administration (SSA) within HEW. SSA, which did not have relationships with doctors, hospitals, and other health care providers, was chosen to administer Medicare because it already provided monthly Social Security benefits to older Americans and disabled workers under the Social Security Act of 1935. Most elderly and disabled workers receiving Social Security benefits are also eligible for Medicare benefits.

Social Security benefits are paid out of two trust funds maintained by the U.S. Treasury: the old-age and survivors insurance trust fund (which pays retirement and survivors benefits) and the disability insurance trust fund (which pays disability benefits). For Medicare, Congress established two additional trust funds:

- **Hospital insurance trust fund.** The hospital insurance trust fund has administered income and expenditures for inpatient hospital and related care provided under Part A of Medicare. Income is generated primarily by payroll taxes; employees and employers each pay 1.45 percent of wage earnings (self-employed individuals pay 2.9 percent). Other sources of income include interest earned from trust fund assets and taxation of Social Security benefits (Brangan, 2001).
- **Supplementary medical insurance trust fund**. The supplementary medical insurance trust fund has administered income and expenditures for physician and outpatient services provided under Part B of Medicare.

> The primary sources of income for this trust fund are beneficiary premiums and federal general revenues (Brangan, 2001).

SSA's primary focus was making Medicare operational. With only a year to get the new Medicare program up and running, SSA performed what can only be called a management miracle. A new Bureau of Health Insurance was created within SSA to oversee Medicare and several other offices that supported that effort. In addition, SSA contacted each of the 19 million Americans age 65 and older to enroll them in the mandatory Medicare Part A (hospital insurance) program and ask them to decide whether or not to enroll in the voluntary Medicare Part B (supplementary medical insurance) program. By March 1966, three months before Medicare's launch, a total of 17.2 million older individuals (90 percent of those eligible) enrolled in Medicare Part B. SSA mailed more than 100 million booklets to older Americans and their families informing them of the new program and its options, signed agreements with more than 7,000 hospitals, conducted civil rights surveys,[16] signed contracts with contractors that process claims, and developed standards for paying providers. SSA also opened 100 new local offices and hired 9,000 additional employees (Ball, 1997; Ball, 2001).

The SSA managers of Medicare feared an initial onrush of demand for hospital services and a lack of interest on the part of physicians in participating. Such fears, which did not actually materialize, led to an emphasis by the managers on pleasing, or even placating, providers to ensure their participation in the program. Medicare spending quickly exceeded initial projections — in Medicare's first five years of operation, total reimbursements rose 72 percent, from $4.6 billion in 1967 to $7.9 billion in 1971 (Congressional Research Service, February 2001) — and SSA was increasingly criticized for failing to contain the program's costs.

The 2 percent "profit" paid by Medicare to hospitals was eliminated administratively in 1969. In 1970, however, a Senate Finance Committee report predicted that the hospital insurance trust fund would be insolvent in three years unless taxes were raised or benefits were reduced (Sorian, 1988). The report also noted that Medicare cost-sharing charges were rising rapidly. For example, the Part A inpatient deductible had jumped from $40 per episode of illness in 1966 to $52 in 1970.

In 1972, Congress enacted the Social Security Amendments of 1972, broadening Medicare eligibility to include individuals under 65 with disabilities and those suffering from end-stage renal disease. Annual increases in the Part B premium (originally set to cover 50 percent of Part B costs each year) were limited to no more than the cost of living adjustments in Social Security benefits to ensure that there would be no net decrease in Social Security benefit checks from year to year.[17] It also took a series of steps designed

[16] Initial survey and certification of hospitals included 500 Social Security and Public Health Service employees inspecting, and in effect, desegregating many hospitals—mainly in the South—that had never complied with Title VI of the Civil Rights Act which forbids discrimination on the basis of race (Ball, 1995).

[17] As a result of the 1972 law, the portion of Medicare Part B costs financed by premiums fell to less than 25 percent. Beginning in 1984, Congress set the premium in law at dollar amounts that were intended to be 25 percent of the costs of an average elderly beneficiary. In 1997, legislation specified that the Part B premium be 25 percent of costs, but the dollar amounts that correspond to 25 percent do not appear in law.

to rein in Medicare spending and improve quality oversight (Congressional Research Service, May 2001).

Overall, however, the 1972 Social Security Amendments did little to curtail Medicare's financial hemorrhaging, and SSA continued to receive much of the blame. In 1976, then-Senator Herman Talmadge (D-GA), Chairman of the Senate Finance Committee Subcommittee on Health, proposed legislation (the Medicare-Medicaid Administrative Reform Act) that would have shifted federal responsibility for Medicare management from SSA to a new entity he called the Health Care Financing Administration, or HCFA. The legislation also would have shifted federal responsibility for the Medicaid program, also created in 1965 to serve the health needs of those people with low incomes, from HEW's Social and Rehabilitative Services agency to the proposed new entity (Constantine, 1995; Oberlander, 2001).

2C. The Health Care Financing Administration (HCFA) Years of Managing Medicare (1977-2001)

Senator Talmadge's bill to create HCFA, though not advancing in Congress in 1975-76, sowed the seeds for a dramatic change in Medicare management in 1977, when the Carter Administration reorganized HEW. In March 1977, HEW Secretary Joseph Califano created HCFA using administrative mechanisms. The HEW Secretary believed that HCFA would help to streamline government; coordinate the nation's largest health care entitlement programs — Medicare and Medicaid; and wring administrative savings from the HEW budget (Califano, 1995). Although HCFA's creation did not yield hoped-for administrative savings, it did improve the coordination and interactions between Medicare and Medicaid. Even so, employees for the two programs brought with them different experiences, skills, and mindsets.

HCFA's creation in 1977 coincided with a greater national focus on health care costs. President Carter's unsuccessful attempts to rein in hospital costs through federal regulation set the stage for later efforts to control Medicare hospital costs. The Carter Administration also proposed, and Congress enacted, legislation creating an independent HEW Office of the Inspector General. This office was given much of the responsibility for policing the Medicare program.

The Reagan Administration years in the 1980s ushered in a new era of efforts to contain health care costs and, with it, dramatic changes in Medicare and its management. Congress enacted the Social Security Amendments of 1983, replacing Medicare's cost-based hospital reimbursement system with a prospective payment system for hospitals based on diagnosis-related groups (DRGs), a concept that had been developed and tested by Medicare managers and their partners in states and academia. In 1989, Congress enacted additional legislation replacing cost-based reimbursement of physicians with a national fee schedule utilizing a resource-based relative value scale (RBRVS). These new payment systems represented a sea change for Medicare and HCFA. Implementing these new payment systems and their annual adjustments required a new level of

expertise and represented Medicare's initiation in a system of administered prices. Medicare's prospective payment system for hospitals and Medicare's physician fee schedule were both designed to encourage providers to use resources more efficiently, reversing the incentives under cost-based reimbursement to provide as many services as possible.

The 1980s were also a period of extended political tension between Congress and the federal executive branch. Many lawmakers distrusted the information they were getting from HCFA, believing the President's political appointees were stifling or blocking the flow of information from HCFA to the legislature. One result of this distrust was the creation by Congress in 1983 of an independent commission to advise Congress on Medicare payment policies for hospitals, the Prospective Payment Assessment Commission (ProPAC). In 1986, Congress created another independent commission to take the lead in developing a physician fee schedule and advise Congress on its subsequent implementation, the Physician Payment Review Commission (PPRC). Subsequently, as part of the Balanced Budget Act of 1997, Congress merged ProPAC and PPRC into a single independent commission that advises Congress on payment and other matters pertaining to Medicare, the Medicare Payment Advisory Commission (MedPAC).

The 1990s were another extraordinarily active period of Medicare policy change. During the Clinton Administration, Congress enacted six major laws that affected Medicare and/or increased HCFA's workload:

- **Omnibus Budget Reconciliation Act of 1993.** This statute made numerous payment and other technical changes in the traditional Medicare program administered by HCFA.
- **Personal Responsibility and Work Opportunity Reconciliation Act of 1996.** This broad welfare reform law had a significant impact on the Medicaid program administered by HCFA.
- **Health Insurance Portability and Accountability Act of 1996.** This law was enacted to protect health insurance coverage for workers and their families when they change or lose their jobs. The law required HCFA to monitor state actions to comply with reform of the small group insurance market and, in some circumstances, to step in if a state fails to comply with the act. The Health Insurance Portability and Accountability also addressed the security and privacy of health data. In addition, the law provided new resources and new authority for HCFA, the U.S. Department of Justice, and the HHS Office of the Inspector General to pursue health care fraud. It expanded the functions of the HHS Office of the Inspector General to include coordination of federal, state, and local efforts to combat fraud (U.S. DHHS and U.S. Department of Justice, April 2002).
- **Balanced Budget Act of 1997.** This far-reaching act included 335 provisions requiring HCFA to make changes in Medicare and Medicaid (DeParle, 2001). It also created the State Children's Health Insurance

Program. Among the changes in Medicare were (1) the creation of the Medicare+Choice program; (2) the creation of prospective payment systems for outpatient hospital departments, home health services, and skilled nursing facilities; (3) a new cost containment system for physician fees, known as the sustainable growth rate; and (4) a new National Medicare Education Program to help current and newly eligible Medicare beneficiaries make informed choices about their health care, including their Medicare health plan options under Medicare+Choice. (Congressional Research Service, 2001).

- **Balanced Budget Refinement Act of 1999 and Medicare, Medicaid, and State Children's Health Insurance Program Benefits Improvement and Protection Act of 2000.** These laws softened or reversed some of the payment reductions enacted in the Balanced Budget Act of 1997 by offering provider "givebacks."

In 1997, HCFA also underwent a major internal reorganization under HCFA Administrator Bruce Vladeck. Though this was not the first HCFA reorganization,[18] it was by far the most extensive. The 1997 reorganization transformed HCFA into an organization with centers for each of the agency's major constituencies:

- HCFA Center for Health Plans and Providers;
- HCFA Center for Beneficiary Services; and
- HCFA Center for Medicaid and State Operations.

According to HCFA Administrator Vladeck, the 1997 reorganization had four purposes: (1) to shake up the agency, (2) to focus on providing services to beneficiaries, (3) to integrate the work of the regional offices and get closer to the "customers," and (4) to develop a strategic planning function (Vladeck, 1997). The 1997 reorganization disrupted HCFA at what turned out to be a critical period for the agency and the Medicare program, namely, the time for implementation of the Balanced Budget Act of 1997. Some HCFA managers were critical of the 1997 reorganization and felt it increased their workload (U.S. General Accounting Office, February 1999). Health care plans and providers — managed care organizations, in particular — were upset by the merging of staff that worked on fee-for-service and managed care elements of Medicare and the shifting of employees with whom they had developed strong working relationships.

Finally, it should be noted that in 1999, HCFA also had to deal with the Y2K computer crisis. This required identifying and renovating all of the computer and information systems involved in both Medicare and Medicaid as well as testing the renovated systems multiple times to make sure the systems would work properly at the beginning of year 2000. Issues related to Y2K computer problems also diverted human and financial resources from the implementation of the Balanced Budget Act, causing delay and discontent among both providers and Congress.

[18] In 1981, for example, the Reagan Administration reorganized HCFA by creating a new layer of political appointees known as Associate Administrators to coordinate the agency's activities.

The many accomplishments of the HCFA era of Medicare management did not prevent an onslaught of criticism of the agency's approach to the program and its relationships with providers, states, and Congress. As the 20th century drew to a close, some critics called for the dismantling of the agency and creation of new entities to oversee some or all of Medicare and HCFA's other programs (National Bipartisan Commission on the Future of Medicare, 1999). Other critics, including some members of Congress who introduced legislation to implement their proposals, called for more measured approaches to reforming HCFA.

2D. Medicare Under the Centers for Medicare and Medicaid Services (CMS) (2001-2003)

The latest era of Medicare management was ushered in July 2001, following an announcement by HHS Secretary Tommy Thompson that HCFA's name was being changed to the Centers for Medicare and Medicaid Services, or CMS, and that the new agency was being restructured around three centers that "reflect the agency's major lines of business" (Thompson, 2001). According to the Secretary, his goal in this reorganization was to make the agency "more consumer-oriented, more responsive to the needs of everyone they deal with — the beneficiaries, the providers, the states."

The 2001 reorganization by Secretary Thompson replaced HCFA with CMS and replaced the three centers that had been created in HCFA in 1997 with the following:

- **CMS Center for Medicare Management**. This center focuses on the management of the traditional fee-for-service Medicare program. This includes the development of payment policy and management of Medicare fee-for-service contractors.
- **CMS Center for Beneficiary Choices**. This center focuses on providing Medicare beneficiaries with information on Medicare, private Medicare plans, and Medigap options. It also manages the private Medicare plans, consumer research and demonstrations, and grievance and appeals processes.
- **CMS Center for Medicaid and State Operations.** This center focuses on programs administered and activities performed by the states, including Medicaid, the State Children's Health Insurance Program, the regulation of private insurance under the Health Insurance Portability and Accountability Act, survey and certification of nursing homes, home health agencies, and other health care facilities participating in Medicare and Medicaid, and the Clinical Laboratory Improvement Amendments of 1988.

Time — and many other factors — will tell whether Secretary Thompson's vision for Medicare management will come any closer to reality than those of HEW Secretary Califano or HCFA Administrator Vladeck.

The debate over the appropriate structure and thrust of Medicare's management continued in the early 2000s with proposals coming from Congress and elsewhere. These congressional proposals differed in content, but many shared common themes, some of which were included as part of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), which President George W. Bush signed into law in December 2003.

Chapter 3. Medicare Administrative Tasks of Particular Interest to Beneficiaries and Providers

Managing Medicare requires the federal government to undertake a number of complex and diverse administrative tasks, among them: (1) determining eligibility for Medicare; (2) collecting Part B premiums from beneficiaries; (3) educating and informing Medicare beneficiaries about their benefits, rights, and options; (4) processing and paying Medicare claims; (5) implementing Medicare payment policies (i.e., developing and implementing payment methodologies, and setting and updating Medicare payment rates); (6) administering private Medicare plans; (7) selecting and managing Medicare contractors; (8) rendering coverage determinations for medical services, procedures, and technologies; (9) combating fraud and abuse in Medicare; (10) ensuring the quality of services provided to Medicare beneficiaries (i.e., setting standards for health care facilities and other providers to participate in Medicare, and overseeing quality improvement efforts; and (11) supporting Medicare research and demonstration projects.

This chapter focuses in depth on four administrative tasks that must be performed if Medicare beneficiaries are to receive covered services and providers are to receive reimbursement for those services:

- Educating and informing Medicare beneficiaries about their benefits, rights, and options;
- Using information technology as a tool for administrative tasks such as processing claims, combating waste, fraud, and abuse, and improving quality;
- Making national coverage decisions for medical services, procedures, and technologies provided to Medicare beneficiaries; and
- Administering private Medicare plans.

3A. Educating and Informing Medicare Beneficiaries

The Medicare program is far too complex for beneficiaries to negotiate without information and assistance. In addition, some Medicare beneficiaries face the challenges of illness and disability, which may impede their ability to comprehend information provided to them (Hibbard et al., 2000).

Medicare beneficiaries and their families have a variety of information needs. Some beneficiaries and families have questions about benefits, cost sharing, and other aspects of Medicare. Some Medicare beneficiaries need to resolve problems with specific services and claims. The creation of the Medicare+Choice program by the Balanced Budget Act of 1997 increased Medicare beneficiaries' needs for information about the new health plan choices available to them under Medicare+Choice, including health maintenance organizations (HMOs), preferred provider organizations, provider sponsored organizations, and private fee-for-service plans. Given the increased likelihood of serious illness and limited incomes among the Medicare population, making a wrong health plan choice may have more serious implications for the Medicare population than it would for a younger, healthier population.

The roles of the Centers for Medicare and Medicaid Services (CMS) and its partners in educating and informing Medicare beneficiaries about their benefits, rights, and options are the primary focus of the discussion that follows. Also discussed in this section are the roles in providing education and information to Medicare beneficiaries played by the Social Security Administration (SSA) and by the contractors that process Medicare claims.

1. The National Medicare Education Program

A key part of CMS's educational efforts is the National Medicare Education Program, begun as a result of the Balanced Budget Act of 1997. Through the National Medicare Education Program, CMS makes available a variety of materials such as the *Medicare & You* handbook and partners with a number of private organizations at the local level to help ensure that Medicare beneficiaries have adequate informational resources to make decisions about their health care. In FY 1999, federal funds available to the National Medicare Education Program for beneficiary education and information were $136 million; they were reduced to $123 million in FY 2000 and to $117 million in FY 2001 (Swanson, August 2001).

CMS Materials. From 1997 to mid-2001, most responsibilities for educating and informing Medicare beneficiaries rested with the Center for Beneficiary Services within the Health Care Financing Administration (HCFA). With the CMS reorganization of June 2001, these responsibilities were transferred to the new CMS Center for Beneficiary Choices.

As discussed below, CMS makes information and education available to Medicare beneficiaries in several forms:

- *The Medicare & You* handbook and other publications;
- A toll-free Medicare hotline that operates 24 hours a day, seven days a week; and
- Medicare beneficiary-oriented website on the Internet.

Medicare & You Handbook. Medicare has always had literature available to beneficiaries explaining the program, its coverage, and beneficiaries' responsibilities. In 1996, HCFA sent every beneficiary an early version of the handbook. Since 1997, HCFA/CMS has invested significant resources in revising the *Medicare & You* handbook to make it clearer and more accessible for its elderly and disabled audiences. The Balanced Budget Act of 1997 mandated that the handbook be sent out annually. (Prior to 1997, the *Medicare & You* handbook was distributed sporadically.) Currently, the *Medicare & You* handbook is mailed every fall to all Medicare beneficiary households and each month to new enrollees. Several interviewees from outside of CMS praised the agency for this work.

The 2001 *Medicare & You* handbook, which was mailed to Medicare beneficiaries in the fall of 2000, included an overview of Medicare, descriptions of the rights and protections afforded to Medicare beneficiaries, and descriptions of health plan options, including HMOs and private fee-for-service plans, available to Medicare beneficiaries in their own communities. The consensus among interviewees was that the *Medicare & You* handbook has evolved significantly since the Balanced Budget Act and that it can be a useful reference, even at a later date when information is needed. Nonetheless, several interviewees questioned the strategy of making the handbook such a significant part of the agency's own educational efforts. The lengthy *Medicare & You* handbook can be daunting, particularly for beneficiaries who face functional limitations that affect their abilities to use it (e.g., poor eyesight or memory problems).[19] According to beneficiary advocates interviewed for this project, Medicare beneficiaries sometimes throw it away when they receive it.

Toll-Free Medicare Hotline. Effective October 1, 2001, CMS offers a toll-free telephone hotline, 1-800-MEDICARE (1-800-633-4227), with telephone counselors available 24 hours a day, seven days a week, to respond to questions from Medicare beneficiaries and their caregivers. The call centers that operate the hotline and answer inquiries work under contract to CMS. CMS promotes the toll-free hotline in the *Medicare & You* handbook, Medicare benefits statements (i.e., the Medicare Summary Notice[20]), other communications with Medicare beneficiaries, and the major media.

[19]The *Medicare & You* handbook is available in audiotape, Braille, large print, and Spanish to help deal with some of these problems.

[20] The Medicare Summary Notice is discussed later in this chapter in Box 3-A. For additional information, see http://www.medicare.gov/Basics/SummaryNotice.asp.

The beneficiary advocates interviewed were generally positive about Medicare's toll-free hotline. Nonetheless, several of them noted that the toll-free Medicare hotline has important limitations:

- **Inability to respond to callers' individual circumstances**. In an effort to ensure that information provided to Medicare beneficiaries is current, consistent, and accurate, the telephone counselors work from scripts of answers to the questions most commonly asked by beneficiaries. Counselors read the scripted answer to the question most similar to the question that the beneficiary actually asks. This approach makes it difficult to respond to individual circumstances.
- **Inability to answer questions pertaining to Medicare claims**. The Medicare hotline emphasizes Medicare's benefits, cost-sharing, basic information about program operations that affect beneficiaries, and health plan choices. Telephone counselors lack access to information from databases of contractors that process claims that would allow them to deal directly with individual beneficiary claim-related problems. To help with questions and problems they cannot resolve using their information and training, the telephone counselors refer beneficiaries to Medicare contractors and to other organizations in their area.

Medicare Beneficiary-Oriented Website on the Internet. A Medicare beneficiary-centered, consumer-oriented website — www.Medicare.gov — was launched by HCFA in June 1998. This website provides a broad array of information on program benefits, health system performance, health care choices, healthy behaviors, and health promotion. One of its features is the *Medicare & You* handbook. In addition, the website hosts tools for comparisons of beneficiary choices. The first was Medicare Compare, which contains detailed comparisons of the benefits, costs, consumer satisfaction survey results, and standardized quality measures of available managed care plans across the country.[21] Medicare Compare allows users to find detailed information on traditional benefits and cost sharing as well as private Medicare plan offerings and Medigap policies available in their zip codes.

The beneficiary advocates interviewed for this study reported that the Internet is a more useful tool for people who counsel beneficiaries about their health care choices than for most Medicare beneficiaries, although increasing numbers of beneficiaries do have access to the Internet. One beneficiary advocate suggested that, as the current population of increasingly computer-literate workers ages into Medicare, the Internet may become a more central mechanism to educate and provide customer service to Medicare beneficiaries, provided that the federal government invests appropriate resources in Medicare website.

[21] More recent tools that provide comparative information to facilitate choices by beneficiaries include Nursing Home Compare, Home Health Compare, and Dialysis Facility Compare.

Other Components of the National Medicare Education Program. In addition to the CMS materials just discussed, the National Medicare Education Program includes the following components, which are briefly described below (U.S. DHHS, HCFA, March 2000):

- National Alliance Network;
- Beneficiary counseling from State Health Insurance Assistance Programs (SHIPs);
- National Train-the-Trainer Program:
- Regional Education About Choices in Health Campaigns (REACH); and
- Citizens' Advisory Panel on Medicare Education.

National Alliance Network. CMS has enlisted over 200 national and local organizations to participate in the National Medicare Education Program. Organizations in this public-private partnership work on behalf of elderly and disabled people to perform outreach to Medicare beneficiaries to help them understand changes in the Medicare program and to provide input on the types of questions and problems that beneficiaries are encountering.

Beneficiary Counseling From State Health Insurance Assistance Programs (SHIPS). The most prominent members of the National Medicare Education Program Partnership Alliance Network in many parts of the country are SHIPs. As of February 2001, there were 53 SHIPs in the country (one in each state plus the District of Columbia, Puerto Rico, and the U.S. Virgin Islands) — 37 are run by state aging administrations, and the other 16 are administered by the state insurance commission (SHIP Resource Center, February 2001; SHIP Resource Center, March 2001). SHIPs received about $16 million per year in FY 1999-2001 from CMS to provide assistance to Medicare beneficiaries.[22] In addition to providing help with Medicare, SHIPs can assist beneficiaries with questions about supplemental and long-term care insurance. SHIPs rely largely on volunteer counselors — often retirees — to work with beneficiaries and their families.

Interviews with SHIP directors in three states, as well as with several other individuals inside and outside of CMS who have worked with SHIPs, elicited the following observations:

[22] These funds included an $11 million base that is divided among the states according to a formula where 75 percent of a state's funds are based on the state's proportion of all Medicare beneficiaries in the country, 15 percent is based on the proportion of the state's beneficiary population that resides in rural areas, and 10 percent is based on the proportion of the state's total population that are Medicare beneficiaries. An additional $5 million a year has been allocated in recent years to State Health Insurance Assistance Programs (SHIPs) for special projects such as peer mentoring and web-based training for Medicare+Choice. Some states have supplemented these resources with funding of their own (SHIP Resource Center, February 2001; SHIP Resource Center, March 2001).

- **Insufficiency of federal funding for SHIPs**. Federal funding for SHIPs is insufficient given the complexity of Medicare and insurance that supplements it. Funding levels have generally reflected the federal government's decision to rely heavily on outside organizations to assure that beneficiaries have adequate information to make their health insurance decisions.
- **Variation in SHIPs' ability to meet Medicare beneficiaries' needs**. The ability of SHIPs to meet Medicare beneficiaries' needs can vary significantly from state to state. In part, a SHIP's ability reflects whether the SHIP has funds from the state or other organizations to supplement the federal funds it receives. It also depends on the extent to which the SHIP has developed close working relationships with Medicare contractors and the CMS regional office to help its counselors resolve beneficiaries' problems. And finally, it depends on the SHIPs' ability to recruit, retain, and adequately train (with the help of the National Medicare Education Program) a sufficient pool of good volunteers.

***National Train-the-Trainer Program*.** This program gives individuals from CMS's partner organizations in the alliance network across the country training related to private Medicare plans and other changes to the Medicare program so that they have the information and tools they need to teach others.

Regional Education About Choices in Health Campaigns (REACH). Each of CMS's 10 regional offices and coalitions of local partners organizations are conducting educational and outreach efforts at the state and local levels to meet the needs of specific groups, such as African Americans, American Indians; Latinos, caregivers, beneficiaries with disabilities who are eligible for Medicare and Medicaid; and rural beneficiaries (U.S. DHHS, HCFA, March 2000).

Advisory Panel on Medicare Education. This panel, which advises CMS about how best to reach beneficiaries to inform them about their benefits and choices, includes a diverse mix of organizations that work with older individuals, disabled persons, and the health care community (U.S. DHHS, HCFA, March 2000). It held its inaugural meeting on February 15, 2000, in Washington, DC.

2. The Social Security Administration's Role in Educating and Informing Medicare Beneficiaries

Although SSA offices may have copies of the *Medicare & You* handbook for Medicare beneficiaries, some interviewees indicated that SSA is not a very useful source of information about the Medicare program for most Medicare beneficiaries. Several beneficiary advocates indicated that, in their experiences, Social Security district offices usually refer beneficiaries with questions about Medicare to Medicare's toll-free hotline or to other sources of help if they know about them.

In the early years of the Medicare program, when SSA had primary responsibility for the management of the program, SSA could call 1,500 Social Security district offices

to provide information and resolve consumer problems. Today, however, the Medicare program is far more complex, and the primary responsibility for managing the program rests with CMS rather than with SSA. Analysts looking at SSA's role in Medicare after HCFA took on the lead agency role in 1977 have noted that "Social Security offices throughout the country ceased to regard Medicare's administrative matters as their business" (Marmor, 1988).

3. Medicare Contractors' Role in Educating and Informing Medicare Beneficiaries

Much of the administration of Medicare is done by private organizations under contract with CMS. The largest category of Medicare contractors is those that process Medicare claims. Other Medicare contractors include (1) health care quality improvement organizations (QIOs), formerly known as peer review organizations (PROs), that perform quality assurance and improvement activities for Medicare; (2) state agencies that survey and certify nursing homes, home health agencies, and other health care facilities; and (3) organizations participating as private plans in the Medicare program. As discussed below, both Medicare contractors that process claims and QIOs play a role in informing Medicare beneficiaries about the Medicare program.

Informational Role of Contractors that Process Claims. When a health care provider or supplier or, in some cases, a beneficiary, submits a claim for Medicare benefits, then a local Medicare contractor[23] determines whether the item or service provided meets the standard of reasonable and necessary. This determination is made with guidance from CMS.

When Medicare beneficiaries have questions about their Medicare fee-for-service bills, including questions about coverage and the scope of benefits, therefore, they are likely to turn to contractors that process claims. Questions posed by Medicare beneficiaries include the following:

- How does one read the provider's bill explanations?
- What is included in Medicare's benefit package?
- What health plan choices are available to the beneficiary?
- How do the claims listed on the benefit notice forms relate to services received and beneficiaries' cost-sharing obligations?

Several interviewees reported noticeable increases in the time that beneficiaries and their advocates spend on "hold" when they call these Medicare contractors with questions as well as variability in the quality and helpfulness of responses they receive. These contractors may not be the best source of information about health plan choices or other general Medicare questions. Interviews and work by the U.S. General Accounting Office (US. General Accounting Office, July 1999) indicate that even these contractors can have trouble providing information about claims they have processed.

[23] A contractor that processes claims has been referred to as either a fiscal intermediary (for Part A claims and specified Part B claims) or a carrier (for Part B claims not processed by fiscal intermediaries).

A Medicare beneficiary's first contact with a contractor may be the receipt of a Medicare Summary Notice (see Box 3-A). CMS has been overseeing a transition from Explanation of Medicare Benefits and Medicare Benefits Notices to the Medicare Summary Notice forms. In order to design a user-friendly Medicare Summary Notice, CMS engaged expert consultants and beneficiary advocates and conducted focus groups with beneficiaries. Even so, the Medicare Summary Notice is not without its critics. One beneficiary advocate interviewed expressed a preference for the older Explanation of Your Medicare Part B Benefits form and its Part A counterpart. In her experience, Medicare enrollees found the Medicare Summary Notice confusing when there was more than one claim on a form, especially if a claim is denied or partially denied. Two other interviewees found little practical difference between the older and newer forms; in their experience, Medicare beneficiaries require help understanding all of the forms.

Another potentially confusing notice that a Medicare beneficiary may receive is the Advance Beneficiary Notice. This notice, which must be delivered by the provider prior to the service and signed by the beneficiary, advises a beneficiary before he or she receives a service from the provider that the provider does not believe that Medicare will pay for the service and that the beneficiary will be fully responsible for payment if Medicare denies the claim. An Advance Beneficiary Notice allows a Medicare beneficiary to make informed decisions about whether to receive a service that is likely to be paid for out of pocket.

Box 3-A. Medicare Summary Notices

A Medicare Summary Notice is a recently designed form intended to replace the older Explanation of Your Medicare Part B Benefits, the Medicare Benefit Notice (Part A), the Explanation of Medicare Benefits (Part A) and Benefit Denial letters. A beneficiary receives a Medicare Summary Notice if any claims for services, medical equipment, or supplies are filed on his or her behalf during the previous month. Unlike the older forms, a Medicare Summary Notice includes information on all Part A and B claims received during the month.

Medicare Summary Notices are sent to Medicare beneficiaries for several reasons: (1) to make sure Medicare beneficiaries know what services are being billed to Medicare on their behalf (as an anti-fraud mechanism); (2) to keep beneficiaries informed of deductibles they have met, numbers of days remaining in their lifetime reserve of hospital days, and other items related to their Medicare benefits and obligations; and (3) to instruct beneficiaries who have questions about information on the forms to call the appropriate contractor.

In 2003, funds to Medicare contractors that process claims for beneficiary communications were at $166.5 million, or around $4 per beneficiary. Beneficiary advocates and representatives of Medicare contractors indicated that they believed these funds have been inadequate for the task of providing good customer service.

Informational Role of Health Care Quality Improvement Organizations (QIOs). CMS has developed performance-based contracts with QIOs to improve patient outcomes nationwide. These organizations, as noted in Chapter 4, are also a resource for Medicare beneficiaries who have complaints about the services they receive.

4. Administrative Issues Related to Medicare Beneficiary Education and Information

Medicare benefits, cost-sharing obligations, and other aspects of the program are complicated and not easily understood. Most Medicare beneficiaries are covered through fee-for-service Medicare, but the types of health plans and benefits available under Medicare increased under the Medicare+Choice program established by the Balanced Budget Act of 1997.

A review of activities related to the provision of education and information to Medicare beneficiaries raises two basic questions:

- How much should the federal government invest in Medicare beneficiary education and information?
- Should the federal government's resources support the provision of beneficiary education and information by CMS, or should such investments supplement the educational and informational activities of private organizations?

Interviewees suggested a need for additional capacity to help Medicare beneficiaries on a one-on-one basis with their individual needs for education and information pertaining to Medicare, not only about health plan choices but also about other aspects of the Medicare program.

In considering whether the federal government's resources should support the provision of beneficiary education and information by CMS or instead supplement the educational and informational activities of private organizations, one must make tradeoffs. Although CMS may be able to ensure some consistency in the services it provides, it may not know local circumstances and needs as well as private organizations. And while private, local organizations may know local circumstances and needs well, they are likely to vary in how well they are able to provide educational and informational services.

The people interviewed for this study mentioned several approaches to providing education and information to Medicare beneficiaries. Although some interviewees saw funding CMS representatives in SSA offices as the most efficient way to help beneficiaries and raise CMS's visibility, others suggested that the same individualized service could be provided by an enhanced toll-free hotline or increased investments in State Health Insurance Assistance Programs (SHIPs) and other organizations.

3B. Using Information Technology as a Tool for Administrative Tasks

Computer and other information technology is critical to the processing of claims, as well as in the performance of a variety of Medicare administrative tasks. Interviews conducted for this study, as well as analyses conducted by both the then-HCFA (U.S., DHHS, HCFA, 1998) and the U.S. General Accounting Office (U.S. General Accounting Office, Feb. 1999; U.S. General Accounting Office, July 1999) suggested that CMS's computer systems were antiquated, inadequate for their tasks, and without sufficient funding for improvement.

1. Medicare Administrative Tasks That Require the Use of Information Technology

CMS uses or has the potential to use computers and other information technology as a tool for more effectively and efficiently performing several Medicare administrative tasks:

- Processing Medicare claims;
- Educating and informing Medicare beneficiaries about their benefits, rights, and options;
- Combating fraud and abuse in the Medicare program;
- Supporting Medicare quality assurance and improvement activities; and
- Providing data on the Medicare program needed for analysis and policymaking.

Processing Medicare Claims. Many of Medicare's data systems were developed in the early 1970s by Medicare contractors to pay claims. As mentioned in Chapter 2, when Medicare was created, its designers decided to build upon the claims processing expertise of commercial insurers and have these private organizations pay claims for Medicare under contract to the federal government. Each contractor that processes claims created its own system using different logic, programming language, and hardware.[24]

Currently, over 90 percent of all Medicare claims are submitted by providers electronically. The federal government has developed standards for electronic claims submissions, and CMS provides contractors that process claims with software updates that reflect changes in the rules and rates by which Medicare reimburses for covered services.

Educating and Informing Medicare Beneficiaries. As discussed earlier in this chapter, CMS maintains a Medicare beneficiary-centered, consumer-oriented website (www.Medicare.gov), which hosts the Medicare Compare and other databases. Starting

[24] Much of the contractors' software was written in COBOL, a now rarely used business programming language. Computers at the CMS central office rely mainly on COBOL as well. In addition, a large portion of the contractors' software was written in "Model 204," a database language that is now completely abandoned elsewhere (U.S. DHHS, HCFA, July 1998).

with the Medicare Compare database, which lays out Medicare's core benefits as well as private Medicare plan and Medigap offerings in each part of the country, CMS took the first steps in using information technology to help beneficiaries and their families better understand and compare their choices. For example, the Medicare Compare database includes rules on coverage and beneficiary cost-sharing obligations as well as comparative data on performance and quality. Information technology could also help beneficiaries and their advocates resolve problems in billing, payment, enrollment, and coverage of needed services, although its use for this purpose at the moment is limited.

Combating Waste, Fraud, and Abuse in Medicare. Flexibility granted to the agency under the Health Insurance Portability and Accountability Act of 1996 (discussed further in Chapter 4) allows HCFA/CMS to contract with various entities to analyze claims in innovative ways to reduce fraud and abuse. These Medicare contractors and federal agencies use computers, along with paper records, to verify that services for which Medicare has paid were actually delivered, appropriately documented, and otherwise conformed to program rules. Now that the bulk of Medicare claims are paid electronically, information technology is used to determine retrospectively whether the program's bills are paid correctly.

Supporting Medicare Quality Assurance and Improvement Activities. As discussed in Chapter 4, CMS administers the Health Care Quality Improvement Program, a program designed to monitor and ensure the quality, effectiveness, efficiency, and economy of services provided to Medicare beneficiaries. This program involves analyzing data from various sources and changing the patterns of care to remedy widespread shortcomings in the health care system.[25] Information technology can be extremely useful in performing this task. CMS has developed performance-based contracts with health care quality improvement organizations (QIOs), formerly known as peer review organizations (PROs), to improve patient outcomes nationwide. QIOs receive data from a national sample of medical records collected and analyzed by Clinical Area Support Quality Improvement Organizations. Each Clinical Area Support Quality Improvement Organization has been charged with helping CMS and QIOs improve quality in specified high-priority clinical areas that were selected on the basis of their public health importance and the feasibility of measuring and improving the quality of care received by Medicare beneficiaries.

QIOs also need Medicare claims data to respond to beneficiaries' particular complaints about services received (or not received). With appropriate systems and timely data, computers could be used in the future for screening claims prior to or concurrent with the delivery of services to yield faster responses to beneficiary complaints and to help ensure the appropriateness of services and quality of care.

Providing Data Needed for Analysis and Policymaking Related to Medicare. Computers can provide valuable data to help analysts and decision makers develop and update complex payment systems and to understand the consequences of current policy

[25] For more information about the Health Care Quality Improvement Program, see http://www.hcqip.com.

and options for the future. As discussed below, many data exist, but there can be significant lags and gaps in their availability.

2. Limitations of Medicare's Existing Information Technology

Interviewees, as well as analyses conducted by HCFA/CMS (U.S., DHHS, HCFA 1998) and the U.S. General Accounting Office (U.S. General Accounting Office, Feb. 1999; U.S. General Accounting Office, July 1999), revealed a broad consensus that the information technology available to the program is grossly inadequate. Some of the problems with Medicare's information technology that hamper its use in administrative tasks are as follows:

- **Real-time data are not available.** The bulk of Medicare's data systems were developed in the early 1970s by Medicare contractors who still use and maintain them. CMS has access to their databases, but the computers run on an older "batch" basis rather than on "real time." The computers process multiple claims or database requests as a group and produce payments or analysis in the same way. In a "real time" system, the databases are immediately available to an authorized user, usually at a networked desktop computer or terminal. Credit cards, for example, make use of real time data systems. When someone makes a credit card purchase, it is immediately recorded in the computer system of the bank that issued the card. Without real time access to data, there are significant delays in the initial availability of data (e.g., to examine trends in service use or unusual billing practices or answer beneficiaries' questions about services received). If such analyses require multiple, iterative computer runs, the analysis takes even longer. This affects the Medicare program's ability to use information technology to improve quality; to combat waste, fraud and abuse; to answer beneficiaries' questions about billing; and to answer questions from Congress and others involved in Medicare policy analysis and planning. Several experts mentioned that in 2001, policy analysts were only just receiving complete data on the program for 1998.
- **Software is difficult to update**. A second consequence of Medicare's antiquated computer systems is that the software used to pay claims has been "patched" repeatedly to incorporate new payment rules, new benefits, fixes for the Y2K bug, and other changes in the program over the last 30 years. Because many different programmers have made these changes, the software can contain many different "approaches" to writing the code, making it difficult for a new programmer to understand. Multiple changes also increase the possibility of introducing errors in the software that might result in improperly paid claims, delays in payments, and the need to spend money on additional fixes.
- **Computer systems are incompatible between CMS and contractors**. A third limitation of Medicare's computer systems is that they cannot easily "talk" to one another. Although CMS has made significant progress in imposing standardization over what Medicare contractors' software systems need to do, the presence of multiple, largely incompatible systems

of hardware and software limits the Medicare program's ability to pull data easily about different Medicare services to help beneficiaries resolve problems, to analyze quality or program integrity, or to conduct research. The authors' analysis for this paper indicates that the problem is not that Medicare does not have a single system. In fact, one lesson from the attempted Medicare Transaction System (MTS) in the late 1990s was that trying to rely on a single computer system for a program as large as Medicare has distinct disadvantages, as discussed below.

3. Lessons from the Medicare Transaction System (MTS)

In the early 1990s, HCFA sought to revamp a large portion of Medicare's information technology by creating the Medicare Transaction System (MTS). The idea with MTS was to create a single, centralized, and integrated computer system that replaced the multiple systems that now exist for Part A, Part B, Medicare managed care, and the program's eligibility files. The system was to be developed and implemented in four years and to rely on modern, real-time claims processing technology (U.S. DHHS, HCFA, July 1998). The focus of MTS was on Medicare's claims processing, but other administrative functions were contemplated as well.

In January 1994, HCFA contracted with a software developer to create and implement the MTS. Under the original schedule, contractors would have started using the system to process claims in late 1996 with the remainder of MTS to be up and running by the end of 1998. The MTS project experienced delays and went over budget, and as a result, HCFA staggered changes and delayed the project's full implementation. Finally in August 1997, in the face of continued contractor delays, its own dissatisfaction, and congressional scrutiny (U.S. General Accounting Office, February 1999), HCFA decided to abandon the MTS project before the contractors had implemented any of the software systems.

None of the people interviewed, apart from a few current or former congressional staff, described the experience with MTS as a "failure." Although critical mistakes were made, they said, such mistakes may have been unavoidable given the breadth of the information technology problems HCFA was seeking to remedy. In fact, several interviewees said that HCFA's decision to abandon the system in 1997 before it had been implemented compared favorably to decisions made by other government agencies when faced with significant problems in procuring large computer systems. Other lessons to be drawn from the experience with MTS, according to interviewees, included the following:

- **Importance of phased development of integrated computer systems**. Although Medicare's computer systems should be integrated across different services and contractors, changes may best be made in discrete pieces and staggered over time. This would allow CMS to alter later phases of the project to incorporate lessons learned in implementing the earlier phases. It would also provide CMS with additional opportunities to measure how well its contractors are fulfilling their obligations and, if necessary, change contractors.

- **Need for specificity in the scope of work for new computer systems**. The scope of work for developing and implementing the new Medicare information technology system should be as specific as possible. Several interviewees indicated that a lack of specificity in the contract's scope of work contributed to the failure of MTS. They attributed this shortcoming to the agency's difficulties in hiring individuals with an up-to-date understanding of information technology.
- **Advantages of commissioning several prototype computer systems**. CMS should consider commissioning several prototype systems before settling on a single system design and contractor, much as the U.S. Department of Defense does when procuring a new jet fighter. Although CMS would spend some money on systems it would not ultimately develop, it would reduce the risk of contracting with a single firm that might fail. Furthermore, the final information technology system might be able to incorporate the best elements of each of the prototypes.
- **Importance of streamlining the federal process for computer procurement**. A former HCFA official interviewed for this paper suggested that general difficulties in procuring large computer systems in the federal government — difficulties that CMS or U.S. Department of Health and Human Services (HHS) officials cannot remedy by themselves — may have contributed to the problems with MTS. According to this official, HCFA had to report to nine different committees or groups elsewhere within the executive branch as the project proceeded. These groups sometimes gave conflicting opinions or instructions. Possibly a more streamlined procurement process would have helped HCFA manage the project better.

4. Issues Related to Medicare's Information Technology

In the late 1990s, HCFA's Administrator created the position of Chief Information Officer to oversee development of a vision statement for future computer improvements for the agency. The vision statement that was subsequently developed continues to be a basis for CMS's information technology goals (US DHHS, HCFA, 1998).

Many of the lessons learned from the Medicare Transaction System (MTS) identified in the previous section were incorporated in CMS's recent vision statement. In particular, the vision statement suggested that CMS should create a new information technology infrastructure in discrete stages, using a series of centralized, technologically compatible databases to replace the existing system of multiple, decentralized contractor systems as well as CMS's current central office computer system. These mutually intelligible databases, unlike MTS, would support the provision of education and information to Medicare beneficiaries. Beneficiaries could use these databases to seek information about the Medicare program and to resolve specific individual problems. Authorized users could input and draw information from the various databases in real time as needed.

Interviewees, although praising the vision statement for computer improvements and the proposed strategy for implementing it, emphasized that CMS has insufficient funds and personnel to carry out any but the very first steps of this strategy. Several interviewees, including some who noted that they are normally wary of "throwing money" at problems, believe that additional resources are needed to overcome the shortcomings of Medicare's information technology infrastructure. In fact, one interviewee with many years of service at HCFA indicated that money for information technology is CMS's most pressing need.

3C. Making National Coverage Determinations for Medicare

The authority to make decisions about which specific items and services within statutorily allowed categories (see Box 3-B) can be covered by the Medicare program is vested with the HHS Secretary. The HHS Secretary has assigned this task to the CMS Administrator, with assistance from the CMS Coverage and Analysis Group in the Office of Clinical Standards and Quality.

Box 3-B. Statutory Limits on Medicare Coverage

Under Title XVIII of the Social Security Act, Medicare beneficiaries are authorized to obtain health services from any institution, agency, or person qualified to participate in the Medicare program. The act lists categories of items and services eligible for Medicare coverage and specifies that no payment may be made for services that are not "reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member" (Social Security Act, Title XVIII, Section 1862 (a) (1) (A)). In recent years, Medicare has also been statutorily authorized to cover certain preventive services, which are mainly disease screenings.

The vast majority of Medicare coverage decisions are made at the local level by Medicare contractors that process Medicare claims. When a health care provider or supplier, or in some cases, a beneficiary, submits a claim for Medicare benefits, then a Medicare contractor processes the claim. If the Medicare contractor determines that the claim is for an item or service that falls within a Medicare benefit category, is reasonable and necessary for the individual, and is not otherwise statutorily excluded, then it pays the claim. Otherwise, it will deny the claim.

Providers and manufacturers can appeal local coverage decisions through the administrative law judges. Local Medicare contractors are not allowed to make coverage decisions that would expand coverage beyond the statutorily allowed Medicare benefits or that would interfere with national coverage determinations by CMS.

Most local coverage decisions by Medicare contractors are made only for specific claims that have been submitted. In some cases, however, a Medicare contractor may opt to issue a local coverage determination addressing all claims for a certain procedure or service.

In some instances, CMS can review the scientific evidence about the procedure in question and issue a "national coverage determination," i.e., a national policy statement that identifies the circumstances under which a particular service will or will not be covered by Medicare. Prior to issuing a NCD, CMS often requests an assessment of the technology and advice from its Medicare Coverage Advisory Committee made up of outside experts. A national coverage determination is binding on both Medicare contractors and the administrative law judges. The number of national coverage determinations by CMS is relatively small: 40 were issued by CMS in 1999 and 2000, although this represents an increase in the frequency of national coverage determinations in recent years (Olson, 2001).

1. Authority for National Coverage Determinations

Prior to 1997, national coverage determinations for Medicare had been the responsibility of HCFA's Bureau of Policy Development, which also had responsibility for payment policy. In 1997, oversight of Medicare coverage policy was transferred to a newly created Coverage and Analysis Group within HCFA's Office of Clinical Standards and Quality. Assigning Medicare coverage and payment responsibilities to two separate entities, according to some of the interviewees for this paper, was an attempt by HCFA to combat perceptions that coverage decisions were driven by the desire to contain costs.

With the creation of CMS (formerly HCFA) in 2001, federal responsibility for Medicare coverage policy remained with the Coverage and Analysis Group in CMS's Office of Clinical Standards and Quality. CMS usually has reserved NCDs for new or important technologies about which there often is disagreement among Medicare contractors over whether the technology meets Medicare's statutory coverage guidelines.

2. Tensions in National Coverage Determinations

National coverage decisions illustrate the tensions that can exist among Medicare's multiple obligations to beneficiaries, to providers and suppliers, and to other taxpayers. Recent research showing a wide variation in medical practice around the country has increased interest in national, evidence-based coverage policies for Medicare.

At the same time, given the importance of Medicare as a payer, a national-level decision that a new procedure or piece of technology does not meet the standard of reasonable and necessary for patients can have significant negative economic implications for providers, suppliers, and manufacturers. Such decisions can also affect local communities. In most local communities throughout the country, biomedical innovation and health care delivery are significant engines of economic development and employment (Vladeck, 1999).

3. Changes to the National Coverage Determination Process in Recent Years

Several changes and proposed changes have been made in recent years to Medicare's national coverage determination process. On April 24, 1999, HCFA published a notice in the Federal Register that it was implementing a new process for making national coverage determinations (64 FR 22619). This process was intended to streamline procedures in the national coverage determination process and increase opportunities for public participation in the process.

The Medicare, Medicaid, and State Children's Health Insurance Program Benefits Improvement and Protection Act enacted in December 2000 reinforced the changes announced by HCFA in 1999. This act required that a national coverage determination be made by HCFA within 90 days of a formal external request; provided mechanisms for outside groups and individuals to participate in the process; and specified appeals processes. The act also created a new administrative review process to enable certain

Medicare beneficiaries to challenge national coverage determinations and local coverage determinations.

Rules proposed by CMS in the Federal Register of August 22, 2002 (67 FR 54534)[26] allow anyone — whether a provider, beneficiary, supplier, or other taxpayer — to formally request a national coverage decision by CMS or a local coverage determination. The right to challenge national coverage determinations and local coverage determinations is separate from the existing appeal rights that Medicare beneficiaries have for the adjudication of Medicare claims.

Under this rule, CMS is required to act on any formal external request that is "complete" (i.e., in writing, with adequate supporting documentation). If CMS had not made any coverage determination by the relevant deadline, local contractors are free to use their own discretion in making Medicare coverage decisions.[27]

CMS, as part of the Medicare national coverage determination process, can seek assistance from the following external bodies:

- **Medicare Coverage Advisory Committee (MCAC).** CMS may ask for advice from MCAC, a federal advisory committee chartered in 1998 to advise CMS on coverage decisions.[28] The MCAC executive committee consists of 17 experts drawn from the public and private sectors with backgrounds in clinical medicine, technology assessment, and other relevant fields as well as consumer and health care industry representatives. In addition, MCAC has six panels with expertise in different areas of health care: (1) diagnostic imaging, (2) drugs, biologics and therapeutics; (3) durable medical equipment; (4) laboratory and diagnostic equipment; (5) medical and surgical procedures; and (6) medical devices and prosthetics. The MCAC executive committee can make recommendations on coverage to the CMS Administrator. The federal Benefits Improvement and Protection Act of 2000 applied the Federal Advisory Committee Act to the six expert panels so the panels can make recommendations directly rather than through MCAC as a whole. One person interviewed for this study stated that there is disagreement about whether additional legislation is necessary to implement this provision.

[26] These rules were finalized on November 7, 2003 (68 FR 63692).

[27] For completed requests that do not require an external technology assessment or review, CMS is required to make a decision within six months. For completed requests that require either an external technical assessment or review but do not require a clinical trial, CMS is required to make a decision within nine months. In either case, CMS must post its proposed decision on its website and allow 30 days for public comment. CMS must issue its final decision within 60 days after the close of the public comment period.

[28] MCAC replaced a Technology Advisory Committee made up of physicians from various government agencies as well as medical directors from contractors that process Medicare claims. Because HCFA had assumed that the medical directors could be deemed appointees from government, the committee had not operated according to the rules of the Federal Advisory Committee Act, which governs groups made up of advisors from outside of the federal government. When the courts determined that the medical directors were actually from the private sector, it was necessary to reconstitute the group as the MCAC and make it subject to the Federal Advisory Committee Act's requirements.

- **Agency for Health Care Research and Quality (AHRQ).** To help MCAC do its review, CMS often requests a technology assessment from AHRQ at the same time it refers a coverage issue to the committee. CMS can also request a technology assessment without referring the question to MCAC. Once CMS requests a technology assessment, AHRQ contracts with one of its "evidence-based practice centers" (groups of outside researchers who review and synthesize clinical evidence on particular medical practices) to perform it. Technology assessments used to take one to two years to complete.[29]

In making a national coverage decision, CMS has four options:

- Decide to cover the service or technology ("a national coverage decision");
- Decide to cover the service or technology with restrictions;
- Decide not to cover the service or technology ("a national non-coverage decision"); or
- Decide that a national coverage decision is inappropriate or unnecessary and refer the decision back to local contractors.[30]

Once a decision has been made by the CMS Administrator, CMS informs the original requestor and announces the decision on the CMS website.

4. Issues Related to Medicare's National Determination Process

The individuals interviewed for this study identified several issues related to Medicare's national coverage determination process and noted that there have been recommendations for changes. As discussed below, the issues include the following:

- Perception of Medicare's national coverage determination process as a "black box";
- Uncertainty about the criteria CMS uses for national coverage determinations;
- Questions about the appropriateness of allowing procedures to secure Medicare coverage via payment mechanisms as opposed to explicit coverage mechanisms;
- A shortage of skilled professionals in the Coverage and Analysis Group of the CMS Office of Clinical Standards and Quality that impedes Medicare's national coverage determination process;
- Concerns about the influence of politics on Medicare's national coverage determination process; and

[29] CMS is now required to complete these assessments within three months.

[30] CMS uses this option mainly for services or practices carried out in only some parts of the country and when the expertise in performing the service is largely limited to those regions (e.g., a new type of transplant procedure developed at an individual academic medical center may, for some time, be performed only by properly trained medical personnel at or near that medical center).

- Slowness in incorporating national coverage determinations into guidelines and software used in Medicare claims process.

Beyond these issues, some interviewees raised a more fundamental issue—specifically, whether coverage determinations should be made at the national or local level. At Medicare's inception, it was thought that allowing coverage decisions to be made primarily at the local level was one way of ensuring that the Medicare program reflected local medical practice. Furthermore, the need for Medicare coverage decisions was less common since biomedical innovation occurred at a slower pace in the 1960s than it does today.

Since then, there has been a growing push for more consistency across the country. Evidence has been mounting that medical practices vary significantly around the country — and that often the variations are not explained by differences in patients' underlying health needs and are not associated with patients' outcomes. In the case of Medicare, this information has given rise to the question of whether taxpayers should pay for such variations in medical practice (when there is evidence they exist). In addition, as the number of Medicare beneficiaries who spend different seasons in different parts of the country grows, inconsistencies in coverage policy become a problem at a more practical level.

Perception of Medicare's National Coverage Determination Process as a "Black Box." Several interviewees described the national coverage determination process of the past as a black box. At times, HCFA made decisions quickly. At other times, the agency took years. To many, it was not clear why HCFA decided to take on some coverage issues but leave others to the discretion of Medicare contractors. Because the agency's national coverage determination process seemed mysterious, it was criticized as being arbitrary, particularly by parties who disagreed with a particular coverage decision.[31] Procedures published by HCFA/CMS in the Federal Register in 1999, 2000, and 2002 are intended to make Medicare's national coverage determination process clearer and more predictable by speeding it up and by delineating deadlines, the range of potential decisions, and the roles of different actors in the process.

Uncertainty about the Criteria CMS Uses for National Coverage Determinations. The perceived arbitrariness of HCFA's earlier national coverage decision process is accompanied by uncertainty about the criteria CMS has used in arriving at its determinations. For those with an interest in obtaining coverage for new technologies and procedures, the lack of defined criteria makes it difficult to understand how and if new technologies are to be covered. On the other hand, specifying criteria where none existed before can narrow the circumstances under which coverage is possible. For that reason, manufacturers and providers seeking favorable coverage decisions in the future may have mixed feelings about specifying criteria.

[31] One person noted that the medical device industry has been particularly critical of past delays in getting coverage decisions, citing a study by the Lewin Group that claims it can take HCFA/CMS five years or longer to include new technologies in Medicare (AdvaMed, 2000).

As CMS attempts to rationalize its national coverage decision process, the question of what role cost or cost-effectiveness should play remains unresolved. According to the interviewees for this paper, some outside observers believe that cost concerns at HCFA/CMS (i.e., a desire to be fiscally conservative in the use of the Medicare trust funds) have played a part in coverage decisions. In January 1989, HCFA published a proposed set of four generally applicable criteria that the agency would use to make coverage decisions (54 FR 4302):

- Safety and effectiveness,
- Experimental or investigational,
- Appropriateness, and
- Cost-effectiveness.

HCFA subsequently withdrew the proposed rule, and the aforementioned criteria were never finalized. Thus, cost or cost effectiveness is not explicitly considered as a deciding factor for Medicare coverage. Nevertheless, the inclusion of cost-effectiveness as a proposed criterion may have contributed to the perception that HCFA takes costs into account when making coverage decisions.

In the Federal Register of May 16, 2000, HCFA offered a new set of proposed criteria for HCFA to use in making national coverage determinations and for Medicare contractors to use in making local coverage decisions (65 FR 31124). HCFA anticipated applying two criteria. First, the item or service must demonstrate *medical benefit*. An item or service is medically beneficial if it produces a health outcome better than the natural course of disease. Second, the item or service must demonstrate *added value* for the Medicare population. An item or service adds value over the existing mix of covered services if it substantially improves health outcomes; provides access to a medically beneficial, different clinical modality; or if it can "substitute" for an existing item or service and lower costs for the Medicare population.

To ensure that HCFA and its contractors would interpret and apply these criteria consistently, HCFA further proposed using the following sequential questions (65 FR 31124):

- **Question #1: Medical benefit**. Is there sufficient evidence that demonstrates the item or service is medically beneficial for a defined population?
  - If the answer is no, then the item or service is not covered under Medicare.
  - If the answer is yes, proceed to next question.
- **Question #2: Added value.** For the defined patient population, is there a medically beneficial alternative item or service that is the same clinical modality as that currently covered by Medicare?
  - If the answer is no, the item or service is covered under Medicare for the defined population.
  - If yes, proceed to next question.

- **Question #3: Added value.** Is the item or service substantially more or substantially less beneficial than the Medicare-covered alternative?
  - If the item or service is substantially more beneficial (i.e., represents a breakthrough), it is covered under Medicare for the defined population.
  - If the item or service is substantially less beneficial, it is not covered under Medicare for the defined population.
  - If the item or service is neither substantially more nor substantially less beneficial, proceed to the next question.
- **Question #4: Added value.** Will the item or service result in equivalent or lower total costs for the Medicare population than the Medicare covered alternative?
  - If yes, the item or service is covered under Medicare for the defined population.
  - If no, it is not covered under Medicare.

In this set of proposed criteria, cost would be taken into account in coverage decisions by HCFA, but only when there is a safe and effective alternative in the same clinical modality that is equally beneficial. HCFA/CMS received significant comments on the criteria, extended the deadline for such reaction, and has not yet formally adopted the proposal.

Questions about the Appropriateness of Gaining Medicare Coverage via Payment Mechanisms. Rather than seeking a Medicare coverage decision for an item or service from a local Medicare carrier or the Coverage and Analysis Group of CMS, providers (in collaboration with relevant provider groups) may apply to the Payment Group in the Center for Medicare Management to receive a new code that allows them to begin billing for the service. By gaining a diagnosis-related group (DRG) or Current Procedure Terminology (CPT) code for services that otherwise do not fit into existing DRGs or CPT codes, many new inpatient technologies and services receive Medicare coverage de facto.[32] A similar option is available for new outpatient hospital procedures under Medicare's new prospective payment system for outpatient hospital care. Questions have been raised about the appropriateness of allowing this practice to continue.

A Shortage of Skilled Professionals in CMS's Coverage and Analysis Group. CMS has had trouble attracting and retaining skilled professionals, a topic addressed at length in Chapter 5. As a result of this problem, there has been a shortage of skilled professionals in the CMS Coverage and Analysis Group, which oversees Medicare's national coverage determination process .

[32] Diagnosis-related groups, or DRGs, are used to determine payments for hospitalizations; Current Procedural Terminology, or CPT, codes are used to bill for medical procedures performed by physicians or other qualified medical personnel.

Almost all interviewees mentioned the agency's salary structure as the main barrier to CMS's being able to hire and retain adequate numbers of needed professionals, including physicians and other clinical personnel, individuals with backgrounds in research methodology and synthesis, and medical librarians.

Concerns about the Influence of Politics on Medicare's National Coverage Decisions. Several interviewees expressed hope that a clear, open process for national coverage decisions would help minimize congressional intervention not justified by scientific evidence.

As discussed in Chapter 2 and Chapter 5, there is a long tradition of congressional involvement in the management of the Medicare program. Health manufacturers, suppliers and providers who stand to benefit from a positive coverage decision often work with Members of Congress to influence Medicare coverage decisions. As noted earlier, these interest groups can be important sources of jobs and economic health in individual congressional districts.

Members of Congress sometimes have linked coverage decisions to resources or other support that CMS needs, holding some appropriations or other legislative action "hostage" in exchange for coverage of a particular technology. Such pressure usually occurs outside of the public light. This phenomenon underscores the important economic role of Medicare in the nation's economy, a role that can sometimes conflict with the program's goals of ensuring beneficiaries' financial access to health care and protecting the Medicare trust funds.

Delays in Incorporating National Coverage Determinations into Guidelines and Software Used in Claims Processing. When CMS has made a decision to cover an item or service, the CMS Coverage and Analysis Group works with other CMS personnel and relevant provider groups to assign or design an appropriate procedural code for the technology or service. Next, changes in payment manuals and software have to be made. Because of limitations in CMS's computer systems, changes in payment manuals and software only take place quarterly. Additionally, the CMS Coverage and Analysis Group is limited in the number of changes it can implement in any given quarter by the capacity of the agency's programmers to incorporate modifications to software used by contractors to pay claims. Furthermore, CMS is required to give Medicare contractors that process claims five months notice before implementing a coverage change.

Interviewees recognized that implementing national coverage changes requires time, but suggested that CMS resources may not be sufficient for the task and that coordination among different parts of CMS and its contractors has been lacking.

3D. Administering Private Health Plans Under Medicare

As noted in Chapter 2, the Balanced Budget Act of 1997 established the Medicare+Choice program to give Medicare beneficiaries more options for receiving Medicare-covered services from private health plans. This program, which became effective January 1, 1998, expanded Medicare beneficiaries' options beyond the traditional fee-for-service Medicare program and HMOs to include other types of managed care plans (i.e., preferred provider organizations and provider sponsored organizations), private fee-for-service health plans, and Medical Savings Accounts.

U.S. policymakers continue to wrestle with fundamental issues concerning the purpose and structure of private plans in Medicare. For some policymakers, private Medicare plans—including HMOs—are an option that should continue to be available, along with traditional fee-for-service arrangements. For other policymakers, private Medicare plans represent a mechanism for transforming Medicare into a more efficient, modern health care program by moving away from a government-run program to market competition among private health plans. Some would also like to see more direct competition between private plans and the traditional program.

The people interviewed for this study generally agreed that deciding upon the purpose of private Medicare plans is a necessary first step in designing a well-functioning administrative system.[33] No matter what goals one seeks for private health plans in Medicare, however, it is clear that certain tasks are required to administer them. Several of these tasks and related issues are discussed later in this section. First, since HMOs have participated in the Medicare program from its inception, the evolution of Medicare managed care from its early years to the creation of Medicare+Choice is described.

1. Background

The Earliest Years of Medicare Managed Care. From the time of Medicare's enactment through 1972, prepaid group practice plans such as Kaiser Permanente, Group Health of Puget Sound, and the Health Insurance Plan of Greater New York participated in Part B of the program under a cost-based reimbursement program (i.e., plan payments reflected enrollees' actual service use). Part A claims for enrollees in these health plans were processed like all other Part A claims. For Part B services, such health plans received estimated payments that were subsequently reconciled with actual use through cost reports filed by the health plans. All administrative responsibilities for Medicare's prepaid health care program at the time rested with the Office of Direct Reimbursement in SSA's Bureau of Health Insurance.

Participation of Prepaid Group Health Plans in Medicare under the Social Security Amendments of 1972. The Social Security Amendments of 1972 allowed prepaid group practice plans, which by then had become known as HMOs, to participate in Medicare Parts A and B either on a cost-based reimbursement arrangement or under a

[33] See Berenson and Dowd, 2002, for a discussion of the pros and cons of different payment approaches to private health plans in Medicare.

risk-sharing arrangement. The risk-sharing arrangement was not popular among plans, because HMOs felt the program provided insufficient financial incentives for them to participate, and because Medicare's retrospective cost-based reimbursement procedures differed significantly from the prepaid group practices' usual methods of determining payments prospectively (Langwell and Hadley, 1989).

In 1980, there were 33 cost-based HMOs but only one plan with a risk-sharing contract (Gornick et al., 1996). The administrative responsibility for both types of managed care arrangements rested with the Office of Group Health Plans within the Bureau of Program Operations (once HCFA came into being in 1977).

From 1980 to 1985, HCFA's Office of Research and Demonstrations initiated demonstrations involving 30 HMOs that were paid on a risk basis. Payments to these HMOs were set prospectively (i.e., the plans received prospectively set payments for each enrollee), and HMOs bore all of the financial risk for their enrollees' health care.

Demonstrations of Risk-Based HMO Contracting Under Medicare Authorized in 1985. In 1985, Congress passed the Taxpayer Equity and Fiscal Responsibility Act. This act authorized the Medicare Competition Demonstrations so that HCFA could study the feasibility, administrative aspects, and other effects of risk-based contracting with HMOs. The Medicare Competition Demonstrations authorized by the act ultimately involved 26 HMOs (four of the original 30 plans dropped out before the end of 1986) (Langwell and Hadley, 1990). The risk-contracting program involving federally qualified HMOs and competitive medical plans[34] continued to be a part of Medicare until congressional passage of the Balanced Budget Act of 1997. In January 1997, 4.7 million beneficiaries (or 12 percent of total Medicare enrollment) received their care through 307 risk-contracting HMOs (US DHHS, CMS, 2003).

Creation of Medicare+Choice in 1997. The Medicare+Choice program was established by the Balanced Budget Act of 1997 to give Medicare beneficiaries more options beyond the traditional fee-for-service Medicare program. Specifically, beneficiaries could receive their Medicare benefits from the following types of private health plans under contract with Medicare (Brangan, 2001).

- **Medicare coordinated care plans.** Medicare coordinated care plans — more commonly known as managed care plans — include HMOs, preferred provider organizations, and provider-sponsored organizations. Coordinated care plans contract with or make arrangements with a network of providers to deliver covered health care benefits. Beneficiaries generally agree to use only the health plan's approved providers.

[34] Competitive medical plans are HMOs that did not have a federal qualification designation under the HMO Act of 1973 (Berenson, 2002).

- **Medicare private fee-for-service plans.** Medicare private fee-for-service plans are plans operated by private insurance companies to provide health coverage to Medicare beneficiaries on a fee-for-service basis.[35]

Changing Medicare Enrollment in Managed Care Plans. Between 1986 and 2000, the number of Medicare beneficiaries enrolled in managed care plans rose from 1 million to 6.3 million (representing 16 percent of all beneficiaries). Immediately thereafter, however, Medicare beneficiaries' enrollment in managed care plans sharply declined, both because of managed care plans' withdrawals from Medicare and service area reductions. For example, as of May 2002, the number of Medicare beneficiaries enrolled in Medicare+Choice plans (primarily HMOs) had fallen to 5.5 million. Analysts identified several reasons for private plans' reduced participation in Medicare earlier this decade, including the Medicare+Choice payment methodology, and other, nonrelated competitive factors.[36]

2. Key Tasks in the Administration of Private Medicare Plans

Most of CMS's responsibilities for administering private Medicare plans fall into the categories of ensuring that health plans meet standards and making payments to participating health plans. As discussed below, a more complete scope of administrative tasks includes:

- Responding to inquiries from private Medicare plans and beneficiaries;
- Managing the annual election period;
- Ensuring that participating private Medicare plans meet certain standards;
- Making payments to private Medicare plans participating in Medicare; and
- Risk adjusting payments to participating private Medicare plans.

Responding to Inquiries from Private Medicare Plans and Beneficiaries. CMS is responsible for responding to inquiries from health plans, beneficiaries, their advocates, and congressional offices about their experiences with private Medicare plans. As discussed earlier in this chapter, CMS maintains a toll-free telephone line to answer general inquiries about Medicare, including private Medicare plans, and to refer callers to non-governmental sources of information.

Managing the Annual Election Period. CMS is responsible for conducting the annual election period to inform Medicare beneficiaries of their choices through a 1-800 number, the Internet, one-on-one counseling, and other decision support; maintaining records about beneficiaries' elections of health plans; and informing the health plans of enrollment decisions.

[35] The Balanced Budget Act of 1997 authorized Medicare beneficiaries to use Medical Savings Accounts, which are combinations of a personal savings account and a high-deductible insurance policy that covers all Medicare services (Brangan, 2001). As of December 31, 2002, however, no Medical Savings Accounts were participating in Medicare.
[36] More recently, enrollment in private Medicare plans has stabilized.

The Balanced Budget Act of 1997 established an annual health plan election period in November for coverage that is effective January 1st of the following year. Prior to the implementation of Medicare+Choice, Medicare enrollees could switch between managed care plans offered in their areas or between the traditional fee-for-service plan and a managed care plan with 30 days' notice. There was no limit on how often beneficiaries could make such changes. The Balanced Budget Act of 1997 phased-out month-to month enrollment over a five-year period. Starting in 2003, it also would have locked beneficiaries in their plans for either six or nine months, depending on when during the year the beneficiary enrolled. The lock in provisions have been delayed until 2006.

Ensuring That Participating Private Medicare Plans Meet Certain Standards. When the Balanced Budget Act of 1997 authorized new types of health plans to participate in Medicare, HCFA developed new regulations, standards, and procedures for approving such organizations to participate in the Medicare+Choice program. Currently, CMS monitors private Medicare plans' compliance with a broad range of requirements, including financial solvency, nondiscrimination during the enrollment period and beyond, grievance and appeals processes, and health care quality.

Previously, when the Taxpayer Equity and Fiscal Responsibility Act of 1985 allowed federally qualified HMOs and competitive medical plans to participate in Medicare, the job of qualifying health plans to join Medicare was assigned to the Office of HMOs within the Public Health Service. The Office of HMOs was transferred from the Public Health Service to HCFA in 1986, and at that time, HCFA assumed all responsibilities for administering Medicare's managed care program.[37]

Making Payments to Private Health Plans Participating in Medicare. Medicare payments, which are set at a county level, have had a significant impact on the availability of managed care options in Medicare. The increased availability of Medicare risk HMOs between 1985 and 1997 was highly correlated with the level of payments (Medicare Payment Advisory Commission, 2001). In December 1999, just under half (49 percent) of all Medicare enrollees in risk HMOs lived in four states — California, Florida, Pennsylvania, and New York (US DHHS, CMS, 2003). These states are also known for their large populations of older people. In areas with little or no availability of private Medicare plans, the absence of such plans has been a highly volatile political issue, because these plans often have provided a means for Medicare beneficiaries to obtain coverage for prescription drugs.

The federal government has virtually no discretion with respect to payments to Medicare managed care plans because this is a matter of policy set in statute. Beginning in 1985, payments to Medicare managed care plans were set at 95 percent of the adjusted average per capita cost (AAPCC), i.e., the average spending for fee-for-service Medicare

[37] The Office of HMOs had some non-Medicare responsibilities from the Health Maintenance Act of 1973 designed to promote the availability of and enrollment in HMOs. HCFA took on these tasks when it absorbed the office in 1986. Although the qualified HMO designation still exists, the broad proliferation of managed care in the 1990s obviated health plans' need for some protections in the HMO Act, most notably, those contained in Section 1310.

beneficiaries adjusted for the enrollee's age, gender, and institutional and welfare status. Consequently, these payments have been lowest in counties with low Medicare fee-for-service spending and highest in counties with high Medicare fee-for-service spending. In the Balanced Budget Act of 1997, Congress authorized a new payment system for private Medicare plans. Through 2003, the capitation rate paid to these plans was the greater of three options: a blended (i.e., local and national) capitation rate, a minimum percentage increase from the previous year, or a guaranteed floor payment (i.e., an amount under which the Medicare county payment rate may not be less than).

Each private Medicare plan calculates its adjusted community rate — the premium the plan would charge to its Medicare enrollees in the absence of any government payment — and the additional costs for furnishing services to Medicare beneficiaries. The private Medicare plan typically returns the difference between the government payment and the adjusted community rate to Medicare beneficiaries in the form of extra benefits or reduced cost sharing. Through 2003, the federal government did not share in any savings that may have been realized.[38] This approach has allowed many managed care plans to attract Medicare beneficiaries via benefits for outpatient prescription drugs, reduced cost sharing, and/or low or "zero" premium plans. In general, as drug costs and other health care costs have risen, the generosity of such health plan benefits has declined (Achman, 2002).

Private health plans participating in Medicare must indicate to CMS at a date specified in statute the counties they intend to serve, the benefits they will provide beyond basic Medicare benefits (if any), and any additional premium they propose to charge.[39] CMS reviews health plans' submissions to determine whether the plans' intentions to serve particular areas conform to nondiscrimination and other federal requirements. It also sends the *Medicare & You* handbook to each Medicare beneficiary in time for the annual plan election period. This handbook contains general information about private plan offerings. CMS makes more specific information about offerings by county of residence available via its toll-free telephone hotline (1-800-MEDICARE) and via its website at www.Medicare.gov.

The calendar of requirements mandated for private Medicare plans and the intense interest of multiple stakeholders (e.g., health plans, providers, and beneficiaries) create challenges for CMS as it strives to balance its obligations to the different groups with which it must work. There is limited time in the statutory schedule to accomplish all of the steps CMS needs to maintain the program; for health plans to determine if they want to participate in Medicare and submit their adjusted community rates, as currently required; for CMS to review this information and prepare information for beneficiaries; and for beneficiaries to receive the information and make informed enrollment decisions.

[38] Health plans can also return the difference between the government payment and the adjusted community rate directly to the U.S. Treasury in the form of a reduction in their Medicare payments from the government, but no plan has ever chosen this option.

[39] In the Public Health Security and Bioterrorism Preparedness and Response Act enacted in June 2002, Congress changed the adjusted community rate filing date from July of each year to "not later than the second Monday in September."

Risk Adjusting Payments to Private Health Plans Participating in Medicare. Private Medicare plans receive a predetermined monthly payment for each of their Medicare enrollees. The amount of the monthly payment depends on factors such as the beneficiary's age, gender, whether the beneficiary is working, and whether the beneficiary is eligible for Medicaid. Some analysts argue that basing health plans' payment on a fixed payment per enrollee (capitation payment) rather than on the costs plans incur gives the plans a strong incentive to manage the care they provide as efficiently and effectively as they can. Others argue that capitation payment gives health plans an incentive to stint on services.

The Balanced Budget Act of 1997 mandated that federal payments to private Medicare plans be adjusted to reflect the health risks of their enrollees. To implement the congressional mandate to risk adjust payments based on health status, HCFA (now CMS) selected an approach that, in addition to demographic characteristics, also considered an enrollee's diagnoses in a base year to risk adjust payment in the payment year: the Principal Inpatient Diagnostic Cost Group, or PIP-DCG. Initially, the PIP-DCG system was to be based on inpatient data only. The system's implementation proved very contentious, and for that reason, Congress twice delayed full implementation of health status risk adjustment; during this time, CMS modified the risk adjustment methodology. Through 2003, risk adjustors were used to determine only 10 percent of plan payments.

To simplify the process of data collection and to address other concerns raised about the PIP-DCG method of risk adjustment, CMS explored alternative approaches. In March 2002, CMS proposed a risk adjustment system that makes use of information about diagnoses in inpatient and ambulatory care settings and varies payment based on whether a beneficiary has one or more of 61 medical conditions during the previous year. CMS is phasing in this revised methodology, the hierarchical coexisting conditions (HCC) risk adjustment model, to risk adjust payments to private Medicare plans beginning in 2004. Full implementation of risk adjustment (i.e., to 100 percent of plan payments) is not scheduled to take effect until 2007.

Risk adjusting payments to private Medicare plans requires collection of data on beneficiaries' use of services. Even though risk adjustment is applied to only a small portion of plan payments, currently CMS must still collect and process the same amount of encounter data it would need if the entire payment were risk adjusted. Since 1998, HCFA/CMS has collected inpatient "encounter" data from health plans to determine enrollees' actual health care utilization, except when this effort was suspended briefly in May 2001. The managed care industry has opposed implementation because of the administrative burden of collecting and reporting "encounter" data, although risk adjustment could relieve health plans of the financial risk of having costlier than average enrollees. As risk adjustment is implemented in the Medicare program, CMS will continue to collect encounter data and use it to calculate payments that reflect the underlying health status of plans' enrollees.

3. Administrative Issues Related to the Management of Private Medicare Plans

Two important and related private Medicare plan administrative issues arose in the interviews and are discussed further below:

- Private Medicare plans' difficulties in working with CMS and its regional offices; and
- Whether CMS should have responsibility for private Medicare plans at all.

Private Medicare Plans' Difficulties Working With CMS and its Regional Offices. Interviewees from private Medicare plans made the following complaints about working with CMS:[40]

- They have to interact with several parts of the agency,
- They sometimes receive inconsistent answers to their questions about Medicare rules and procedures, and
- They find working with CMS personnel to be confusing and unnecessarily complex.

In addition, several policymakers interviewed reported having heard these complaints from private Medicare plans that participated in Medicare in recent years.

On the issue of inconsistent information, health plans indicated that different regional offices can give different information, a particular problem for health plans that operate in more than one region. Health plans also mentioned the potential for receiving conflicting information from the national and regional levels. In particular, they mentioned instances of having received inconsistent information from CMS concerning Medicare education programs for beneficiaries, the health plan enrollment process, and rules governing health plan contracts and payments from the federal government.

Interviewees attributed such difficulties to various factors. Several of the people interviewed suggested that the new responsibilities and increased workload placed on HCFA/CMS by the Balanced Budget Act of 1997 contributed to increased reliance on regional offices. A few believed that HCFA/CMS had already been moving toward giving regional offices a greater role in the operations of Medicare, noting that the 1997 agency reorganization (discussed in Chapter 2) itself gave CMS regional offices more autonomy. And one person suggested that conflicts and inconsistencies in communications have been due, at least in part, to the fact that regional CMS employees report to their CMS regional administrator rather than to a supervisor in the CMS national office in Baltimore with functional responsibility for the tasks they perform.

Some of the interviewees praised the 1997 HCFA reorganization, suggesting that it made sense to have separate organizational units responsible for beneficiary protection

[40] Similar complaints about confusing and inconsistent communications have been reported by Medicare beneficiaries and providers, as discussed elsewhere in this paper.

activities (Center for Beneficiary Services) and for working with health plans (Center for Health Plans and Providers). This approach avoids the potential conflict of having a single entity both promote and protect health plans and providers and, at the same time, look out for Medicare beneficiaries' interests. As described in Chapter 2, however, the 2001 agency reorganization (in which HCFA was renamed CMS) pulled together all functions related to Medicare+Choice as well as information for beneficiaries into the Center for Beneficiary Choices (U.S. DHHS, 2001).

Appropriateness of Having CMS Administer Private Health Plans in Medicare. The second administrative issue raised in interviews is whether CMS should have responsibility for private Medicare plans at all. The administration of Medicare managed care has moved back and forth between relative centralization of responsibility within one unit of HCFA/CMS to a division of responsibility based on the type of administrative task to be performed:

- In 1985, during the first year of the Taxpayer Equity and Fiscal Responsibility Act risk program, the Office of Group Health Plans within HCFA administered all aspects of both cost-based and risk-based managed care except those activities outlined earlier that fell to the Public Health Service's Office of HMOs.
- In 1986, the same year in which HCFA absorbed the staff and responsibilities of the Office of HMOs, the Office of Prepaid Health Care was split into two units. One unit, which remained at HCFA headquarters in Baltimore, continued to perform most administrative activities. The second, smaller unit, located in Washington, DC, reported directly to the Administrator and had responsibility for analysis and policy development related to managed care (Zarabozo, 2001).
- In 1994, the HCFA administrator brought the policy shop and parts of the agency with administrative responsibilities for Medicare and Medicaid managed care[41] together into the Office of Managed Care, based in Baltimore. This structure remained in place until 1997.
- In 1997, as discussed in Chapter 2, HCFA was transformed into a matrix organization with major centers for each of the agency's major groups of customers: (1) Center for Health Plans and Providers, (2) Center for Beneficiary Services, and (3) Center for Medicaid and State Operations. Medicaid managed care was assigned to HCFA's Center for Medicaid and State Operations; tasks related to beneficiary information about health plans to the Center for Beneficiary Services; and issues related to private Medicare plan participation and payments to the Center for Health Plans and Providers.
- In mid-2001, as discussed in Chapter 2, HCFA was renamed CMS, and the new agency was reorganized around the following three centers: (1) Center for Medicare Management, focusing on the management of the traditional fee-for-service Medicare program; (2) Center for Beneficiary

[41] Medicaid's managed care program is completely separate from the Medicare+Choice managed care program and has different rules; like Medicaid as a whole, Medicaid's managed care program is largely administered by the states.

Choices, which provides Medicare beneficiaries with information on original Medicare, private Medicare plans, and Medigap options, and manages the private Medicare plans; and (3) Center for Medicaid and State Operations, which focuses on programs administered by the states, including Medicaid and the State Children's Health Insurance Program.

The people interviewed for this study who support the removal of private Medicare plans from CMS offered the following three arguments in support of their position:

- **Conflict of interest at CMS**. There is an inherent conflict of interest in having the institution that sets the rules by which private Medicare plans and traditional fee-for-service Medicare compete also run traditional fee-for-service Medicare. This was a central argument in an Institute of Medicine report released in 1996 before the implementation of the Medicare+Choice program (Institute of Medicine, Committee on Choice and Managed Care, 1996).
- **Possible anti-managed care bias at CMS.** Some believe that there has been an anti-managed care "bias" among CMS staff that has negatively affected the implementation and management of private Medicare plans.
- **Lack of in-house experience with private health insurance plans at CMS.** Because of the way Medicare evolved, CMS staff has had relatively little in-house experience with how private health plans — whether managed care plans or private fee-for-service plans — conduct their business. Even in recent years, it can be argued, claims payment has been perhaps the agency's central task. By contrast, private insurers have evolved further from simply paying claims to attempting to be more of a "value purchaser" (National Academy of Social Insurance, Study Panel on Fee-for Service Medicare, 1998; Etheredge, 1995).

On the other hand, some of the people interviewed favor maintaining the status quo, i.e., keeping CMS as a single agency to administer both the traditional fee-for-service Medicare program and private Medicare plans. They argued that a single agency prevents confusion and inconsistencies for Medicare beneficiaries, providers, health plans, contractors, and policymakers. With two agencies, for example, a Medicare beneficiary who left a private Medicare plan to return to the traditional Medicare program would have to deal with two different federal agencies, despite the fact that all Medicare enrollees are beneficiaries of a single overarching program.

Chapter 4. Other Medicare Administrative Tasks

The federal government and its contractors must perform other administrative tasks in addition to the four tasks discussed in the previous chapter. Among these additional tasks, which are discussed in this chapter, are the following:

- Determining eligibility and collecting premiums;
- Implementing Medicare payment systems;
- Selecting and managing Medicare contractors (e.g., the local fiscal intermediaries and carriers that pay Medicare claims);
- Combating waste, fraud, and abuse in Medicare;
- Ensuring the quality of services provided to Medicare beneficiaries (i.e., setting standards for health care facilities and other providers to participate in Medicare, and overseeing quality improvement efforts); and
- Sponsoring Medicare research and demonstration projects.

4A. Determining Eligibility and Collecting Premiums

Currently, the Social Security Administration (SSA) retains responsibility for determining individuals' eligibility for Medicare, for collecting Medicare Part B premiums by deducting them from monthly Social Security retirement and disability benefit payments, and for providing information to Medicare beneficiaries through its district offices. Since SSA maintains records about whether individuals have paid the requisite payroll taxes to become eligible for Medicare, and almost all Medicare beneficiaries receive Social Security payments each month, having SSA determine Medicare eligibility and collect Part B premiums seems to make sense.

In return for performing these administrative tasks, SSA receives annual payments mainly from the Medicare trust funds plus much smaller amounts transferred from Center for Medicare and Medicaid Services' (CMS) appropriated administrative funds according to interagency agreements. In 2000, the amount SSA received from the trust funds was $998 million (Swanson, July 2001).[42]

4B. Implementing Medicare Payment Systems

Congress has written the laws governing Medicare reimbursement rates with great specificity. Under the Balanced Budget Act of 1997, much of the traditional Medicare program (Part A and B) has moved, or is moving, toward administered pricing mechanisms. This means that Medicare payments to providers are prospectively set by the federal government through a formula or fee schedule rather than based on individual providers' charges.

[42] The SSA tap on funds from the Medicare trust funds covers all of the activities mentioned here — eligibility determination, Part B premium collection, and beneficiary assistance in SSA district offices (Swanson, July, 2001).

The primary role of the federal executive branch in Medicare payment is to concentrate on the technical details of implementing the payment formulas enacted in law. CMS's role in the realm of Medicare payment includes the following activities:

Implementing new provider payment systems mandated by law. In order to implement new payment systems mandated by Congress, CMS must perform tasks, such as: (1) developing the formulas and rules to pay for each service (often based on CMS funded external research); (2) promulgating necessary regulations; (3) informing contractors, provider groups, and beneficiaries about new payment rules; and (4) developing software or software specifications for Medicare's fiscal intermediaries and contractors to process claims under the new system.

Updating provider payment levels on an annual basis. Unless otherwise specified by Congress, the Secretary of Health and Human Services has responsibility for determining and implementing annual updates in payment levels under the various prospective payment systems. Such updates involve informing contractors and helping them update claims software and informing providers.

Monitoring and analyzing impacts of payment systems. Monitoring the impacts of existing reimbursement systems requires analysis and research. Although CMS performs or commissions some of this work itself, the Medicare Payment Advisory Commission (MedPAC) established by Congress in 1997 also advises Congress about payment policy and other potential changes to Medicare.

In addition, it should be noted that the basis for a new payment method often arises from in-house or commissioned research sponsored by the executive branch. The diagnosis-related group (DRG) system and the resource-based relative value scale (RBRVS) now used to determine Medicare inpatient hospital and physician payments, respectively, were developed via research funded by HCFA. The same is also true for some of the changes incorporated into the Balanced Budget Act of 1997, including those for home health and skilled nursing facility payments.

Several interviewees pointed out that, although Congress limits CMS's role in determining Medicare payment policy, the mandate for several new prospective payment systems by the Balanced Budget Act required significant effort by the agency. This work was done in a relatively short period of time and without appreciable new resources. Because of the displeasure of many service providers covered by the new Medicare reimbursement systems, Congress altered or delayed aspects of several of the systems in 1999 and 2000, thereby adding to CMS's workload.

4C. Selecting and Managing Medicare Contractors

Much of the administration of Medicare is done by private organizations under contract with CMS. The discussion that follows below focuses primarily on the selection and management by CMS of the largest category of Medicare contractors — namely,

those that process Medicare claims from providers, suppliers, and beneficiaries. Other types of Medicare contractors, which are discussed elsewhere in this paper, include (1) Medicare managed care and private fee-for-service plans; (2) state agencies that survey and certify nursing homes, home health agencies, and other health care facilities, allowing them to participate in the program; and (3) health care quality improvement organizations (QIOs), formerly known as peer review organizations (PROs), that perform quality assurance and improvement activities for Medicare.

Contractors That Process Medicare Claims. As noted in Chapter 2, when Medicare was created, its designers decided to build upon the claims processing expertise of commercial insurers and have these private organizations pay claims for Medicare under contract. A decision was made to utilize private insurance companies — primarily Blue Cross/Blue Shield plans — for claims processing. The use of local Medicare contractors to process Medicare claims in each state continues to this day. The 10 CMS regional offices negotiate budgets with each contractor that processes claims in their region and also have primary responsibility for monitoring how well the contractors perform their duties.

Contractors that process primarily Part A claims submitted by hospitals, skilled nursing facilities, home health agencies, and hospices (historically known as *fiscal intermediaries*) have served a number of roles in the Medicare program. These roles include determining whether to pay or deny a claim based on Medicare's coverage rules, determining the appropriate payment amount for each claim under Medicare's reimbursement rules, making those payments to providers or beneficiaries, answering questions from providers and beneficiaries, passing on information or instructions from CMS to providers, and auditing provider records. Since the beginning of Medicare, the bulk of contractors that process Part A claims have been Blue Cross plans (Steinhouse, 2000). CMS was precluded by law from using competitive bidding to select fiscal intermediaries. Instead, groups of providers have had the right to nominate the geographically based organizations from which CMS chooses the fiscal intermediary to process their claims. Providers also have had the right to ask to be reassigned to a different contractor. Consequently, multiple contractors that process Part A claims have functioned in a given area. Some have been designated as regionally based contractors to process home health care claims.

Contractors that process Part B claims (historically known as *carriers*) have had duties that parallel those that process primarily Part A claims. CMS has contracted with these contractors to cover a particular geographical region for a one-year period, and the agency usually has renewed those contracts automatically. In recent years, Medicare moved to four regional contractors that process Part B claims to administer the durable medical equipment benefit, and CMS reduced the overall number of Medicare contractors that process either Part A or Part B claims.

Issues Related to Selecting and Managing Medicare Contractors That Process Medicare Claims. Interviews suggested a number of difficulties with the system of contractors that process Medicare claims. Some of these issues echoed

challenges uncovered in other reviews of Medicare administration (Scanlon, May 2000; Steinhouse, 2000):

- **Inadequate Funding for Specific Tasks Performed by Contractors**. Interviewees suggested two particular areas where the contractors' budgets should be increased, namely provider education and beneficiary information.[43]

    - **Provider education**. Between 1995 and 1999, funds for provider education fell by 50 percent from $31.4 million to $15.8 million where it remained in 2001 (Tilson, May 2001). This decrease occurred at the same time that substantial changes in Medicare program and payment policies were implemented under the Balanced Budget Act of 1997, the Balanced Budget Refinement Act of 1999, and the Medicare, Medicaid, and State Children's Health Insurance Program Benefits Improvement and Protection Act of 2000. Medicare's efforts to combat waste, fraud and abuse increased significantly, making providers less certain about exactly how to bill appropriately for services.
    - **Beneficiary information**. Contractors also serve as a resource for beneficiaries trying to resolve problems or confusion about their Medicare claims. Funds provided to contractors that process claims for communicating with beneficiaries increased from $136.1 million in 1998 to $181.6 in 2000. Beneficiary advocates, former HCFA officials, and contractor representatives interviewed for this study argued that this amount (less than $5 per beneficiary) was insufficient given the growing complexity and large number of recent changes in the Medicare program and lack of resources elsewhere to answer questions about claims.

- **Inflexible Contracting Rules**. The original restrictions on the scope and selection of Medicare contractors were seen as necessary to garner the support of providers for Medicare. In addition, it made sense that the federal government should make use of the bill paying infrastructure that commercial insurers and the Blue Cross/Blue Shield plans already had in place.

    Because of the difficulty in contracting with organizations other than those that already process Medicare claims, however, HCFA/CMS has only sparingly used its power to "fire" a Medicare contractor (U.S. General Accounting Office, July 1999). Contractors that process claims have sometimes turned to members of Congress to block attempts by CMS to negotiate more favorable contract terms, end a contract, or reassign duties to another contractor (Steinhouse, 2000). Many interviewees, including some with affiliations with contractors that process claims, suggested that HCFA/CMS's inability to use competitive bidding for contractor services has been a significant impediment to getting good service at the best price.

[43] It should be noted that although contractors can use Medicare funds to help cover some of their overhead costs, by statute they are not allowed to make a profit on their Medicare business. Some observers consider this restriction a potential disincentive to participate or provide the best service (Scanlon, May 2000).

- **Delineation of Contracting Responsibilities**. A number of interviewees with experience both inside and outside of CMS cited a tendency for contractors to receive conflicting information from the agency's central office and the relevant regional office. This uncertainty may create inefficiency for both CMS and the contractors. Several mentioned that, after a period in which regional offices were given more autonomy in dealing with contractors that process claims, there has been a movement towards centralizing decision making at CMS headquarters in Baltimore.

4D. Combating Waste, Fraud, and Abuse in Medicare

Estimates were made in the mid-1990s that as much as $20 billion in Medicare funds were spent improperly each year (U.S. General Accounting Office, February 1997). In 1996, the HHS Office of the Inspector General estimated that 14 percent of Medicare payments were made improperly (U.S. DHHS, HCFA, March 2001). Improper Medicare payments are not just payments made wrongly because of outright fraud; they also include payments for legitimate items or services that are unnecessary, inappropriate, or for which providers have not given adequate documentation or have made mistakes in coding services and billing.

In the face of concerns about health care waste, fraud, and abuse in Medicare and other programs, Congress mandated vigorous efforts to reduce these problems. In particular, it enacted the Health Care Portability and Accountability Act of 1996 (HIPAA), which created the following two programs:

Health Care Fraud and Abuse Control Program. HIPAA required the establishment of the Health Care Fraud and Abuse Control Program, a far-reaching program to combat fraud and abuse in health care, including both public and private health plans. The Health Care Fraud and Abuse Control Program is jointly directed by the U.S. Attorney General and the Secretary of the Department of Health and Human Services (HHS) acting through the HHS Office of the Inspector General. The program uses dedicated money from the Medicare hospital insurance trust fund for coordinated federal, state, and local law enforcement activities with respect to health care fraud and abuse. An amount equaling recoveries from health care investigations — including criminal fines, forfeitures, civil settlements and judgments, and administrative penalties, but excluding restitution, compensation to the victim agency, and funds awarded to those who file "qui tam" suits (described under the Medicare Integrity Program below) on behalf of the federal government — is required by HIPAA to be deposited in the Medicare trust funds (U.S. DHHS and U.S. Department of Justice, April 2002). All funds deposited in the trust fund as a result of HIPAA are available for the operations of the trust fund.

Medicare Integrity Program. HIPAA also created the Medicare Integrity Program to help reduce Medicare payment errors and protect and strengthen the Medicare trust funds. The goal of program integrity is to "pay it right," i.e., pay the right amount, to the right provider, for the right service, for the right beneficiary (U.S. DHHS, HCFA,

March 2001). The emphasis is on making accurate payments when claims are first submitted. The central activities of the Medicare Integrity Program — cost report audits, medical review, anti-fraud activities, and Medicare secondary payer activities — are performed by fiscal intermediaries, carriers, and other Medicare contractors (U.S. DHHS, HCFA, March 2001). Overpayments recovered, fines, and penalties go to the Medicare trust funds (U.S. DHHS, HCFA, March 2001).

These federal efforts to combat fraud and abuse in health care have resulted in somewhat lower Medicare spending. In 1999, the federal government collected $490 million related to health care fraud cases[44] (and shared $44 million with private individuals as part of *qui tam* cases[45]). Health Care Fraud and Abuse Control Account expenditures (i.e., the amount the federal government spent in pursuing healthcare fraud and abuse) for that same year were $137 million. In 2001, the federal government won or negotiated more than $1.7 billion in judgments, settlements, and administrative impositions in health care fraud cases and proceedings (U.S. DHHS and U.S. Department of Justice, April 2002). As a result of these activities, as well as prior year judgments, settlements, and administrative impositions, the federal government collected more than $1.3 billion. More than $1 billion of the funds collected and disbursed in 2001 were returned to the Medicare trust funds. The Medicare trustees credited the deterrent effect of the fraud and abuse campaign with contributing to the decrease in Medicare spending observed several years ago (Kellison and Moon, 2000).

Interviewees revealed somewhat mixed views about federal efforts to limit fraud and abuse in Medicare. On the one hand, interviewees, particularly current and former congressional staff and former HHS political appointees, expressed strong support for continued efforts to eliminate improper payments. On the other hand, many of these same interviewees, joined by representatives of providers and contractors, suggested that the threat of *qui tam* suits and the aggressiveness of fraud control efforts, particularly by the U.S. Department of Justice, were having undesirable and unintended effects on providers. According to interviewees, in these suits and investigations, paper errors can be interpreted as attributed to criminal intent; consequently, providers may settle these suits even if they are without merit out of fear of the negative publicity and high cost that would accompany a protracted fight with the government. Some other interviewees indicated that providers have become overly conservative in their billing practices and perhaps less inclined to participate in Medicare because of the intensity of the anti-fraud efforts. Thus far, there has been no evidence of a decline in the number of participating providers or in the number of claims taken on assignment (i.e., claims in which the provider accepts Medicare's allowed charges as full payment).

[44] Proceeds go to the Medicare Hospital Insurance Trust Fund, but cases can involve other public and private health insurance.

[45] *Qui tam* is the Latin abbreviation for "who sues on behalf of the King as well as for himself." Under the False Claims Act, private citizens are permitted to file *qui tam* lawsuits in the name of the U.S. government against government contractors whom they accuse of acting improperly with taxpayer money. The claimant often is a "whistleblower" who worked for the contractor or a provider or other individual with some knowledge of the contractor's operations. Successful *qui tam* lawsuits can result in significant damages, much of which is given to the claimant.

The anti-fraud and abuse efforts by the HHS Office of the Inspector General and U.S. Department of Justice have evoked concern from providers. In interviews of individuals outside of CMS, however, there was a sense that CMS should share the blame with law enforcement agencies for these concerns. Suggestions for change raised by interviewees include (1) more funding for contractors to educate providers and answer their questions about correct billing practices, and (2) an up-to-date computer system for CMS that allows easier and timelier analysis of billing practices to seek out patterns of improper billing. The latter is cited as a tool for identifying providers who may need help in billing correctly as well as cases to be investigated for outright fraud. In addition, some interviewees suggested that CMS and its contractors need more funds to review more claims for problems before they are paid.

4E. Ensuring the Quality of Services Provided to Medicare Beneficiaries

CMS oversees a number of quality-related activities for Medicare. Notably, many activities intended to ensure the quality of service provided to Medicare beneficiaries are performed by private organizations or state agencies under contract to CMS. In general, CMS uses six main strategies to address quality in the Medicare program, some of which are discussed in more detail below:

- Establishing and enforcing standards;
- Providing technical assistance through the quality improvement organizations (QIOs);
- Promoting collaboration and partnerships;
- Supporting or directly providing beneficiary assistance;
- Structuring payment and coverage to improve care; and
- Rewarding performance.

Quality Standards for Health Care Facilities Participating in Medicare. All health care facilities must meet certain minimum standards of quality in order to participate in the Medicare program. Hospitals that have been accredited by the Joint Commission on Accreditation of Healthcare Organizations, a private, not-for-profit organization with offices in Oakbrook, IL, and Washington, DC, are deemed to be certified to participate in Medicare. Health care facilities that have been accredited by other organizations recognized by the U.S. Department of Health and Human Services (HHS) as applying standards as stringent as Medicare's are also deemed to be certified to participate in Medicare.

Most health care facilities and providers that have not been accredited by an HHS recognized organization have to be periodically surveyed and certified as meeting Medicare's "conditions of participation," or "conditions for coverage."[46] The planning, coordination, and implementation of survey, certification, and enforcement programs for

[46] To avoid a conflict of interest, the CMS regional office serves as the surveying and certifying agency for state mental hospitals. They perform the same task for Indian Health Service facilities in order to maintain federal jurisdiction over federally run facilities (Steinhouse, 2000).

all Medicare and Medicaid suppliers, and for laboratories under the auspices of the Clinical Laboratory Improvement Act, is the responsibility of the CMS Center for Medicaid and State Operations. CMS is required by law to contract with state agencies to perform the task of survey and certification. The same state agencies also certify providers for participation in Medicaid and the State Children's Health Insurance Program (Steinhouse, 2000). The federal government pays the states for their survey and certification activities. In 2003, federal appropriations for such activities totaled $252 million. In 1990, following attempts by HCFA to expand Medicare's ability to conduct survey and certification by imposing user fees, Congress banned the agency from collecting user fees for Medicare (Steinhouse, 2000).[47]

Issues Related to CMS's Role in Health Care Facility Survey and Certification Activities. The interviews did not elicit many comments about CMS's role in planning, coordinating, and implementing survey, certification, and enforcement programs for health care facilities participating in Medicare. The few individuals who mentioned its role suggested that perhaps it should be taken out of CMS and placed elsewhere within HHS, such as to an existing Public Health Service agency or to a new agency reporting to the Secretary of Health and Human Services. Among the arguments cited by interviewees for moving this function out of CMS were the following:

- The same health care facilities must be certified for Medicare, Medicaid, the State Children's Health Insurance Program, and programs outside of CMS's jurisdiction;
- Survey and certification requires an understanding of clinical medicine and public health — skills found more readily in other parts of HHS; and
- Removing the survey and certification function out of CMS would ease CMS's burdens, if only marginally.

Overseeing Medicare's Health Care Quality Improvement Program. CMS administers Medicare's Health Care Quality Improvement Program (http://www.hcqip.com), which is designed to monitor and improve the quality, effectiveness, efficiency, and economy of services provided to Medicare beneficiaries. Since the time of Medicare's creation in 1965, Congress has recognized the importance of implementing systems to ensure that elderly beneficiaries received care consistent with medical quality standards. The Social Security Act mandated that health care facilities participating in the program conduct "utilization review" with committees of physicians. The purpose was to review the appropriateness of care for samples of cases, as well as long stays in hospitals or skilled nursing facilities.

Over the years, systems related to the quality of medical care provided under Medicare have evolved from quality assurance systems, based primarily on retrospective quality review, to proactive quality improvement systems (Bhatia et al., 2000):

- **Professional Standards Review Organization (PSRO) Program established in 1972**. The PSRO program, created by Congress in the 1972 amendments to the Social Security Act, was the first national quality

[47] The one exception to this ban is the Clinical Laboratory Improvement Act, which requires user fees.

assurance program administered as part of Medicare. Under this program, nonprofit physician organizations in local communities received federal funds to review Medicare-reimbursed items and services to determine whether they were medically necessary, met professionally recognized quality standards, and were provided in the most effective, economic manner possible (Bhatia et al., 2000). With a focus on utilization review, PSROs were widely viewed as a mechanism for controlling health care utilization and costs, not as a means of improving clinical quality of care.

- **Utilization and Quality Control Peer Review Organization (PRO) Program established in 1982.** In the Peer Review Improvement Act of 1982, Congress dismantled the PSRO program and replaced it with the Utilization and Quality Control Peer Review Organization (PRO) Program (Bhatia et al., 2002). Under this program, organizations known as PROs were set up in 54 regions (each state, the District of Columbia, and three U.S. territories) to monitor the utilization and quality of hospital care provided to Medicare patients. PROs had less autonomy from HCFA than PSROs had had, were chosen through competitive bids, and unlike PSROs, could not delegate quality assurance functions to health care facilities (Institute of Medicine, 1990).
- **Health Care Quality Improvement Program established in 1992.** Although the first PRO contract cycle (1984-86) primarily emphasized reducing inappropriate hospital admissions, by the time of the third contract cycle (1989-93), HCFA had shifted PROs' focus toward collaborative efforts with providers to prospectively improve quality (Bhatia et al., 2002). The Medicare Health Care Quality Improvement Program launched by HCFA in 1992 was a significant milestone in the movement from quality assurance to quality improvement. The national Medicare quality improvement projects involve the efforts of CMS, CMS's 10 regional offices, and the 54 contracted health care quality improvement organizations (QIOs), which were previously known as PROs.

QIOs are expected to develop partnerships with hospitals, health plans, and physicians to profile patterns of medical care, identify areas in which treatment of Medicare and Medicaid beneficiaries could be improved, assist in the development of quality improvement efforts, and measure improvement (National Academy of Social Insurance, Study Panel on Fee-for-Service Medicare, 1998; Steinhouse, 2000). In the Balanced Budget Act of 1997, Congress gave QIOs the additional responsibility of helping to reduce fraud and abuse in the Medicare program (a task that involves, among other things, the systematic analysis of claims data). QIOs work under performance-based contracts with CMS and are evaluated on improvements in quality indicator rates.

Annual spending on QIOs varies according to where in the three-year funding cycle QIOs may be. In 2000, Medicare spent $580 million on

QIO activities (Steinhouse, 2000). The President's FY 2002 budget, however, estimated QIO spending to be $111 million in FY 2001 and $390 million for FY 2002 (U.S. Office of Management and Budget, 2001). Spending in FY 2003 was $702 million (U.S. Office of Management and Budget, 2004). Like all administrative costs, the federal funds used to pay QIOs come directly from the Medicare trust funds; unlike other Medicare administrative costs, however, funds for QIOs are not subject to congressional appropriations and do not count against discretionary spending caps.

Issues Related to CMS's Work with Health Care Quality Improvement Organizations (QIOs). The individuals interviewed for this study did not comment on CMS's administration of QIOs themselves. The chief comment was that CMS needs an improved information technology infrastructure to work with these organizations. One interviewee familiar with QIOs indicated that many of these organizations have felt hamstrung by Medicare's outdated data systems.[48] A few other interviewees commented that the funding mechanism for QIOs — a trust fund that is outside the congressional appropriations process — should be replicated for other Medicare administrative functions, thereby ensuring more adequate resources for Medicare management.

4F. Supporting Medicare Research and Demonstration Projects

CMS supports a variety of research and demonstration projects, including analyses, experiments, demonstrations, and pilot projects, in efforts to resolve major health care financing issues and to develop innovative methods for the administration of Medicare and Medicaid (U.S. DHHS, CMS, 2002). The agency also conducts demonstration projects to explore alternative policies of health care coverage and delivery.

History of Responsibility for Medicare-Related Research and Demonstration Projects. Research sponsored by HCFA produced important advances in payment methodology and care delivery (e.g., Medicare's prospective payment system; centers of excellence; the Program of All Inclusive Care for the Elderly, better known as PACE; and social HMOs).

During the 1997 agency reorganization discussed in Chapter 2, HCFA was transformed into an organization with major centers for each of the agency's major constituencies: (1) the Center for Health Plans and Providers, (2) the Center for Beneficiary Services, and (3) Center for Medicaid and State Operations. In addition, the responsibilities of HCFA's Office of Research and Demonstrations were divided. Demonstrations, many of which are mandated by Congress, were moved to the relevant center; thus, for example, demonstrations related to managed care were moved to the Center for Health Plans and Providers. The Office of the Actuary continued to track Medicare spending patterns and provide analytical support to Congress and trustees of the

[48] This same individual suggested that HCFA's move during the 1990s to be more directive towards the QIOs was not always in the best interest of Medicare and its beneficiaries, though no specific examples were given.

two Medicare trust funds. Remaining research and evaluation functions, including responsibility for the Medicare Current Beneficiary Survey,[49] were assigned to HCFA's new Office of Strategic Planning. In 2001, when the three centers created in the previous reorganization were replaced with three new centers to reflect the three major areas of focus by CMS, the Office of Strategic Planning, Office of the Actuary, and research and demonstration responsibilities within the various CMS centers remained unchanged.

CMS spent $74 million of its appropriated funds on research, demonstrations, and evaluations in FY 2003, according to the President's FY 2005 budget (US Office of Management and Budget, 2004). This figure includes all such CMS activities, not just those for Medicare. The figure does not include the amount spent on in-house research by CMS employees, especially Office of Strategic Planning and Office of the Actuary employees; their salaries and other expenses related to the research and analysis are included in the $567 million spent in FY 2003 for "federal administration" of Medicare.

The CMS Office of Research, Development, and Information coordinates CMS research. For fiscal years 2002 and 2003, the priority areas for CMS's discretionary contracts, cooperative agreements, or grants were as follows: (1) monitoring and evaluating CMS's programs; (2) improving managed care payment and delivery; (3) improving fee-for-service payment and delivery; (4) researching future trends influencing the programs; (5) strengthening Medicaid and State programs; (6) meeting the needs of vulnerable populations; (7) assessing outcomes, quality, and performance; and (8) building research capacity research (U.S. DHHS, CMS, 2002).

Issues Related to CMS's Role in Supporting Medicare-Related Research and Demonstration Projects. Policymakers face several questions about CMS's role in supporting research and demonstration projects:

- **Should CMS conduct research related to Medicare, or should that responsibility be given to another federal agency?** Interviewees disagreed on this point. On the one hand, some were of the view that CMS should focus its limited resources solely on program operations; for that reason, the agency's research and demonstration activities should be transferred to other parts of HHS with expertise in research (e.g., the Agency for Health Care Research and Quality within the Public Health Service). On the other hand, some interviewees argued that supporting research and demonstration projects is integral to Medicare program operations and planning for the program's future; for that reason, it would be unwise to move research and demonstrations to agencies that may lack a sufficient understanding of Medicare to ensure quality and usefulness of the work. One individual feared that other agencies might not give Medicare research the same priority as CMS does.
- **If CMS engages in Medicare research and demonstration projects, what should the focus be?** Most interviewees believed that CMS should

[49] The Medicare Current Beneficiary Survey is an ongoing representative survey of over 16,000 beneficiaries that collects information about beneficiaries' demographic characteristics, their health status, and their access to, use of, and spending for health care.

focus its Medicare research and demonstration projects on immediate challenges or policy questions (e.g., patterns of prescription drug use). Some interviewees stated that, in addition, CMS should undertake a broad portfolio of research to address longer-term challenges to the Medicare program and to develop innovations that are "outside the box."

- **What is the appropriate amount to spend on research and demonstrations related to Medicare, and what role should Congress have in determining that research agenda?** Several interviewees expressed the opinion that too little was spent on research and demonstrations within CMS. They mentioned that research and related activities within CMS amount to less than 1/30th of 1 percent of all Medicare spending. By comparison, most private sector organizations expect to spend more than 1 percent (sometimes significantly more) on research and demonstrations in order to enhance their operations and anticipate future challenges. None of the interviewees suggested what amount CMS should spend on Medicare research and demonstrations activities, but they did point to reasons why even CMS has limited control over the funds they currently receive. For example, some interviewees complained about the extent to which Congress "earmarks" research and demonstration funds for specific projects and for specific research institutions, often as a result of lobbying by those institutions or other interested parties. One individual suggested that CMS was further limited in its ability to develop a research and demonstrations agenda for Medicare because the U.S. Department of Health and Human Services and U.S. Office of Management and Budget often blocked CMS from issuing solicitations for new grant programs.

Chapter 5. Conclusions: Cross-Cutting Issues and Challenges for Medicare Management

The bulk of this paper has focused on administrative tasks required to manage Medicare. This chapter highlights several cross-cutting and interrelated issues and challenges for the federal government in performing these tasks, specifically:

- Inadequacy of resources for Medicare administrative and management tasks;
- Medicare officials' conflicting roles and demands;
- Increased Congressional involvement in Medicare management;
- Strained relations between Medicare and health care providers;
- Ambiguities in the functions of the federal Center for Medicare and Medicaid Services (CMS) and its regional offices; and
- Questions about the role of CMS itself.

5A. Inadequacy of Resources for Administrative and Management Tasks

In the past two decades, several developments have increased the need for more administrative resources to manage Medicare in the best interests of Medicare beneficiaries, health care providers, and U.S. taxpayers:

- **An expansion in the types and complexity of interventions that medicine can offer patients.**
- **Medicare payment reforms that have moved Medicare from a system of reimbursement based on providers' own costs or charges to a system of administered prices.** These payment reforms have dramatically increased the technical skills and experience needed to understand and implement Medicare legislation. The shift to prospective payment has required CMS to implement and update various systems (including communications with contractors and providers), as well as to set and enforce standards for computer software that pays claims.
- **An expansion of the options through which beneficiaries can receive their Medicare benefits via the Medicare+Choice program enacted by Congress in the Balanced Budget Act of 1997.** The Medicare+Choice program, which allowed Medicare beneficiaries to choose among managed care plans, private fee-for-service plans, and Medical Savings Accounts, was implemented in 1998. Significant policy questions remain about the role of managed care in Medicare's future. Nonetheless, the expansion of private health plans in Medicare has created the need for CMS staff to address fundamentally new administrative challenges. It has expanded the need for staff who understands modern private health insurance. It has also expanded the need for CMS staff to improve Medicare beneficiary education and customer service.

- Several other resource-intensive congressional mandates in the Balanced Budget Act of 1997 and subsequent laws that have added to CMS's responsibilities.

The overwhelming conclusion of this paper, as well as of numerous expert, bipartisan assessments presented to Congress (Roper, 2001; Wilensky, 2001; DeParle, 2001; Vladeck and Cooper, 2001) and published in academic journals (Butler et al., 1999), is that the funding and personnel for Medicare's burgeoning administrative and management tasks are woefully inadequate.

And if Medicare's administrative resources are insufficient now, some observers note, any significant expansions or restructuring of the Medicare program in the future will stretch those resources even further. Some interviewees for this study expressed the concern that, if Congress enacted a benefit in an area of health care with which CMS has little experience, CMS might not have the flexibility, time, or money to obtain the expertise needed to implement the law successfully.

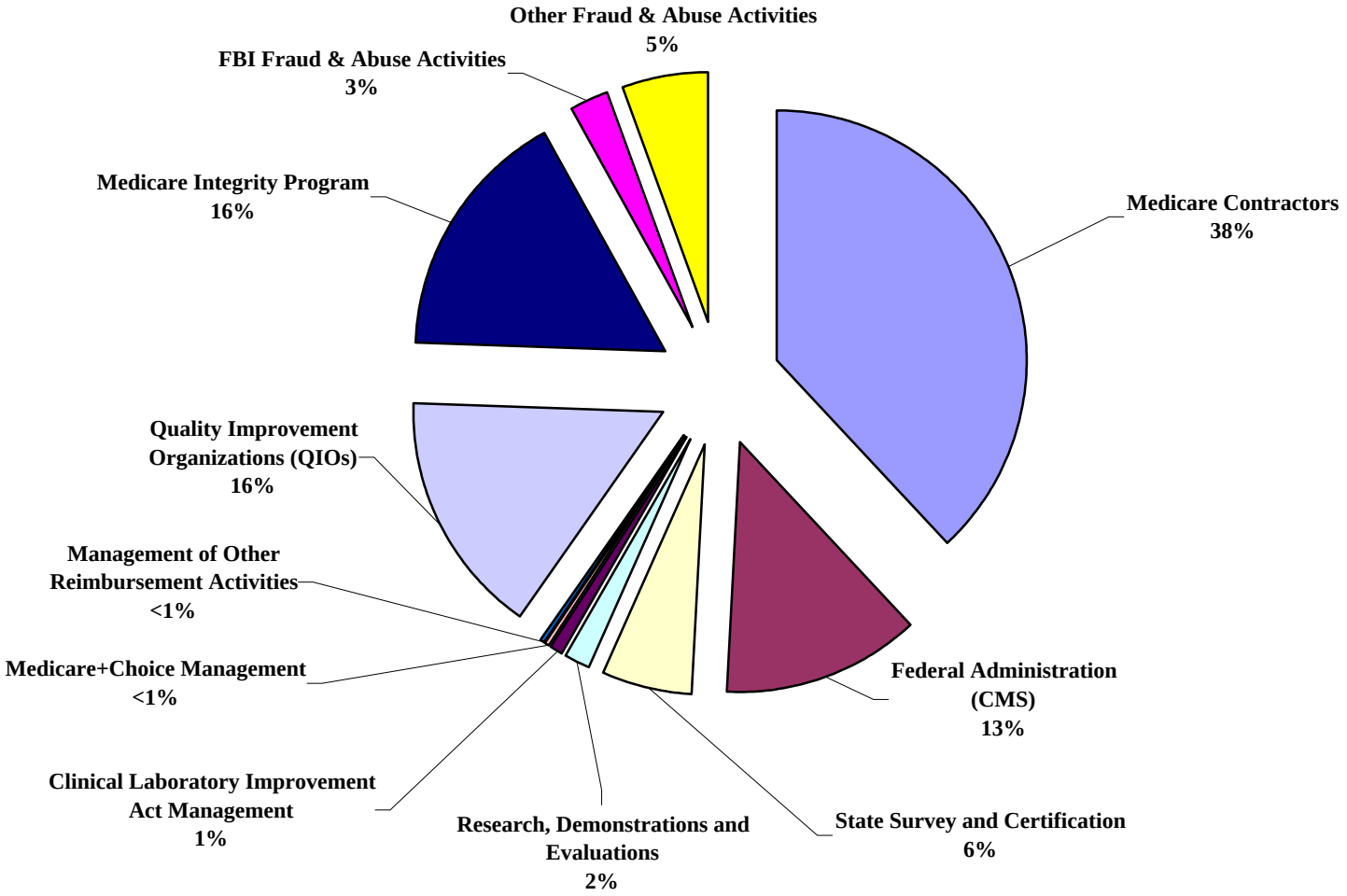
Inadequate Funding for Medicare Administration and Management. Medicare's budget in FY 2003 was $273 billion. In FY 2003, additional federal expenditures on Medicare administration and management were an estimated $4.4 billion (US Office of Management and Budget, 2004). (If one excludes spending on health care quality improvement organizations (QIOs) federal expenditures on Medicare administration and management were equal to about $3.7 billion.)

Figure 5-1 illustrates the allocation of the $4.4 billion in federal funding for Medicare administration and management: 38 percent went to Medicare contractors; 24 percent went to reduce fraud and abuse; 16 percent went to QIOs; and 6 percent went to state survey and certification agencies, and 13 percent went to the Centers for Medicare and Medicaid Services (CMS) for federal administration.

Federal expenditures on Medicare administration and management have *not* kept pace with spending on medical services provided to Medicare beneficiaries. Figure 5-2 illustrates trends in Medicare administrative and management spending as a percentage of benefit payments from FY 1979 to FY 2003. (Unlike Figure 5-1, this chart excludes federal expenditures for Medicare QIOs.) In FY 1979, spending on Medicare administration and management represented 3.1 percent of Medicare benefit payments. As can be seen, the percentage has declined significantly since then. Since FY 1979, Medicare administrative spending as a percentage of benefit payments underwent two significant declines — dropping from 3.1 to 1.7 percent of benefit payments in the FY 1979-84 period and from 1.7 to 1.1 percent of benefit payments in the FY 1991-96 period.

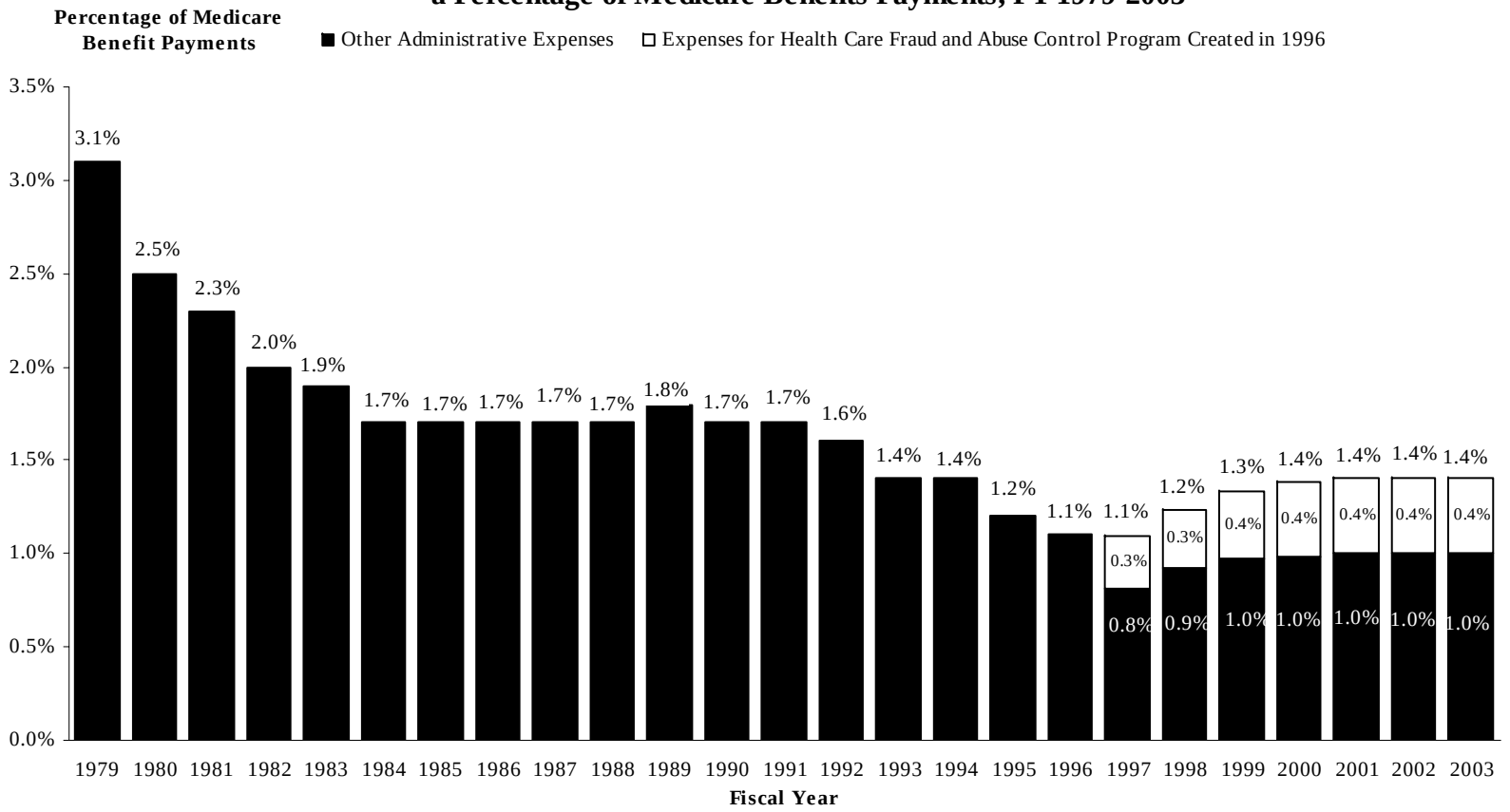
As shown in Figure 5-2, the percentage rose slightly between FY 1996 and FY 2000, such that, in FY 2000, Medicare administrative and management spending represented 1.4 percent of Medicare benefit payments. By comparison, administrative expenses as a percentage of benefit payments represented, on average, 5 percent for

Figure 5.1: Allocation of the $4.4 Billion in Federal Spending on Medicare Administration and Management in FY 2003



SOURCE: Budget of the U.S. Government, Fiscal Year 2005, Appendix.

Figure 5-2. Medicare Administrative and Management Expenditures as a Percentage of Medicare Benefits Payments, FY 1979-2003



*Administrative expenditures depicted do not include expenditures on quality improvement organizations (QIOs). HIPAA responsibilities were not Medicare related, but CMS (HCFA) did not receive additional appropriations to carry out these responsibilities. Figures in column may not sum to total due to rounding.

SOURCE: Sibyl Tilson, 2001; Budgets of the U.S. Government, Fiscal Years 1979-2005; Congressional Budget Office, 2000.

Medicaid, 12.2 percent for Blue Cross/Blue Shield plans, and 25 percent for commercial insurance plans (which have to spend money on marketing and sales) (Tilson, January 2001). Furthermore, much of the latest increase in the percentage of Medicare administrative spending shown in Figure 5-2 is due to the Health Care Fraud and Abuse Control Account created in 1997 (see discussion below), the funds for which go to CMS contractors and other parts of the federal government. Excluding the Health Care Fraud and Abuse Control Account, Medicare administrative spending (including special funds appropriated by Congress to help implement Medicare+Choice and to address Y2K problems) has remained at or below 1 percent of Medicare benefit payments since FY 1997.

Several of the interviewees suggested that the unique congressional appropriations process for Medicare may be contributing to underinvestment in program administration. For other federal health agencies, such as the National Institutes of Health, administrative budgets are considered together with expenditures designed to improve health. Because Medicare is an entitlement program, however, federal expenditures for benefits and administration are determined separately.

- **Medicare benefits expenditures.** Spending for Medicare benefits is nondiscretionary spending. Payment of Medicare benefits is made automatically from two federal Medicare trust funds: (1) the hospital insurance trust fund (for Part A benefits); and the (2) supplementary medical insurance trust fund (for Part B benefits). Benefit payments do not count toward annual domestic spending caps.
- **Medicare administrative expenditures.** Administrative spending (with the exception of spending for PRO/QIOs and anti-fraud and abuse activities) is discretionary spending. Funds for most Medicare management functions are appropriated by the Congress from the Medicare trust funds. With a few exceptions, these funds do count toward domestic spending caps.

Appropriating lawmakers consider Medicare's administrative expenditures in isolation, apart from benefits, so they may not directly recognize Medicare and CMS's role in the health of the roughly 40 million Medicare beneficiaries. Hence, when CMS's administrative budget competes for funds against human genome research and many other popular programs in the U.S. Department of Health and Human Services, it seldom emerges a winner.

Lack of Personnel for Medicare Administration and Management. Medicare's administrative resource problems also include insufficient personnel. In 1999, CMS employed 4,139 full-time equivalent employees (nearly 600 fewer than it employed in 1979) (Tilson, January 2001). Given the size and complexity of Medicare and the other programs administered by CMS, the number of people employed by CMS is relatively small. Almost a third of the CMS employees worked in the agency's 10 regional offices and another 385 worked exclusively on Medicaid (Tilson, January 2001). (By comparison, the Social Security Administration, with an overall budget of $402 billion in 1999 (US Office of Management and Budget, 2002) and duties that many

people would consider to be more straightforward (e.g., maintaining payroll tax records, determining eligibility, processing checks, and answering beneficiary inquiries) than those required of CMS for Medicare — employed about 60,000 full-time equivalent employees.) This number includes staff supporting an extensive infrastructure of local offices with direct contact with beneficiaries (Social Security Administration, 2003).

CMS also has had difficulty attracting individuals with certain types of training and expertise, particularly medicine and information technology. In addition, CMS has had little success in hiring individuals with experience in managed care or other parts of the private health insurance industry. To the extent that Medicare is expected to move away from simply paying claims to incorporate more modern, relevant practices of health insurance, such expertise is vital.[50] The aging of the CMS senior staff and a string of relatively recent departures of key personnel to the private sector could exacerbate these trends. New federal retirement rules may create incentives for more staff to leave government service after only a few years of training rather than spend their careers at CMS or elsewhere in the federal government.

A major limiting factor appears to be CMS's salary structure. The agency simply cannot provide compensation sufficient to compete with health plans or other private organizations for the best and the brightest. A number of interviewees also pointed to CMS's inability to retain talented young professionals, given the better salaries they can garner in the private sector. Others pointed out that CMS does not provide opportunities for staff to spend time working in a private organization in order to get new experience that will be of use to Medicare — a problem that is certainly not unique to Medicare.

Inadequacy of Medicare's Information Technology. As discussed in Chapter 3, CMS uses or has the potential to use computers and other information technology as a tool for more effectively and efficiently performing several Medicare administrative tasks: processing Medicare claims; educating and informing Medicare beneficiaries about their benefits, rights, and options; combating fraud and abuse in the Medicare program; supporting Medicare quality assurance and improvement activities; and providing data on the Medicare program needed for analysis and policymaking. Interviews conducted for this study, as well as other analyses, suggested that CMS's current computer systems were antiquated, inadequate to their tasks, and without sufficient funding for improvement.

[50] See, for example, Ethredge, June 1995.

5B. Medicare Officials' Conflicting Roles and Demands

Medicare managers report that they are often torn by competing roles and demands. Medicare has several missions:

- Serving Medicare beneficiaries' health care needs;
- Protecting the financial integrity of the Medicare program and preserving the solvency of the Medicare trust funds;
- Making sure providers are adequately paid to ensure their participation in the Medicare program;
- Ensuring the quality of services provided to Medicare beneficiaries;
- Guarding against fraud and abuse in the program;
- Working with a large number of private contractors to both ensure their quality and keep them pleased; and
- Working with states and localities, responding to Congress, and serving the political and policy priorities of both the Secretary of Health and Human Services and the President of the United States.

Some of these missions are complementary, but others sometimes conflict. Thus, Medicare managers must ensure adequate participation in Medicare by health care providers, but also see to it that providers meet performance and quality standards. To ensure that the program will be available to meet the needs of future Medicare beneficiaries, Medicare managers must maintain the financial viability of Medicare and the Medicare trust funds, which means, among other things, that they must guard against waste, fraud, and abuse in the Medicare program. Compounding the situation is the fact that, because of Medicare's enormous size, impact on the health of older beneficiaries and those with disabilities, and potentially huge effect on local and national economies, Medicare managers are often placed under an unforgiving microscope.

5C. Congressional Involvement in Medicare Management

Congressional involvement in the management of Medicare — which constrains decision making on the part of CMS and the executive branch — has sharply increased over the past 20 years. Furthermore, with the legislative and executive branches of the federal government frequently controlled by different parties in recent years, the relationship between Congress and executive branch in managing Medicare has often been strained.

Congressional Involvement in the 1980s. As discussed in Chapter 1, the 1980s ushered in a new era of cost containment and dramatic changes in Medicare and its management.[51] It was during this time that Congress passed important legislation that increasingly moved Medicare away from cost-based reimbursement to a system of

[51]Several pieces of major legislation have been enacted by Congress in the course of the Medicare program's history, often in an effort to help control costs. These include the Social Security Amendments of 1967, 1972, and 1983, the Medicare and Medicaid Anti-Fraud and Abuse Acts of 1978 and 1987, the nine budget reconciliation acts between 1980 and 1993, and the Balanced Budget Act of 1997 (Dowdal, 1998).

administered prices. First, Congress enacted the Social Security Amendments of 1983, replacing Medicare's cost-based hospital reimbursement system with a prospective payment system that pays a predetermined rate for each discharge that varies depending on the patient's condition (diagnosis-related groups or DRGs). Second, in 1989, Congress enacted additional legislation replacing cost-based reimbursement of physicians with a national fee schedule utilizing a resource-based relative value scale (RBRVS).

During the 1980s, there was considerable distrust between the Reagan Administration and the Democratic-controlled U.S. Congress. Members of Congress and their staffs believed that HCFA was not providing them with timely, accurate information about the program. Consequently, Congress decided to create its own Medicare advisory bodies. In 1983, Congress created the Prospective Payment Assessment Commission (ProPAC), an independent commission to advise Congress on Medicare payment policies for hospitals. In 1986, Congress created the Physician Payment Review Commission (PPRC) to take the lead in developing a Medicare physician fee schedule and advise on its subsequent implementation. Also, in the late 1980s and 1990s, Congress expanded CMS's duties by adding federal oversight of clinical laboratories (required by the Clinical Laboratory Improvement Amendments of 1988) and oversight of state regulation of private health insurance required by HIPAA.

Congressional Involvement in the 1990s. In the 1990s, Republicans were more often in control of the Congress and Democrats ran the executive branch, but the same patterns of distrust just described continued. Health care costs during the first part of the decade were escalating at an alarming rate, and Congress responded in part by enacting the Health Insurance Portability and Accountability Act of 1996, which provided new resources and authority to combat health care fraud and abuse. In addition, Congress created far-reaching changes in Medicare via the Balanced Budget Act of 1997. Among other things, the Balanced Budget Act (1) created the Medicare+Choice program to give Medicare beneficiaries more options for managed care and other health plans; (2) created prospective payment systems for outpatient hospital department, home health, and skilled nursing facility services; (3) created a new cost-containment system for physician fees, known as the sustainable growth rate; (4) established a new Medicare beneficiary education program; (5) created the State Children's Health Insurance Program; and (6) merged ProPAC and PPRC into a single body, the Medicare Payment Advisory Commission (MedPAC), to advise Congress on matters pertaining to Medicare.

The addition by Congress of new programs to CMS's responsibilities, plus imposition by Congress of various methods of cost containment on Medicare, has complicated both the management and the administration of the Medicare program. Although the programs added to CMS's responsibilities during these years were considerably smaller in size and scope than either Medicare or Medicaid, their management requires understanding of policy issues distinct from those for Medicare or Medicaid and different administrative and management skills. Developing, administering, and overseeing the new rules taxed the abilities of many Medicare employees who were not necessarily trained to perform these tasks (Brown, 1985). Furthermore, as discussed below, the program integrity efforts and some cost-

containment initiatives mandated by Congress in the 1990s created considerable friction between Medicare and one of its major categories of constituents — health care providers.

Congressional Involvement in the Early 2000s. Members of Congress' interest in Medicare and CMS remains quite intense. Currently, most of the services provided to Medicare beneficiaries are subject to some form of cost control. Medicare's providers and suppliers can be an important engine of local economic development, so Members of Congress are often willing to intervene on behalf of providers and suppliers in their own districts to seek coverage of a particular technology or favorable reimbursement rates.

Strained Relations Between Medicare and Health Care Providers. The federal government's recent emphasis on seeking to contain Medicare costs by modifying provider payment methods and by undertaking efforts to combat fraud and abuse, in addition to complicating the management and the administration of the Medicare program for CMS, has created considerable friction between the Medicare program and the health care provider community. First, whereas hospitals, physicians, and other health care providers used to simply submit a Medicare claim for the amount they deemed appropriate to charge, providers now have to learn and understand a series of regulatory structures that not only tell them how much they can charge but, in many cases, how the services are to be delivered (i.e., they must learn under what circumstances particular services are covered and how to submit claims with the proper "coding" for services delivered). This frustration is compounded by the fact that providers often receive bad advice from contractors about how to bill for Medicare services and that they can be held legally responsible if they follow this bad advice (U.S. General Accounting Office, July 1999). Second, the anti-fraud and abuse efforts launched in the mid-1990s have added new dynamics to this mix, leading many providers to see Medicare (and CMS) as an adversary. In the words of one interviewee, this new approach "may cause a break in Medicare's tradition of conciliation and compromise" in resolving payment disputes with providers.

Health care providers' anger about Medicare payment rates and regulatory requirements is often channeled through Congress in the form of criticism of CMS and its management of the program. Several current and former CMS employees interviewed reported that the constant drumbeat of criticism from Congress and health providers in recent years has adversely affected CMS employee morale and productivity.

5D. Ambiguities in the Functions of CMS and its Regional Offices

CMS has 10 regional offices: Region I located in Boston; Region II in New York; Region III in Philadelphia; Region IV in Atlanta; Region V in Chicago; Region VI in Dallas; Region VII in Kansas City; Region VIII in Denver; Region IX in San Francisco; and Region X in Seattle. The CMS regional offices currently have a variety of responsibilities, among them:

- Working with contractors that process Medicare claims;
- Working with private managed care and fee-for-service plans;

- Working with state agencies that undertake survey and certification activities of health care facilities seeking to participate in federal programs such as Medicare and Medicaid; and
- Working with private organizations involved in the National Medicare Education Program mandated in the Balanced Budget Act of 1997.

Although Medicare was designed as a national program with uniform benefits and eligibility rules, the 10 CMS regional offices and Medicare contractors have considerable leeway in making decisions about what is covered, which health plans can participate, how contracts are established and managed, and how facilities are inspected and certified. This somewhat decentralized approach allows Medicare to recognize the regional and local variations in the practice of medicine and delivery of health care, but it can result in a widely varying Medicare program for beneficiaries and providers. Medicare is a national program, yet with different regional offices making decisions, an individual Medicare beneficiary often faces different Medicare rules in different places. Furthermore, two decades of research showing that geographic variations in medical practice are not explained by underlying differences in health status and do not necessarily lead to improved outcomes has increased scrutiny of such variations.[52]

Several of the individuals interviewed suggested that communication and coordination between the national and regional CMS offices is inadequate. The lack of communication and coordination often results in outside organizations' receiving conflicting information from different offices. Avoiding these communications and coordination problems may be made more difficult by the fact that regional employees report to and are evaluated by the regional administrators, rather than by staff in the national office with ultimate responsibility for the employees' duties.

5E. Questions about the Responsibilities of CMS Itself

A final crosscutting issue suggested by the analysis in this paper is what the responsibilities of CMS itself should be. Should CMS be an agency devoted to the management of one program, Medicare, or two programs, Medicare and Medicaid? Should CMS also have other health policy responsibilities, as it does now?

CMS's predecessor HCFA was created at a time when national health insurance was a prominent part of the political dialogue. Having a single agency with broad expertise and responsibility for many health policy issues might have seemed to make sense. Today, given all of the other challenges faced by CMS, it may be reasonable to ask whether the agency should have a narrower focus.

Finding an answer may not be easy. The list of activities that some observers have suggested Congress carve out of CMS is varied:

[52] Although there is significant evidence of geographic variations in medical practice, there is much more limited evidence about which medical practices lead to the best outcomes for a given condition. This lack of evidence makes it difficult to cover only those services that lead to the best clinical outcomes.

- Responsibilities for the Medicaid program. CMS is the lead federal agency for Medicaid, a federal-state program that has provided health insurance to very low-income people since 1965. Some interviewees advocated removing Medicaid as a CMS responsibility, but other interviewees thought Medicare and Medicaid are too closely linked to separate their administration. A large subset of Medicaid beneficiaries is also eligible for Medicare. In 1998, 10 percent of Medicaid beneficiaries were elderly (i.e., Medicare beneficiaries) and accounted for 27 percent of all Medicaid spending. Another 17 percent of Medicaid beneficiaries were blind or disabled (i.e., largely Medicare beneficiaries) and accounted for 39 percent of Medicaid dollars (Kaiser Commission on Medicaid and the Uninsured, 2001).
- Responsibility for research and demonstrations pertaining to health care programs such as Medicare and Medicaid;
- Responsibilities related to the state survey and certification process for health care providers participating in programs such as Medicare and Medicaid;
- Oversight responsibilities under the Health Insurance Portability and Accountability Act of 1996;
- Oversight responsibilities under the Clinical Laboratory Improvement Amendments of 1988;
- Responsibilities for private Medicare plans, and
- Responsibilities for the State Children's Health Insurance Program enacted in 1997.

Separate from the question of whether any of these responsibilities should be a part of CMS is the question of where one might place them if they were removed. HCFA/CMS originally received some of these duties (e.g., those under the Health Insurance Portability and Accountability Act and the Clinical Laboratory Improvement Amendments) because it was considered the best available option.

5F. Concluding Thoughts

This paper underscores the magnitude and complexity of responsibilities in managing the Medicare program and identifies several challenges federal administrators face in performing these tasks. Ultimately, Medicare's administrative infrastructure should support the program's basic policy goals of ensuring access to affordable, accessible, high-quality care for what is generally considered one of the most vulnerable segments of society. However, the situation described in this paper has made it difficult to develop solutions that support the program's ability to accomplish these policy goals. Furthermore, the challenges outlined in this paper do not even begin to include those that emerge from adopting substantial changes in Medicare's benefits or basic structure.

Appendix A: Individuals Interviewed for this Project

In the fall of 2001, the authors conducted structured telephone interviews with the following national experts in Medicare management and policy. As the biographies suggest, the interviewees represented a wide range of relevant experiences, philosophies, and political parties. *The positions listed reflect the job titles they held at the time of the interviews.*

Jennifer Baxendell
House Ways and Means Committee. Working for Chairman Bill Thomas and Health Subcommittee Chairwoman Nancy Johnson, she has focused on Medicare reform and prescription drug coverage. During the previous two Congresses, prior to joining the Ways and Means Committee staff, Ms. Baxendell was on the staff of Chairman Bill Roth's Senate Finance Committee. There she worked on Medicaid and the State Children's' Health Insurance Program in addition to Medicare reform.

Robert A. Berenson, M.D.
Senior Advisor to the Academy for Health Services Research and Health Policy and Adjunct Professor at the University of North Carolina School of Public Health and the Fuqua Business School at Duke University. From April 1998 until January 2000 he served in the Health Care Financing Administration (HCFA) as Director of the Center for Health Plans and Providers and as HCFA's Acting Deputy Administrator.

Kathleen Buto
Senior Health Advisor at the Congressional Budget Office (CBO). She joined CBO in 2000 from the Health Care Financing Administration (HCFA), where she was the senior career policy official of the agency. Ms. Buto served as the Deputy Director for HCFA's Center for Health Plans and Providers. Before 1997, she served as HCFA's Associate Administrator for Policy, directing the policy development, research and demonstrations, and actuarial functions of the agency.

Gary Claxton
Senior Researcher at the Institute for Health Care Research and Policy at Georgetown University. Mr. Claxton served from March 1997 until January 2001 as the Deputy Assistant Secretary for Health Policy at the U.S. Department of Health and Human Services, where he advised the Secretary on health policy issues, including improving access to health insurance, Medicare reform, administration of the Medicare and Medicaid programs, financing for prescription drugs, expanding patient rights, and health care privacy.

Carol A. Cronin, M.S.W.
Independent consultant on consumer health information. She also chaired the federal Advisory Panel on Medicare Education, which advises the Health Care Financing Administration (HCFA) on issues related to the education of Medicare beneficiaries. Previously, Ms. Cronin served as the first director of the Center for Beneficiary Services at HCFA where she was responsible for planning, implementing and evaluating the National Medicare Education Program.

Nancy-Ann DeParle
Health care consultant in Washington, D.C., Senior Advisor to JP Morgan Partners, LLC, and Adjunct Professor at the Wharton School of the University of Pennsylvania. From November 1997 until October 2000, DeParle served as Administrator of the Health Care Financing Administration (HCFA). Before joining the U.S. Department of Health and Human Services, Ms. DeParle was Associate Director for Health and Personnel at the White House Office of Management and Budget, where she oversaw budget and policy matters relating to all federal health programs.

Senator David F. Durenberger
President of Public Policy Partners, L.L.C. He served as U.S. Senator from Minnesota from 1978 to 1995. He authored and co-authored most Medicare/Medicaid, health insurance, and other health reform legislation from 1980 until 1993.

Jack Ebeler
President and CEO of the Alliance of Community Health Plans. The Alliance of Community Health Plans is a national alliance of leading not-for-profit and provider-based health plans. Previously, he was Senior Vice President and Director of the Health Care Group at the Robert Wood Johnson Foundation, the nation's largest philanthropy devoted solely to health and health care. In 1995 and 1996 he served in the U.S. Department of Health and Human Services as Deputy Assistant Secretary for Planning and Evaluation/Health and then as Acting Assistant Secretary for Planning and Evaluation. From 1977-1981, Mr. Ebeler served as Special Assistant to the Administrator of the Health Care Financing Administration.

Joseph P. Flynn
Vice President of the American Federation of Government Employees, AFL-CIO. He has been involved in contract negotiations with the Centers for Medicare and Medicaid Services (CMS). Previously he worked as a Health Insurance Specialist at HCFA, as the Director of the New Mexico Medical Assistance Program, and as the President of the Maryland Industrial Relations Research Association.

Bruce Merlin Fried
Partner in Health Law Group at Shaw Pittman. Shaw Pittman is an international law firm based in Washington, DC. He served as the Director of the Center for Health Plans and Providers at the Health Care Financing Administration (HCFA), where he was responsible for policy and operations for the Medicare program. Prior to that, Mr. Fried was Director of HCFA's Office of Managed Care, where he managed the rapid growth of Medicare and Medicaid managed care.

Leslie Fried
Associate staff director with the American Bar Association (ABA) Commission on Legal Problems of the Elderly. She joined the ABA in September 1998, as the Medicare Advocacy Project attorney, a collaborative project with the Alzheimer's Association. She specializes in Medicare issues and responds to Alzheimer's-related Medicare inquiries from local Alzheimer's Association chapters.

John Gage
President of the American Federation of Government Employees (AFGE) Local 1923. From 1976-1981, he was the Vice President of that local. He became President of AFGE in 1981. AFGE Local 1923 is the exclusive representative for more than 20,000 Social Security Administration and Health Care Financing Administration employees.

Barbara Gagel
Former Chairman of AdminiStar Federal and Anthem Alliance, Anthem Insurance Companies, Inc. AdminiStar Federal is a subsidiary of Anthem Alliance and has been a Medicare contractor since the program's inception. The company holds contracts as a fiscal intermediary for Medicare Part A for Indiana, Illinois, Kentucky, and Ohio and as a carrier for Medicare Part B for Indiana and Kentucky. It also operates the 1-800-MEDICARE hotline. Ms. Gagel worked at the Health Care Financing Administration (HCFA) from its creation until 1992 and served as Director of the Health Standards and Quality Bureau (1992-96) and Director of the Bureau Program Operations (1987-1992). She also worked as the Regional Administrator of the Chicago Regional Office of HCFA from 1982-1987.

Aileen Harper
Associate Director of the Center for Health Care Rights in Los Angeles. For more than 10 years, Ms. Harper has directed Medicare advocacy program services for the Center for Health Care Rights.

Michael Hash
Principal at Health Policy Alternatives, Inc. Health Policy Alternatives, Inc. is a Washington based health consulting firm specializing in health policy and financing issues. From March 1998 through December 2000, he served as the Deputy Administrator and Acting Administrator of the Health Care Financing Administration (HCFA). He served from 1990 to 1995 as the Senior Staff Associate of the Subcommittee on Health and the Environment of the House Energy and Commerce Committee with responsibilities for Medicare legislation and health care reform proposals.

Thomas V. Holohan, M.A., M.D., FACP
Chief Officer for Patient Care Services in the Veterans Health Administration (VHA), U.S. Department of Veterans Affairs. The Office of Patient Care Services is comprised of 13 Strategic Healthcare Groups that are responsible for the development of clinical programs and policy, and for the monitoring of clinical care. Prior to coming to VHA, Dr. Holohan was Director of the Center for Health Care Technology.

Michelle P. Holzer
Program Officer for the Maryland State Department of Aging's Senior Health Insurance Assistance Program. The program is a volunteer-based model featuring claims assistance, counseling, public education, and legal advocacy services for older persons. There are 19 Senior Health Insurance Assistance Program projects in Maryland, serving the entire state.

Lauren LeRoy, Ph.D.
President and CEO of Grantmakers In Health (GIH). GIH is a nonprofit educational organization serving trustees and staff of foundations and corporate giving programs working in the health field. Before joining GIH, Dr. LeRoy was Executive Director of the Medicare Payment Advisory Commission (MedPAC), a nonpartisan congressional advisory body charged with providing advice and technical assistance on Medicare and broader health system issues. Prior to MedPAC, Dr. LeRoy served as Executive Director of the Physician Payment Review Commission (PPRC), one of two congressional advisory commissions merged to create MedPAC in October 1997. She joined PPRC at its inception in 1986 as Deputy Director and later became Executive Director in 1995.

Steven M. Lieberman
Executive Associate Director of the Congressional Budget Office (CBO). At CBO, he concentrated primarily on health and social security issues. From 1976 to 1992, he worked at the White House Office of Management and Budget, focusing for 14 years on Social Security, Medicare, and Medicaid.

Linda M. Magno
Managing Director for Policy at the American Hospital Association (AHA). Immediately before joining the AHA in 1988, Ms. Magno spent nearly four years as Director of the Health Care Financing Administration's (HCFA) Division of Hospital Payment Policy, where she directed the development and issuance of annual Medicare regulations updating the hospital prospective payment system; developed refinements to the prospective payment system; and implemented legislative changes enacted by Congress.

Gretchen Margraf
Program Director of the Ohio Senior Health Insurance Information Program (OSHIIP). She held this position since November 1996. OSHIIP is a state and federally funded program that educates, counsels, and advocates for Medicare beneficiaries regarding Medicare and other health insurance matters.

Kathleen E. Means
Senior Health Policy Advisor at Patton Boggs. Before joining Patton Boggs in 2001, Ms. Means directed the health care staff for the Republican majority on the Committee on Finance of the U.S. Senate. She also served on the Republican majority staff for the Health Subcommittee of the House Committee on Ways and Means, and in the Senior Executive Service for the Health Care Financing Administration (HCFA). Ms. Means began her career in health care financing in 1969 at the Bureau of Health Insurance (BHI), the federal agency that preceded HCFA in managing the Medicare program. She worked in a series of progressively responsible positions at BHI, HCFA, and the Office of the Secretary at the U.S. Department of Health and Human Services.

Janet G. Newport
Corporate vice president of public policy for PacificCare Health Systems, Inc., and company liaison with key government agencies and Congress. Ms. Newport has served on several American Association of Health Plans technical and advisory committees and has been an industry representative on the Health Care Financing Administration's (HCFA) Medicare Council. She has also served as an industry representative on internal HCFA technical committees.

Shana Olshan, MPH
Technical Advisor for the Coverage and Analysis Group in the Centers for Medicare and Medicaid Services' Office of Clinical Standards and Quality. Previously, she served as special assistant to the Director of the Office of Clinical Standards and Quality and health insurance specialist in the area of physician payment.

Steven A. Pelovitz
Director of the Survey and Certification Group in the Center for Medicaid and State Operations at the Centers for Medicare and Medicaid Services. Mr. Pelovitz has been responsible for budget and financial management functions relating to health care facility survey and certification and the Clinical Laboratory Improvement Act.

Carol Raphael
President and CEO of the Visiting Nurse Service (VNS) of New York. VNS is the largest voluntary home health care organization in the United States. Before joining VNS, Ms. Raphael, worked for nine years at the New York City Human Resources Administration, leaving as executive deputy commissioner of the Income and Medical Assistance Administration.

Thomas R. Reardon, M.D.
President of the American Medical Association (AMA) (June 1999-2000). A member of the AMA Board of Trustees since 1990, he served on its Executive Committee since 1994, as Secretary-Treasurer to the AMA from 1994 to 1995, as Vice Chair of the Board of Trustees from December 1995 to June 1997, and as Chair of the Board of Trustees from June 1997 to 1998. Dr. Reardon served on the Physician Payment Review Commission for eight years (1986-94).

William Scanlon, Ph.D.
Director of Health Care Issues at the U.S. General Accounting Office (GAO). Before joining GAO in 1993, he was the Co-Director of the Center for Health Policy Studies, an Associate Professor in the Department of Family Medicine at Georgetown University, and had been a Principal Research Associate in Health Policy at the Urban Institute. His research has focused on the Medicare and Medicaid programs, especially provider payment policies, and the provision and financing of long-term care services.

David G. Schulke
Executive Vice President of the American Health Quality Association (AHQA). AHQA represents the nation's network of health care quality improvement organizations (formerly known as peer review organizations, or PROs).

Bridgett Taylor
Member of Democratic staff of the House Committee on Commerce. From 1991-1995, she served as the Associate Director for Health, Office of the Assistant Secretary for Legislation in the U.S. Department of Health and Human Services.

Monica Tencate
Health Policy Director for the Senate Finance Committee under Senator Chuck Grassley (R-IA). Ms. Tencate's responsibilities include development, coordination, and management of the health policy agenda, including the Medicare, Medicaid, and State Children's Health Insurance Programs, as well as policies to address the uninsured, and long-term care.

Sean Tunis, M.D., M.Sc.
Director of Coverage and Analysis Group in the Office of Clinical Standards and Quality at the Centers for Medicare and Medicaid Services (CMS). CMS relies on this group to determine Medicare coverage policy and issue nationally applied coverage decisions. Prior to joining CMS, Dr. Tunis was a Senior Research Scientist with The Lewin Group, where he led the design and conduct of prospective comparative effectiveness studies.

Bruce C. Vladeck, Ph.D.
Senior Vice President for Policy of Mount Sinai NYU Health and Director of the Institute for Medicare Practice and Professor of Health Policy and Geriatrics at the Mount Sinai School of Medicine. Dr. Vladeck was HCFA Administrator from 1993 through September 1997.

Gail Wilensky, Ph. D.
John M. Olin Senior Fellow at Project HOPE. At Project HOPE, an international health foundation, she analyzed and developed policies relating to health reform and to ongoing changes in the medical market place. She has served as Chair of the Medicare Payment Advisory Commission and the Physician Payment Review Commission. In 1989-91, she served as the Administrator of the Health Care Financing Administration.

Paul R. Willging, Ph.D.
Director of the Seniors Housing and Care Program in the Graduate Division of Business and Management of Johns Hopkins University. He also held an appointment as the Senior Associate in Johns Hopkins' School of Public Health. Previously, he held positions at the Health Care Financing Administration (HCFA), where he worked as Deputy Administrator and Deputy Director of HCFA's Bureau of Program Operations.

Donald A. Young, M.D.
Interim President of the Health Insurance Association of America (HIAA). Prior to joining HIAA, Dr. Young served as the Senior Vice President for Policy and Clinical Services at the American Association of Health Plans and was Executive Director of the Prospective Payment Assessment Commission. Earlier, he was Deputy Director of the Health Care Financing Administration's Policy Bureau.

Appendix B: Questions Asked in Structured Interviews

The instrument the authors of this paper used to conduct structured telephone interviews with national experts in Medicare management and policy is presented below.

A. GENERAL QUESTIONS (ask all respondents)

1. What are the 2 or 3 most important management challenges facing CMS/HCFA?
2. What are the 2 or 3 management functions that CMS currently performs well?
3. What 2 or 3 management functions does CMS currently perform poorly?
4. What lessons can be learned from these functions that can be applied to running Medicare (and CMS's other programs)?
5. Does CMS have too many management functions to perform them well? If so, how might those functions be simplified to improve performance?
6. Does CMS (and its contractors) have sufficient resources to perform its management functions? Where might additional resources have the greatest impact?
7. Are there sufficient personnel at CMS to perform its management functions? If not, where would additional personnel be best assigned or reassigned?
8. Are there other changes that are needed in the area of personnel (e.g., hiring/recruiting practices, quality of life) that need to be addressed to improve management of Medicare?
9. How well do CMS's regional offices function as a conduit of information between providers and communities and CMS's national offices?
10. Is Congress being too prescriptive with its Medicare legislation (e.g., micromanaging)? Or is Congress leaving too many difficult decisions to CMS?
11. How did the "spin off" of SSA into an independent agency affect Medicare management? Are additional changes needed to ameliorate any of those affects?
12. How does management of Medicare compare with other large, complicated management challenges? Is it more complex? Less complex? About the same?

B. SPECIFIC QUESTIONS (ask respondents with expertise in these areas)

1. Managed Care

a. How well does CMS manage Medicare+Choice?

b. What, if any, changes are needed in management of M+C?

c. Is there an inherent conflict of interest in having CMS manage both the FFS and M+C programs?

d. Are there sufficient resources and personnel to manage M+C?

2. Consumer/Beneficiary Information/Services

a. How well does CMS perform its consumer education function?

b. Do the SHIPs serve as an effective on-the-ground consumer assistance function? If not, what changes might help them function better?

c. How well do Medicare contractors serve consumer needs for information/assistance?

d. Would Medicare benefit from a greater local presence? If so, do you have any ideas for such a presence?

3. Information Technology

a. Does CMS (and its contractors) have sufficient IT to perform its various functions?

b. What priorities should CMS set for its future IT acquisitions?

c. Does CMS need to readdress the Medicare Transaction System issue? If so, what lessons should it have learned from earlier efforts?

4. National Coverage

a. How well does CMS perform its task to make decisions about coverage of new medical technologies/services?

b. What changes would you recommend in this area?

5. Relationship with Contractors

c. How well does CMS manage its contractors?

a. Are there too many contractors? If so, what is the optimal number of contractors? In what areas?

b. Are changes needed in the process of selecting contractors?

c. How well do CMS regional offices perform their relations with contractors?

6. Rate Setting

a. How well does CMS perform its responsibilities for setting and updating payment rates?

b. Is CMS getting the "right kind" of assistance from MedPAC, GAO, OIG, and other advisory/oversight bodies in this area?

c. Is Congress providing too little/too much or the right amount of guidance in the area of rate setting?

7. Program Integrity

a. How well does CMS perform its responsibility to oversee and enforce the integrity of the Medicare program?

b. How well does CMS interact with other bodies (e.g., DOJ, OIG, GAO) in performing these functions?

c. Are sufficient resources/personnel being dedicated to this task?

d. Is there an inherent conflict in having CMS perform this task while also trying to maintain good relations with providers and beneficiaries?

8. Quality Assurance/Certification

a. How well does CMS perform its responsibility for assuring quality and safety in provision of Medicare services?

b. Are sufficient resources/personnel being dedicated to this task?

c. Are current partnerships with states and private entities (e.g., JCAHO, NCQA) functioning well? If so, should they be expanded?

d. Is the PRO/QIO program functioning well? If not, what changes are needed?

9. Research and Demonstrations

a. How well does CMS perform its R&D responsibilities?

b. Are such functions appropriately housed in CMS? If not, where?

c. Are sufficient resources/personnel dedicated to this task?

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