PROGRESS on the nation's health policy agenda, like so many other things, was interrupted by the tragic events of September 11. However, that disaster has not changed a view shared by Democratic and Republican policymakers: the Centers for Medicare and Medicaid Services (CMS), formerly known as the Health Care Financing Administration (HCFA), is badly in need of repair. The federal agency is the single largest purchaser of health care in the world, with an estimated $476 billion paid for health care services in 2001 on behalf of 70 million disabled, elderly, and poor beneficiaries. In recent years, however, the agency has come under sharp criticism from Congress for the regulatory burden it imposes on physicians and hospitals and its insular ways. Equally disturbing has been the aggressive campaign waged by government against health care fraud and abuse. The campaign has generated fear among physicians, although very few have been found guilty or even accused of illegal activity. In this report, I sketch the agency's vast responsibilities and discuss regulatory reforms that are moving forward in Congress on a bipartisan basis. I also emphasize the ideological divide between Republicans and Democrats, which will prevent broader reforms of Medicare for the foreseeable future.

There have always been conflicts between the CMS and its predecessors, on the one hand, and physicians, hospitals, clinical laboratories, home health agencies, kidney dialysis centers, and suppliers of durable medical equipment, on the other. Medicare is the largest single source of income for all these groups. No amount of regulatory relief will entirely erase these inherent conflicts. The CMS has a fiduciary role as guardian of tax revenues that represent 15 percent of the federal budget. Legislators, the medical profession, and health care organizations have questioned the agency's ability to manage its vast domain. Even George W. Bush and Al Gore felt compelled to call for reforms of the Medicare program during their campaigns for the presidency. Bush said that Medicare reform was essential because of its precarious finances and the complexity of its bureaucracy.

THE GROWTH OF THE AGENCY

In 1965, Congress created Medicare and Medicaid for elderly and poor persons, respectively. Congress vested responsibility for managing Medicare in the Social Security Administration. Medicaid is also subject to federal oversight, but state governments actually operate the programs. Congress eventually grew dissatisfied with the performance of the Social Security Administration, which failed to constrain Medicare expenditures and had a penchant for accommodating providers. In 1977, Joseph A. Califano, Jr., the Secretary of Health, Education, and Welfare in the Carter administration, "moving quickly and secretly" to avoid criticism, created HCFA. The new agency's responsibilities were to manage Medicare and Medicaid. Over the next two decades, however, Congress assigned the agency many additional responsibilities without providing the funds for a commensurate increase in its administrative capacity.

Since 1996, the agency has been responsible for implementing some 700 provisions of five major laws: the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, the Health Insurance Portability and Accountability Act of 1996, the Balanced Budget Act of 1997, the Balanced Budget Refinement Act of 1999, and the Benefits Improvement and Protection Act of 2000. Some of the most expansive provisions contained in these laws called for the agency to tackle new tasks that fell outside the expertise of its staff, such as regulating private health insurance and establishing electronic-data standards for the entire health care industry. Perhaps the most controversial of all these measures was the Balanced Budget Act of 1997. The act reduced Medicare payments to virtually every clinical laboratory, hospital, skilled nursing facility, and home health care agency in the United States, with an estimated total reduction of $112 billion for the period from 1998 through 2002.

Congress has always played a large part in shaping the policies of the agency, down to a remarkably prescriptive level of detail. The vigilance of Congress stems from its continued concern about the rapid growth of health care expenditures in most years, particularly during periods when the federal government has operated at a deficit. Congress has also responded to the persistent lobbying and the campaign contributions of an array of health care organizations that rely on CMS programs as lines of business. Their efforts — combined with a recognition by legislators that the 1997 budget law had placed many providers under financial duress — proved remarkably successful in persuading Congress to act. Through budget laws enacted in 1999 and 2000, Congress restored an estimated $51 billion of the Medicare funds that had been cut in 1997.

THE ROLE OF PRIVATE CONTRACTORS AND OTHER GOVERNMENT AGENCIES

The CMS receives most of the criticism leveled at its programs. Much of the agency's work, however, is actually carried out by private contractors and state agencies, as well as by other federal entities in the
The capacity of the CMS to administer its expanded portfolio of programs has declined precipitously. In 1999, for example, the agency had 4219 (full-time-equivalent) employees, as compared with 4961 in 1980. With a small staff, no marketing expenses or need to provide a return on private investments, and tight congressional control of other CMS expenses, the agency's administrative expenses have fallen to about 2 percent of its claim payments (Fig. 1). Management of Medicare accounts for almost all of the agency's administrative expenses. By comparison, the administrative costs of the average private insurer represent about 11 percent of claim payments. Although the CMS is often praised for its low operating expenses, "this efficiency sometimes has been achieved at the expense of sound management," as Nancy-Ann DeParle, a former administrator of the agency, noted in recent congressional testimony. As an example, she pointed out that the toll-free telephone lines physicians had used to call carriers with questions about Medicare billing were eliminated to allow for increased expenditures to educate beneficiaries.

When physicians do call their carriers, more often than not they receive wrong or inaccurate answers to their questions, according to additional testimony delivered in September before the House Ways and Means Subcommittee on Health by Leslie G. Aronovitz of the General Accounting Office. An assessment of the accuracy of information provided by carriers to physicians, Aronovitz said, uncovered a disturbing pattern:

We placed approximately 60 calls to the provider inquiry lines of five carriers' call centers. The three test questions, all selected from the "frequently asked questions" on the carriers' Web sites, concerned the appropriate way to bill Medicare under different circumstances. The results of our test, which were verified by a CMS coding expert, showed that only 15 percent of the answers were complete and accurate, while 53 percent were incomplete and 32 percent were entirely incorrect.

The General Accounting Office concluded, "Mismatches between resources, authorities, and the agency's responsibilities have hindered CMS' efforts to acquire appropriate expertise, modernize outdated and inefficient information systems, and conduct oversight activities." Fourteen health policy experts from across the political spectrum, including three former administrators of the agency who served during the terms of Democratic and Republican presidents, expressed a similar view in a joint statement issued in 1999:

[The difficulties stem from the] unwillingness of both Congress and the Clinton administration to provide the agency the resources and administrative flexibility necessary to carry out its mammoth assignment. This is not a partisan issue, because both Democrats and Republicans are culpable for the failure to equip HCFA [the Health Care Financing Administration] with the human and financial resources it needs. . . . This is also not an endorsement of the present or past administrative activities of the agency. Congress and the administration should insist on an agency that operates efficiently and in the public interest.14

THE VIEWS OF PROVIDERS

Most practicing physicians, hospitals, and other providers view the CMS in the context of the regulatory requirements with which they must cope. Congressional testimony by medical organizations is replete with tales of anger, frustration, and wasted time.
that result from complying with an endless stream of regulations, many of which are issued by the agency's private contractors. But, of course, a regulation that one person considers overly prescriptive another person may view as a necessary safeguard against inadequate care. This difference in perspective has been aptly demonstrated by the long struggle over patients' rights legislation. In any event, Medicare remains very popular with beneficiaries and the public.15

INVESTIGATION OF FRAUD AND ABUSE

Congress and the executive branch have been much more willing to spend money on the investigation of health care fraud and abuse than on improvements in the administrative capacity of the CMS. Between 1989 and 2000, the number of Medicare claims rose by about 70 percent, to more than 800 million, whereas funds provided to contractors for the review of payment claims increased by less than 11 percent.16 By 2000, more than a quarter of the agency's total administrative expenses were allocated to the campaign against fraud and abuse. An expert on public administration wrote:

It is remarkable to contrast the progression of stronger antifraud legislation ... with the increasing squeeze on resources over the same period for the administration of Medicare outside of fraud-and-abuse enforcement. It would seem that all parties would be better off if Congress devoted additional resources to allow for sound management of the Medicare program, including the institution of effective systems and administrative measures to monitor and deter inappropriate [payment] claims before rather than after they become the subject of enforcement actions.10

Medicare's private contractors (carriers) pay providers and are supposed to safeguard the program against fraudulent practices. Time and again, however, their performance has been found wanting. Since 1993, six contractors have settled civil and criminal charges stemming from allegations that they did not check payment claims to ensure proper payment or that they made payments that were the responsibility of other insurers.17 In contrast, federal enforcement activities have been rigorous, even "heavy-handed," as Eric Holder, then deputy attorney general, conceded in a February 1999 speech to the American Hospital Association.

In 1986, Congress amended the False Claims Act, and turned it into a tool against fraud and abuse. Since then, almost $7 billion has been recovered in civil fraud cases. Of that amount, 41 percent was health related, primarily involving for-profit companies that operate clinical laboratories, hospitals, or nursing homes.18 On October 3, the Justice Department announced that TAP Pharmaceutical Products had settled the charges against it for $875 million, the largest settlement of a case involving charges of health care fraud to date.19 Over the past four years, according to the Office of the Inspector General in the Department of Health and Human Services, its enforcement efforts have resulted in the criminal conviction of an average of 18 physicians a year.20 Civil penalties were imposed on an average of 20 physicians per year for misconduct related to their medical practices. These numbers are very small in comparison with the 650,000 physicians who participate in the Medicare program.

The government also recovered $149 million from 15 universities that ran afoul of Medicare policies related to the payment of teaching physicians. Although these fines were paid, the academic medical community was particularly upset over the billing and documentation standards applied by the Office of the Inspector General when it conducted audits of teaching hospitals to determine whether attending physicians were present when residents performed services billed by the senior doctors.

Providers have not been the only targets of fraud and-abuse investigations. In 2000, Bruce C. Vladeck, who served as the administrator of HCFA from 1993 to 1997, was accused by the General Accounting Office of making improper Medicare payments to the Visiting Nurse Service of New York, the New York City Health and Hospitals Corporation, and the Los Angeles County Department of Health Services. Vladeck was never charged by the Justice Department, nor did the department ever acknowledge that he was even under investigation. Having never been formally accused by prosecutors, Vladeck was not formally found to be innocent. However, at a hearing on March 28, 2000, before the Permanent Subcommittee on Investigations of the Senate Governmental Affairs Committee, the General Accounting Office did acknowledge that it had identified no illegal or improper actions on Vladeck's part.21 A short time later, the Justice Department, without having made any public statement on the subject, agreed to pay 40 percent of Vladeck's legal fees (Vladeck BC: personal communication).

THE BUSH ADMINISTRATION'S RESPONSE

For the moment, the Bush administration has put aside broader and far more contentious proposals to reform Medicare. Nonetheless, some changes are in the works, and others are probably forthcoming. At his confirmation hearing, Health and Human Services Secretary Tommy Thompson expressed his concern over Medicare's regulatory burden: "Complexity is overloading the system, criminalizing honest mistakes and driving doctors, nurses and other health professionals out of the program." Soon after becoming secretary, he changed the agency's name and announced plans to "take aggressive, positive steps towards bringing a culture of responsiveness" to the entire department. At a hearing in June before the Senate Finance Committee, Thompson said, "if I cannot understand the rules [proposed by the CMS], I
will reject them. If I cannot understand them, I do not expect doctors, hospital administrators, and clinics to be able to understand them either.”

At the hearing, Thompson and Thomas Scully, the new CMS administrator, outlined plans to streamline the procedures of the agency. These include a shift to an all-electronic procedure that would enable providers to react more readily to proposed regulatory actions, the assignment of a senior staff person as a key contact for every group of providers, and a campaign to educate the public about Medicare beginning in late 2001. If Congress delegates new duties to the CMS, Thompson said, they should be accompanied by the necessary administrative funds.

At a hearing in July before the House Ways and Means Committee, Thompson announced that the department had directed Aspen Systems, a private consulting company, to cease work on the current draft of new guidelines for documenting evaluation and management services. A previous draft, developed jointly by the American Medical Association and the CMS, had been criticized as a “scorched-earth response to Medicare fraud” and “a step backward.” Thompson said, “After six years of confusion, I think it makes sense to try to step back and assess what we are trying to achieve. We need to go back and re-examine the actual codes for billing doctor visits. For the system to work, the codes for billing these visits need to be simple and unambiguous.”

Thompson and Scully have placed particular emphasis on reaching all constituencies through “opendoor policy forums.” Thompson has assigned senior CMS staff members to work directly with state governments. Believing that the agency should provide states with greater flexibility, Thompson has approved hundreds of waivers of federal requirements that stipulate how Medicaid programs should operate. The Medicaid program is the largest item in many state budgets. When the economy slows down, it often becomes a prime target for reducing expenditures. Thompson has established a regulatory-reform group to identify rules that unnecessarily burden physicians, hospitals, and other providers. The Department of Health and Human Services also plans to contract with private vendors to “combine Medicare’s many outdated accounting systems into a single, unified system that will better ensure that the program pays correctly.”

THE CONGRESSIONAL RESPONSE

Although Congress has applauded the initial steps taken by Thompson, legislators are moving to place their own imprimatur on regulatory relief through the efforts of three committees: the House Commerce Subcommittee on Health and the House Ways and Means Committee, which share jurisdiction over Medicare, and the Senate Finance Committee. On October 11, the House Ways and Means Committee unanimously approved a relief measure. Representative Nancy Johnson (R-Conn.), its chief sponsor, said the bill would authorize the CMS to “competitively contract” with the “best entities available to process, make [provider] payments and answer questions.” Currently, the CMS may select as private contractors only those entities that are nominated by providers. The bill, she said, would also “enhance Medicare education and technical assistance for physicians . . . and protect the rights of providers in the audit and recovery process to ensure that the repayment process is fair and open.” The legislation would offer providers “easier avenues” to appeal audits of their Medicare payments and would allow providers 30 days to comply with the new regulations. Providers would also be able to delay “disputed repayments” until after the “second level of external appeal,” rather than after the first level.

Two weeks later, the House Commerce Committee reported a similar measure. The two House committees reconciled the differences between their respective bills and sent the compromise measure to the full House of Representatives, which approved it unanimously on December 4. It is likely that the Senate Finance Committee will report a bill that resembles the House measure. The Congressional Budget Office concluded that the bill approved by the House would require no new federal spending. Because of the strong demands for federal spending on other priorities, Congress will go to some lengths to keep the no-cost feature in the final bill it sends to the President. This feature makes it likely that the bill will become law but also limits its potential for improving the administrative capacity of the CMS.

Congress will also have to decide whether to change the policies that shape the federal campaign against fraud and abuse. Congress is more willing than the Bush administration to relax repayment schedules when Medicare is found to have overpaid a provider. The administration seems determined to maintain its aggressive stance against fraud and abuse. At his confirmation hearing in May, Scully told the Senate Finance Committee, “I certainly have every intention of aggressively enforcing the fraud statutes, and I have no intention to work to water them down.”

THE PARTISAN DIVIDE
OVER MEDICARE REFORM

Investing new resources in the CMS means, by definition, strengthening Medicare’s largest component, the traditional fee-for-service program, which serves all but 5.6 million of the program’s 40 million beneficiaries. Although most providers, beneficiaries, and Democratic legislators favor strengthening the traditional component, most Republicans believe that Medicare must be modernized through the expansion of contracts with private health plans. Scully, the former head of the Federation of Amer-
ican Hospitals, which represents for-profit hospitals, is an outspoken advocate of this approach. In his first public remarks as CMS administrator, he said the Bush administration would seek to double the enrollment of Medicare beneficiaries in health maintenance organizations (HMOs) within four years. In September, however, the CMS announced that 536,000 Medicare beneficiaries — approximately 10 percent of those enrolled in the program — would lose their HMO coverage because of cutbacks by these plans. Although Scully had sought to forestall this exodus by urging executives of every plan under contract with Medicare to reconsider, managed-care companies have reduced their Medicare enrollments for four consecutive years. They have cited financial losses caused by the gap between federal payment levels and rising medical costs.

In 2000, responding to industry concerns, Congress increased Medicare's payment rates. However, only 4 of the 118 HMOs that had planned to withdraw from or reduce their involvement in the Medicare program reversed their decisions. The HMOs that stayed in the program raised out-of-pocket costs for Medicare beneficiaries and reduced prescription-drug and other benefits. Representative Bill Thomas (R-Calif.), chairman of the House Ways and Means Committee and a strong advocate of expanding the involvement of health plans in Medicare, has stated, "The current reimbursement formula fails to pay the true cost of health care." Others disagree. The General Accounting Office has repeatedly reported that Medicare overpays health plans that provide services to the program's beneficiaries.

Neither Democrats nor Republicans have fully embraced the challenge of upgrading the capacity of the CMS to manage its far-flung responsibilities. The Bush administration has proposed moderate additional sums to begin an overhaul of the agency. More money will be needed to replace outdated computer systems, raise salaries, and attract new staff members who have the skills required to manage a modern health insurance program and restore the confidence of physicians and others that the federal government can be a reliable business partner. Many in both parties have found it more expedient to criticize the agency's inadequate performance than to take on the difficult task of improving it.

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