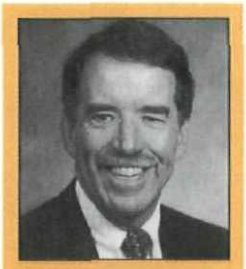
# HCFA: From the Inside Out

BY MICHAEL HASH

As federal policy makers focus more sharply on the need to modernize Medicare, the primary target for reform now appears to be the agency that runs the program—the Health Care Financing Administration (HCFA), recently renamed the Centers for Medicare & Medicaid Services (CMS). Perhaps sensing that fundamental reforms of the Medicare program are beyond their reach, leaders in Congress and the Bush administration seem to have set their sights on restructuring the agency and reforming the way it conducts its business. The first step in this reform effort appears to be changing the agency's name and some internal reorganization that gives more emphasis to the management of the Medicare+Choice program.

In many respects, all this attention to HCFA and its operations is long overdue. For years the agency's workload has expanded while its resources—both financial and human—remained relatively flat. Each new budget bill from Congress has added layer upon layer of complex, prescriptive policies. New responsibilities such as the implementation of the State Child Health Insurance Program (SCHIP) and the new insurance portability protections under the Health Insurance Portability and Accountability Act have been assigned to HCFA. New technology and advancements in care have intensified pressure on the program to make coverage and payment decisions more rapidly. Finally, aggressive efforts to detect and prevent fraud and to improve the accuracy of the claims payment systems have been launched.

Meanwhile, the agency's primary mission—to serve its beneficiaries and to be a reliable business partner for the health plan and provider community—has suffered. Investments in customer service and provider education have lagged. Beneficiary and provider inquiries often get incomplete or inconsistent responses, and appeals simply take too long. The claims processing system, which handles nearly 1 billion claims a year, is seriously strained and in need of a substantial capital investment. Most disturbing, however, has been the erosion of trust and respect between the agency and those that it serves.



*Mr. Hash is principal, Health Policy Alternatives, Washington, DC, and former acting administrator of the U.S. Health Care Financing Administration.*

This year's reform debate holds the possibility of fostering a constructive dialogue on how to improve the agency's performance. Health and Human Services (HHS) Secretary Thompson and Administrator Scully have acknowledged that HCFA is overworked, understaffed, and underfinanced. The key to any reform effort is focusing on the root causes of performance problems, designing workable solutions, matching resources to the required work, and building in accountability measures. However, if the result of all this attention is merely a reorganization or a few changes in operating procedures, the effort will likely be more harmful than helpful.

## A Few Facts About CMS

CMS-administered programs provide health insurance to more than 74 million people—about one fourth of all Americans. It spends more than $360 billion a year for covered services and operates on an annual budget of about $2.2 billion—two thirds of which is paid to 55 private contractors that process claims, pay providers, and handle appeals. An agency staff of approximately 4500 provides policy and operations support in Baltimore and 10 regional offices across the country. In partnership with the states and private entities, CMS provides oversight of the health care system by conducting inspections at thousands of hospitals, nursing facilities, home health agencies, laboratories, and hospices.

The agency was completely reorganized in 1997 with the goal of enhancing its focus on beneficiaries and integrating its policy and operational activities. As a result, most of the work in the agency now requires collaboration of staff across components of the organization. In addition, CMS, as a part of HHS, must get concurrence on major policies from other parts of the department, the Office of Management and Budget, and the White

House. And, extensive oversight of the agency comes from the HHS inspector general, the General Accounting Office, and Congress.

All these responsibilities and relationships would be difficult to manage under the best of circumstances. Certainly CMS's current circumstances are not ideal. The agency's discretion has been severely circumscribed by ever more prescriptive legislation eroding much of its capacity to fix unexpected problems. Failures to coordinate the work of regional offices and contractors and to hold them accountable for consistent implementation of policy are a source of great irritation to providers and health plans. As a result, a continuing drumbeat of criticism by providers and many in Congress has all but drowned out any dispassionate appraisal of the agency or serious discussion of what it will take to improve performance.

### Considerations for Reform

The most important ingredient in a CMS reform strategy is to change the tone and the content of the debate. All the stakeholders need to focus on a common vision for how CMS should look and function. The hostility and mistrust that characterize the relationships of CMS, providers, and congressional leaders need to be set aside before an honest conversation about problems and solutions can be held. Four priority areas should be addressed in any reform strategy:

- A substantial investment in customer service and education needs to be made. The National Medicare Education Program, launched by the Balanced Budget Act of 1997, has significantly improved the quality and accessibility of Medicare information. Yet much more needs to be done to improve the responsiveness of contractors to beneficiary and provider inquiries and appeals. Providers and health plans also need access to timely and consistent information about coverage, payment, and billing policies, which are complex and not always clearly explained. If customer service and education are not a high priority across CMS, the broad public support the program has always enjoyed will be forfeited.
- Now is the time to reassess the agency's efforts to eliminate Medicare fraud. Fraud is a serious problem; CMS has a responsibility to root it out as effectively as possible. In addition, some activities at CMS and in federal law enforcement agencies have eroded trust in the fairness of the procedures used to identify and sanction providers. Now is the time for a discussion about how to communicate Medicare policies more clearly and consistently as well as prevent enforcement activities from undermining the goodwill and support of honest providers.
- Human resources at CMS need to be enhanced by recruiting a more diverse staff. Given the scope of activities, the agency needs more health professionals, health plan leaders, and experts in new technology and services. Although CMS has many talented and dedicated staff, not enough of them have had recent, relevant experience in the private sector or are likely to be at the agency after the next wave of retirements. Moreover, few opportunities exist for staff to rotate to private sector jobs or for private sector leaders to spend time working at CMS. The agency should commit to an aggressive plan for staff recruitment and retention that enhances the its capacity for change and adaptation and ensures a continuation of Medicare's leadership role.
- A significant and sustained financial investment in the administrative budget of CMS must be made. An operating budget of less than 2% of program expenditures is not adequate for the scope of agency functions. Former Administrator Bill Roper, MD, put it clearly in recent congressional testimony: "When I hear people brag about how little Medicare spends on administration, I cringe. That should be a source of embarrassment, not pride." Unfortunately, CMS's administrative budget competes for dollars in a pool of funds that includes the National Institutes of Health and other popular federal programs. A plan for doubling the agency's budget should be considered in any reform strategy.

*As the debate on reform unfolds, we must all turn down the rhetoric, look for common ground, and find the compromises that will advance the interests of beneficiaries, providers, and taxpayers.*

The programs administered by CMS provide health coverage for one fourth of all Americans. For many millions, Medicare, Medicaid, and SCHIP are essential lifelines to the enormous benefits of our health care system. We have an obligation to ensure that the promise of these programs is a reality for today's beneficiaries and those to come. As the debate on reform unfolds, we must all turn down the rhetoric, look for common ground, and find the compromises that will advance the interests of beneficiaries, providers, and taxpayers. □

JOURNAL OF THE CATHOLIC HEALTH ASSOCIATION OF THE UNITED STATES www.chausa.org

HEALTH PROGRESS®

Reprinted from *Health Progress*, July-August 2001