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Testimony

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House of Representatives

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MEDICARE

Successful Reform  
Requires Meeting Key  
Management Challenges

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G A O

Accountability \* Integrity \* Reliability

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Mr. Chairman and Members of the Committee:

I am pleased to be here today as you discuss the long-term sustainability and the more immediate management challenges of the Medicare program. As noted in our companion statement today by the Comptroller General, the Hospital Insurance trust fund is expected to run a cash deficit in 15 years.<sup>1</sup> This projection, while only a partial picture of Medicare's fiscal health, nevertheless sounds the alarm for the longer term, when it is projected that, without meaningful reform, demographic and cost trends will drive Medicare to fiscally unsustainable levels. As the Congress examines large-scale reform proposals, it is also focusing on improvements needed in Medicare program management to meet current 21<sup>st</sup> century needs and expectations.

In that spirit, the Committee asked us to report on the agency that runs Medicare, newly named the Center for Medicare and Medicaid Services (CMS) and formerly known as the Health Care Financing Administration (HCFA).<sup>2</sup> My remarks today will focus on (1) the Medicare agency's record in carrying out selected program activities, (2) key factors affecting program management, and (3) challenges the agency faces in running a more modern Medicare program. My comments are based on our previous and ongoing work.

In brief, against a backdrop of Medicare reform proposals, the management of the Medicare program has come under close scrutiny. Our past work shows that HCFA had some notable successes as Medicare's steward but also had serious shortcomings. The agency was successful in developing payment methods that have helped contain Medicare cost growth and in paying its fee-for-service claims quickly and at low administrative cost. However, the agency's efforts to ensure that claims were paid appropriately achieved mixed results. In addition, the performance of Medicare claims administration contractors in communicating with Medicare providers was often substandard. For example, in our ongoing work for the Committee, we find shortcomings in how Medicare contractors provide information to physicians and respond to their questions.

HCFA took significant steps in recent years to address certain weak areas, such as strengthening payment safeguards, but several factors deterred improvements. The agency's 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.

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<sup>1</sup>*Medicare: New Spending Estimates Underscore Need for Reform* (GAO-01-1010T, July 25, 2001).

<sup>2</sup>Our statement will refer to "HCFA" where our findings apply to the organizational structure and operations associated with that name.

Stakeholder expectations for a modern Medicare program are putting increased pressure on CMS to improve agency operations, particularly the agency's relationship with the Medicare beneficiary and provider communities. Such improvements will require efforts by the agency to implement a performance-based management approach that holds managers accountable for accomplishing program goals. However, in combination with agency actions, congressional attention also appears to be warranted to meet the challenges associated with administering Medicare in the 21<sup>st</sup> century.

## BACKGROUND

The complexity of the environment in which CMS operates the Medicare program cannot be overstated. It is an agency within the Department of Health and Human Services (HHS) but has responsibilities over expenditures that are larger than those of most other federal departments. Medicare alone ranks second only to Social Security in federal expenditures for a single program. Medicare is expected to spend nearly \$240 billion in fiscal year 2001; covers about 40 million beneficiaries; enrolls and pays claims from nearly 1 million providers and health plans; and has contractors that annually process about 900 million claims. Among numerous and wide-ranging activities associated with the Medicare program, CMS must monitor the roughly 50 claims administration contractors that pay claims and establish local medical coverage policies;<sup>3</sup> set tens of thousands of payment rates for Medicare-covered services from different providers, including physicians, hospitals, outpatient and nursing facilities, home health agencies, and medical equipment suppliers; and administer consumer information and beneficiary protection activities for the traditional program component and the managed care program component (Medicare+Choice plans).

The providers billing Medicare—hospitals, general and specialty physicians, and other practitioners—along with program beneficiaries and taxpayers, create a vast universe of stakeholders whose interests vary widely. Not surprisingly, then, the responsibility to be fiscally prudent has made the agency that runs Medicare a lightning rod for those discontented with program policies. For example, the agency's administrative pricing of services has often been contentious, even though a viable alternative is not easily identifiable. It is impractical for the agency to rely on competition to determine prices. The reason is that when Medicare is the dominant payer for services or products, the agency cannot use market prices to determine appropriate payment amounts, because Medicare's share of payments distorts the market. Moreover, Medicare is prevented from excluding some providers to do business with others that offer better prices.<sup>4</sup>

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<sup>3</sup>Most medical policies for determining whether claims for services provided are medically necessary and covered by Medicare are established locally by the claims administration contractor that serves the specific geographic area involved.

<sup>4</sup>Statutory constraints on limiting the providers from which Medicare beneficiaries may obtain medical services or products have resulted in the program including all qualified providers who want to participate.

In addition, Medicare's public sector status means that changing program regulations requires obtaining public input. The solicitation of public comments is necessary to ensure transparency in decision-making. However, the trade-off to seeking and responding to public interests is that it is generally a time-consuming process and can thwart efficient program management. For example, in the late 1990s, HCFA averaged nearly 2 years between its publication of proposed and final rules.<sup>5</sup>

Consensus is widespread among health policy experts regarding the growing and unrelenting nature of the Medicare agency's work. The Balanced Budget Act of 1997 (BBA) alone had a substantial impact on HCFA's workload, requiring, among other things, that the agency develop within a short time frame new payment methods for different post-acute and ambulatory services. It also required HCFA to preside over an expanded managed care component that entailed coordinating a never-before-run information campaign for millions of beneficiaries across the nation and developing methods to adjust plan payments based partially on enrollees' health status.

The future is likely to hold new statutory responsibilities for CMS. For example, some reform proposals call for expanding Medicare's benefit package to include a prescription drug benefit. As we have previously reported, the addition of a drug benefit would entail numerous implementation challenges, including the potential for the annual claims processing workload to double to about 1.8 billion a year.

#### MANAGEMENT OF MEDICARE HAS BEEN A MIXED SUCCESS

Tasked with administering this highly complex program, HCFA has earned mixed reviews in managing Medicare. On one hand, the agency presided over a program that is very popular with beneficiaries and the general public. It implemented payment methods that have helped constrain program cost growth and ensured that claims were paid quickly at little administrative cost. On the other hand, HCFA had difficulty making needed refinements to payment methods. It also fell short in its efforts to ensure accurate claims payments and oversee its Medicare claims administration contractors. In recent years, HCFA took steps to achieve greater success in these areas. However, the agency now faces criticism from the provider community for, in the providers' view, a program that is unduly complex and has burdensome requirements.

#### Medicare's New Payment Methods Have Helped Contain Cost Growth

HCFA was successful in developing payment methods that have helped contain Medicare cost growth. Generally, over the last 2 decades, the Congress required HCFA to move Medicare away from reimbursing providers based on their costs or charges for every service provided and to use payment methods that seek to control spending by rewarding provider efficiency and discouraging excessive service use. Payment development

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<sup>5</sup>This finding reflects the last half of 1997 and the first half of 1998 and an average of 631 days.

efforts have been largely successful, but making needed refinements to payment methods remains a challenge. For example, Medicare’s hospital inpatient prospective payment system (PPS), developed in the 1980s, is a method that pays providers fixed, predetermined amounts that vary according to patient need. This PPS succeeded in slowing the growth of Medicare’s inpatient hospital expenditures. Medicare’s fee schedule for physicians, phased in during the 1990s, redistributed payments for services based on the relative resources used by physicians to provide different types of care and has been adopted by many private insurers.

More recently, as required by the BBA, HCFA worked to develop separate prospective payment methods for post-acute care services—services provided by skilled nursing facilities, home health agencies, and inpatient rehabilitation facilities—and for hospital outpatient departments. Prospective payment methods can help constrain the overall growth of Medicare payments. But as new payment systems affected provider revenues, HCFA often received criticism about the appropriateness and fairness of its payment rates. HCFA had mixed success in marshaling the evidence to assess the validity of these criticisms and in making appropriate refinements to these payment methods to ensure that Medicare was paying appropriately and adequately.

Medicare Processes Claims Inexpensively,  
But Greater Scrutiny Over Payments Needed

HCFA also had success in paying most claims within mandated time frames and at little administrative cost to the taxpayer. Medicare contractors process over 90 percent of the claims electronically and pay “clean” claims<sup>6</sup> on average within 17 days after receipt. In contrast, commercial insurers generally take longer to pay provider claims.

Under its tight administrative budget, HCFA kept processing costs to roughly \$1 to \$2 per claim—as compared to the \$6 to \$10 or more per claim for private insurers, or the \$7.50 per claim paid by TRICARE—the Department of Defense’s managed health care program.<sup>7</sup> Costs for processing Medicare claims, however, while significantly lower than other payers, are not a straightforward indicator of success. We and others have reported that HCFA’s administrative budget was too low to adequately safeguard the program. Estimates by the HHS Inspector General of payments made in error amounted to \$11.9 billion in fiscal year 2000, which, in effect, raises the net cost per claim considerably. At the same time, HCFA estimated that, in fiscal year 2000, program safeguard expenditures

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<sup>6</sup>These are claims that have been filled out properly and whose processing has not been stopped by any of the systems’ computerized edits. According to HCFA data on claims processed in fiscal year 1999, about 81 percent of Medicare claims were processed and paid as clean claims.

<sup>7</sup>Much of the cost difference appears attributable to differences in program design and processing requirements, but we and others believe that TRICARE has opportunities to reduce this administrative cost. See *Defense Health Care: Opportunities to Reduce TRICARE Claims Processing and Other Costs* (GAO/T-HEHS-00-138, June 22, 2000).

saved the Medicare program more than \$16 for each dollar spent.<sup>8</sup> Taken together, these findings indicate that increasing the investment in CMS' administrative functions is a cost that can ultimately save program dollars.

However, HCFA's payment safeguard activities have raised concerns among providers about the clarity of billing rules and the efforts providers must make to remain in compliance. To fulfill the program's stewardship responsibilities, claims administration contractors conduct medical reviews of claims and audits of providers whose previous billings have been questionable. These targeted reviews have been a cost-effective approach in identifying overpayments.

Providers whose claims are in dispute, however, have complained about the burden of reviews and audits and about the fairness of some specific steps the contractors follow. Their concerns about fairness may also emanate from the actions of other agencies involved in overseeing health care—such as the HHS Office of Inspector General and the Department of Justice—which, in the last several years, have become more aggressive in pursuing health care fraud and abuse.

CMS faces a difficult task in finding an appropriate balance between ensuring that Medicare pays only for services allowed by law and making it as simple as possible for providers to treat Medicare beneficiaries and bill the program. While an intensive claims review is undoubtedly vexing for the provider involved, very few providers actually undergo such reviews. In fiscal year 2000, Medicare contractors conducted complex medical claims reviews of only 3/10 of 1 percent of physicians—1,891 out of a total of more than 600,000 physicians who billed Medicare that year.<sup>9</sup> We are currently reviewing several aspects of the contractors' auditing and review procedures for physician claims to assess how they might be improved to better serve the program and providers.

#### Communications with Providers Were Poor

Congressional concern has recently heightened regarding the regulatory requirements that practitioners serving Medicare beneficiaries must meet. Of the several studies we have under way to examine the regulatory environment in which Medicare providers operate, one study, conducted at the request of this Committee, examines ways in which explanations of Medicare rules and other provider communications could be improved. The preliminary results of our review of several information sources from selected carriers—the contractors that process physicians' claims—indicate a disappointing performance record. In particular:

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<sup>8</sup>As part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Congress created the Medicare Integrity Program (MIP), which gave HCFA a stable source of funding for program safeguard activities. In fiscal year 2000, HCFA used its MIP funding to support a wide range of anti-fraud-and-abuse efforts, including provider and managed care organization audits and targeted medical reviews of claims.

<sup>9</sup>Complex medical reviews are in-depth reviews of claims by clinically trained staff based on examination of medical records. In contrast, routine medical reviews may be carried out by nonclinical staff and do not involve review of patient records.

- Bulletins. Contractor bulletins, which are newsletters from carriers to physicians outlining changes in national and local Medicare policy, are viewed as the primary source of communication between the agency and providers. However, providers have complained that the information in these bulletins is often difficult to interpret, incomplete, and untimely. We reviewed the bulletins issued since February 2001 by nine carriers to determine, among other things, whether they included notices about four new billing procedures that were going into effect in early July 2001. The bulletins of five carriers either did not contain notices about the billing procedures until after the procedures had gone into effect or had not published this information as of mid-July. We also found that many of the bulletins contained lengthy discussions with significant technical and legalistic language.
- Telephone call centers. Call centers are intended to serve as another important information source for providers on a variety of matters, including clarification of Medicare's billing rules. Contractors maintain these call centers to respond to the roughly 80,000 provider inquiries made each day. We placed about 60 calls to 5 carrier call centers to obtain answers to common questions (those found on the "Frequently Asked Questions" Web pages at various carriers' web sites). For 85 percent of the calls placed, the answers that call center representatives provided were either incomplete (53 percent) or inaccurate (32 percent).
- Web sites. A third source of information for Medicare providers is the Internet. The agency imposes minimum requirements on carriers to maintain Web sites. Of 10 carrier Web sites we examined, 8 did not meet all of the Web site requirements, which include, among others, the inclusion of a frequently-asked-questions Web page and the capability for providers to send e-mail inquiries to customer service. These 8 also lacked the required links to both the CMS and Medicare Web sites. Many lacked user-friendly features: 7 did not have "site maps," which list the Web site's contents, and although 6 sites had search functions, only 4 worked as intended. Five sites contained outdated information.

Although these results cannot be generalized to all carriers, the carriers we reviewed serve tens of thousands of physicians and the results are consistent with some of the concerns recently expressed by physicians in the Medical Group Management Practice Association.<sup>10</sup>

Our study, to be issued this fall, seeks to identify the actions CMS can take to ensure that carriers improve the consistency and accuracy of their communications with providers; it will also assess the adequacy of carriers' budgets to conduct these activities.

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<sup>10</sup>These concerns are contained in a June 2001 letter from Medical Group Management Practice Association to the House Budget Committee staff.

## VARIOUS CONSTRAINTS COMPLICATE EFFORTS TO MANAGE MEDICARE EFFECTIVELY

CMS faces several limitations in its efforts to manage Medicare effectively. These include divided management focus, limited capacity, lack of a performance-based management approach, and constraints impeding the agency's ability to hold Medicare contractors accountable.

### Agency Focus Is Divided Across Multiple Programs and Responsibilities

CMS' management focus is divided across multiple programs and responsibilities. Despite Medicare's estimated \$240-billion price tag and far-reaching public policy significance, there is no official whose sole responsibility it is to run the Medicare program. In addition to Medicare, the CMS Administrator and senior management are responsible for oversight of Medicaid and the State Children's Health Insurance Program. They also are responsible for individual and group insurance plans' compliance with standards in the Health Insurance Portability and Accountability Act of 1996 in states that have not adopted conforming legislation. Finally, they must oversee compliance with federal quality standards for hospitals, nursing homes, home health agencies, and managed care plans that participate in Medicare and Medicaid, as well as all of the nation's clinical laboratories. The Administrator is involved in the major decisions relating to all of these activities; therefore, time and attention that would otherwise be spent meeting the demands of the Medicare program are diverted.

A restructuring of the agency in July 1997 inadvertently furthered the diffusion of responsibility across organizational units. The intent of the reorganization was to better reflect a beneficiary-centered orientation throughout the agency by dispersing program activities across newly established centers. However, after the reorganization, many stakeholders claimed that they could no longer obtain reliable or timely information. In addition, HCFA's responsiveness was slowed by the requirement that approval was needed from several people across the agency before a decision was final.

The recent change from HCFA to CMS reflects more than a new name. It consolidates major program activities: the Center for Medicare Management will be responsible for the traditional fee-for-service program; the Center for Beneficiary Choices will administer Medicare's managed care program. We believe that this new structure is consistent with the desire to be more responsive to program stakeholders.

### Agency Capacity Limited Relative to Multiple, Complex Responsibilities

As we and others have consistently noted, the agency's capacity is limited relative to its multiple, complex responsibilities. Human capital limitations and inadequate information systems hobble the agency's ability to carry out the volume of claims administration, payment, and pricing activities demanded of it.

Staff shortages—in terms of skills and numbers—beset the agency that runs Medicare. These shortages were brought into sharp focus as HCFA struggled to handle the number and complexity of BBA requirements. When the BBA expanded the health plan options in which Medicare beneficiaries could enroll, HCFA’s staff had little previous experience overseeing these diverse entities, such as preferred provider organizations, private fee-for-service plans, and medical savings accounts. Few staff had experience in dealing with the existing managed care option—health maintenance organizations. Half of HCFA’s regional offices lacked managed care staff with clinical backgrounds—important in assessing quality of care issues—and few managed care staff had training or experience in data analysis—key to assessing plan performance against local and national norms and monitoring trends in plan performance over time.<sup>11</sup>

At the same time, CMS faces the potential loss of a significant number of staff with valuable institutional knowledge. In February 2000, the HCFA Administrator testified that more than a third of the agency’s current workforce was eligible to retire within the next 5 years and that HCFA was seeking to increase “its ability to hire the right skill mix for its mission.” As we and others have reported, too great a mismatch between the agency’s administrative capacity and its designated mandate could have left HCFA, and now CMS, unprepared to handle Medicare’s future population growth and medical technology advances.<sup>12</sup> To assess its needs systematically, CMS is conducting a four-phase workforce planning process that includes identifying current and future expertise and skills needed to carry out the agency’s mission.<sup>13</sup> HCFA initiated this process using outside assistance to develop a comprehensive database documenting the agency’s employee positions, skills, and functions. Once its future workforce needs are identified, CMS faces the challenge of attracting highly qualified employees with specialized skills. Due to the rapid rate of change in the health care system and CMS’ expanding mission, the agency’s existing staff may not possess the needed expertise.

Another constraint on agency effectiveness has been inadequate information systems for running the Medicare program. Ideally, program managers should be able to rely on their information systems to monitor performance, develop policies for improvement, and track the effects of newly implemented policies. In reality, most of the information technology HCFA relied on was too outdated to routinely produce such management information. As a result, HCFA could not easily query its information systems to obtain prompt answers to basic management questions. Using its current systems, CMS is not in a position to report promptly to the Congress on the effects of new payment methods on beneficiaries’ access to services and on the adequacy of payments to providers. It cannot

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<sup>11</sup>HHS Office of the Inspector General, *Medicare’s Oversight of Managed Care: Implications for Regional Staffing* (OEI-01-96-00191, April 1998).

<sup>12</sup>Gail Wilensky and others, “Crisis Facing HCFA & Millions of Americans,” *Health Affairs*, Vol. 18, No. 1 (Jan./Feb. 1999).

<sup>13</sup>HCFA’s workforce planning efforts were in line with our guidance in *Human Capital: A Self-Assessment Checklist for Agency Leaders* (GAO/GGD-99-179, Sept. 1999).

expeditiously determine the status of debt owed the program due to uncollected overpayments.

Strategic Management Approach  
Lacks Performance Component

To encourage a greater focus on results and improve federal management, the Congress enacted the Government Performance and Results Act of 1993 (GPRA)—a results-oriented framework that encourages improved decision-making, maximum performance, and strengthened accountability. Managing for results is fundamental to an agency’s ability to set meaningful goals for performance, to measure performance against those goals, and to hold managers accountable for their results. As late as January 1998, we reported that HCFA lacked an approach consistent with GPRA to develop a strategic plan for its full range of program objectives. Since then, the agency developed a plan, but it did not tie global objectives to management performance.

Last month, we reported on the results of our survey of federal managers at 28 departments and agencies on strategic management issues. The proportion of HCFA managers who reported having output, efficiency, customer service, quality, and outcome measures was significantly below that of other government managers for each of the performance measures. HCFA was the lowest-ranking agency for each measure—except for customer service, in which it ranked second from the lowest. In addition, the percentage of HCFA managers who responded that they were held accountable for results to a great or very great extent—42 percent—was significantly lower than the 63 percent reported by the rest of the government.

Agency Has Difficulty Holding Claims  
Administration Contractors Accountable

Constraints on the agency’s flexibility to contract for claims administration services have also frustrated efforts to manage Medicare effectively. Under these constraints, the agency is at a disadvantage in selecting the best performers to carry out Medicare’s claims administration and customer service functions.

At Medicare’s inception in the mid-1960s, the Congress provided for the government to use existing health insurers to process and pay physicians’ claims and permitted professional associations of hospitals and certain other institutional providers to “nominate” their claims administration contractors on behalf of their members. At that time, the American Hospital Association nominated the national Blue Cross Association to serve as its fiscal intermediary.<sup>14</sup> Currently, the Association is one of Medicare’s five intermediaries and serves as a prime contractor for member plans that process over 85 percent of all benefits paid by fiscal intermediaries. Under the prime contract, when one

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<sup>14</sup>Intermediaries primarily review and pay claims from hospitals and other institutional providers, while carriers review and pay claims from physicians and other outpatient providers.

of the local Blue plans declined to renew its Medicare contract, the Association—rather than HCFA—chose the replacement contractor. This process effectively limited HCFA’s flexibility to choose the contractors it considered most effective.

HCFA also considered itself constrained from contracting with non-health insurers for the various functions involved in claims administration because it did not have clear statutory authority to do so. As noted, the Congress gave HCFA specific authority to contract separately for payment safeguard activities, but for a number of years the agency has sought more general authority for “functional contracting,” that is, using separate contractors to perform functions such as printing and mailing and answering beneficiary inquiries that might be handled more economically and efficiently under one or a few contracts. HCFA sought other Medicare contracting reforms, such as express authority for the agency to pay Medicare contractors on an other-than-cost basis, to provide incentives that would encourage better performance.<sup>15</sup>

#### KEY HURDLES EXIST AS AGENCY SEEKS TO MOVE FORWARD

Although the health care industry has grown and transformed significantly since Medicare’s inception, neither the program nor the agency that runs it has kept pace. Nevertheless, CMS is expected to make Medicare a prudent purchaser of services using private sector techniques and improve its customer relations.

#### Agency Faces Challenges in Adopting Modern Management Strategies

Private insurance has evolved over the last 40 years and employs management techniques designed to improve the quality and efficiency of services purchased. In a recent study, an expert panel convened by the National Academy of Social Insurance (NASI) suggested that Medicare test private insurers’ practices designed to improve the quality and efficiency of care and determine whether these practices could be adapted for Medicare.<sup>16</sup> Private insurers have taken steps to influence utilization and patterns of service delivery through efforts such as beneficiary education, preferred provider networks, and coordination of services. They are able to undertake these efforts, in part, because they have wide latitude in how they run their businesses. In contrast, federal statutory requirements and the basic obligation to be publicly accountable have hampered agency efforts to incorporate private sector innovations.

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<sup>15</sup>For a discussion of this issue, see Chapter 3 in *Medicare Contractors: Despite Its Efforts, HCFA Cannot Ensure Their Effectiveness or Integrity* (GAO/HEHS-99-115, July 14, 1999).

<sup>16</sup>*From a Generation Behind to a Generation Ahead: Transforming Traditional Medicare*, Final Report of the Study Panel on Fee-for-Service Medicare, National Academy of Social Insurance (Washington, D.C.: January 1998).

Medicare's efforts to encourage use of preferred providers is a case in point. The Medicare statute generally allows any qualified provider to participate in the program. This is significant in light of HCFA's experiment related to coronary artery bypass graft surgery in which certain hospitals—identified as those with the best outcomes for these surgeries—were designated to receive bundled payments for hospitals and physicians delivering certain expensive procedures.<sup>17</sup> The experiment cut program costs by 10 percent for the 10,000 coronary artery bypass surgeries performed and saved money for beneficiaries through reduced coinsurance payments. HCFA began a similar experiment at selected acute-care hospitals, which involves bundling payments for hospital, physician, and other health care professionals' services provided during a beneficiary's hospital stay for selected cardiovascular and orthopedic procedures. However, more wide-scale Medicare implementation of such hospital and physician partnership arrangements may be difficult. Providers have raised concerns about government promotion of certain providers at the expense of others, thus creating a barrier to this and other types of preferred provider arrangements.

Efforts to facilitate disease management provide another example of the potential limitations of adapting private sector management strategies to Medicare. HCFA was able to implement broad-based education efforts to encourage the use of Medicare-covered preventive services, but the agency could be deterred in approaches targeting individual beneficiaries most likely to need the help. For example, the agency has overseen the dissemination of more than 23,000 posters with tear-off sheets that beneficiaries can hand to physicians to facilitate discussions of colon cancer screening that otherwise might be avoided because of unfamiliar terms and sensitive issues. It has also been involved in a multifaceted effort to increase flu vaccinations and mammography use. However, the agency may be less able to undertake the more targeted approaches of some private insurers, such as mailing reminders to identified enrollees about the need to obtain a certain service. Because targeting information would require using personal medical information from claims data, CMS could encounter opposition from those who would perceive such identification to be government intrusion. Providers might also object to a government insurance program advocating certain medical services for their patients.

In its study, NASI concluded that these and other innovations could have potential value for Medicare but would need to be tested to determine their effects as well as how they might be adapted to reflect the uniqueness of Medicare as both a public program and the largest single purchaser of health care. In addition, CMS would likely need new statutory authority to broadly implement many of the innovations identified in the NASI study.

#### Agency Seeks to Meet Expectations for Improved Customer Service for Providers

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<sup>17</sup>A number of studies prior to this experiment have found that hospitals with the greatest volume of these procedures generally had better outcomes, as measured by mortality and complications.

Congressional concern has heightened recently regarding the regulatory burden on the practitioners that serve Medicare beneficiaries. In his testimony before the Senate Committee on Finance, the Secretary of HHS emphasized the importance of communication between CMS and providers, stating, “When physicians call us...we need to respond quickly, thoroughly and accurately.”<sup>18</sup> Under the spotlight held by both the Congress and the Administration, CMS is expected to improve its customer service to the provider community.

Concern about regulatory burden is not limited to providers in Medicare’s traditional fee-for-service program. Policymakers are also concerned about the regulatory burden on health plans that participate in the Medicare+Choice program. During each of the last 3 years, substantial numbers of health plans reduced the geographic areas they served or terminated their Medicare participation altogether. Cumulatively, these withdrawals affected more than 1.6 million beneficiaries who either had to return to the fee-for-service program or switch to a different health plan. Industry representatives have attributed the withdrawals, in part, to Medicare+Choice requirements that they characterize as overly burdensome.<sup>19</sup>

HCFA took steps to address plans’ regulatory concerns by modifying some requirements or delaying their implementation. It also launched an initiative designed to help the agency better understand plans’ concerns, assess them, and recommend appropriate regulatory changes. At the request of the House Ways and Means Subcommittee on Health, we are evaluating Medicare+Choice requirements. Our study will compare Medicare+Choice requirements with the requirements of private accrediting organizations and those of the Office of Personnel Management for plans that participate in the Federal Employees Health Benefits Program. The study’s objective is to document differences in these sets of requirements and determine whether these differences are necessary because of the unique nature of the Medicare program and the individuals it serves.

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<sup>18</sup>Statement Before the Senate Committee on Finance, Hearing on Medicare Governance: Perspectives on the Centers for Medicare and Medicaid Services (formerly HCFA) (June 19, 2001).

<sup>19</sup>Industry representatives have also cited Medicare’s payment rates as a cause of the withdrawals. They believe that Medicare payments are inadequate for the services health plans provide. However, our studies have estimated that such payments exceed what Medicare would have spent if beneficiaries enrolled in health plans instead received services through the traditional fee-for-service program. See *Medicare+Choice: Payments Exceed Cost of Fee-for-Service Benefits, Adding Billions to Spending* (GAO/HEHS-00-161, Aug. 23, 2000).

## Agency Strives to Improve Beneficiary Education

CMS is also expected to improve communications with beneficiaries, particularly as the information pertains to Medicare+Choice health plan options. The agency has made significant progress in this regard but continues to face challenges in meeting the sometimes divergent needs of plans and beneficiaries.

As required by the BBA, HCFA began a new National Medicare Education Program (NMEP).<sup>20</sup> For 3 years the agency has worked to educate beneficiaries and improve their access to Medicare information. It added summary health plan information to the Medicare handbook and increased the frequency of its distribution from every few years to each year. It also established a telephone help line and an Internet Web site with comparative information on health plans, Medigap policies, and nursing homes and sponsored local education programs.

Beginning this fall, it will become more important for beneficiaries to be aware that Medicare+Choice health plan alternatives to the traditional fee-for-service program may be available in their area and to understand each option and its implications. As required by the BBA, Medicare will now have an annual open enrollment period each November when beneficiaries must select either the fee-for-service program or a specific Medicare+Choice plan for the following calendar year. Beneficiaries will have strictly limited opportunities for changing their selection outside of the open enrollment period, a provision known as “lock-in.”

CMS recently announced that it would fund a \$35 million advertising campaign this fall to help beneficiaries learn about Medicare’s new features—such as the proposed discount prescription drug card program, coverage for preventive services and medical screening examinations, and the annual enrollment and lock-in provisions—and provide general information about Medicare+Choice plans and the availability of Medicare’s Web site and telephone help line. The agency will also extend the operating hours of the help line and add an interactive feature to the Web site designed to help beneficiaries select the Medicare option that best fits their preferences.

CMS has made other decisions about the fall information campaign that illustrate the sometimes difficult trade-off between accommodating plans and serving beneficiaries. To encourage health plan participation in the Medicare+Choice program, CMS has allowed plans additional time to prepare their 2002 benefit proposals. This extension will hamper the ability of CMS and health plans to disseminate information before the BBA-established November open enrollment period. CMS will not, for example, include any information about specific health plans in the annual handbook mailed to Medicare households.<sup>21</sup> To reduce the potentially adverse effects of an abbreviated fall information

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<sup>20</sup>We have reviewed the agency’s NMEP activities to date and will soon release a report discussing our findings.

<sup>21</sup>As a result of these decisions, the Secretary of HHS is now the subject of a lawsuit that claims he did not have the authority to change the benefit filing date and that the BBA requires an annual mailing containing comparative health plan information.

campaign, the agency will allow health plans to distribute marketing materials with proposed benefit package information marked “pending Federal approval.” CMS will also extend the open enrollment period through the end of December.

### CONCLUDING OBSERVATIONS

Medicare is a popular program that millions of Americans depend on to cover their essential health needs. However, the management of the program is not always responsive to beneficiary, provider, and taxpayer expectations. CMS, while making improvements in certain areas, may not be able to meet these expectations effectively without further congressional attention to the agency’s multiple missions, limited capacity, and constraints on program flexibility. The agency will also need to do its part by implementing a performance-based management approach that holds managers accountable for accomplishing program goals. These efforts will be critical in preparing the agency to meet the management challenges of administering a growing program and implementing future Medicare reforms.

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Mr. Chairman, this concludes my prepared statement. I will be happy to answer any questions you or other Committee Members may have.

### GAO CONTACT AND ACKNOWLEDGMENTS

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## **Related GAO Products**

*Medicare Management: Current and Future Challenges* (GAO-01-878T, June 19, 2001).

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*Medicare: HCFA Faces Multiple Challenges to Prepare for the 21<sup>st</sup> Century* (GAO/T-HEHS-98-85, Jan. 29, 1998).