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MEDICARE MANAGEMENT

Current and Future Challenges

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Mr. Chairman and Members of the Committee:

We are pleased to be here as you discuss the ability of the Health Care Financing Administration (HCFA), to carry out its mission to manage the Medicare program now and in the future. Although HCFA was renamed last week to become the Centers for Medicare and Medicaid Services (CMS), our statement will continue to refer to HFCA where our findings apply to the organizational structure and operations associated with that name. Because of Medicare's vast size and complex structure, in 1990 we designated it as a high-risk program—that is, at risk of considerable losses to waste, fraud, abuse, and mismanagement—and it remains so today. Since that time, we have consistently reported on HCFA's efforts to safeguard Medicare payments and streamline operations.

With congressional attention on proposals by Members and others to reform or modernize Medicare, the program's management by HCFA has become a prime concern. Proposals for Medicare reform recommend altering HCFA's governance structure, making improvements to existing operations, or some combination of both. They are being made against a backdrop of growing expectations for how the nation's largest health insurance program should be managed.

Therefore, my remarks today will focus on (1) HCFA's record of performance in managing Medicare and (2) gaps that exist between the agency's success in operating the program and the expectations held by HCFA's stakeholder community to make the program more modern and efficient. My comments are based on previous and ongoing work by us and published reports by others.

In brief, as the nation's largest insurer, HCFA is closely watched by a vast universe of stakeholders. The agency has had some notable successes as Medicare's steward, but has also had serious shortcomings. HCFA has been successful in developing payment methods that have helped to contain Medicare cost growth and paying its fee-for-service claims quickly and at low administrative cost. However, HCFA's oversight of claims administration has not been sufficient to ensure that claims contractors operated effectively and that claims were paid properly, and its oversight of nursing homes and other providers did not adequately ensure care quality. Further, HCFA has been unable to rely on its outdated computer systems to produce reliable management information. Without this information, HCFA has had difficulty effectively managing the program, including being able to measure the impact of recent payment method changes and developing needed refinements.

HCFA has taken significant steps to address weak areas, but its ability to improve its performance is constrained by multiple factors. HCFA's ability to manage has been diminished by frequent turnover in leadership, a relatively sparse cadre of senior executives, human capital challenges that threaten to worsen in the near future, the lack of a performance-based approach to management, constraints on its contracting authority that limit its flexibility to choose claims administration contractors and assign administrative tasks, and archaic information technology systems incapable of providing critical, timely management information. The desire to strengthen Medicare management argues for increased capacity, better documentation of the agency's resource needs, and means to hold managers accountable for results.

Background

The complexity of the environment in which HCFA 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 spending totaled over $220 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 Medicare's numerous and wide-ranging activities, HCFA must monitor the roughly 50 claims administration contractors that pay claims and set local medical coverage policies;[1] 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, the managed care program component (Medicare+Choice plans), and Medicare supplemental insurance policies (Medigap).

The providers billing Medicare create, with program beneficiaries, a vast universe of stakeholders—hospitals, general and specialty physicians, and other providers of health care services—whose interests vary widely. HCFA's responsibility to run the program in a fiscally prudent way has

[1]Most medical policies for determining whether services are reasonable, are necessary, and should be covered are set locally by the insurance companies that Medicare contracts with for fee-for-service claims administration.

made the agency a lightening rod for those discontented with program policies. In particular, HCFA's administrative pricing of services has often been contentious. However, when Medicare is the dominant payer for services or products, HCFA cannot rely on market prices to determine appropriate payment amounts because Medicare's share of payments distorts the market. Moreover, because Medicare is prevented from excluding some providers to do business with others that offer better prices,[2] it is largely impractical for HCFA to rely on competition to determine prices.

Medicare's public sector status also means that any changes require public input. Thus, HCFA is constrained from acting swiftly to reprice services and supplies even when prevailing market rates suggest that payments should be modified. The solicitation of public comment is a necessary part of the federal regulatory process 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.[3]

Consensus is widespread among health policy experts regarding the growing and unrelenting nature of HCFA's work. The Balanced Budget Act of 1997 (BBA) alone has had a substantial impact on HCFA's workload, requiring, among other things, that the agency develop new payment methods for different post-acute-care and ambulatory services within a short time frame and 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 means to adjust plan payments based partially on enrollees' health status.

HCFA Has Mixed Record of Success

Tasked with administering this highly complex program, HCFA earns mixed reviews in managing Medicare. On one hand, HCFA presides over a program that is very popular with beneficiaries and the general public. It

[2]Statutory constraints on excluding providers from participating in Medicare have resulted in the program traditionally including all qualified providers who want to participate.

[3]This finding reflects the last half of 1997 and the first half of 1998 and an average of 631 days.

has implemented payment methods that have helped constrain program cost growth and has paid claims quickly at little administrative cost. On the other hand, HCFA has difficulty making needed refinements to payment methods. It has also fallen short in its efforts to ensure accurate claims payments, oversee its Medicare claims administration contractors, and ensure the quality of Medicare services. In recent years, HCFA has taken steps to achieve greater success in these areas. However, the agency now faces criticism for imposing payment safeguards that many providers feel constitute an undue administrative burden.

HCFA's New Payment Methods Have Helped Contain Cost Growth

HCFA has been successful in developing payment methods that have helped to contain Medicare cost growth. Generally, over the last 2 decades, Congress has required HCFA to move Medicare away from reimbursing providers based on their costs for every service provided and use payment methods that seek to control spending by rewarding provider efficiency and discouraging excessive service use. Some efforts have been more successful than others, and 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 has 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—as well as for hospital outpatient departments. Prospective payment systems can help to constrain the overall growth of Medicare payments. But as new payments systems affect provider revenues, HCFA often receives criticism about the appropriateness and fairness of its payment rates. HCFA has had mixed success in marshalling the evidence to assess the validity of these criticisms and to make appropriate refinements to these payment methods to ensure that Medicare is paying appropriately and adequately.

Medicare Processes Claims Inexpensively, But Greater Scrutiny and Control Needed

HCFA has 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[4] on average within 17 days after receipt. In contrast, commercial insurers generally take longer to pay provider claims.

Under its tight administrative budget, HCFA has 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.[5] 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 is 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. Taken together, these findings suggest that an investment in HCFA's administrative functions is a trade-off that could ultimately save program dollars.

Moreover, due in part to HCFA's historically uneven oversight, the performance of some Medicare's claims administration contractors has been unsatisfactory. Among its failings, HCFA relied on unverified performance information provided by contractors and limited checking of each contractor's internal management controls. HCFA's performance reviews and treatment of problems identified were not done using consistent criteria across contractors. In the last year, HCFA has taken significant steps to improve its management and oversight of contractors. Nevertheless, key areas needing improvement remain, such as policies to verify contractor-reported data and controls over contractor accountability and financial management, including debt collection activities.

[4]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.

[5]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).

A major aspect of contractor performance—the stewardship activities that contractors conduct to safeguard Medicare dollars—is itself a story of mixed results. In the early 1990s, HCFA's contractors decreased certain key safeguard activities to maintain claims processing timeliness under constrained budgets. In order to ensure that program safeguards were strengthened, the Congress created the Medicare Integrity Program (MIP), which gave HCFA a stable source of funding for these activities as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). 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.

These audits and reviews, targeted at providers whose previous billings or cost reports have been questionable, have been a cost-effective approach in identifying overpayments. Based on HCFA's estimates, in fiscal year 2000, MIP saved the Medicare program more than $16 for each dollar spent. As part of its safeguard efforts, HCFA also has begun to measure how accurately its contractors process claims, to determine if individual contractors are effective in safeguarding program payments. Such objective information could provide HCFA with important management information and identify contractors' "best practices" that could serve as a model for others.

While HCFA has strengthened its payment safeguard activities, these efforts have raised concerns among providers about the clarity of billing rules and the efforts needed to be in compliance. Providers whose claims are in dispute have complained about the burden of reviews and audits and about the fairness of some specific steps the contractors follow. However, their concerns about fairness may also emanate from the actions of other health care overseers—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.

HCFA faces a difficult task in finding an appropriate balance between ensuring that Medicare pays only for services allowed by law while 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 them. In fiscal year 2000, HCFA's contractors conducted complex medical claims reviews of only three-tenths of 1 percent of physicians—1,891 out of a

total of more than 600,000 physicians who billed Medicare that year.[6] We are currently reviewing several aspects of HCFA's auditing and review procedures for physician claims to assess how they might be improved to better serve the program and providers.

HCFA's Oversight of Health Care Quality Generally Has Been Weak

HCFA's oversight of health care quality, a resource-intensive activity, has significant shortcomings. The agency is responsible for overseeing compliance with federal quality standards for the services delivered to Medicare beneficiaries. As much of the actual inspection of quality is carried out by the states, HCFA must work with the states to ensure that the inspectors of nursing homes, home health agencies, renal dialysis centers, psychiatric hospitals, and certain Medicare-certified acute care hospitals identify significant care problems.[7] Our findings on nursing home quality present a very disturbing picture: in 1999, we reported that an unacceptably high number of the nation's 17,000 nursing homes—an estimated 15 percent—had recurring care problems that caused actual harm to residents or placed them at risk of death or serious injury. Our previous findings showed that complaints by residents, family members, or staff alleging harm to residents remained uninvestigated in some states for weeks or months. HCFA's efforts to oversee state monitoring of nursing home quality were limited in scope and effectiveness, owing, in part, to a lack of expert staff to assess the state inspectors' performance.

Even with this record of weak federal oversight, nursing homes get more scrutiny than other health care providers. States survey nursing homes at least yearly, on average, whereas other facilities are surveyed much less frequently. For example, home health agencies were once routinely reviewed annually, but surveys now vary and can be as infrequent as every 3 years. In addition, our work has shown that the number of HCFA-funded inspections of dialysis facilities declined significantly between 1993 and 1999, dropping the proportion reviewed from 52 percent to 11 percent. Yet, in 1999, 15 percent of the facilities surveyed had deficiencies severe

[6]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.

[7]The Joint Commission on the Accreditation of Health Care Organizations oversees quality in about 80 percent of Medicare-certified acute care hospitals; the other Medicare-certified hospitals, nursing homes, renal dialysis centers, home health agencies, and laboratories have quality reviewed by state surveyors.

enough, if uncorrected, to warrant terminating their participation in Medicare.

Major Gaps Exist Between HCFA's Capabilities and Stakeholder Expectations

In addition to the challenges inherent in running Medicare, other factors associated with HCFA's structure and capacity diminish the agency's ability to administer the program effectively. These limitations leave HCFA poorly positioned to operate Medicare as a modern, efficient health care program.

Multiple Constraints Help Explain Agency's Mixed Record

HCFA faces several limitations in its efforts to manage Medicare effectively. These include divided management focus, little continuity of leadership, limited capacity, lack of a performance-based management approach, and insufficient flexibility to modernize program operations.

Agency Focus and Leadership

HCFA's management focus is divided across multiple programs and responsibilities. Despite Medicare's $220-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 HCFA 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 HIPAA standards 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 interspersing program activities across newly established centers. However, after the reorganization, many stakeholders claimed that they could no longer obtain consistent 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 could improve efforts to more efficiently manage aspects of Medicare.

At least two other factors weaken agency focus. First, the frequent turnover of the administrator has complicated the agency's implementation of long-term Medicare initiatives or pursuit of a consistent management strategy. The maximum term of a HCFA administrator is, as a practical matter, only as long as that of the President who appointed him or her. Historically, their actual tenure has been even shorter. In the 24 years since HCFA's inception, there have been 21 administrators or acting administrators, whose tenure has been, on average, about 1 year. Over 15 percent of the time, HCFA has had an acting administrator. These short tenures have not been conducive to carrying out strategic plans or innovations an administrator may have developed for administering Medicare efficiently and effectively.

Of equal concern is the sparseness of HCFA's senior ranks. Its corps of senior executives is smaller than that of most other civilian agencies having significantly smaller annual expenditures. In fiscal year 1999, HCFA had 49 senior executive officials to manage Medicare, Medicaid, and SCHIP (among other programmatic responsibilities) and nearly $400 billion in expenditures. While some tasks at HCFA are contracted out—thus providing HCFA with purchased executive expertise—contractors' objectives may not be fully aligned with those of the agency. Indeed, the critical need to oversee contractors effectively to ensure that they are fulfilling their responsibilities has been repeatedly demonstrated.

Agency Capacity

In addition to leadership constraints, the agency's capacity is limited relative to its multiple, complex responsibilities. Inadequate information systems and human capital hobble HCFA's ability to carry out the volume of claims administration, payment and pricing, and quality oversight activities demanded of the agency.

Ideally, program managers should be able to rely on their information systems to create a feedback loop that allows them to monitor performance, use the information to develop policies for improvement,

and track the effects of newly implemented policies. In reality, most of the information technology HCFA relies on is too outdated to routinely produce such management information. Despite major advances in information technology in recent years, HCFA relies on outmoded systems, some of which date back to the 1970s, to pay claims and maintain data on beneficiaries' use of services. As a result, HCFA cannot easily query its information systems to obtain prompt answers to basic management questions. Using its current systems, HCFA is not in a position to report promptly to the Congress on the effects of new prospective payment policies on beneficiaries' access to services and on the adequacy of payments to providers. It cannot expeditiously determine the status of debt owed the program due to uncollected overpayments. It cannot obtain reliable data on beneficiaries enrolled in managed care plans and must reconcile one system's output with data from other systems. Finally, HCFA lacks a set of rules to govern how it will develop, implement, and operate systems to prevent and detect inappropriate access.

Staff shortages—in terms of skills and numbers—also beset HCFA. These shortages were brought into sharp focus as the agency 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 the appropriateness of a health plan's denial of services to a beneficiary—and few managed care staff had training or experience in data analysis—key to monitoring internal trends in plan performance over time and assessing plan performance against local and national norms.[8]

Staffing constraints have also handicapped HCFA's efforts to ensure quality of care. In recent years, the agency has made negligible use of its most effective oversight technique for assessing state agencies' abilities to identify serious deficiencies in nursing homes—an independent survey performed by HCFA employees following the completion of a state survey.

[8]HHS Office of the Inspector General, *Medicare's Oversight of Managed Care: Implications for Regional Staffing*, (OEI-01-96-00191, April 1998).

Conducting a sufficient number of these comparisons is important because of concerns that some state agencies may miss significant problems, but HCFA lacked sufficient staff and resources to perform enough of these checks. In 1999, the number of HCFA independent surveys averaged about two per state—a frequency totally inadequate to fairly measure any state's performance.

At the same time, HCFA faces the 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 leave HCFA unprepared to handle Medicare's future population growth and medical technology advances.[9] To assess its needs systematically, HCFA 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 and analyzing the gaps between them.[10] 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, HCFA faces the challenge of attracting highly qualified employees with specialty skills. Due to the rapid rate of change in the health care system and HCFA's expanding mission, the agency's existing staff may not possess the needed expertise. While the Congress has granted exemptions from the Office of Personnel Management salary rules for information technology staff, these exemptions do not extend to other skills—such as clinical experience and managed care marketing expertise.

Strategic Management Approach Lacks Performance Component

While HCFA has many resource-related challenges—including rehabilitating its information systems—the agency has not documented its resource needs well. As early as January 1998, we reported that the agency lacked an approach—consistent with the Government Performance and

[9]Gail Wilensky et al. and "Crisis Facing HCFA & Millions of Americans," *Health Affairs*, Vol. 18, No. 1 (Jan./Feb. 1999).

[10]HCFA's workforce planning efforts to date have been in line with our guidance on this subject, as articulated in *Human Capital: A Self-Assessment Checklist for Agency Leaders* (GAO/GGD-99-179, Sept. 1999).

Results Act of 1993 (GPRA)—to develop a strategic plan for its full range of program objectives. Since then, the agency has developed a plan, but it has not tied global objectives to management performance. Moreover, its workforce planning efforts remain incomplete.

To encourage a greater focus on results and improve federal management, the Congress enacted 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. 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, where it ranked second lowest. It should therefore be no surprise that HCFA managers' responses concerning the extent to which they were held accountable for results—42 percent—was significantly lower than the 63 percent reported by the rest of the government.

Agency Authority and Flexibility

Statutory constraints are another structural issue that at times frustrate HCFA's efforts to manage effectively. One such constraint involves HCFA's authority to contract for claims administration services. 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 gave professional associations of hospitals and certain other institutional providers the right 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 intermediary.[11] 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 of the local Blue plans declines to renew its

[11]Intermediaries primarily review and pay claims from hospitals and other institutional providers covered under Medicare part A, while carriers review and pay claims from physicians and other outpatient providers covered under part B.

Medicare contract, the Association—rather than HCFA—chooses the replacement contractor. This process effectively limits HCFA's flexibility to choose the contractors it considers most effective.

HCFA has 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 has been seeking other Medicare contracting reforms, such as giving the agency general authority to pay Medicare contractors on an other-than-cost basis, to provide incentives that would encourage better performance.[12]

Growing Expectations Underscore Need to Address HCFA Governance and Management Issues

Although the health care industry has grown and transformed significantly since HCFA's inception, the agency and Medicare, in particular, have not kept pace. Nevertheless, HCFA is expected to make Medicare a prudent purchaser of services using private sector techniques, improve its customer relations, and be prepared to implement benefit and financing reforms.

Private insurance has evolved over the last 40 years and now offers comprehensive policies and employs management techniques designed to improve the quality and efficiency of services purchased. 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 because many have detailed data on service use across enrollees and providers, as well as wide latitude in how they run their businesses. In contrast, HCFA's outdated and inadequate information systems, statutory constraints, and the fundamental obligation to be publicly accountable have stymied efforts to incorporate private sector innovations. In a recent study, the National Academy for Social Insurance has concluded that these innovations could have potential value for Medicare but would need to be

[12]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).

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, HCFA would need enhanced capacity to broadly implement many of these innovations.

HCFA is also expected to improve its customer service to the provider community. In seeking answers from HCFA headquarters, regional offices, and claims administration contractors, providers contend that the agency does not speak with one voice, adding frustration to complexity. We are currently studying ways in which communication with providers—including explanations of Medicare rules—could be improved.

HCFA has also been expected to improve communications with beneficiaries, particularly as the information pertains to health plan options. As required by the BBA, HCFA began a new National Medicare Education Program. For 3 years the agency has worked to educate beneficiaries and improve their access to Medicare information by annually distributing a Medicare handbook containing comparative health plan information; establishing a telephone help line and an Internet web site with, among other things, comparative information on nursing homes, health plans, and Medigap policies; and sponsoring local education programs. Although funding for these activities previously came largely from user fees collected from Medicare+Choice plans, future funding is less certain.[13] At the same time, such outreach efforts are becoming increasingly important, because in 2002 beneficiaries' options for switching health plans will be more limited than they are today.

The future is likely to hold new challenges for CMS. For example, the agency may be expected to oversee a prescription drug benefit administered by third parties. As we reported to this Committee last year, the administration of a drug benefit would entail numerous challenges, as the strategies now used by the private sector are not readily adaptable to Medicare because of its public sector obligations. Those challenges notwithstanding, the capacity issue remains. The number of prescriptions for Medicare beneficiaries could easily approach the current number of claims for all other services, or about 900 million annually.

[13]The Balanced Budget Refinement Act of 1999 significantly reduced the amount of user fees HCFA can collect from Medicare+Choice plans in 2001 and subsequent years.

Today's processing and scrutiny of drug claims by pharmacy benefit managers (PBM) is very different from Medicare's handling of claims for other services. PBMs have the ability to provide on-line, real-time drug utilization reviews. These serve a quality- and cost-control function by supplying information to pharmacists regarding such things as whether a drug is appropriate for a person based on his or her age, medical condition, and other medications, as well as whether the drug is covered under the insurer's benefit and what copayments will apply.

If the use of PBMs or other entities were an option in administering a Medicare prescription drug benefit, it is not clear how much they or the others would have to increase current capacity or instead use more of the capacity already built into their information and claims processing systems—a consideration that could significantly affect the administrative costs that may be incurred. To administer this benefit through such contracts would require the agency to increase its managerial ranks with the personnel qualified to oversee such an operation. This would include staff with pharmaceutical industry expertise who could structure performance contracts in line with program goals for beneficiary access and fiscal prudence.

To meet these and other expectations will require an agency with adequate capacity to manage the Medicare program. The agency will need sufficient flexibility to act prudently, while being held accountable for its results-based decisions and their implementation. It will also need to devote management attention to the fundamentals of day-to-day operations.

Concluding Observations

Medicare is a popular program that millions of Americans depend on for covering their essential health needs. However, the management of the program has fallen short of expectations because it has not always appropriately balanced or satisfied beneficiaries', providers', and taxpayers' needs. For example, stakeholders expect that Medicare will price services prudently; that providers will be treated fairly and paid accurately; and that beneficiaries will clearly understand their program options and will receive services that meet quality standards. In addition, there are expectations that the agency will be prepared to implement restructuring or added benefits in the context of Medicare reform. Today's Medicare agency, while successful in certain areas, may not be able to meet these expectations effectively without further congressional attention to its multiple missions, capacity, and flexibility. The agency will also need to do its part by implementing a performance-based approach

that articulates priorities, documents resource needs, and holds managers accountable for accomplishing program goals.

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

For more information regarding this testimony, please contact me or Leslie G. Aronovitz at (312) 220-7600. Other contributors to this statement include Sheila Avruch, Barrett Bader, and Hannah F. Fein.

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