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The Administration of Medicare: A Neglected Issue

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The administration of Medicare urgently needs attention. Although the Centers for Medicare and Medicaid Services (CMS) currently pays claims promptly, Medicare’s administration is weakened by CMS’s limited capacity and flexibility, and especially by neglect of investment in its people and systems. The growing gap between the agency’s capacity and its responsibilities contributes to a loss of stature, which in turn fosters congressional micromanagement and further loss of capacity and flexibility.

Disinvestment in Medicare’s administration reflects similar neglect across much of the federal government. Medicare’s potentially powerful constituency of beneficiaries, which has a stake in improved administration, has been silent on this issue. Federal agencies and programs generally would benefit from restoration of the capacity that once existed in the Executive Office of the President to improve executive branch organization and management.
I. Introduction: Medicare and the Vending Machine
Model of Government

A review of the literature concerning Medicare reveals attention to important issues like the funding of the program, proposed new areas of coverage such as prescription drugs, the impact of demographics on the program, and possible new ways to pay providers. With exceptions such as reports by the General Accounting Office (GAO) and a recent study by a panel of the National Academy of Social Insurance (NASI), analysts and scholars have not devoted the same level of attention to studying the administration of Medicare and the implications of administration for the success of the program.1

1. See generally STUDY PANEL ON MEDICARE'S GOVERNANCE AND MGMT., NAT'L ACAD. OF SOC. INS., MATCHING PROBLEMS WITH SOLUTIONS: IMPROVING MEDICARE'S GOVERNANCE AND MANAGEMENT (Kathleen M. King et al. eds., 2002) [hereinafter STUDY PANEL]; see also WILLIAM T. GORMLEY JR., MEDICARE, ACCOUNTABILITY, AND STRUCTURAL REFORM: FINAL REPORT TO THE ASSISTANT SECRETARY FOR PLANNING AND EVALUATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES 1–21 (2000) (discussing various options and proposals for
It is time to focus on the administration of Medicare. This Article contends that Medicare's administration is both weak and in serious decline. Weak administration does not bode well for a program as large and complex as Medicare, which seeks to pay almost $250 billion annually in claims for medical services provided to about forty million beneficiaries. Weak administration presents even more of a problem given the substantially increased demands that the program will face as the baby boom generation retires and becomes eligible for Medicare.

Many of Medicare's administrative shortcomings result from a significant disparity between its responsibilities and resources, both in personnel and dollars. At the inception of the Medicare program, providers expressed apprehension about governmental intervention into health care. As a result, the government created a different structure for administering Medicare than for administering Social Security. The Social Security Administration (SSA), with an in-house staff of 63,000, processes Social Security payments directly to over forty-five million beneficiaries according to a schedule of benefits that is easy to administer. By contrast, the Centers for Medicare and Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA), currently has an in-house staff of fewer than 5,000. CMS, however, must reorganizing the Medicare program. Also missing until recently was discussion of governance issues relating to Medicare. That gap now has been filled by the NASI study and by an article by Timothy Stoltzfus Jost. See generally Timothy Stoltzfus Jost, Governing Medicare, 51 ADMIN. L. REV. 39 (1999) (providing a thorough overview of Medicare governance).

2. See infra Part II (evaluating the Centers for Medicare and Medicaid Services administration of Medicare on the basis of four key factors: capacity, flexibility, accountability, and life cycle).


7. This Article uses the terms HCFA and CMS, depending on the context, to refer to the same agency.
administer a much more complex set of payments for Medicare services for almost as many beneficiaries through numerous third parties that together employ another 22,500 people.  

The gloomy assessment of the Medicare administration that this Article presents, however, must be tempered with recognition of the positive points. CMS regularly publishes its payment regulations on time and assures that about a million providers are paid on time for the 900 million claims that they file annually. This prompt payment is an impressive accomplishment, especially for an agency as small as CMS. Unlike some troubled agencies, CMS continues to have an unblemished record for the integrity of its officials. This is a base on which the agency can improve the administration of Medicare. Many of the problems besetting Medicare administration reflect the impact of external forces rather than insurmountable problems within CMS.

The weakness in the administration of Medicare, and general inattention to that weakness except at a fairly high level of analysis, is puzzling. The forces that have weakened Medicare administration resemble those that also have weakened other areas of government. Yet, in contrast to many other government programs, Medicare benefits from the widespread support of an influential and well-organized constituency of beneficiaries. Medicare would seem to be one part of government where the political process would demand and achieve effective administration.

For Medicare, the need for effective administration is especially important because of the pressures caused by increasing health care costs. Congress has tightened limits on Medicare payments to the point that some providers are

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10. See Jost, supra note 1, at 96–97 (stating that Medicare has a wide range of constituents that includes persons eligible for health care under the program); id. at 40 (describing Medicare’s beneficiaries as “active participants in the political process”).
limiting or ending their participation in the program. As a result, the benefits of an effective payments system could be immense. Malcolm Sparrow, a healthcare fraud expert, estimates that the Medicare program is losing fifty to seventy-five billion dollars annually to fraud. An improved payments system that could detect fraud schemes early would help ease the financial pressure on the program.

Part of the puzzle can be explained by the general inattention paid to administration except by the most sophisticated interest groups. Political scientist Donald Kettl suggests that many Americans, including congressional policymakers, have a "vending machine" model of government—we place money into a program and goods and services emerge. The vending machine model leaves little room to consider the complexities of managing the people, money, and systems needed to make a government program work.

Why have policymakers neglected the machinery of government? Those experienced in the ways of Washington, D.C. give the expected answers: (1) administration is not nearly as rewarding politically as the actual services delivered to constituents; and (2) more money for administration means more money for bureaucrats and the bureaucracy. Those who adopt the vending machine model tend to ignore important matters such as the differences among programs and the need for careful attention to the resources, organization, and management needed to keep the machinery operating well.

The Medicare program is structured, at least superficially, to embody the vending machine model. Sallyanne Payton and others have pointed out that beneficiaries pay little attention to administration because Medicare is required

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12. See, e.g., Terry M. Moe, The Politics of Bureaucratic Structure, in CAN THE GOVERNMENT GOVERN? 267, 267–270 (John E. Chubb & Paul E. Peterson eds., 1989) (stating that dominant interest groups are likely the only entities to have both the power and the expertise to make meaningful changes to the administration of federal agencies).


14. On the latter point, see Medicare Governance: Perspectives on the Centers for Medicare and Medicaid Services (Formerly HCFA): Hearing Before the S. Comm. on Fin., 107th Cong. 5 (2001) [hereinafter Medicare Governance] [prepared statement of Michael E. Gluck, Research Assoc. Professor, Inst. for Health Care Research & Policy, Georgetown Univ.] (describing how people often assume that expenditure of tax dollars on administrative agencies only serves to support additional bureaucracy rather than supporting the provision of benefits to the public).
to pay virtually all claims within thirty days. 15 As long as the program works well enough to meet this basic demand, beneficiaries see little need to concern themselves with the machinery that produces these results. Indeed, this inattention can be seen as a triumph of Medicare administration: because CMS routinely makes its benefit payments on time, beneficiaries have little incentive to discover the complicated and deficient administrative systems that produce those benefits. 16 Only beneficiary advocacy groups, who have a stake in the long run viability of the Medicare program, might have an interest in paying attention to Medicare administration. But these groups also seem to have largely neglected the issue. 17

This Article is organized as follows. Part II examines the administration of Medicare from the perspective of the capacity, the flexibility, the accountability, and the life cycle of CMS, the administering agency. Part III assesses the consequences of the decline in the quality of Medicare administration. Part IV looks at the disinvestment that has weakened Medicare administration and the administration of many government programs. Part V makes recommendations for improving the administration of federal programs, including Medicare. It then concludes that the beneficiary constituency of

15. See Sallyanne Payton, Professionalism as Third-Party Governance: The Function and Dysfunction of Medicare, in Making Government Manageable (Thomas H. Stanton & Benjamin Ginsburg eds., forthcoming Jan. 2004) (describing how the payment of medical claims by Medicare is largely automatic and occurs with little interference by CMS, creating a situation where providers have the incentive to maintain the status quo rather than advocating changes to the current administration) (on file with the Washington and Lee Law Review).

16. Another possibility is that beneficiaries and their advocates can more easily interact with state governments than with a federal agency. Thus, it seems that consumer advocates for Medicaid, administered by CMS through the states, focus more on the program’s inner workings and implementation than do Medicare advocacy groups. See, e.g., NAT’L HEALTH LAW PROGRAM, INC., RECOMMENDATIONS FOR MAKING THE CONSUMERS’ VOICE HEARD IN MEDICAID MANAGED CARE: A GUIDE TO EFFECTIVE CONSUMER INVOLVEMENT 10–13 (1999) (discussing a program where working groups from various states cooperated with a national organization to develop recommendations to improve consumer involvement in Medicaid managed care).

17. CMS recently has taken steps to increase the involvement of the agency’s constituent groups, including beneficiaries, in the agency’s internal processes. Administrator Tom Scully formed twelve so-called “open door” groups of beneficiaries and health care providers, including disabled beneficiaries, diversity beneficiaries, hospitals, and health plans. About half of these groups are chaired by the administrator or deputy administrator of CMS. Participants may attend the group sessions, which are conducted roughly every two months in person or through a toll free phone number. The purpose of the sessions is to bring participants into direct contact with the CMS officials who can answer their questions. Judging from two sessions monitored by the author, most of the participants’ questions appear to address immediate concerns such as coverage or claims rather than higher-level administrative issues. CTRS. FOR MEDICARE & MEDICAID SERVS., OPEN DOOR INITIATIVE, at http://www.cms.gov/opendoor (last visited Oct. 13, 2003) (on file with the Washington and Lee Law Review).
Medicare is a valuable potential source of support for improvements in the administration of the program. More generally, improvements in the administration of government programs will require a restoration of capacity in the Executive Office of the President (EOP) to provide guidance and support for those improvements. Both beneficiary groups and policymakers will benefit from looking beyond the vending machine model to address the major issues of administration that confront many government programs today.

II. Inside the Vending Machine: The Administration of Medicare

Four criteria can help to evaluate the administrative ability of CMS to administer the Medicare program: 18 (1) Capacity: What is the capacity of CMS, in terms of people, administrative budget, systems, and needed organization to administer the Medicare program; (2) Flexibility: What flexibility does CMS have, under the law and in practice, to administer the program; (3) Accountability: How is CMS held accountable for its administration of Medicare; and (4) Life Cycle: As the agency matures, what strengths and shortcomings manifest themselves?

Application of these four criteria to the administration of Medicare reveals that, although CMS is currently paying claims promptly, the agency has shortcomings in capacity, flexibility, and forms of accountability. In addition, the emergence of serious life cycle issues means that attention to administrative issues is of great importance in order to ensure the quality of the agency’s performance in the future. Consider each of the four criteria in turn.

A. Capacity

The capacity of Medicare administration is seriously constrained by limitations on resources. Resource limitations result in inadequate staffing, systems, and funding. The inadequate staffing of CMS is striking. In 2002,
CMS had only 4,497 full-time-equivalent (FTE) employees. This number is less than the 4,961 FTE employees the agency had in 1980 when the workload and number of beneficiaries were much lower.

Tight staff ceilings are a special problem for an agency such as CMS that needs to keep up with developments in healthcare and technology. One consequence of the agency's limited ability to hire is that CMS has a graying workforce. In February 2000, the HCFA Administrator testified that over one-third of the agency's employees would be eligible to retire in the following five years, depriving the agency of a potentially large number of workers with valuable institutional memory.

Funding constraints for Medicare's administration are severe. Figure 1 on page 9 shows the dramatic decline in Medicare administrative expenses as a percent of benefit payments from 1970 to 1999. In 1999, a group of fourteen prominent healthcare policy experts from across the political spectrum signed an open letter calling for Congress and the administration to address the "crisis facing HCFA and millions of Americans." The letter stated that limited resources and lack of administrative flexibility threatened to cripple the administration of Medicare:


23. Medicare Management, supra note 9, at 23 (discussing the impact of the retirement of a large number of experienced HCFA personnel on the Agency's human capital).


25. See Stuart M. Butler et al., Crisis Facing HCFA & Millions of Americans, Health Aff., Jan./Feb. 1999, at 8, 9 (requesting cooperation between the legislative and executive branches to fix problems with the HCFA).
The mismatch between the agency's administrative capacity and its political mandate has grown enormously over the 1990s. As the number of beneficiaries, claims, and participating provider organizations; quality and utilization review; and oversight responsibilities have increased geometrically, HCFA has been downsized.26

Calls for increased administrative resources also have come from the Medicare Payment Advisory Commission (MedPAC)27 and the Study Panel on Medicare's Governance and Management of NASI.28

Figure 1

Medicare Administrative Expenses as a Percent of Benefit Payments, Fiscal Years 1970-1999

Medicare's administrative costs have been declining as a percentage of total program spending.

Source: HCFA/Office of Strategic Planning: Data from Medicare Current Beneficiary Survey.

Note: Data Are Reported for Community-Dwelling Beneficiaries Only.

26. Id. at 9.

27. See Medicare Payment Advisory Comm'n, Report to the Congress: Reducing Medicare Complexity and Regulatory Burden 22 (2001) (recommending that Congress provide resources for CMS to thoroughly test regulations before their implementation, and calling for Congress to appropriate the necessary funds for CMS to purchase new technology that would simplify the agency's administrative processes while simultaneously improving the exchange of information between Medicare participants).

28. See Study Panel, supra note 1, at 8 (stating the panel's finding that CMS's resources are insufficient to support its growing administrative responsibilities).
When the SSA administered Medicare, the program's administrative budget was significantly higher than it is today. At that time, the administrative budget amounted to 3.1% of the total program for Part A (care in hospitals and other institutional settings), and 11% for part B (physician, other professional, and specified services and supplies).\(^2\) However, by 1999, those numbers decreased to 1.5% and 1.9%, respectively.\(^3\) By contrast, private sector administrative costs of insurance companies, for example, can range from 12% and higher.\(^4\) A private insurer, however, would have some costs, such as marketing, underwriting, taxes, and the need to make a profit, which CMS does not incur. But the point remains that CMS's administrative expenses are seriously under-funded.

Although technology is changing the nature of the work required for Medicare administration, CMS often has been unable to keep up with these changes. The agency is limited in the systems that it can acquire or modernize. Some of the critical CMS information systems are decades old and rely on operating software that is rarely used by any entity other than CMS.\(^5\) In addition, many of these systems are incompatible with one another.\(^6\)

Major contributors to the problem are the lack of adequate resources for administration of the Medicare program and the lack of a multiyear commitment for the funding that is needed for any major acquisition. As the

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29. See Medicare 2000, supra note 24, at 43 fig.22 (showing Medicare's administrative costs as a percentage of total spending in 1970).

30. See id. (showing Medicare's administrative costs as a percentage of total spending in 1999).

31. See Medicare: 21st Century Challenges Prompt Fresh Thinking About Program's Administrative Structure: Hearing Before the S. Comm. on Fin., 106th Cong. 4 n.4 (2000) (prepared statement of William J. Scanlon, Dir. of Health Fin. & Public Health Issues, Health, Educ. & Human Servs. Div., U.S. Gen. Accounting Office) (stating that the HCFA Administrator testified that the Agency spends less than 1% of benefit outlays on program management, compared with private health insurers that spend 12% or more of their budgets on administration); see also Health Care Financing Administration's Role and Readiness in Medicare Reform: Hearing Before the S. Comm. on Fin., 106th Cong. 5 (2000) (statement of Nancy-Ann Min DeParle, Adm'r, Health Care Fin. Admin.) (stating that the HCFA's administrative budget is approximately 1.5%, lower than any insurance company in the private sector).


GAO reported, "CMS' IT [information technology] projects compete for resources with other agency responsibilities of national importance, some of which are also lacking in funds and staff." The GAO calls the allocation of funds for IT in this environment "a difficult juggling act." Allocating funds for a financial management system meant that CMS had to decrease or eliminate funding for other systems, including a centralized national provider enrollment database and a contractor-monitoring database. The third-party administration of Medicare is another part of the problem. CMS administers its claims payment process through a myriad of contractors that operate divergent systems. This variation greatly complicates the design of any common system.

Perhaps most importantly, the agency has been unable to develop the capacity needed to modernize its claims payment systems. HCFA failed at its effort in the 1990s to create a single modern claims processing system. Any long-term effort to improve the claims payment systems will require a multiyear commitment of funds plus a well-conceived technology plan backed by the in-house expertise needed for implementation. As the GAO testified:

Owing to a failed attempt in the 1990s to modernize Medicare's multiple information systems, HCFA's current systems remain seriously outmoded. Without effective systems, the agency is not well positioned to collect and analyze data regarding beneficiaries' use of services—information that is essential to managing the program effectively and safeguarding program payments.

The absence of such monitoring systems results in the agency lacking the ability to manage its core programs effectively. In addition, fraud and abuse activities can drain resources from the Medicare program more easily if the agency does not have the proper systems in place. The CMS information systems can take months to respond to a query before generating information about the services that beneficiaries receive and the payments made to

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34. Id. at 18.
35. Id.
36. Id.
37. See Brian Friel, Medicare Transactions, Gov't Executive, Apr. 2000, at 68, 68–70 (discussing HCFA's failed attempt to replace its outdated information system with a large integrated system that would handle all of the agency's problems).
The absence of proper information technology systems means that too much of the Medicare claims payment process is left to law enforcement after fraud and abuse actually are detected. Both providers and beneficiaries have a stake in improved CMS IT systems that will reduce the pressure for fraud and abuse enforcement.\footnote{See \textit{Information Systems}, supra note 33, at 7 (stating that the structure of several of CMS's key databases prevents the easy retrieval of beneficiary information).}

Tight resource constraints also result in CMS lacking the ability to increase the level of payments for Medicare contractors to process claims, engage in program safeguard activities, and otherwise play a major role in administering the program.\footnote{See Thomas H. Stanton, \textit{Fraud-and-Abuse Enforcement in Medicare: Finding the Middle Ground}, \textit{Health Aff.}, July/Aug. 2001, at 28, 33-35 (describing how the improvement of HCFA's information systems would vastly improve the agency's ability to detect and prevent fraud, thereby benefiting Medicare's constituents).} Nancy-Ann Min DeParle testified that when she led the agency, HCFA reduced the cost to process a Medicare claim to about one dollar as a means of stretching the contractor budget.\footnote{See Memorandum, supra note 20, at 5 (noting that the number of HCFA claims processing contractor full-time-equivalent-employees (FTEs), a proxy of the number of staff members working in the department, fell from 28,051 in fiscal year 1992 to 22,200 in fiscal year 1998).} To reduce processing costs and shift to electronic claims, the agency again engaged in a juggling act. To accommodate increased spending in areas such as beneficiary education and outreach, HCFA permitted its contractors to reduce other services.

For example, HCFA eliminated the toll-free lines that physicians used to call carriers with questions about Medicare billing.\footnote{See \textit{Patients First: A 21st Century Promise to Ensure Quality and Affordable Health Coverage: Joint Hearing Before the Subcomm. on Health and the Subcomm. on Oversight \& Investigations of the House Comm. on Energy and Commerce}, 107th Cong. 249 (2001) [hereinafter \textit{Patients First}] (prepared statement of Nancy-Ann Min DeParle, former Adm'r, Health Care Fin. Admin.); \textit{see also} Memorandum, supra note 20, attachment IV (listing HCFA budget justification data on contractor claims processing costs, in current and 1988 constant dollars, for the years 1997 through 2001, when Nancy-Ann Min DeParle was the administrator of the agency).} It then reinstated these lines, presumably because of complaints from providers who find Medicare billing rules to be too complicated and difficult to understand.\footnote{See \textit{Patients First}, supra note 43, at 249 (prepared statement of Nancy-Ann Min DeParle, former Adm'r, Health Care Fin. Admin.) ("We even eliminated the toll-free lines that physicians used to call carriers with questions about Medicare billing in order to accommodate increased spending on other areas, including beneficiary education and outreach.").} The reinstatement of these lines on a shoestring budget, however, was not enough to

\footnote{Id.}
do the job. In 2001, the GAO reported that it had tested the carrier provider inquiry lines and found them seriously wanting. The GAO placed about sixty calls to the provider inquiry lines of five different carriers and asked three test questions taken from the "frequently asked questions" page on the carriers' own web sites. The GAO found that only 15% of the carrier responses were complete and accurate while 53% were incomplete and 32% were entirely incorrect. The GAO found that scarce CMS resources and understaffing contributed to the problem. Undoubtedly, given the outcry that followed the disclosure of the GAO results, CMS will induce the carriers to improve their provider communications. The only question remaining is which important administrative activities the agency must curtail to accommodate the new priority.

Payment of hundreds of billions of dollars of claims annually is a major challenge, which is compounded by the frequent modifications needed to deal with annual updates in fee schedules, new policies, and changes in the law. In 2000, Medicare's claims contractors, the carriers and fiscal intermediaries that pay claims on behalf of CMS, received over 700 change orders. These orders required changes in the way that payments are calculated or paid. Lack of adequate capacity also means that CMS cannot meet the congressional demands for new regulations and notices, which are needed to implement new laws that adjust the Medicare program. In 2001, Nancy-Ann Min DeParle testified that since 1996, Congress had enacted five major pieces


We found that carriers' bulletins and Web sites did not contain clear or timely enough information to solely rely on those sources. Further, the responses to phone inquiries by carrier customer service representatives were often inaccurate, inconsistent with other information they received, or not sufficiently instructive to properly bill the program.

47. See id. at 5 (describing the GAO method for assessing the accuracy of information provided by carrier inquiry lines).

48. Id.

49. See id. at 6 (discussing how a lack of administrative resources and personnel contribute to shortcomings in CMS's provider communications).

50. See Information Systems, supra note 33, at 6 (stating that recent Medicare legislation caused the agency to implement many system changes).

51. See id. (stating that changes in legislation required Medicare contractors to substantially modify their methods for processing claims).
of legislation that required HCFA to implement over 700 provisions for Medicare and other programs.\textsuperscript{52} The Balanced Budget Act (BBA) alone contained "some 335 provisions requiring changes, in some cases major changes, to virtually every aspect of the Medicare program, as well as substantial changes in Medicaid."\textsuperscript{53} HCFA published thirty-nine regulations and seventy-one notices to implement the BBA, but this was insufficient to implement the law completely.\textsuperscript{54} As Timothy Jost points out, the issuance of regulations by CMS has been prodigious, but insufficient.\textsuperscript{55} Some rulemaking proceedings have taken over a decade. The immense regulatory workload that results from the structure of the Medicare program, repeated congressional enactments that require yet further regulations for implementation, and resistance from powerful constituent groups all contribute to cause the delay.\textsuperscript{56}

People who follow the Medicare program closely paint a bleak picture of the consequences of CMS's incapacity. They describe management of Medicare today as management by crisis.\textsuperscript{57} To deal with the most pressing problems of the moment, CMS must cannibalize people and resources from other activities. No continuity in projects and no long-run plan for improvement exist. CMS sacrifices other priorities to meet short-term demands. This sacrifice results in gaps in information and performance. Even though the core mission of the agency revolves around making proper payments to providers, the agency is unable to link patient-level data across sites of care or easily aggregate information about the adequacy of the payments that providers receive for Medicare services.

\begin{itemize}
  \item \textsuperscript{52} Patients First, supra note 43, at 247 (prepared statement of Nancy-Ann Min DeParle, former Adm'r, Health Care Fin. Admin.).
  \item \textsuperscript{53} Id.
  \item \textsuperscript{54} See id. at 248 (stating that despite publishing a large number of notices and regulations, the HCFA lacked the staff to fulfill all of the requirements of the BBA).
  \item \textsuperscript{55} See Jost, supra note 1, at 89 (asserting that although the HCFA has issued a huge number of rules governing the Medicare program, its efforts satisfied neither the agency's own regulatory goals nor the program's needs).
  \item \textsuperscript{56} See id. at 89–91 (describing the lengthy delay in many HCFA rulemaking proceedings and citing several reasons for such delay).
  \item \textsuperscript{57} Interviews with unnamed present and former HCFA and CMS officials (Oct. 31, 2002 & July 10, 2003); see also Waste, Fraud and Abuse in Federal Programs: Hearing Before the House Comm. on Ways & Means, 2003 WL 21667336 (statement of David M. Walker, Comptroller Gen., U.S. Gen. Accounting Office) (describing Medicare as a "high-risk program" because it is "highly vulnerable to waste, fraud, abuse, and mismanagement); Government Efficiency, Financial Management: Use of Management Tools in Formulating the Budget: Hearing Before the House Comm. on Gov't Reform, 2003 WL 1559001 (statement of Patricia A. Dalton, Dir., Strategic Issues) (describing Medicare as a "high-risk" program); Medicare: The Need for Reform: Hearing Before the House Comm. on Budget, 107th Cong. 50 (2001) (statement of William J. Scanlon, Dir., Health Care Issues) (stating that Medicare management needs to be improved to meet "current 21st century needs and expectations").
\end{itemize}
The constraints on resources for Medicare may reflect not only the general disinvestment of government, discussed in Part IV below, but also concerns about the possible consequences of strong and capable Medicare administration. For example, Sallyanne Payton suggests that:

In the great American political debate Medicare has a unique place because it is an age-delimited piece of a universal national health insurance program, the rest of which might be created in an appropriate political moment . . . . Actions affecting Medicare tend to be evaluated politically, therefore, for their potential to advance or retard the cause of national health insurance, for their effect in creating or tending to block the creation of an administrative infrastructure sufficient to allow the government to make a credible claim that it can administer a national health insurance system, and for their potential to push future development toward one model or another of government-sponsored health coverage.58

Indeed, some policy makers cite the shortcomings of Medicare administration as reasons to consider moving to other models of healthcare delivery, such as the management of private plans in a system comparable to the Federal Employees Health Benefit System. The basic structure of the Medicare program and the role of CMS in administering Medicare now are matters for open political discussion. In summary, CMS lacks the capacity at multiple levels—including administrative, budget, staffing, and systems—to carry out its work properly. The vending machine may be functioning, but not with the correspondence between resources and functions that was apparent in earlier years and that is needed today.

B. Flexibility

The administration of Medicare is constrained by a number of inflexibilities. Major inflexibilities relate to managing the activities of the contractors and other third parties that carry out the administration of Medicare. Figure 2, below, sets forth the major functions of Medicare, including the setting of prices for fee-for-service Medicare services, claims processing and payment, and overseeing the quality of institutional care.59

In all of these activities, CMS relies heavily on third parties. The setting of prices for fee-for-service physician services, for example, depends on the Current Procedure Terminology (CPT) codes that the American Medical Association

59. See MEDICARE MANAGEMENT, supra note 9, at 4–5 (detailing CMS’s responsibilities in managing the Medicare program).
establishes and updates.\textsuperscript{60} The most important of Medicare’s administrative functions is the setting of prices annually and the payment of claims. CMS does not pay claims directly. Instead, CMS depends on numerous Medicare fiscal intermediaries and carriers as claims administration contractors, which together employ thousands of people.\textsuperscript{61} These contractors help CMS administer the Medicare program, including the processing of claims for hospitals and providers. In addition, CMS contracts with other firms to provide so-called program safeguard services, including monitoring to detect fraud and abuse.\textsuperscript{62} By contrast, CMS has fewer than 5,000 in-house staff members to manage not only the Medicare program, but also Medicaid and other healthcare programs.\textsuperscript{63}

Heavy reliance on third parties causes significant inflexibility in the administration of Medicare. Besides being limited by the disparity in size between its inhouse staff and the size of the claims administration contractors, CMS also is limited administratively by the terms of its relationship with them. Under the law, provider associations, rather than CMS, nominate fiscal intermediaries.\textsuperscript{64} The providers have selected Blue Cross and Blue Shield Plans and the National Blue Cross/Blue Shield Association as contractors.\textsuperscript{65} Carriers must be insurance companies.\textsuperscript{66} Although the Medicare law does not specifically exempt these contracts from provisions of the Federal Acquisition Regulations (FAR), the provider nomination provisions of the law "have always been understood as necessarily overriding the usual government contract requirements for competitive bidding."\textsuperscript{67}

\textsuperscript{60} See Bruce Vladeck, \textit{The Political Economy of Medicare}, \textit{Health Aff.}, Jan./Feb. 1999, at 22, 28 (stating that the American Medical Association holds the copyright on the basic coding terminology needed for Medicare’s system of paying physicians and that the Association controls many of the technical aspects of that payment system).

\textsuperscript{61} See supra text accompanying notes 5–8 (describing how CMS, relying on a small staff, must process claims for a large number of beneficiaries through carriers and intermediaries that themselves have a substantial total number of employees).

\textsuperscript{62} \textit{Medicare Management}, \textit{supra} note 9, at 12–13.

\textsuperscript{63} See supra text accompanying note 19 (stating that in 2002 CMS had only 4,497 full-time equivalent employees).

\textsuperscript{64} See Edward Steinhouse, \textit{Natl. Acad. of Soc. Ins.}, \textit{Government Contracting in the Medicare Program} 4 (2001) (stating that the "most unusual feature" of the fiscal intermediary contract is that the contractor is chosen by the provider, not by the government) (on file with the Washington and Lee Law Review).


\textsuperscript{66} Steinhouse, \textit{supra} note 64, at 7.

\textsuperscript{67} \textit{Id.} at 4.
### Figure 2

Examples of CMS’s Responsibilities in Managing Selected Medicare Program Activities

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<th>Setting prices</th>
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| In accordance with legislatively prescribed guidelines, CMS sets tens of thousands of fees or prices to pay suppliers for Medicare-covered items and to pay providers—including physicians, hospitals, rehabilitation and nursing facilities, and home health agencies—for Medicare-covered services. For example, CMS must:
| • develop rates for physicians that reflect the resources involved in providing individual services as well as variations in their costs across local markets and
| • set rates for acute care hospitals reflecting services beneficiaries will need based on diagnoses and adjust payments to reflect geographic cost differences. |

<table>
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<tr>
<th>Overseeing fee-for-service claims administration</th>
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| In monitoring about 50 Medicare claims administration contractors, CMS must determine whether the contractors, among other things,
| • meet performance standards for timeliness and accuracy of claims processing;
| • identify insurers that should have paid claims that were mistakenly billed to Medicare;
| • operate fraud units that explore leads and develop and refer cases to law enforcement agencies;
| • identify and investigate instances or patterns of inappropriate billing that could result in unnecessary payments and serious financial losses to the program; and
| • collect overpayments. |

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<tr>
<th>Educating beneficiaries</th>
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<tbody>
<tr>
<td>CMS is responsible for improving beneficiary understanding of the Medicare program. To do this, CMS has launched a national education campaign, Medicare &amp; You, to provide Medicare beneficiaries with information about Medicare and their health plan choices. Information is made available to beneficiaries through a variety of channels, including print materials mailed to all beneficiaries, toll-free telephone service, and an Internet site.</td>
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<th>Ensuring that institutional care meets Medicare requirements</th>
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| To help ensure that Medicare beneficiaries receive quality care, CMS
| • contracts with state agencies to survey institutional providers, such as SNFs [Skilled Nursing Facilities], home health agencies, and dialysis facilities, and certify that they meet Medicare’s conditions of participation and associated standards;
| • conducts training activities to help ensure that state surveyors are qualified to enforce the federal quality standards for care; and
| • is required, for certain providers, such as hospitals, to accept accreditation by the Joint Commission on the Accreditation of Health Care Organizations or other accrediting bodies. |

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Overseeing Medicare+Choice

CMS contracts with managed care plans, requiring, among other things, that they
• provide basic benefits to enrollees;
• comply with applicable provider requirements, including those relating to
certification and participation; and
• operate quality assessment and performance improvement programs.

CMS must
• review for accuracy the promotional literature and membership materials that
each plan distributes to beneficiaries; and
• ensure that plans have adequately informed beneficiaries of their right to appeal
adverse coverage or payment decisions.69

In addition to being awarded without full and open competition, the
contracts also must cover the entire range of claims processing and related
activities, with exceptions such as work that has been delegated to the program
safeguard contractors. The contracts cannot be terminated without cause and
without providing the contractor with an opportunity for a public hearing.70
The contracts may not provide performance incentives and must be cost-based
rather than performance-based.71 CMS also must rely on many other third
divisions to administer its programs. These programs include state agencies
needed to oversee institutional providers, such as skilled nursing facilities,
home health agencies, and dialysis facilities, and to certify that they meet
Medicare’s standards. Likewise, these third parties include certain providers,
such as hospitals, that must attain accreditation by the Joint Commission on the
Accreditation of Health Care Organizations or other accrediting bodies.72

For CMS, these third parties create a number of inflexibilities. First, the
use of contractors creates a bureaucratic division between CMS and the
contractors that provide the services. This bureaucratic division costs CMS
information about the program it must administer and also removes significant
management flexibility. The carriers and fiscal intermediaries, in addition to
the people that work for them, have connections with members of Congress.
Among other consequences, when carriers or fiscal intermediaries consolidate,
CMS comes under pressure to assure that the employees of the merged

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69. See Medicare Management, supra note 9, at 4–5 (detailing CMS’s responsibilities
in managing the Medicare program).

70. See Medicare Contracting Reform, supra note 65, at 3 (stating that Medicare
contractors cannot be terminated without a public hearing under the Social Security Act).

71. Study Panel, supra note 1, at 45.

72. See, e.g., JCAHO, supra note 68 (describing JCAHO).
institutions are protected, even if efficiency might be achieved through closure of some facilities.

Second, the bureaucratic divisions among contractors create inflexibility. Contractors use divergent payment systems to pay claims to the providers that they serve. CMS has worked assiduously over the years to reduce the number of payment systems that contractors use to pay Medicare claims and has succeeded in reducing the number. Lack of uniformity of payment systems creates difficulty for CMS in trying to link claims either to providers or to beneficiaries across the United States. The results in terms of the creation of openings for fraud and abuse can be imagined, but are harder to quantify. The results in terms of frustration of providers, including many companies that serve multiple states, are more directly palpable.

The problem of bureaucratic division also arises in other contexts. For example, the new program safeguard contractors, created pursuant to the Health Insurance Portability and Accountability Act (HIPAA) in 1996, have assumed many of the functions of trying to assure that payments for claims are proper, including audits and investigation for possible fraud. Many of these functions are supposed to be taken over from the claims administration contractors. One can imagine, in a system hungry for resources, that the transfer of these functions and the needed cooperation of the existing claims administration contractors with the new program safeguard contractors will not always take place smoothly.

A third inflexibility derives from the fact that CMS is limited to the terms of its contracts with each contractor. Without adequate funds or authority to create incentives for good performance, CMS lacks the ability to create good performance, especially among the claims administration contractors. The extent to which the system of contractors actually has become dysfunctional is surprising. Numerous outside reviews have found that the contractors may fail to check provider claims properly to prevent payment errors.

One predominant reason for this substandard performance relates back to the capacity of Medicare administration and the limited resources that the

73. See Information Systems, supra note 33, at 3–4 (describing Medicare’s multiple, contractor-operated claims processing systems).

74. See Medicare Management, supra note 9, at 12–13 (describing how these efforts will help safeguard Medicare money by identifying when other companies should pay claims instead of Medicare).

government has dedicated to pay for processing claims. It would cost a carrier or fiscal intermediary much more to create and operate a system for paying each claim for the appropriate amount than merely to pay each claim promptly. Carriers and intermediaries have no incentive to audit or investigate questionable claims. As with other financial services where a federal program is subject to excessive parsimony, the government tends not to get more than the quality of service that it paid for. Moreover, as noted above, the law limits CMS to cost-based reimbursement contracts. These constraints, coupled with nearly flat payments to contractors, have resulted in a shrinking pool of available companies. Since 1980, the number of Medicare contractors has dropped by half, indicating that these companies do not find Medicare business as attractive as in the past.

Another major area of inflexibility for Medicare administration concerns the limitations on CMS’s ability to hire, promote, and terminate employees. The agency also is limited in its ability to contract for services. In addition, it is restricted in its ability to adjust its administrative budget in response to changes in demand for Medicare services. These inflexibilities affect many agencies across government. However, the consequences are more pronounced for a major program such as Medicare that serves forty million beneficiaries.

CMS would benefit from various forms of personnel flexibility that Congress has granted to other agencies. These areas include the creation of excepted service positions so that CMS could hire a limited number of people with specialized skills in medicine, information technology, or finance at levels of compensation somewhat greater than the usual civil service limits. CMS also would benefit from the creation of a program of term appointments, allowing the agency to hire people for terms of up to five years. This flexibility could infuse the agency with people that have fresh skills and perspectives, who might not be ready to sign up for a full civil service career. CMS also needs some basic flexibility in the personnel area. Currently, CMS has only fifty-four

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76. See Medicare Contracting Reform, supra note 65, at 3 (stating that the Social Security Act calls for the use of cost-based reimbursement contracts).
77. Study Panel, supra note 1, at 45.
78. HCFA Role and Readiness, supra note 3, at 43 (prepared statement of Nancy-Ann Min DeParle); Management Challenges, supra note 3, at 13.
80. Study Panel, supra note 1, at 57.
Senior Executive Service (SES) positions, ten of which are noncareer. The GAO has testified that this is a far lower allocation of SES positions than Congress has provided for other agencies with significantly smaller budgets and less onerous responsibilities.

The shortcomings in CMS’s authority to contract for carriers and fiscal intermediaries have already been noted. Numerous commentators, including GAO officials and former HCFA administrators Nancy-Ann Min DeParle and Bruce Vladeck, have called for modernization of the statutory requirements relating to carriers and fiscal intermediaries. Needed changes include: (1) subjecting these contractors to competition so that low performers have an incentive to improve; (2) expanding the types of firms that are eligible to compete; and (3) removing a statutory provision that requires these contractors to be paid on a cost-basis and that prohibits them from making a profit.

Both houses of Congress passed legislation in the 108th Congress to improve the relationship between CMS and its contractors and to permit competition among claims administration contractors. Competition would be a great step forward, but it should not be assumed that it would be a panacea. The contracting process will be cumbersome and slow. Consider, for example, TRICARE, the military health system administered by the Department of Defense that provides health benefits to over eight million active duty personnel, their dependents, and retirees. A GAO review of the TRICARE health coverage program found numerous shortcomings. TRICARE is much smaller than Medicare in the number of beneficiaries it serves and it uses

81. Id.
82. Id.
83. See supra Part II.B (discussing flexibility as one of Medicare’s shortcomings).
84. See Patients First, supra note 43, at 250–51 (recommending that legislation should be adopted which would “broaden the pool of qualified private sector entities to do the job [process claims, interact with hospitals, physicians, and other health care providers], permit incentive based contracts, and allow consolidation to achieve economies of scale”); BRUCE C. VLADECK & BARBARA S. COOPER, THE HENRY J. KAISER FAMILY FOUND., REPORT No. 1627, MAKING MEDICARE BETTER 15 (2001) (arguing for modernizing statutory requirements concerning Medicare’s relationships with its fiscal intermediaries and carriers).
85. See supra note 84 and accompanying text (arguing for modernization of statutory requirements).
88. See generally id. (describing shortcomings with TRICARE’s contracting approach).
competition to select its health care contractors. The GAO reported that a single contract proposal consisted of 33,000 pages, and one contractor official stated that the company proposal cost about five million dollars to bid. Because of the costs to prepare a proposal, bid protests were common. The contracts are large, complex, and prescriptive in nature. The need for numerous change orders (that is, required changes in work, compared to what was specified in the original contract agreement) has made costs difficult to predict and has created funding shortfalls. Finally, once again for CMS, the issue of resources will be paramount. In good part, the strength of the CMS relationship with its contractors will depend on the resources that the agency is permitted to devote to paying contractors for good work and to assuring their performance.

The current relationship of CMS with its carriers and fiscal intermediaries is symptomatic of the general inflexibility of the Medicare program. The law provides that "any willing provider" that is properly certified may provide Medicare services and receive payment. This reflects a culture of Medicare that resists changes to permit greater flexibility in the delivery of Medicare services. While a panel of NASI proposed that the management of Medicare should include more innovation and pilot programs, efforts such as the demonstration programs to bring price competition to Medicare+Choice plans have foundered because of constituency concerns. As the GAO has concluded in a different context, "Medicare's particular dilemma is that the number of special interests affected and the dollars involved make it difficult

89. Compare the eight million people eligible for care through TRICARE with the forty million elderly and disabled people enrolled in Medicare. Id. at 1.
90. Id. at 5.
91. See id. (describing how losing contractors claim they have everything to gain by protesting the award to another bidder even at substantial cost).
92. See id. at 5–6 (describing the contracts).
93. See id. at 7–8 (discussing how Department of Defense TRICARE contract adjustments and change orders have forced the Department to request additional funding from Congress).
THE ADMINISTRATION OF MEDICARE

even to test on a limited basis the prudent purchasing techniques employed by the private sector.\textsuperscript{96}

Finally, CMS is subject to budget inflexibility that has limited the agency's ability to make the investments in staffing, systems, and contractor payments that are needed to keep up with its burgeoning workload.\textsuperscript{97} The Medicare budget is divided between mandatory dollars to pay for services and discretionary funds to pay for administration.\textsuperscript{98} This means, as Robert Berenson and Dean Harris point out, that investments in increased program effectiveness would involve increased spending on program administration while the savings would accrue to the Medicare trust funds.\textsuperscript{99} One option for overcoming this problem, albeit not without its own defects, would be to set the administrative budget for Medicare according to a formula related to the program's payments for services.\textsuperscript{100} Another option would be to create a special administrative fund similar to the Health Care Fraud and Abuse Control (HCFAC) account that funds fraud and abuse activities of CMS and other agencies.\textsuperscript{101} As a part of the reporting requirements of the law, the agencies submit an annual report that includes a discussion of the activities for which funds have been expended and the monetary results of activities.\textsuperscript{102} This latter


\textsuperscript{97.} See Robert A. Berenson & Dean M. Harris, Using Managed Care Tools in Traditional Medicare—Should We? Could We?, LAW & CONTEMP. PROBS., Autumn 2002, at 139, 146 (describing the division of the Medicare budget and stating that this division presents a major barrier to adopting cost-cutting techniques).

\textsuperscript{98.} See id. ("A major barrier to adopting managed care cost-cutting techniques is the division of the Medicare budget between mandatory dollars to pay for services and discretionary dollars to pay for administration.").

\textsuperscript{99.} See id. (stating that "[a]dopting virtually any managed care technique would involve increased spending on program administration, yet savings would accrue to the trust funds").

\textsuperscript{100.} See Medicare Governance, supra note 14, at 51 (prepared statement of Michael E. Gluck, Research Assoc. Professor, Inst. for Health Care Research & Policy, Georgetown Univ.) (discussing the possible benefits of an option of setting Medicare's administrative budget according to a formula related to benefit payments).


option would preserve accountability to Congress while allowing CMS increased flexibility to make investments in improved Medicare administration.  

C. Accountability

CMS is accountable for its administration of Medicare both to higher levels of the Executive Branch and to Congress. Congress enforces accountability through the power of the purse, the power to hold hearings, and the power to change the law that authorizes both CMS and the Medicare program. In the case of CMS, congressional accountability has turned into congressional micromanagement. As described earlier, Congress regularly changes the details of the Medicare program. Former HCFA Administrator Bruce Vladeck points out that many of these changes are enacted at the behest of narrow interests. He points to statutory provisions that skew prospective payment systems towards particular classes of providers, which also include express preferences for particular hospitals. Under these circumstances, he sees the prospective payment system as losing much of its simplicity and rationality to become more like the Internal Revenue Code. In 2000, the HCFA Administrator, Nancy-Ann Min DeParle, testified that:

In the two and a half years that I have been Administrator, HCFA has been the subject of more than 1100 audits and oversight reviews by the General Accounting Office and HHS [Health and Human Services] Inspector

103. Senate Bill 1895, introduced in the 106th Congress by Senators John Breaux (D-La.) and Bill Frist (R-Tenn.), would require CMS to submit an annual business plan to Congress, which, until 2008, would be subject to an up-or-down vote. S. 1895, 106th Cong. (1999). After that, CMS could implement its business plan without express congressional approval. See FRESH THINKING, supra note 96, at 11 (explaining how the Breaux-Frist Medicare reform proposal would seek to improve HCFA’s management capacity). The annual business plan would allow CMS to propose changes in provider payment rates, contracting provisions, and purchasing strategies. Id. CMS no longer would be subject to the annual appropriations process and instead would include those expenses in the premium that it proposed in its business plan. Id.

104. See supra notes 52–55 and accompanying text (describing congressional action requiring changes to Medicare).

105. See Vladeck, supra note 60, at 27 (relating how various groups work to protect and advance their own narrowly focused interests through the political process).

106. See id. (describing various statutory provisions that are targeted towards certain hospitals or groups of hospitals).

107. See id. ("With every passing year, the prospective payment system (PPS), which was touted by some of its initiators as a model of uniform, ‘scientific’ national policy, looks less like theoretical exercise in health economics and more like the Internal Revenue Code.").
General. We receive, on average, more than 700 letters a month from members of Congress, and our contractors receive thousands more.\textsuperscript{108} In addition, congressional committees and subcommittees hold large numbers of oversight hearings with respect to CMS and Medicare.

CMS also is held accountable for the actions of third parties that help to administer the Medicare program. As Lester Salamon and others have pointed out, the use of third parties to deliver public services creates management challenges and can complicate the lines of accountability.\textsuperscript{109} This complication can be seen most clearly in the case of the contractors that pay Medicare claims. Indeed, several of CMS's claims administration contractors committed fraud against the program.\textsuperscript{110} A 1999 GAO report summarizes the problem:

Since 1990, nearly one in four claims administration contractors has been alleged—generally by whistle-blowers within the company—to have integrity problems; GAO identified at least 7 of HCFA's current 58 contractors as being actively investigated by the HHS OIG [Office of Inspector General] or Justice. Since 1993, HCFA has received criminal and civil settlement decrees totaling over $235 million from six contractors after investigations of allegations that the contractor employees deleted claims from the processing system, manufactured documentation to allow processing of claims that otherwise would have been rejected because the services were not medically necessary, and deactivated automatic checks that would have halted the processing of questionable claims.\textsuperscript{111}

Moreover, the strong constituencies that surround the Medicare program also impede CMS's ability to manage the program in an accountable manner. Timothy Jost points out that providers have impeded CMS's ability to issue regulations to implement laws.\textsuperscript{112} Providers also have registered strong objections to CMS's efforts to improve the collection of information, for example with respect to documentation of provider claims.\textsuperscript{113} CMS seems to be

\textsuperscript{108} HCFA Role and Readiness, supra note 3, at 48 (prepared statement of Nancy-Ann Min DeParle).


\textsuperscript{110} MEDICARE CONTRACTORS, supra note 75, at 4.

\textsuperscript{111} Id. at 4–5.

\textsuperscript{112} See Jost, supra note 1, at 90 (attributing some of the delay in HCFA issuing rules to the fact that the rules are controversial and are met with large amounts of comments and with intense lobbying by certain medical providers).

\textsuperscript{113} See, e.g., U.S. GEN. ACCOUNTING OFFICE, GAO-01-1014 T, MEDICARE MANAGEMENT: CMS FACES CHALLENGES IN SAFEGUARDING PAYMENTS WHILE ADDRESSING PROVIDER NEEDS 4–5 (2001) [hereinafter SAFEGUARDING PAYMENTS] (documenting several provider complaints and
caught in a bind—it is held accountable for administrative shortcomings, but often lacks the political backing or the tools to hold third parties or program participants accountable. Sometimes the missing tools involve statutory limitations as well as lack of political backing, such as when Medicare pays higher prices for medical products than other payors.114 Other times, such as when CMS relies on states to conduct surveys of quality of care of nursing homes, home health agencies, and kidney dialysis facilities, CMS is held accountable for shortcomings in state performance.115

The atmosphere has turned negative for CMS.116 Indeed, one of the reasons the agency changed its name was to try to diminish some of the opprobrium that was perceived to attach to HCFA.117 Much of the criticism of CMS has been misdirected and should be directed instead at the nature of the Medicare program, with its complexities, constantly changing statutory prescriptions, and a political context that prevents CMS from adopting useful efficiencies that would be available to a private sector company in a similar business. One may fear that the discrediting of CMS has reached such proportions that Congress is in danger of allowing CMS to become the ineffective agency that some vocal constituents so often deride. The agency must be held accountable, but the current relationship with Congress is not the way to assure good performance. Not only beneficiaries, but also members of concerns in the light of CMS expansion of safeguard and enforcement activities), available at http://www.gao.gov/new.items/d011014t.pdf.


115. See id. at 33–38 (observing deficiencies in state surveys of nursing homes, home health agencies, and kidney dialysis centers, and indicating that CMS is responsible for overseeing the adequacy of state surveys).

116. Thus, a postmortem on one failed Medicare+Choice pricing experiment concluded: "Don’t let HCFA be your face on the Hill . . . . [T]he credibility of HCFA staff is low and will have to be restored before the Medicare policy-making process can improve." Nichols & Reischauer, supra note 95, at 41.

117. See Press Release, Department of Health and Human Services, The New Centers for Medicare & Medicaid Services (CMS) (June 14, 2001) ("Changing the agency’s name is the first, visible sign of the many steps being taken to change the agency and drive it to be [sic.] responsive and effective agency that it should be . . . . [M]uch of the criticism of the agency has focused on the length of time it takes to get a response from the agency. CMS is making responsiveness to beneficiaries, providers, plans, states, and other stakeholders a focus of the agency."). at http://www.hhs.gov/news/press/2001pres/20010614a.html (on file with the Washington and Lee Law Review).
Congress, may be ignoring the needs of good administration because they have adopted the vending machine model of how Medicare should operate.

D. Life Cycle

Three types of life cycle issues can complicate the effectiveness of an administrative agency. The first relates to design flaws that were built into program administration at the inception of an agency or program. The second relates to the institutional culture that results from an agency's history. The third relates to changes in an agency's staffing and systems as the agency matures.

Similar to many other agencies and programs of the federal government, CMS and Medicare are limited administratively by political compromises made at the start of the program. While the reliance on so many third parties, each with its own constituency and influence, makes the administration of Medicare a daunting task, the costs of third-party governance were foreseen at the inception of Medicare and were understood to be the price for obtaining provider support for the new program. Sylvia Law cites a 1962 memorandum of a task force of the Department of Health, Education and Welfare (now HHS) that highlights the tradeoff, in this case with respect to the use of Blue Cross in program administration:

A considerable price would be paid in order to get the initial public relations advantages with professional groups that might come from using Blue Cross, e.g., loss of direct contact with providers so that the Federal Government would not have detailed knowledge of problems and because of this, the loss of ability to react quickly to problems of administration, budget, program, etc.

The second life-cycle issue relates to the origins of an institution's culture. The pressures in 1965 to start the Medicare program and to prepare to process


119. See generally STEINHOUSE, supra note 64, at 3–7 (discussing the role of intermediaries in the administration of Medicare and discussing problems associated with the use of those intermediaries).

120. SYLVIA A. LAW, BLUE CROSS: WHAT WENT WRONG 34 (2d ed. 1976) (quoting HEW memorandum from Arthur E. Hess, Chairman, Sub-taskforce on Use of Blue Cross and Other Insurers, to Wilbur J. Cohen, Under Sec’y of the Dep’t of Health, Educ., & Welfare 1 (May 10, 1962)).
the claims of nineteen million people eligible for the program within one year had the effect of emphasizing ability to pay claims quickly rather than assuring that claims were paid correctly:

The basic driving force behind all of the early efforts in establishing the Medicare system was to pay bills. Congress, the presidency, SSA, and its contractors all feared the political reverberations, the public frustration, and the disillusionment that would set in if the system fell apart because of the complexities of processing and paying claims. As a result of the major concern to achieve operational readiness quickly, little attention was paid in the first few years to the problems of cost control.

At its inception, administration of Medicare was assigned to the SSA. CMS (then called HCFA) was not created until 1977. The administration of Medicare by the SSA also affected the outlook of the people responsible for Medicare—they saw their function as the prompt payment of Medicare claims, comparable to the agency’s obligation to make prompt payment of Social Security benefits.

Unfortunately, the analogue between administration of Medicare and Social Security is misplaced. Social Security uses a large in-house staff to make payments directly to beneficiaries. By contrast, Medicare relies on third parties who pay the claims of yet other third parties, such as doctors, hospitals, and skilled nursing facilities for Medicare services. These third parties have interests that may not coincide with those of the government or of beneficiaries. This conflict of interest, along with the annual changes in Medicare coverage and payment levels, requires the agency that administers Medicare to take on the responsibilities of a regulatory agency to assure not only that Medicare claims are paid promptly, but also that they are paid in the appropriate amount.

121. Hollander & Smith, supra note 4, at 7.
122. Jost, supra note 1, at 86.
123. Id.
124. See id. at 86–87 (describing the psychology of the Social Security officials who originally implemented the Medicare program and suggesting that this mentality continues to affect the administration of the Medicare program).
125. Sallyanne Payton points out how the professionalism of some provider groups may reduce the problem of dissonance between those providers and beneficiaries. See Payton, supra note 15, at 7–11, 21–24 (discussing the tension between third-party payers, physicians, and beneficiaries and explaining how the use of professional standards to determine appropriate care may reconcile a provider’s professional responsibilities and a patient’s needs for individualized care).
Even after the transfer of Medicare to the new HCFA, federal officials seemed reluctant to take on the role of a regulatory agency. As a former HHS General Counsel wrote:

Put simply, HCFA has viewed itself as a check-writing agency whose missions are to determine when people can receive money for doing something and then to pay that money when they do it. Historically, it has not viewed itself as a regulatory agency and has resisted legislative efforts to transform it into one.126

This pattern changed only in the 1980s, with enactment in 1983 of the Prospective Payment System for hospitals and the enactment in 1989 of the Medicare Fee Schedule for physician payments.127 As Jonathon Oberlander observes, these enactments were "regulatory revolutions" for Medicare:

Cost containment became the administrative hallmark of HCFA, which saw itself in terms of health financing and purchasing of medical services. Fiscal pressures were the driving force behind Medicare reform, and in contrast to SSA's mission as protectors of social insurance, Congress looked upon HCFA to protect the federal budget.128

Only in the 1990s did the agency begin to address the problem of fraud and abuse in a serious way. Moreover (and this may reflect resource constraints as well as the difficult political context for effective action), the agency seemed unable to issue many of the regulations needed to implement legislation that Congress enacted. The most recent GAO report on Medicare as a high-risk program lists one program area after another where the agency has neglected to promulgate regulations that the GAO believes are appropriate for proper implementation of the Medicare program.129 Indeed, Michael Astrue, the former HHS General Counsel, contends that at least some congressional enactments have come about because of exasperation in Congress about Medicare administration and a feeling that enacting a new law is the best way

128. Id. at 24.
129. See generally MANAGEMENT CHALLENGES, supra note 3.
to assure that the program is implemented in a way that reflects congressional intent.\footnote{See Astrue, supra note 126, at 76 (describing HCFA’s reluctance to view itself as a regulatory agency and describing congressional efforts to change this view and to encourage HCFA regulatory responsibility by enacting statutes that indirectly regulate medical providers). Astrue also points to the reluctance of HCFA to accept responsibility for policing fraud and abuse as leading to the unique characteristics and responsibilities of the HHS Office of Inspector General. See id. (attributing the broad responsibilities of this office to the HCFA’s resistance of additional regulatory responsibility).}

The third life-cycle issue involves changes in the strength of a maturing agency. The decline in resources for administration of Medicare and tight limits on the size of the CMS workforce already have been noted.\footnote{See supra Part II.A (discussing the limits on CMS’s capacity to administer the Medicare program in terms of people, administrative budget, systems, and organization).} Workforce limitations mean that an agency’s personnel tend to get older as personnel constraints prevent the hiring of younger cohorts.\footnote{See, e.g., AN AGENCY AT RISK, supra note 21, at xiv (stating that although the quality of senior staff is high, HCFA lacks enough high-quality mid-level staff to replace the current senior staff); supra notes 19–26 and accompanying text (discussing Medicare resource constraints that result in inadequate staffing).} The agency faces staff shortages, both in terms of skills and numbers,\footnote{U.S. GEN. ACCOUNTING OFFICE, GAO-01-1006T, MEDICARE: SUCCESSFUL REFORM REQUIRES MEETING KEY MANAGEMENT CHALLENGES 9 (2001), available at http://www.gao.gov/new.items/d011006t.pdf.} and the shortages will be exacerbated as older staff retire. As noted earlier, CMS now is facing the prospect that roughly one-third of its workforce will be eligible to retire in the next five years.\footnote{See Medicare Management, supra note 9, at 23 (reporting that CMS has estimated that about 35% of its workforce will be eligible to retire over the next five years).} Many of the successors who will be recruited or promoted to replace the retirees are unlikely to possess either the institutional knowledge or the skills needed to administer the program well.\footnote{See id. (stating that the upcoming retirements of CMS employees heightens concerns raised about the agency’s loss of technical and managerial expertise); INFORMATION SYSTEMS, supra note 33, at 21 (“CMS also faces the possibility of losing its current employees who have technical and managerial expertise.”).}

In summary, an evaluation of the capacity, flexibility, accountability, and life cycle of CMS reveals an agency that is losing its ability to administer the Medicare program. While the vending machine metaphor may characterize the general perspective of policymakers and Medicare beneficiaries, the actual administration of Medicare—once Congress has placed the money into the system and specified the types of outputs that it desires in any particular year—reveals the shortcomings of the perceived model. Unseen by policymakers and beneficiaries, the innards of the administrative system are losing their strength.

130. See Astrue, supra note 126, at 76 (describing HCFA’s reluctance to view itself as a regulatory agency and describing congressional efforts to change this view and to encourage HCFA regulatory responsibility by enacting statutes that indirectly regulate medical providers). Astrue also points to the reluctance of HCFA to accept responsibility for policing fraud and abuse as leading to the unique characteristics and responsibilities of the HHS Office of Inspector General. See id. (attributing the broad responsibilities of this office to the HCFA’s resistance of additional regulatory responsibility).

131. See supra Part II.A (discussing the limits on CMS’s capacity to administer the Medicare program in terms of people, administrative budget, systems, and organization).

132. See, e.g., AN AGENCY AT RISK, supra note 21, at xiv (stating that although the quality of senior staff is high, HCFA lacks enough high-quality mid-level staff to replace the current senior staff); supra notes 19–26 and accompanying text (discussing Medicare resource constraints that result in inadequate staffing).


134. See Medicare Management, supra note 9, at 23 (reporting that CMS has estimated that about 35% of its workforce will be eligible to retire over the next five years).

135. See id. (stating that the upcoming retirements of CMS employees heightens concerns raised about the agency’s loss of technical and managerial expertise); INFORMATION SYSTEMS, supra note 33, at 21 ("CMS also faces the possibility of losing its current employees who have technical and managerial expertise.").
III. The Decline of Medicare Administration: Does it Matter?

In the vending world, when a particular machine becomes old, decrepit, or obsolete, the vending company will replace it with a shiny new one. By contrast, CMS and Medicare have been subject to a relentless combination of external pressures and increasing demands that have left CMS without much of its original ability to administer the program.136 What are the consequences of this weakening of Medicare administration?

On the one hand, one should recognize that, for all of the challenges it faces, CMS has done a remarkable job of holding together the administration of Medicare. Medicare covers about forty million elderly and disabled beneficiaries and pays on a timely basis $210 billion in claims to about 700,000 physicians, 6,000 hospitals, and thousands of other providers and suppliers.137 For the large majority of beneficiaries, Medicare provides healthcare on a fee-for-service basis.138 CMS contracts with about fifty carriers and fiscal intermediaries, essentially insurance companies, to process almost one billion fee-for-service claims a year.139 Medicare provides coverage to the remaining beneficiaries who are enrolled in 346 private managed care plans, where a single monthly payment covers needed services.140

On the other hand, timely payment is not the same as proper payment of Medicare claims. Rising healthcare costs are calling the future nature of the program into question.141 If Malcolm Sparrow is only partially right in his estimate of a fifty to seventy-five billion dollar annual loss due to Medicare fraud,142 the improvement of CMS's ability to detect and prevent much of that fraud would make a major contribution to restoring confidence in the program, especially in the fee-for-service part of Medicare.

136. See infra Part IV (suggesting that Medicare and CMS are not alone in this plight).
137. HCFA Role and Readiness, supra note 3, at 43 (prepared statement of Nancy-Ann Min DeParle); MANAGEMENT CHALLENGES, supra note 3, at 13.
139. HCFA Role and Readiness, supra note 3, at 43 (prepared statement of Nancy-Ann Min DeParle).
140. Id.
141. See MANAGEMENT CHALLENGES, supra note 3, at 6 (stating that Medicare spending growth has brought congressional attention to the need for reform).
142. See Holding, supra note 11, at A1 (discussing the estimated losses to the Medicare program resulting from fraud).
Moreover, providers have a stake in improved administration. First, a number of providers have threatened to leave the Medicare program because of increasing pressure on the level of fees that the programs pays, especially for physician services. A reduction in payments for fraudulent claims can increase the resources available to pay legitimate claims. This is especially true because of the relative value scales that Medicare uses to pay claims—to the extent that fraudulent claims may be concentrated in certain specialty areas, providers in other areas of practice will be disadvantaged.

Second, weak payment systems mean that too much of the process of dealing with improper claims is left to law enforcement rather than the claims systems themselves. Improved payment systems might help reduce the administrative burdens on responsible providers that today are being subjected to increasing paperwork requirements in an effort to detect improper claims and that currently feel threatened by the prospect of litigation under the False Claims Act. Third, the absence of timely and accurate information about the Medicare program undermines CMS's credibility. For example, when CMS is unable to provide reliable and timely information about providers' transaction costs—for example, for pharmaceutical drugs and medical products covered under Medicare—and beneficiaries' use of Medicare services, CMS finds it difficult to defend its position that payments for such services might be reduced. Finally, a weakening of administrative capability can cause unexpected trouble. This has happened to government agencies from time to time. The immense scale of the Medicare program, and the lack of depth in a

143. See Robert Pear, Medicare Fees for Physicians in Line for Cuts, N.Y. TIMES, Aug. 12, 2003, at A1 (discussing physician reaction to expected cuts in Medicare payments to health care providers).


145. See Thomas H. Stanton, Medicare Fraud and Abuse Enforcement in Medicare: Finding Middle Ground, HEALTH AFF., July/Aug. 2001, at 28, 33 (suggesting that effective administration of the claims payment process would help reduce payment of inappropriate claims).

146. MANAGEMENT CHALLENGES, supra note 3, at 12 (stating that CMS has difficulty defending its position to adjust payments downward when analyses of data on providers' transaction costs and beneficiaries' use of Medicare services are unreliable).

147. See, e.g., Ariana Eunjung Cha, At NASA, Concerns on Contractors, WASH. POST, Feb. 17, 2003, at A1 (discussing concerns expressed over the privatization of NASA operations which may have compromised agency oversight of safety and quality control in light of the February 1, 2003 space shuttle tragedy); James Glanz, Bureaucrats Stifled Spirit of Adventure, NASA Critics Say, N.Y. TIMES, Feb. 18, 2003, at A1 (discussing how NASA's reliance on outside contractors has contributed to the weakened technical and scientific ability of its
system stretched for administrative resources, mean that unforeseen problems could materialize that might cause difficulty to a large number of beneficiaries and providers.

When one balances the benefits and costs of improving the quality of Medicare administration, depriving CMS of the resources that it needs has not been cost effective. CMS has been deprived of needed resources in its budget, staffing, and systems. CMS also needs other support as well, including political support for improvements in program design that could reduce the costs of the program. For policymakers who adhere to the vending machine model, the lesson is clear—unless the machine is refurbished, it cannot continue to carry out the increased number and variety of transactions that consumers will require from the Medicare program.

IV. External Forces and the General Decline of Government Institutions and Programs: An Emerging Crisis—The Disinvestment of Government

Medicare and CMS are not the only government programs and agencies with administrative capabilities that policymakers have neglected. Starting in the 1970s and accelerating in the 1980s, many domestic agencies found themselves seriously constrained in available resources to administer their programs. In 1988, Comptroller General Charles A. Bowsher delivered the Webb lecture to the National Academy of Public Administration (NAPA) in which he warned of an emerging crisis, what he called the "disinvestment of government."
By the 1990s the crisis foretold by Bowsher began to emerge. Budget and
staff cuts have turned many agencies into hollow organizations.\textsuperscript{151} The United
States Commission on National Security/21st Century looked at the activities of
agencies relating to homeland security and found that the Department of State
was "starved for resources."\textsuperscript{152} Moreover, "[t]he Customs Service, the Border
Patrol, and the Coast Guard are all on the verge of being overwhelmed by the
mismatch between their growing duties and their mostly static resources."\textsuperscript{153}
The Commission reported that the problem of hollow government was
widespread and not merely confined to the domestic side of government:

As it enters the 21st century, the United States finds itself on the brink of an
unprecedented crisis in competence in government . . . . Both civilian and
military institutions face growing challenges . . . in recruiting and retaining
America's most promising talent.\textsuperscript{154}

Once an agency finds itself hampered for resources to carry out its
mission, a downward spiral can begin. Members of Congress, especially under
circumstances of divided government, begin to perceive that an agency is not
carrying out the law in the manner that they wish. The experience of the
Department of Housing and Urban Development (HUD) is instructive in this
regard.\textsuperscript{155} A NAPA panel reported, "Problems at HUD made members of
Congress uneasy, frustrated, and even angry. . . . Signs of internal management
dysfunction at HUD were evident."\textsuperscript{156}

One of the critical issues of concern to Congress was HUD's loss of
control over the third parties, especially realtors, co-insurers, and mortgage
lenders, on which delivery of HUD programs depends.\textsuperscript{157} In HUD's case, the


\textsuperscript{153} Id. at 16.

\textsuperscript{154} Id. at xiv.

\textsuperscript{155} See generally Nat'l Acad. of Pub. Admin., \textit{Renewing HUD: A Long-Term Agenda for Effective Performance} 2 (1994) [hereinafter \textit{Renewing HUD}].

\textsuperscript{156} Id.

\textsuperscript{157} See id. (describing political embarrassment caused by HUD scandals involving its private-sector real estate brokers, mortgage lenders, and co-insurers).
loss of control led to actual scandals. 158 Otherwise, the description of a cycle of disinvestments, diminished performance, congressional displeasure, and further diminished performance could have been written about a number of federal agencies. The panel’s description of HUD is remarkable for its applicability to other parts of government today:

HUD at mid-1993 was an organization bogged down in programs, regulations, and handbooks, and too distant from its varied communities of users. Though clear on paper, lines of decision-making had blurred among field, regions and headquarters. An inflexibly-applied hiring freeze made it increasingly difficult to manage declining resources as responsibilities expanded. While struggling staff attempted some innovative ways to meet these challenges, more often HUD’s communities of clients were frustrated by increasing delays in reaching decisions and a perceived emphasis on compliance rather than partnerships for solving the nation’s housing and community development problems. 159

V. Administering Medicare in the Twenty-First Century: Where Do We Go from Here?

A. Improving the Management Capability of Government Agencies and Programs

The events of September 11, 2001 have brought into sharp focus the costs of hollow government and the neglect of the administrative capacity of agencies to carry out their missions. Many years ago, the EOP included an Office of Management and Organization (earlier a part of the Administrative Management Division), housed first in the Bureau of the Budget and then in the new Office of Management and Budget (OMB), that had responsibility for enhancing the management and organization of government organizations and programs. 160 That office had responsibility for enhancing the institutional capacity of the presidency and, by extension, the rest of the executive branch. 161

158. See id. (describing a HUD scandal that led to criminal prosecutions and convictions of department officials).

159. Id. at 61.

160. See, e.g., Emmette S. Redford & Marlan Blisset, Organizing the Executive Branch: The Johnson Presidency 220–21 (1981) (describing the functions of the Office of Management and Organization as including the safeguarding of the constitutional position of the President, maintaining consistency in concepts of organization, and acting as a repository of knowledge on organization history and issues).

161. Id.
The OMB today has lost much of its ability to contribute to the management capacity of government agencies. On July 24, 2001, William Clinger, formerly Chairman of the House Committee on Government Reform and Oversight, wrote to Vice President Cheney to express his concern about the consequences for the management capacity of the President:

In my years in Congress I witnessed the erosion of presidential authority, interest, and capacity in management with dismay . . . . Major issues, such as today’s concern about the future of Medicare organization and administration, are being left to the vagaries of subcommittee politics. When asked how the new Medicare proposals should be organized and administered, the Executive Office is silent. The truth is that the President has little in-house capabilities to frame an answer to organizational management issues. He is forced by the vacuum in management capacity and knowledge to become a defensive and reactive player. Presidents nonetheless are going to be held responsible for how well the Medicare program works (whichever variation is adopted) without having much ability to shape the administrative issues in advance.1

In recent years, the governmental affairs and government reform committees of both houses have lost much of their traditional capacity to deal with issues of government organization and management.163 In his memorandum to the Vice President, Clinger related the weak management capacity in OMB to an erosion of the ability of Congress to look at crosscutting government management issues:

The Government Reform Committee in the House used to be able to act as the government-wide watchdog in cooperation with the BOB [Bureau of Budget]/OMB. Personnel issues, for instance, once centralized so that the parts of the larger system could be coordinated and related to one another, are increasingly being assigned to departments and agencies that then deal exclusively with their oversight committees whose perspective is narrow and definitely not concerned with presidential interests. Thus, the weakening of the M in OMB has also meant the weakening of their correspondent committees on the Hill.164

The danger of the many urgent proposals in the aftermath of September 11, 2001 is that they seek to upgrade administrative capabilities with respect to homeland security, but generally leave the rest of the government’s programs in

162. Memorandum from William Clinger, former Chairman of the House Committee on Government Reform and Oversight, to Richard Cheney, Vice President of the United States 2 (July 24, 2001) (on file with the Washington and Lee Law Review).
163. See id. at 2 (stating that the Government Reform Committee in the House used to act as the government-wide watchdog in cooperation with the BOB/OMB).
164. Id.
the same sorry state of neglect that they were in before. A strategic organization and management capability in the EOP is needed for the entire executive branch to provide help for agencies and programs across the government. This capability would help enhance the provision of Medicare services, and improve the organizational structure for energy programs, federal housing programs, and other major government commitments that are being implemented by troubled agencies or departments.

The new office might have the following general responsibilities:

- **Government Organization:** Review government-wide organizational structure on a continuing basis, periodically reporting to the president and Congress on the state of government organization, and submit proposals to improve the performance and efficiency of federal programs and the capacity of federal agencies.

- **Cooperation and Coordination:** Facilitate interagency and intergovernmental cooperation and assist in developing effective coordinating mechanisms throughout the government.

- **Systems Improvement:** Provide leadership for improvement of agencies’ administrative and program delivery systems. Administrative systems include, for example, personnel, procurement, and information resources.

- **Early Warning:** Analyze agency capacity and operations, for example, with respect to national homeland security, public health, or financial vulnerabilities, to detect potentially damaging gaps and shortcomings.

- **Special Organizations:** Oversee the overall operations and management of government corporations, government-sponsored enterprises, quasi-governmental entities, and other institutions with a governmental interest.

- **Reorganization and Management Legislation:** Develop criteria and standards to be met prior to the submission of legislation to establish new, or reorganize existing, government corporations, enterprises, and other entities with a governmental interest; provide advice on the workability of proposed programs and legislation as they are being developed.

- **Fostering Management Analysis Capacity:** Help departments and agencies to develop internal management analysis capabilities.  

165. *Cf. To Establish an Office of Management in the Executive Office of the President: Hearing Before the Subcomm. on Gov't Mgmt., Info., & Tech. of the H. Comm. on Gov't Reform, 106th Cong. 39 (1999) [hereinafter To Establish] (prepared statement of Herbert N. Jasper, Fellow, Nat'l Acad. of Pub. Admin., former Prof'l Mgmt. staff member, Bureau of Budget) (suggesting possible objectives of a program to improve management); id. at 88 (prepared statement of Ronald C. Moe, Specialist, Gov't Org. & Mgmt., Congressional Research Serv.) (discussing possible statutory provisions that could address six areas of management concern).
The question of location of organizational expertise in the EOP has been a matter of considerable debate within NAPA. On the one hand, many Academy Fellows who are current or former OMB officials argue that organization, management, and budget are inseparable. They argue that the design of programs and agencies must be accomplished with close attention to the resources that may be required. On the other hand, many other Academy Fellows argue that a fundamental conflict exists between the management and budget functions. In their view, the primacy of budget constraints since the 1980s has meant that the budget function inevitably dominates over the issues of government effectiveness that the organization and management function must address. They point to a general neglect of the management function at OMB, especially in the past few years, and urge that the organization and management function be in a separate office from OMB. While the budget function requires OMB to wield power to constrain resources that agencies and programs would like to have, the organization and management function is more supportive in nature and calls for the establishment of collaborative working relationships with agency officials that could be jeopardized by budget conflicts.

After weighing these considerations, it appears that with appropriate top-level support, the organization and management function could operate well within OMB, as it did historically in the BOB. As a practical matter,

166. Compare infra note 167 (arguing for the integration of OMB functions), with infra notes 168–70 (supporting the separation of OMB functions).
167. See To Establish, supra note 165, at 13 (prepared statement of Edward G. DeSeve, Acting Deputy Dir. for Mgmt., Office of Mgmt. & Budget) ("OMB's activities are part of a comprehensive whole—from policy development through program implementation and evaluation. These important responsibilities should be carried out in an integrated manner, not through fragmented organization.").
168. See id. at 80 (prepared statement of Ronald C. Moe) (arguing that budgetary and management values are distinct, as budgetary values have a short-term perspective whereas management values operate with a long-term perspective).
169. See id. at 42 (prepared statement of Herbert N. Jasper) (discussing several reports that recommended the separation of OMB's management functions from its budgetary functions); see also id. at 82 (prepared statement of Ronald C. Moe) (expressing that some scholars believe that budgetary values and priorities displace management values when they are combined because management values lack immediate political appeal).
170. See id. at 38 (prepared statement of Herbert N. Jasper) (arguing that the Deputy Director for Management at OMB cannot effectively carry out both management and budgetary functions and noting that OMB has ignored management issues in the past); see also id. at 82 (prepared statement of Ronald C. Moe) (expressing that some scholars believe that governmental activities are essentially "unmanaged" because of the displacement of management values and priorities by budgetary values and priorities).
however, and with some notable exceptions, OMB has not been able to prevent budget considerations from seriously undermining the management function. Therefore, the office responsible for organization and management should be a small independent office within the EOP. Traditionally, the influence of the Division of Management and Organization of the BOB rested on its support from the President and organizational knowledge and competence.\textsuperscript{171} The effectiveness of such an office today similarly will depend on: (1) support from the President for its work; (2) other demands for its services; and (3) the abilities of its leadership and staff.

If such an office existed today, it would greatly add to the President's capacity to address the critical issues of organization, management, and coordination that have become a national priority with respect to assuring homeland security across all of the agencies and programs of government. This capacity should strengthen the authority of the congressional government affairs committees. Expanded authority and capability among the committees, in turn, is likely to increase the stature of the new office as well. The need for a solid analysis of executive organization and management likely will continue to be strong for quite some time.

\textbf{B. Improving the Administration of Medicare}

One issue concerning the future of Medicare administration is where important economic, demographic, technological, and political external forces will go in the future. The consequences of economic and demographic issues for Medicare's administration are hard to predict, but increasing healthcare costs and an increasing number of eligible Medicare beneficiaries undoubtedly will lead to major program changes in the future. Eventually, technology may become easier for CMS to apply to the administration of claims processing and other systems. CMS faces a strategic imperative on the technology front—to counter the current downward spiral in confidence in CMS administration, the agency must gain control over the information concerning its program so that it can become accepted, perhaps even respected, as a participant in deliberations over Medicare's administration and the program's future.

Assuming that fee-for-service coverage remains a part of Medicare, Gail Wilensky has asked important questions about the politics of Medicare

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\item[171.] \textit{See Redford \& Blissett, supra} note 160, at 220–23 (describing how the Division of Management and Organization operated).
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\end{footnotesize}
administration: "One question is whether HCFA will be given the power to administer a modernized fee-for-service program. Will Congress allow HCFA the flexibility that will be needed to run such a program and will Congress and the Administration provide HCFA with the resources needed to carry out such a task." Wilensky adds, "History is not encouraging on either of these issues." The voice of beneficiaries on behalf of effective program administration has been missing from the political debate. Only the beneficiaries can provide a political counterweight to the other interests that predominate in making administration of Medicare so difficult. Academics have not highlighted administration of Medicare as a critical issue. Academics also have not highlighted the larger policy issues such as the financing of Medicare and the extent of program coverage.

Will anything actually happen to reverse today's downward spiral of low confidence and even lower investment in Medicare administration? The lessons from other federal departments and agencies are mixed. To take one example, the U.S. Coast Guard languished for years, attempting to carry out its mission with an obsolescent fleet that was the third oldest of the forty main naval powers in the world. Then came September 11, 2001 and a recognition of the importance of the Coast Guard to the well-being of the United States. This recognition led to the greatest infusion of funds that the agency has ever seen and the establishment of a seventeen-billion-dollar program to provide the ships and systems that the agency has long needed.

Given the strong beneficiary constituency of Medicare and the importance of the program to a large number of people, such a development for CMS is not out of the question. At least as likely, however, is that the status quo of continuing decline will prevail in the future. The example of HUD already has been discussed. The 1994 NAPA report on HUD contained the following recommendation:

The department should be preserved only if it can demonstrate the capacity to manage its resources responsibly, and if the administration,

172. Patients First, supra note 43, at 239 (statement of Gail R. Wilensky, John M. Olin Senior Fellow, Chair of Project Hope, MedPAC).
173. Id.
Congress, and HUD can put aside the past to look toward how the department can best help communities meet their needs in a flexible fashion. If, after five years, HUD is not operating under a clear legislative mandate and in an effective, accountable manner, the president and Congress should seriously consider dismantling the department and moving its core programs elsewhere.176

It has been many years since the publication of that NAPA report, and HUD continues to operate without a clear legislative mandate and with substantial operational shortcomings in major programs.177 Absent the impact of a calamitous event such as September 11, 2001, administration would seem to be a neglected issue not only for Medicare, but also across much of the rest of the government.

176. RENEWING HUD, supra note 155, at x.
177. See MANAGEMENT CHALLENGES, supra note 114, at 3–4 ("While we recognize HUD’s progress, serious weaknesses remain . . . . For example, the single-family mortgage insurance programs remain a high-risk area because of continued weaknesses in the mortgage insurance process, evidence of fraud, and the variety of management challenges HUD faces in implementing corrective actions.").
ADDENDUM

On December 8, 2003, as this Article was in publication, the President signed into law the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.\footnote{Pub. L. No. 108-173, 117 Stat. 2066, available at http://www.westlaw.com.} The 700-page bill made numerous changes to the Medicare program that will require CMS to issue new regulations, provide new policy guidance, procure new payment of contractor services, studies, and demonstration projects, and establish a new prescription drug benefit. In its depth and extent of prescriptive detail, the 2003 legislation resembles earlier enactments, such as the Medicare-related provisions of the BBA of 1997. The administrative burden on CMS is likely to increase even more if, as some expect, Congress follows up this year’s law with a large technical corrections bill next year.

Nonetheless, the new legislation also gives one several grounds for optimism that Congress did not neglect administration of Medicare this time around. First, the new law allocates close to $1 billion over two years—2004 and 2005—to pay for costs of implementation, including new hires, added contractors, and new systems. CMS is said to be scrambling to find qualified people to hire for the Medicare Advantage program and other implementation tasks.\footnote{See Steve Teske, Medicare: CMS Faces Massive Task of Implementing New Drug Bill as Administrator Scully Leaves, BNA DAILY REPORT FOR EXECUTIVES, No. 233, Dec. 4, 2003, at A13 (stating that the agency needs to find qualified staff and contractors to do the work, and that “[t]he availability of personnel remains an open question among many familiar with the workings of the industry and the health care community”) (on file with the Washington and Lee Law Review).}

Second, the 2003 legislation includes a reform that policy advocates have sought for many years—a reform of the relationship of CMS to its payments contractors. The law eliminates the distinction between Part A contractors (carriers) and Part B contractors (fiscal intermediaries) and merges the authority for both types of entity into a new category called a "Medicare Administrative Contractor" (MAC). The Secretary of HHS is authorized to contract competitively with the new MACs, and to renew the contracts annually for up to five years. All contracts must be competed for at least every five years using the competitive process. Federal Acquisition Regulations (FAR) apply to MAC contracts except to the extent they conflict with a specific Medicare requirement. The law does not extend FAR requirements to other contractors under Title XVIII. The law requires the Secretary to establish contract
performance requirements and to develop standards for measuring the extent to which a contractor has met the requirements.\(^3\)

Third, the law is notable for what it did not do. The House bill would have established a new Medicare Benefits Administration, including a Medicare Policy Advisory Board, within HHS but separate from CMS, to administer parts of the Medicare program other than Parts A and B. The Senate bill would have established a new Center for Medicare Choices within HHS but separate from CMS, to administer parts of the Medicare program other than Parts A and B. Either of these proposals would have greatly complicated Medicare administration by fragmenting responsibilities into distinct organizations that would have been potential competitors, while depending on one another for coordination of the provision of Medicare services.

The final law instead created a center within CMS to administer Parts C and D of Medicare, provide notice and information to beneficiaries, and carry out other duties that the HHS Secretary may specify. The head of the new center reports directly to the administrator of CMS.\(^4\) This organizational solution is far superior to trying to fragment Medicare services across separate units within HHS.

Despite these positive developments in the new legislation, most of the aspects of neglect of Medicare administration remain. CMS continues to lack adequate resources, in funding as well as people. While the substantial new funding resources provided to CMS for the years 2004–2005 will help to compensate for some of the costs of implementing the new law and drug benefit program, CMS Administrator Tom Scully is reported to have said that Medicare may need more money for implementation in later years.\(^5\) Moreover, there has been a significant turnover in senior executives at CMS over the past several years, which would seem to imply the kind of loss of experience and institutional memory that HCFA officials forecasted in the 1990s.\(^6\)

The new law does provide some flexibility in personnel rules so that CMS can add new staff for the new center that will administer Medicare Parts C and D.\(^7\) This flexibility, however, does not extend to the parts of CMS that

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4. Id. § 900.
5. See Teske, supra note 2 ("More money for implementation may be needed in the future, but Scully said he doubted the agency could implement the bill faster with more funding.").
6. In December 2000, CMS had forty-four employees in the Senior Executive Service; twenty-two of them have left as of this writing, three years later. E-mail from Sharon Appleby, Deputy Group Director, Human Resources Management Group, CMS, to Thomas Stanton (Dec. 9, 2003) (on file with the Washington and Lee Law Review).
administer Medicare Parts A and B. The new law also did not improve the issue of accountability in the form of micromanagement. The law requires CMS to implement numerous specific provisions by specific dates. Given the public attention focused on the new prescription drug benefit, CMS will be under significant pressure to start the program within the very tight timetable that the legislation sets. On balance, then, administration continues to be a neglected issue for Medicare, despite some promising features in the new law.