

The crisis in management at the Centers for Medicare and Medicaid Services (Part I): Capacity

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Authors' note: This is the first paper in a two part series. This paper will take a look at the growth of CMS's mission and responsibility with a focus on capacity; while the second paper will explore the consequences of capacity problems for accountability and make recommendations designed to improve performance.

INTRODUCTION

The role of the federal government in health care was radically altered on July 30, 1965 when President Johnson signed the Health Insurance for the Aged bill into law. In the half century since, Medicare and Medicaid have steadily expanded, adding new beneficiaries, new benefits, and new oversight responsibilities. Over the years, underlying health care costs and program spending have risen steadily so that the two programs administered by the Centers for Medicare and Medicaid Services (CMS) have taken up an ever larger portion of the federal budget. When Medicare and Medicaid were fully implemented in 1969, they constituted 4.3 percent of total federal spending. In 2014, Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and subsidies in the Affordable Care Act took up 24 percent of all federal spending.¹ The cost of entitlement programs has grown so much since the 1960s that they threaten to crowd out discretionary spending.²

Over the years, more and more people became eligible for benefits and more and more oversight responsibilities were added to the program. As the population increased, medical technology improved,

1 Center on Budget and Policy Priorities, "Policy Basics: Where Do Our Federal Tax Dollars Go?" March 11, 2015. <http://www.cbpp.org/research/policy-basics-where-do-our-federal-tax-dollars-go>

2 D. Andrew Austin, "The Budget Control Act and Trends in Discretionary Spending," Congressional Research Service November 26, 2014. <https://www.fas.org/sgp/crs/misc/RL34424.pdf>

as did its costs; more effective drugs and treatments were discovered and the utilization of benefits increased. The increasing cost of federal health care became a bit like the old adage about the weather—everyone complains about it but no one seems to be able to do anything about it. In addition to all these factors contributing to rising costs has been the understandable inability of politicians to say “no” to expansions of benefits. Expansion presented more and more management challenges, including the failure of congress to adequately fund the administrative needs of the agency in the face of their reluctance to modify benefits or limit expansion.

Not only have the sheer numbers of beneficiaries changed but the health care industry has changed as well. As the health care industry has become more complex, it has presented challenges to CMS’s ability to support innovation as it attempts to adapt to and leverage change in the system and drive delivery reform and cost constraints.³ All of these challenges have contributed to an increasing crisis in management capacity of the organization (CMS) that is supposed to oversee these enormous programs.

EARLY MANAGEMENT AND GROWTH

The first entity designated to manage the Medicare program was housed inside the Social Security Administration (SSA) at the newly established Bureau of Health Insurance. The responsibility for Medicaid was given to the Social Rehabilitation Service (SRS), a separate agency within the Department of Health, Education and Welfare (HEW). In the first year of the program, enrollment in Medicare was 19.1 million and Medicaid was four million.

The new Medicare program ended up in the Social Security Administration for two reasons. First, it was social security officials who had worked with Congress and formulated the program. Second, processing claims was what the Social Security Administration was good at. SSA was (and is) a straightforward beneficiary program; people earn money throughout their working lives, the earnings are recorded and the checks are sent out. While this is an oversimplification—compared to the complexity of running what was, in fact, a giant insurance company, the SSA mission was comparatively simple. And in the early years of the health care programs, simply getting the checks out to providers in time was the most important mission.

Leonard D. Schaeffer, the former Administrator of the Health Care Financing Administration and founding Chairman and CEO of Wellpoint, remembers that, “Medicare was operated just like Social Security. The measure of efficacy in Social Security was ‘Did you get the checks out on time?’ At that time, HCFA didn’t see itself as part of the health care system—it was providing financial support to Social Security beneficiaries. Social Security checks are not hard to calculate.”⁴ And Jonathan Oberlander, in his history of Medicare, sums it up as follows: “Social insurance privileged claims payment over cost control, and the SSA’s experience lay in paying benefits, not in delivering medical care.”⁵ This was not unintentional. Again according to Oberlander, in Medicare, “policymaking in search of fiscal control of program payments was subordinated to the overriding goal of securing the program’s acceptance among medical providers, and thereby a successful start to Medicare.”⁶

3 It should be noted that Medicare and Medicaid, while administered by the same entity, are administered in different ways and pose separate challenges. Medicare is a federally run payment program while Medicaid is largely administered by the states.

4 Interview with Leonard D. Schaeffer, October 28, 2015. For a more in depth look at Schaeffer’s leadership at HCFA see: “Managing Change: Leonard Schaeffer at HCFA and Blue Cross of California, ([Cambridge, MA, Harvard Kennedy School of Government Case Study, C-16-92-1131.0](#)) HCFA was the organization that took over from the Bureau of Health Insurance.

5 Jonathan Oberlander, *The Political Life of Medicare*, (Chicago, University of Chicago Press) 2003, p. 114.

6 *Ibid.*, 115.

Changes to the two programs began rather quickly after their initial passage. In 1967, the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit was added for all children on Medicaid. And Medicare was given the authority to conduct demonstration projects. In 1972, Medicare was expanded to cover people under age 65 with long-term disabilities and with end-stage renal disease. Medicaid coverage was extended to low-income elderly, blind, and disabled people who qualified for the new SSI (Federal Supplemental Security) program.

Almost as soon as Medicare was enacted, concerns regarding growing costs and reports of fraud and abuse began to appear. By 1969, a Senate Committee was investigating soaring costs, fraudulent billings by doctors and administrative laxity. In 1972, amendments to the Social Security Act called for the creation of professional standard review organizations (PSROs) to deal with higher than expected utilization rates and the resulting increases in costs. By the mid-1970s, the term “Medicaid Mills” had entered the nation’s lexicon—referring to clinics that routinely padded their billings to the government. Newspaper stories about doctors sending in fraudulent bills and clinical laboratories taking kickbacks for business also began to appear with increasing frequency. In 1977, Congress enacted legislation increasing the penalties for fraud in the Medicare and Medicaid programs nonetheless, in addition to concerns about fraud, the operational burdens on the agency continued to grow.

One example of the increasing congressional concern over the program is illustrated in a 1975 report that Congressman Parren J. Mitchell asked the Comptroller General to produce on the cost increases in the programs since their enactment. Medicare spending had more than tripled since 1967, its first year of operation. Medicaid spending had increased by a factor of six.⁷ This would not be the first time Congress would be concerned about exploding costs in the program. As the Comptroller General’s report documented, costs of Medicare Part A (hospital insurance) per eligible beneficiary ballooned between 1967 (\$151.70 per eligible) and 1975 (\$442.34 per eligible.)⁸ Similar cost increases were happening in the Medicaid program. Chief among the reasons for cost increases were an increase in the number of beneficiaries, and an increase in the use of services by beneficiaries.⁹ In addition, inflation in the health care sector remained a problem. As an example, the report noted “... the reported average cost per day of inpatient hospital care increased 40 percent in California and 102 percent in New Mexico.”¹⁰

In 1976 the new Director of the Congressional Budget Office, Alice Rivlin, testified before Congress that overall increases in inflation in the private health care sector would have the same impact on the public sector.¹¹

7 “Report to the Human Resources Task Force House Committee on the Budget. History of the Rising Costs of the Medicare and Medicaid Programs and Attempts to Control These Costs: 1966 – 1975,” Comptroller General of the United States, February 11, 1976.

8 *Ibid.*, p. 5.

9 *Ibid.*

10 *Ibid.*, page i, Digest.

11 Statement of Alice Rivlin, Director, Congressional Budget Office, before Subcommittee on Health and the Environment, Interstate and Foreign Commerce Committee, U.S. House of Representatives, February 25, 1976. Accessed at: <https://www.cbo.gov/sites/default/files/94th-congress-1975-1976/reports/76doc120.pdf>

COMBINING MEDICARE AND MEDICAID UNDER THE HEALTH CARE FINANCING ADMINISTRATION

As program costs skyrocketed, the Secretary of Health, Education and Welfare in the Carter Administration, Joe Califano, decided that the Medicare and Medicaid programs needed to be combined into a new agency, separate from SSA and SRS. By that time, these two programs had become the largest purchasers of health care in the world and any attempt at cost containment came into conflict with the dominate philosophy at SSA which was to pay claims as quickly as possible. So in 1977, the Health Care Financing Administration (HCFA) was created to take over administration of the Medicare and Medicaid programs, thereby removing them from the Social Security Administration and the Social Rehabilitation Service, in the hope that the new agency could leverage program spending in order to limit the increases in federal spending and in total health care system spending.

As in the first decade of their existence, however, both programs continued to grow. In 1980, coverage of home health services was broadened and oversight responsibilities were added for supplemental insurance or “medigap.” In 1981, changes to the Medicaid program increased oversight responsibilities for waivers and for payments to hospitals with low income patients. 1982 saw an expansion of HMOs into Medicare and once again added more oversight responsibilities. In 1983, the Medicare hospice benefit was added as was a major reform of the payment system for hospitals (physician payments were reformed in 1989). These were not the first and not the last efforts to refine the method of reimbursing providers; efforts which continue today. But it should be noted that payment reforms added even more administrative complexity than did the additional beneficiaries.

In 1986, Medicaid expanded coverage for pregnant women and infants up to the poverty level.

In a rare exception to the rule of continual expansion, a 1988 law—The Medicare Catastrophic Coverage Act, which would have added prescription drug coverage as well as assistance to low-income seniors—was passed and then repealed after only 18 months, largely as a result of opposition among seniors to the new premiums and benefits structure.¹²

Nonetheless, growth continued into the 1990s as Medicaid expanded coverage of pregnant women and children up to age six and up to 133 percent of the poverty line, and then expanded it again for children up to age 18. New provisions were also added to further help low income seniors pay Medicare premiums. The 1997 Budget Act created yet another program, CHIP, the Children’s Health Insurance Program, designed to cover uninsured children in low-income families not eligible for Medicaid. It also created the Medicare + Choice program, (now called Medicare Advantage)—also known as Medicare Part C. And in 1999, the “Ticket to Work and Work Incentives Improvement Act” expanded Medicare and Medicaid eligibility to certain disabled beneficiaries who returned to work. In 1999, the Budget Act increased reimbursements to some providers and to some hospitals.

¹² The only portion that survived was the Qualified Medicare Beneficiary Program (QMB).

CENTERS FOR MEDICARE AND MEDICAID SERVICES: A NEW NAME AND NEW FOCUS

In 2001, Secretary of Health and Human Services (HHS) Tommy Thompson changed the name of the Health Care Financing Administration (HCFA) to the Centers for Medicare and Medicaid Services (CMS). In the process he announced a series of reforms designed to refocus the agency and make it the “responsive and effective agency that it should be.”¹³ The restructuring created three centers reflecting the agency’s major lines of business: The Center for Medicare Management; the Center for Beneficiary Choices; and the Center for Medicaid and State Operations. These centers were in charge of (respectively): traditional fee for service; the education of beneficiaries; and the oversight of state implementation of Medicaid and CHIP. The name change also reflected the fact that HCFA had become the whipping boy for many of the problems and high costs of the two programs.¹⁴

Two years later, in 2003, the Bush Administration signed into law the Medicare Prescription Drug Program, effective in 2006, which not only added a new optional outpatient drug benefit, but expanded Medicare to cover new preventative services as well.

Implementation of the prescription drug coverage program encountered technological problems, bad back-end data, and overwhelmed call centers that at times provided inaccurate information. Many predicted that seniors would not be able to navigate the program because of its complexity and that it would fail because of a lack of interest on the part of the insurance companies. But Congress included in the legislation approximately \$1 billion in funds for implementation—most of which was spent on education and outreach to seniors. The money was critical, according to Mark McClellan, the Administrator of CMS in charge of getting the new program up and running. In recalling the startup phase he said that the implementation funding and other provisions such as special hiring authority (for instance, the agency had no pharmacists on staff when the legislation was passed) enabled them to hire the right expertise and write the regulations on time.¹⁵ Despite early doubts, by the end of the first year of implementation, complaints about the new drug law were hard to find.

But the addition of yet another new program increased, once again, the administrative challenges on CMS. By the time Barack Obama became president, CMS was dealing with a wide range of problems such as the prevalence of unnecessary procedures and tests, rising drug prices, increased utilization, poor care coordination, poor care delivery, pricing failures, and administrative complexity in addition to the ever present issues of fraud and abuse.

And then, on March 23, 2010, a mere four years after implementation of Medicare Part D, President Obama signed into law what would be the signature domestic policy accomplishment of his administration, the Patient Protection and Affordable Care Act (ACA). By that summer, opposition to the new law had reached fever pitch and had become the focal point of a new group of extremely conservative Republicans known as the Tea Party. When the Republicans took over Congress in the fall of 2010, they did so determined to repeal the new law. Almost immediately the House Republicans began voting to repeal the ACA—something they have done over sixty times as of the publication of this paper.

13 CMS. “The New Centers for Medicare & Medicaid Services (CMS)” June 14, 2001. Accessed on 03/09/2016 here: <http://archive.hhs.gov/news/press/2001pres/20010614a.html>

14 One of our interviewees who is familiar with President Clinton told us that he came into office with the view from his Arkansas experience that HCFA was overly regulatory and bureaucratic.

15 Interview with Mark McClellan on December 1, 2015.

While they were unable to achieve their goal of repeal, animosity to the new law meant that whenever possible, the Republican Congress opposed efforts to fund implementation of the law (funding had been critical to the successful implementation of Medicare Part D). For instance, according to a Congressional Research Service report, between 2010 and 2012, Congress obligated a total of \$456 million to support the federal ACA exchange operations.¹⁶ This amount was exceptionally small given that so many states ended up opting out of creating their own exchanges and joined the federal exchange. (Animosity towards the law was also evident on a state by state basis where many Republican Governors and legislatures ended up putting roadblocks in the way of implementation.)

But the picture gets even worse. Again, according to the CRS, “Of that amount, \$331 million came from annual discretionary appropriations that cover the routine costs of running federal agencies, including salaries and expenses: \$307 million from CMS’s Program Management account, and an additional \$24 million from the HHS Departmental Management account.”¹⁷ In other words, in an already overstretched agency, funds for a large new program were being diverted from the routine costs of running other, already existing complex programs.

Requests for increases in discretionary spending for 2013, the critical first year of the program, were denied by Congress. Added to the Congressional hostility towards the law were two years of sequestration that required across the board cuts in spending in nearly all discretionary programs. With the addition of the ACA, an enormous new mandate was placed on an already overworked federal agency—with almost no new funding to make sure the work got done properly.

Of course more money may not have prevented the crash. (It should be noted that big technology efforts often crash in the private sector as well.) But, as subsequent studies have shown, there were organizational and leadership problems coming from the White House and CMS as well as a lack of implementation money. One study concluded, “... we found that HHS and CMS made many missteps throughout development and implementation that led to the poor launch. Most critical was the absence of clear leadership, which caused delays in decision making, lack of clarity in project tasks, and the inability of CMS to recognize the magnitude of problems as the project deteriorated.”¹⁸ The shortage of funds and a confusing management structure contributed to the problems of implementation, which included massive changes to Medicare as well. The federal health exchange websites went live on October 1, 2013 and almost immediately crashed as thousands of Americans attempted to buy health care and get subsidies from the new program. An excruciating several months followed in which President Obama’s biggest domestic policy accomplishment was excoriated by friends and enemies alike. The website debacle fueled continued opposition to the law and reinforced beliefs that the federal government was unable to run a “two car funeral.”

ORGANIZATIONAL CAPACITY

Organizational capacity is a key aspect of any successful undertaking—whether public or private. And yet, almost from the beginning, the nation’s two largest health care programs have been administered in a way that short changes the importance of managing such enormous and complex programs. A simple chart illustrates the problem. The federal budget is divided into two important categories—mandatory and discretionary spending. The first category includes all the entitlement programs. Spending in this category is a function of the number of people who meet the

16 “Federal Funding for Health Insurance Exchanges,” October 29, 2014, Congressional Research Service R- R43066.

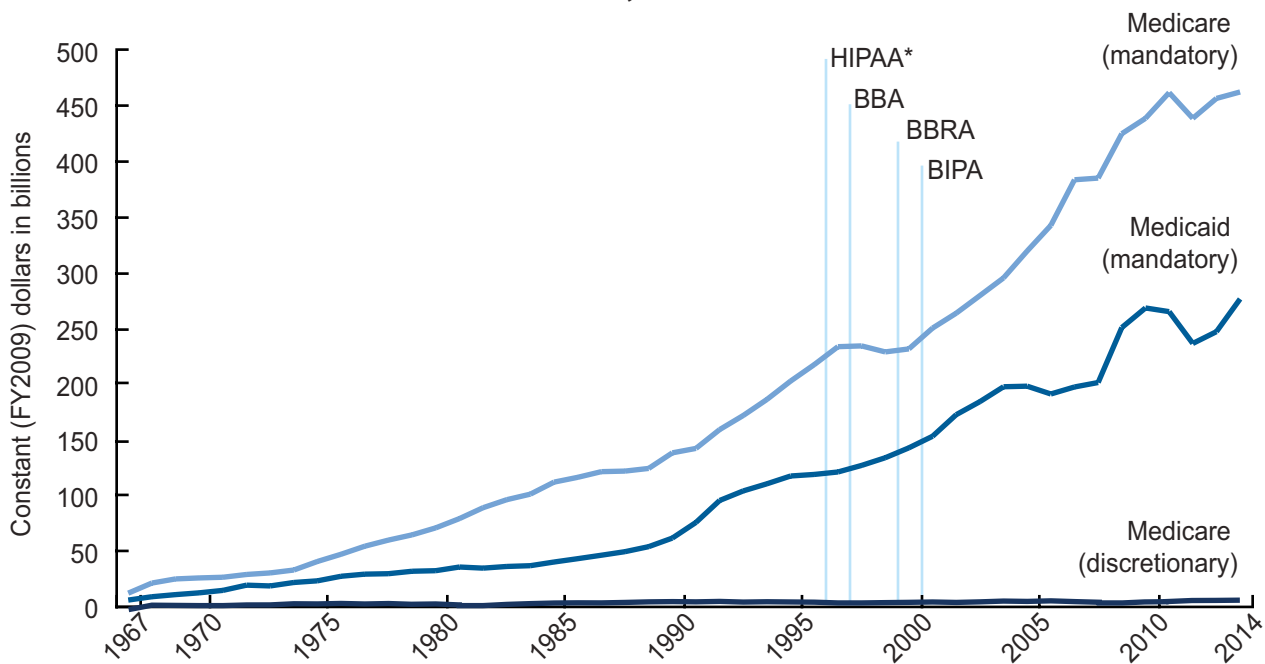
17 “Discretionary Spending Under the Affordable Care Act,” October 28, 2014, Congressional Research Service R- 41390.

18 Office of Inspector General, Department of Health and Human Services, “HealthCare.gov: CMS Management of the Federal Marketplace,” February 2016. Accessed at: <http://oig.hhs.gov/oei/reports/oei-06-14-00350.pdf>

statutory requirements to get the benefit. So, for instance, as the number of people over the age of 65 increases, the costs increase automatically. The second category, discretionary, includes all of the administrative costs needed to establish eligibility, settle disputes, and get the checks out to the states (for Medicaid) and to the right providers at the right time (for Medicare). This category of funding is debated and controlled each year by Congress.

The following chart contains three lines. The top line (light blue) is the amount of money spent on Medicare on the mandatory side of the budget between 1967 and 2014. Note the enormous increases. They are, as we have seen, a function of more people and more services being added to the program over the years. The second line (blue) shows the spending for Medicaid on the mandatory side of the budget. Increases are similarly dramatic. And then note the bottom line (dark blue). This is the amount of money spent on the discretionary side of the budget or, all the money spent to administer programs that these days cost nearly three quarters of a *trillion* dollars! In 1967, the first full year of the program, the federal government spent 1.4 billion dollars to run a program costing 18.2 billion dollars. In 2014, the federal government spent 5.9 billion dollars to run a program costing 639.2 billion dollars.

Mandatory and discretionary outlays for Medicare and Medicaid, 1967-2014

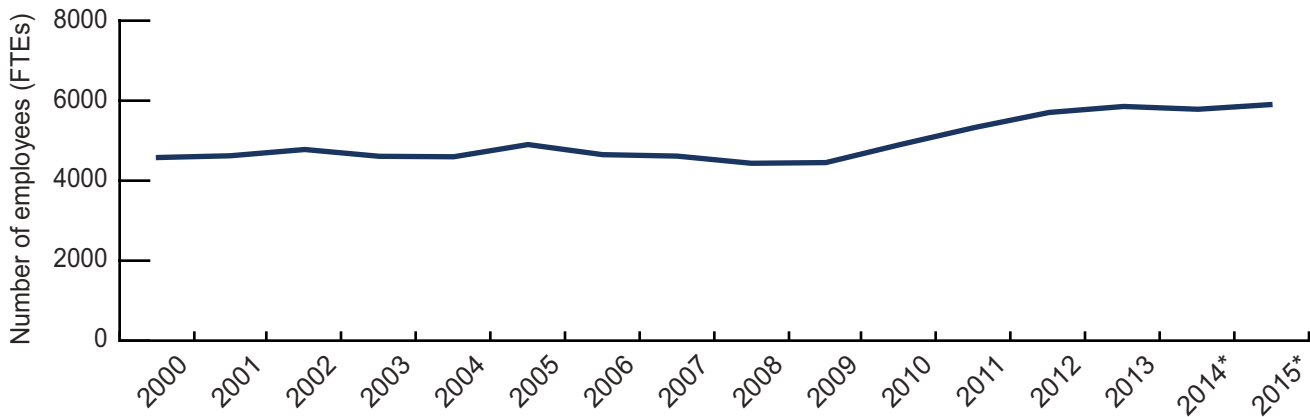


Source: OMB historical tables

* HIPAA is the Health Insurance Portability and Accountability Act that was passed by Congress in 1996. BBA is the Balanced Budget Act of 1997. BBRA is the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999. BIPA is the Benefits Improvement and Protection Act of 2000.

What is also surprising is how little change there has been in the number of people employed to administer all the programs under the CMS umbrella—increasing from 4,435 in 2009 to just below 6,000 in 2014.

Close-up: CMS FTEs (as of Sept 2015)

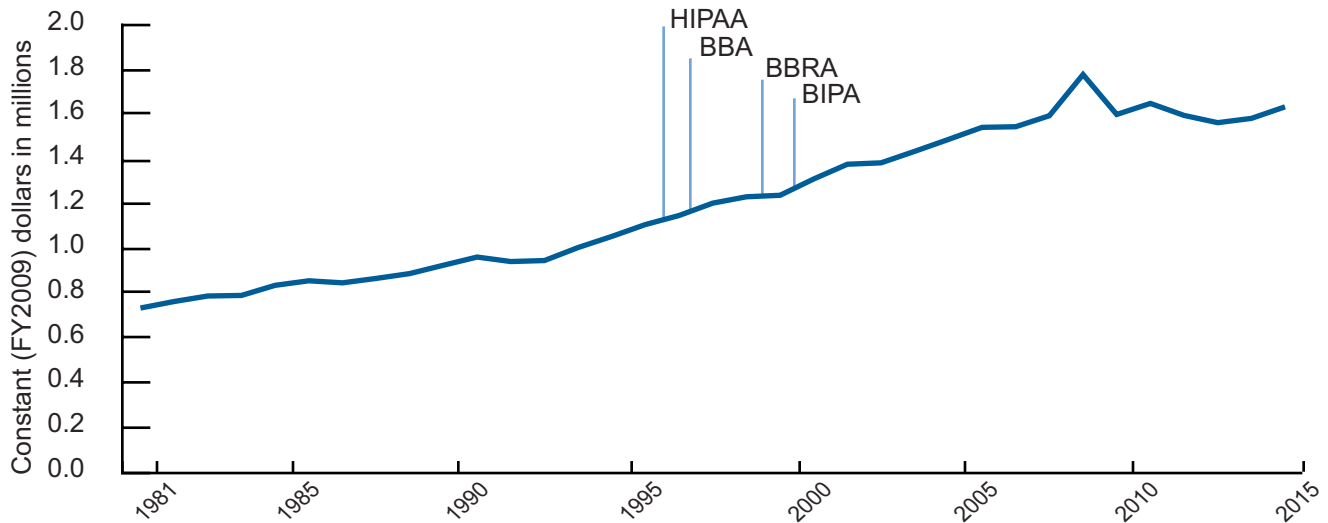


*projected

Source: OPM

The story told above has been repeated throughout the federal government. In a provocative new book called “Bring Back the Bureaucrats,” the political scientist John Dilulio Jr. includes the chart below that shows the increase in federal spending per federal bureaucrat. For the last quarter century, federal spending has grown much faster than the federal workforce.¹⁹

Outlays per federal employee



Source: OMB historical tables

¹⁹ John J. Dilulio Jr., *Bring back the bureaucrats: Why more federal workers will lead to better (and smaller!) government*. Templeton Foundation Press, 2014.

CONCLUSION: THE CONSEQUENCES OF CHRONIC LACK OF ORGANIZATIONAL CAPACITY

We are not arguing that the federal workforce should grow at the same rate as federal spending. Obviously the federal government should be expected to continually increase productivity—or do more with less—especially beginning in the 1990s given the rapid increases in information technology. Nonetheless, the case can be made that in all our federal programs, but especially in the enormous health care programs, we have been starving Peter to save Paul. One person with great familiarity with the agency said “The amount of mission creep they [CMS] have is staggering. What they are asked to do has grown exponentially.”²⁰ This is not totally a question of human resources. As Mark McClellan points out, by and large, the same permanent civil servants who implemented the prescription drug act were still at CMS implementing the Affordable Care Act, but with different outcomes.

The consequences of chronic underfunding on the administrative side have gotten even worse during the years of a highly polarized Congress. According to the same expert quoted above, “When the approps [short for appropriations] dollars start to dry up, you cut back on program integrity. So does education, oversight and all [that’s left] goes to paying the claim on time. ... This goes back to the social security model. The bottom line mission? Pay the client.”²¹

A polarized Congress like the one we have today can’t bring itself to cut the big stuff—like programs and beneficiaries—so it cuts the little stuff instead, such as administrative budgets which contain, for instance, civil servants and information technology systems. In 1990, the Government Accounting Office began publishing the “High Risk List.” The list consists of government agencies with serious management problems. It is published every two years at the start of a new Congress. Illustrating the severity of the problems experienced by organizations that end up on the list, University of Maryland professor Don Kettle noted, “Since GAO began identifying high-risk problem areas in 1990, only about two dozen, or one-third, have successfully moved off the list.”²² Medicare made it onto the very first high risk list in 1990 and has remained on it ever since. Medicaid has been included every year since 2003.

THE CRISIS IN MANAGEMENT AT THE CENTERS FOR MEDICARE AND MEDICAID SERVICES (PART II): ACCOUNTABILITY

In Part II of this study, we will explore in greater depth the consequences of low organizational capacity. What follows is a preview of that paper.

First is the issue of fraud. Medicare and Medicaid have been plagued by fraud ever since their inception and yet, the resources needed to investigate fraud have always come under the discretionary side of the budget. Thus, when the money to run agencies is cut, funding for fighting fraud gets cut too. The Inspector General’s office in the Department of Health and Human Services (which bears a great deal of the burden of tracking down fraud) lost approximately 400 staffers in 2013, the result of the lower caps on discretionary spending implemented in the wake of the government shutdown. Given that improper payments regularly run in the tens of billions of dollars, and that

²⁰ Off the record interview on November 14, 2015.

²¹ Ibid.

²² Charles S. Clark, “The Odds of Getting off GAO’s High-Risk List Aren’t Good,” *Government Executive Magazine*, May 12, 2015.

investigators return around \$8 for every dollar invested in them—this is not smart management.²³ Medicare and Medicaid are constantly under fire for their inability to control costs and root out fraud and yet they are simultaneously handcuffed from making real progress.

Second is the issue of regulating and paying the providers—hospitals, pharmacies, insurance companies and doctors. Chronic understaffing provides challenges to the execution of core functions and constrains policy innovation, resulting in a wide variety of complaints and appeals from providers. Often they are not told the empirical basis for the government’s decision or, when they are, they have questions about the methodology and are not given a way to engage. The increasing complexity of the programs and the long delays in issuing regulations—not to mention political interference—results in constantly changing guidance and regulations. Providers operate in a cloud of uncertainty that hurts their business and their efficiency. For example, in recent years, hospitals have challenged the “Two Midnight Rule” as arbitrary and an interference with medical judgment.²⁴ Pharmaceutical networks have challenged changes to Medicare Part D which they say would increase costs without improving service to seniors.

Third is the problem of overseeing the contractors known as “Medicare administrative contractors (MACs).” These payment contractors interact with a wide variety of other contractors called “functional contractors,” who deal with call centers, quality control and fraud prevention. Currently, CMS oversees 16 MACs that process fee-for-service claims for nearly 70 percent of the Medicare beneficiary population, and collectively processed over \$1.2 billion Medicare claims in 2015.²⁵

Fourth is the issue of constant congressional interference. When, for instance, Medicare limits hospital stays due to cost control pressure, the public complains immediately—to their congressional representative. As one expert told us, “The agency [Medicare] is highly susceptible to congressional pressure.”²⁶ And another one told us that “Congress wants to step on the brake and the accelerator at the same time.”²⁷

Fifth is the problem of leadership. The CMS administrator is a presidential appointee requiring Senate confirmation, and turnover has been high. The average tenure of a HCFA/CMS administrator has been only 1.22 years. The average for Senate-confirmed CMS administrators has been 2.28 years and the average for acting CMS administrators has been .55 years.²⁸ GAO and others have often questioned whether or not the high turnover rate and the periodic absence of a confirmed leader have been harmful to the agency.

Last, but certainly not least, are the beneficiaries for whom these programs are enormously important. But increasing complexity has become a problem for beneficiaries as well as for the government’s administrators. And due to the importance of these programs in the lives of their beneficiaries, proposed changes, no matter how benign, are viewed with suspicion and fear – often stoked by politicians of one party or the other.

23 Fred Schulte, “Medicare fraud outrunning enforcement efforts,” Center for Public Integrity, July 1, 2013.

24 CMS adopted the Two-Midnight rule for admissions beginning on or after October 1, 2013. This rule created the criteria used when determining whether inpatient or outpatient admission is payable under Medicare Part A. In general, the Two-Midnight rule stated that inpatient admissions will generally be payable if the admitting practitioner expected the patient to require a hospital stay that crossed two midnights and the medical record supports that reasonable expectation.

Accessed at: <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-07-01-2.html>

25 CMS. “What is a MAC.” Accessed at:

<https://www.cms.gov/Medicare/Medicare-Contracting/Medicare-Administrative-Contractors/What-is-a-MAC.html#FunctionalK>

26 Interview with Mark Merritt on November 20, 2015.

27 Interview with Jack Ebeler on December 1, 2015.

28 See <http://khn.org/news/cms-chief-job/> and

<https://www.cms.gov/About-CMS/Agency-Information/History/downloads/CMSAdministratorsTenure.pdf>

These problems argue for a good hard look at the organizational capacity of CMS. Controlling costs and improving quality in health care programs is no simple matter. Recently, CMS has been asked to move to a reimbursement system that is value based. As one experienced official told us, “What the hell does that mean?” The ability to move from a fee for service payment system to something requiring greater detail and evaluation will place even greater pressure on the agency.

Whether Democrat or Republican, liberal or conservative—Congress and the next administration must take a long hard look at the mismatch between CMS mission and capacity. CMS is now running not only a classic beneficiary program but an insurance marketplace as well, adding challenges of expertise as well as capacity. In next our next paper we will elaborate on some of the long-term consequences and challenges going forward, as well as offer some ideas for reform.

GOVERNANCE STUDIES

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