Policy High Points: Medicare And Medicaid In The New Millennium

Modernizing Medicare was rewarding—but there is room for much more.

by Thomas A. Scully

The three years that I spent at HCFA/CMS were the most rewarding of my career. I had worked with the Health Care Financing Administration (HCFA) as a Senate staffer, in the White House (George H.W. Bush), and as an outside lawyer and president of a hospital association. I thought I understood HCFA. I really did not.

The issues are endless, as is the complexity. It is a fairly small agency (4,500 staff) but an enormous amount of spending ($600 billion plus, including Medicaid). There is simply no way to deal with it all effectively. There is a friendly bipartisan mafia of former HCFA administrators—from Leonard Schaeffer to Bill Roper and Nancy-Ann DeParle. They all warned me about the job—and still I underestimated the task.

The staff of the Centers for Medicare and Medicaid Services (CMS) was terrific. There is a core of dedicated career people—such as Michael McMullan, Tom Gustafson, Charlene Brown, and Gary Bailey—who work incredibly hard and keep the programs running no matter the political leadership. Although few are Republican or conservative, I always thought that the career staff were supporting me, even if they did not like all of my “market-oriented” ideas. They can run the agency without the political appointees. I saw my job as generating new ideas and needed change in both policy and operations, stirring the pot to make them think differently.

There were many policy high points—mostly notably the Medicare reform and the drug benefit. In a decade, the program will be far more competitive and efficient and will provide far better coverage, especially for poor seniors. But I will leave that judgment to time. The drug discount card did exactly what it was designed to do: act as a short-term benefit to get immediate help to the poorest beneficiaries as the full prescription drug benefit was being developed. Possibly our
most important effort was quality measurement—in skilled nursing facilities (SNFs), home health agencies, and hospitals, and putting it on the Internet and in full-page newspaper ads. Consumer information will drive the fastest change in health care, and I am very excited to see Congress and Mark McClellan pouring more fuel on that fire. Information works to change behavior—fast.

One operational high point was openness. In 2001 HCFA was perceived by the provider world to be bureaucratic and unresponsive. I was determined to open the place up—to get staff to talk to their constituents (patients and providers). The staff was eager to change HCFA’s image and to communicate more openly. Changing the name to CMS was done to get a “fresh start” in the perception of the outside world and to update the agency’s self-image. The “open-door” meetings we held were an effort to engrain a new culture of communication. I think that both worked, and I am excited that McClellan has continued the open-door program.

There were also disappointments. One of the major flaws at the CMS was that there were not enough people with actual health-sector experience. Too often CMS staff still see providers as the “enemy” (and some are). Most people in health are truly interested in serving patients—and the agency would benefit from having more staff who had actually worked in these systems. Examples: For the $16 billion dialysis sector, there was no policy staff with experience in end-stage renal disease (ESRD) when I arrived. The hospital outpatient/ambulatory surgery center (ASC) payment area is driven by antiquated Medicare payment polices—with irrational payment driving irrational behavior. Yet in ASCs, as in hospice, rehab hospitals, and long-term acute care hospitals, there was no staff that had ever actually worked in one of those facilities. McClellan has made huge steps in bringing in experienced clinicians in many areas, and I am certain that this will help the agency perform at a higher level.

On the policy side, reverse mortgages—tied to structured long-term care insurance policies—could be a big positive step in financing high-quality long-term care and could reduce pressure on the Medicaid program. Programs are in place in the departments involved, to do this without legislation. The all-consuming Medicare Prescription Drug, Improvement, and Modernization Act (MMA) distracted us from finalizing reforms, but it makes so much sense that I hope the department can pull it off in this second term.

Every agency can improve, and the CMS has its flaws. But it is a terrific place, with great people, and an amazingly worthy mission. I hope that more people in the health world will devote part of their careers to public service in Medicare and Medicaid. It was fun, and a great learning experience. It feels great getting up every day trying to improve the lives of millions of beneficiaries; you should try it!