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THE NEW CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS)

Overview: *Today HHS Secretary Tommy G. Thompson unveiled the first wave of reforms designed to strengthen the health care services and information available to nearly 70 million Medicare and Medicaid beneficiaries and the health care providers who serve them, along with a newname for the agency that administers these two popular programs - the Centers for Medicare & Medicaid Services.*

In addition to the name change, the Secretary today announced that the agency is being restructured around three centers that reflect the agency's major lines of business; launching a national media campaign to give seniors and other Medicare beneficiaries more information to help them make decisions about how they want to get their health care, including enhancements to 1-800-MEDICARE (1-800-633-4227); improving the culture of responsiveness to beneficiaries, physicians and other health care providers, states and lawmakers; and reforming the Centers for Medicare & Medicaid Services relationship with the private companies that process and pay fee-for-service Medicare claims.

Background

Medicare and Medicaid, enacted in 1965, originally provided health care coverage to Americans over the age of 65. In 1972, Medicare was expanded to Americans living with disabilities. The joint federal-state Medicaid program provides health care coverage to low-income families with children under 21. These programs were created in the Social Security Act and were administered by the Social Security Administration until 1977. That year, Medicare and Medicaid were transferred to the Department of Health and Human Services and to the Health Care Financing Administration. In 1997, the State Children's Health Insurance Program (SCHIP) was included in the Balanced Budget Act.

Today, as part of this package of reforms, the agency is being renamed the Centers for Medicare & Medicaid Services and being refocused along its three primary lines of service - the Center for Medicare Management, Center for Beneficiary Choices and the Center for Medicaid and State Operations.

Rename and restructure HCFA as the Centers for Medicare & Medicaid Services

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 responsive and effective agency that it should be. The new name of the Centers for Medicare & Medicaid Services reflects the scope of the agency's mission - to serve Medicare and Medicaid beneficiaries. It will help consumers identify the agency that administers their health insurance and will help to develop a more consumer-friendly association. In addition, the agency will be restructured to focus more clearly on its distinct lines of business.

The new name, the *Centers for Medicare & Medicaid Services* (CMS), was based on the results from extensive focus groups with beneficiaries and interviews with other stakeholders, the new name will increase consumers' understanding of the government's role in health care while making sure that they know where to go to get the information and assistance they need about the Medicare and Medicaid programs.

The new Centers for Medicare & Medicaid Services will be organized around 3 centers to clearly reflect the agency's major lines of business: traditional fee-for-service Medicare; Medicare+Choice and state-administered programs, such as Medicaid and SCHIP.

- The Center for Medicare Management will focus on management of the traditional fee-for-service Medicare program. This includes development of payment policy and management of the Medicare fee-for-service contractors.

- The Center for Beneficiary Choices will focus on providing beneficiaries with information on Medicare, Medicare Select, Medicare+Choice and Medigap options. It also includes management of the Medicare+Choice plans, consumer research and demonstrations, and grievance and appeals functions.

- The Center for Medicaid and State Operations will focus on programs administered by states. This includes Medicaid, the State Children's Health Insurance Program (SCHIP), insurance regulation functions, survey and certification, and the Clinical Laboratory Improvements Act (CLIA).

Launch and enhance the Medicare education campaign

An important part of CMS' work is to help beneficiaries and their caregivers become active and informed participants in their health care decisions. Few beneficiaries understand Medicare and the coverage options and costs associated with Medicare, such as Medigap, and Medicare+Choice. In fact, results from the 1999 Medicare Current Beneficiary survey found that nearly half of Medicare beneficiaries do not know they can select among different health plan choices within Medicare and about one-fourth do not know that Medicare does not pay for all of their health care expenses. More than half of beneficiaries say they know little or almost nothing about the availability and benefits of Medicare+Choice plans. Only about one-fourth say they know everything or most of what they need to know.

Therefore, CMS is implementing a number of new and expanded services to make it easier than ever for Medicare beneficiaries to learn about their choices. This will include:

- *Expand call center services.* Effective October 1, Customer Service Representatives at 1-800-MEDICARE (1-800-633-4227) will be available 24 hours a day, 7 days a week, to respond to questions from beneficiaries and their caregivers. Callers will be able to get information about the choices which best meet their needs immediately by phone and will also be offered the option of receiving a copy of the information in the mail for further discussion and review. This service will be available on October 1.

- *Develop a web-based decision tool.* A Decision Support Tool will enhance the suite of consumer information databases that currently reside on the www.medicare.gov. This new tool will allow users to narrow down the health plan choices (available in their zip code) based on what is most important to them. It will also allow them to do a direct out-of-pocket cost comparison between all health insurance options, and get more detailed information on the plans that most meet their needs. The final tool will be implemented October 1.

- *Undertake a Medicare education campaign.* A $35-million national advertising campaign will be undertaken in the fall corresponding with the 2002 open enrollment period informing Medicare beneficiaries about these expanded services to help Medicare beneficiaries get the information they need to make informed decisions about their health insurance options. It will include national television, radio and prints ads as well as supporting specific local advertising.

Create a culture of responsiveness

Timely, consistent communication is the hallmark of an effective organization. CMS staff are highly professional and technically competent. However, much 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. The following are some of the steps being taken:

- *Identify individual senior staff members to work with stakeholders.* Individual senior staff members will serve as the primary contact for beneficiary groups, for health plans, for physicians, for providers, and for suppliers to strengthen communication and interaction between and among HCFA and program stakeholders.

- *Identify individual contact persons to work with states.* One Medicaid/SCHIP contact person will work with each state at both the regional and central office level. They will troubleshoot, resolve disputes and generally break through bureaucratic bottlenecks within CMS. They will also be directly accountable to the CMS Administrator and the Director of the Center for Medicaid and State Operations as they respond to state issues.

- *Respond in a more timely manner to requests for information.* CMS will respond to requests for information from Congress and other external audiences promptly. Specifically, by October 1, CMS will respond to direct congressional inquiries within 14 days, rather than the months it sometimes takes today.

- *Enhance and revitalize the Professional Relations Staff.* The Professional Relations Staff will focus on reaching out to national provider, health plan, and health practitioner associations and groups with a renewed spirit of openness as they develop partnership-like relationships.

- *Expand the role of the Physicians' Regulatory Issues Team.* The Physicians' Regulatory Issues Team, an agency-wide group led by a physician, will identify specific workable solutions to problematic Medicare requirements.

- *Expand the physician information available on the Internet.* CMS will make more information available to practicing physicians and their office staff at cms.hhs.gov. CMS is creating a new Internet architecture that organizes existing information so that it will be easier for the physician user.

- *Develop a better system of provider training and problem resolution.* CMS will enhance its system of provider training and resolution of problems through formal training on new requirements, satellite broadcasts, and Web-based information and learning.

- *Release data and information in a timely manner.* Data, information, and trend analyses will be available in a more timely manner and with the requirements that will be necessary for individuals or organizations to obtain the data. This will include the information about protecting the confidentiality of the data.

Develop Medicare contracting reform legislation

The administration is developing a reform proposal to allow CMS more flexibility to promote greater efficiency and enhance contractor performance. Since the Medicare program was created, the government has contracted with private health insurance companies for claims processing and related administrative services. To manage the Medicare program effectively and efficiently, CMS wants to improve its relationship with the Medicare fee-for-service contractors and increase its ability to reward well-performing contractors. The legislation will help improve services to beneficiaries through better and more efficient relationships with its contractors.

Through this legislation, CMS hopes to accomplish the following:

- Provide flexibility to CMS and its contractors to better adapt to changes in the Medicare program.

- Promote competition, leading to more flexible efficiency and accountability.

- Establish better coordination and communication between CMS, its contractors and health care providers.

- Promote CMS' ability to negotiate incentives for Medicare contractors to perform well.

- Improve CMS' contractor performance evaluation processes, while maximizing objectivity in contractor evaluation.

- Stabilize and guide CMS' business relationship with its contractors.

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