Turning Medicare And Medicaid Into Health Programs: The Role Of Organizational Culture

Joining organizations with different cultures and histories proved a formidable challenge in the 1970s but one that was overcome.

by Leonard D. Schaeffer

MY SERVICE AS THE SECOND ADMINISTRATOR of the Health Care Financing Administration (HCFA) began 30 October 1978. Joseph Califano, then secretary of health, education, and welfare (HEW), was impatient to establish HCFA as a highly efficient, well-managed health care financing organization. To make that vision a reality, we had to develop a new organizational culture in HCFA, capable of supporting a more active role for Medicare and Medicaid in our health care economy.

The challenge. Today most experts believe that institutional culture is the major barrier to implementing change. This was not well understood in the late 1970s. However, even twenty-seven years ago it was obvious that the Medicare and Medicaid bureaus had very different histories and belief systems and that despite their large budgets, neither played a leadership role in the U.S. health care system.

The Medicare Bureau, originally part of the Social Security Administration (SSA), reflected that agency’s values. SSA staff considered the senior population to have earned their benefits and saw the agency’s role as getting checks out on time to “beneficiaries” who were entitled to the maximum payout. Medicaid, by contrast, was closely linked to welfare as part of Social and Rehabilitative Services Administration. This agency monitored state programs whose “clients” had to prove that they were eligible for assistance, while program officials were ever vigilant for “welfare cheats.” One of the few traits common to both programs was their focus on the administrative process of financial reimbursement after treatment had been rendered. HCFA also incorporated several Public Health Service pro-
grams, which brought a third cultural dynamic into play.

It was my view that appropriate integration of Medicare and Medicaid could create regulatory and purchasing power with the potential to transform our health care economy. The most significant challenge to achieving this goal was to design a new organization and culture for HCFA that could leverage this power to better serve those who depended on these two programs.

Managing cultural change. We reorganized HCFA and collocated functions, creating a single integrated policy staff for Medicare and Medicaid and a single integrated operations team to oversee the operations of both programs. The move and reorganization received substantial public attention, but organizational change by itself does not change behavior.

To motivate and redirect staff activity, we began to foster a new set of shared values at HCFA. Two cultural changes were essential. The first was to define HCFA's activities as health care programs for all beneficiaries—in both Medicare and Medicaid; the second was to define HCFA's responsibility to lead and leverage change in health care nationally.

The effort to reshape the culture at HCFA fit within a new health-oriented worldview that was developing in Congress and the nation. And it reinforced the aspirations of some of the leading career staff at HCFA—the people who build lasting change for the programs and the public.

The CMS today. Much has transpired over the past quarter-century: massive changes in program payments, improvements in Medicaid and child health coverage, and a new prescription drug program in Medicare. The Centers for Medicare and Medicaid Services (CMS) we see today is clearly a national leader in health care.

However, major challenges remain. The CMS must deal with rising costs, enrolling more low-income people in Medicaid, quality issues, and the aging baby boomers. To do so effectively, organizational culture must continue to evolve, and the CMS must continue to reinvent itself to better meet the needs of the people it serves.

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