CMS History Page Quiz

Questions:

1. In what year did a Presidential health task force first recommend that the Medicare program cover outpatient prescription drugs?

   A. 1963
   B. 1969
   C. 1986
   D. 1993

   ANSWER

2. When Medicare began, what sort of efforts did hospitals and nursing homes need to make to integrate their facilities for black and white patients?

   A. A good faith effort
   B. All deliberate speed
   C. Integration was required before participation in the program could begin
   D. Facilities south of the Mason-Dixon line were exempt

   ANSWER

3. What agency originally administered Medicare?

   A. HCFA (Health Care Financing Administration)
   B. CMS (Centers for Medicare & Medicaid Services)
   C. SSA (Social Security Administration)
   D. SRS (Social and Rehabilitative Service)

   ANSWER

4. What agency originally administered Medicaid?

   A. HCFA (Health Care Financing Administration)
   B. CMS (Centers for Medicare & Medicaid Services)
   C. SSA (Social Security Administration)
   D. SRS (Social and Rehabilitative Service)

   ANSWER

5. Which Secretary established the Health Care Financing Administration?

A. Secretary Califano
B. Secretary Cohen
C. Secretary Sullivan
D. Secretary Thompson

ANSWER

6. In what year was HCFA established?

A. 1965
B. 1977
C. 1992
D. none of the above

ANSWER

7. What was the purpose of joining Medicare and Medicaid together in the Health Care Financing Administration?

A. Move away from a two-class system of health care
B. Get the administrative capacity in hand and in order, ready for national health insurance
C. Improve staffing and management of Medicaid
D. All of the above

ANSWER

8. President Johnson's Medicare proposal would have covered physician services.

A. True
B. False

ANSWER

9. President Reagan proposed adding what benefits to Medicare?

A. Unlimited hospital days
B. A limit on beneficiary out-of-pocket expenses
C. Expanded nursing home coverage
D. All of the above.

ANSWER

10. In 1965, what was the three-layer cake?

A. Medicare Part A, Medicare Part B, Medicaid
B. Medicare, Medicaid, SSI
C. Social Security, private pensions, and retirement savings
D. Neapolitan

ANSWER

11. Maternal and child health services were first added to the Social Security Act in which year?

A. 1935
B. 1965
C. 1980
D. 1997

ANSWER

12. Which President signed into law the extension of Medicare to the disabled and those with end-stage renal disease?

A. President Johnson
B. President Nixon
C. President Carter
D. President Reagan

ANSWER

13. President Franklin Delano Roosevelt included national health insurance in his proposed Social Security legislation.

A. True
B. False

ANSWER

14. Which President thought that health maintenance organizations (HMOs) would help contain the growth in health care spending?

A. President Nixon
B. President Reagan
C. President Clinton
D. All of the above

ANSWER

15. Who received the very first Medicare card?

A. President Eisenhower
B. President Roosevelt
C. President Truman
D. President Nixon

ANSWER

16. The Health Care Financing Administration was renamed the Centers for Medicare & Medicaid Services in the summer of 2001 by:

A. Secretary Sullivan
B. Secretary Shalala
C. Secretary Thompson
D. Secretary Califano

ANSWER

17. In what year did HMO's begin their participation in the Medicare program?

A. 1966
B. 1972
C. 1982
D. 1997

ANSWER

18. Federal law first defined HMOs for the commercial sector.

A. True
B. False

ANSWER

19. Home and community-based care waivers in the Medicaid program were enacted into law in:

A. 1972
B. 1981
C. 1990
D. 1997

ANSWER

20. Medicaid eligibility was tied to eligibility for Aid to Families with Dependent Children program until what happened?

A. AFDC was replaced by TANF (Temporary Assistance to Needy Families) in the welfare reform law of 1996
B. President Nixon abolished AFDC and replaced it with a negative income tax in 1972
C. People turn 65 and become eligible for Medicare
D. All of the above

ANSWER

21. The Clinical Laboratory Improvement Amendments of 1988 was enacted in part due to reports about women dying of cervical cancer after their pap smear tests were not evaluated properly.

A. True
B. False

ANSWER

22. Medicaid was expanded to cover additional low-income pregnant women and children in:

A. 1986
B. 1988
C. 1989
D. All of the above

ANSWER

23. Nursing home quality standards were improved by Congress in 1987 as a result of:

A. An Institute of Medicine study calling for enhanced Federal standards
B. Concern about mentally ill individuals not receiving active treatment
C. Excessive use of physical and chemical restraints in nursing home patients
D. All of the above

ANSWER

24. Why is CMS located in Baltimore instead of Washington, D.C.?

A. The Social Security Administration is located in Baltimore
B. Not enough office space in Washington, D.C.
C. Most CMS employees live in Baltimore
D. Medicaid was first located in Baltimore

ANSWER

25. In 1965, President Lyndon B. Johnson signed H.R. 6675 (The Social Security Act of 1965; PL 89-97) to:

A. Provide health insurance for the elderly and the poor
B. Establish the Head Start program
C. Establish the Department of Health, Education and Welfare
D. Beautify our highways

ANSWER

26. The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program:

A. Is a benefit for all Medicaid children
B. Focuses on hearing loss
C. Expanded Medicaid to include pregnant women
D. None of the above

ANSWER

27. The Balanced Budget Act of 1997 (BBA):

A. Created the State Children's Health Insurance Program (SCHIP)
B. Established new health plan options for Medicare beneficiaries
C. Reduced the rate of growth in Medicare spending
D. All of the above

ANSWER

28. Before Medicaid, Federal grants to States for medical care programs for aged people not on public assistance but unable to pay for needed medical services was provided under a program called:

A. Kerr-Mills
B. Truman-Capote
C. Nixon-Goldwater
D. Kennedy-Johnson

ANSWER

29. When the Medicare program was established, the Part B premium was set to cover what percentage of the Part B program's cost?

A. 25%
B. 50%
C. 75%

D. 100%.

ANSWER

30. How many Medicare claims for physician, hospital and other services are paid every year?

A. About 1 million
B. About 1 billion
C. About 1 trillion
D. None of the above.

ANSWER

31. Medicare covers preventive services such as testing for prostate cancer, flu and pneumonia shots, mammograms, and bone density scans.

A. True
B. False

ANSWER

32. In the Medicare program, what does DRG stand for?

A. Diagnosis-Related Group
B. Differential Regional Geography
C. Disease Registry Graph
D. Doctors and Relatives Group

ANSWER

Answers:

1. B. In January 1967, 6 months after Medicare implementation began, President Johnson requested the Secretary of the Department of Health, Education, and Welfare (HEW) to study adding outpatient prescription drugs to Medicare. In 1969, the task force made a number of recommendations including that drugs be added to the Medicare benefit package.

BACK

2. C. The Civil Rights Act (enacted in 1964, one year before Medicare was enacted) prohibited recipients of Federal funds from discrimination based on race, color, or national origin. The Secretary of HEW asked the Public Health Service to work with hospitals and nursing homes to ensure that facilities were integrated prior to the launch of Medicare on July 1, 1966.

BACK

3. C. The Social Security Administration was the agency responsible for administering Medicare from 1965 until 1977 when Secretary Califano reorganized HEW and created the Health Care Financing Administration. SSA administered the retirement social insurance program through which most people became eligible for Medicare.

BACK

4. D. The Social and Rehabilitative Service (SRS) was the agency responsible for administering Medicaid from 1965 until 1977 when Secretary Califano reorganized HEW and created the Health Care Financing Administration. SRS administered welfare programs including the Aid to Families with Dependent Children (AFDC) program through which many people became eligible for Medicaid.

BACK

5. A. In 1977, Secretary Califano created the Health Care Financing Administration (HCFA) in order to improve administration of both Medicare and Medicaid, improve the staffing of the Medicaid program, and to create a new administrative structure to implement national health insurance. Moreover, he thought one agency could move away from a two-class system of health care in which Medicaid beneficiaries were disadvantaged. (see oral histories of Califano, Champion, and Wortman)

BACK

6. B. See number 5.

BACK

7. D. See number 5.

BACK

8. B. President Johnson's Medicare proposal would have covered hospital and other institutional services for the elderly. He did not propose coverage of physician services because of the opposition of organized medicine to government-sponsored health insurance. Congressman Wilbur Mills combined President Johnson's proposal to cover institutional care and called it "Part A" of Medicare with a voluntary program to pay for physician and other outpatient services and called it "Part B" of Medicare.

BACK

9. D. President Reagan proposed expanding Medicare to cover a number of additional services in the Medicare Catastrophic Coverage Act (MCCA) which was enacted in 1988. The new benefits were financed by increased premiums on Medicare beneficiaries. After upper-income elderly complained about having to finance the new benefits, many of which they already received as retirement benefits from their former employers, the Congress repealed most of MCCA in 1989.

BACK

10. A. Congressman Wilbur Mills, Chairman of the House Ways and Means Committee, created what was called the "three-layer cake" by starting with President Johnson's Medicare proposal (Part A), adding to it physician and other outpatient services (Part B), and creating Medicaid which significantly expanded federal support for health care services for poor elderly, disabled, and families with dependent children. Medicare became Title 18 of the Social Security Act and Medicaid became Title 19.

BACK

11. A. The Social Security Act was originally enacted into law in 1935. Title V included Federal funding to States for maternal and child health services. Title V is administered today by the Health Resources and Services Administration in HHS.

BACK

12. B. President Nixon signed the Social Security Amendments of 1972 into law which expanded Medicare to include the disabled receiving Social Security benefits, after a 24 month waiting period, and those with end-stage renal disease (ESRD). ESRD was a life-threatening disease that could be treated with very expensive kidney dialysis services.

BACK

13. B. In 1935, FDR decided not to include national health insurance in his proposed Social Security legislation because of concern that opposition to it would jeopardize the entire proposal. Instead, he had a task force further explore the issue.

BACK

14. D. All the Presidents thought that HMOs would help to contain the growth in health care spending by reducing inappropriate utilization and better managing health care services.

BACK

15. C. President Truman was the first President to propose a national health insurance plan. Subsequent debate resulted in the enactment of the Medicare program in 1965.

To honor his efforts to expand health insurance coverage, President Johnson presented former President Truman and his wife Bess with the first two Medicare cards at a signing ceremony at the Truman library in Independence, Missouri on July 30, 1965.

BACK

16. C. Secretary Thompson announced that the Health Care Financing Administration would be renamed the Centers for Medicare & Medicaid Services on July 1, 2001 as part of his initiative to create a new culture of responsiveness in the agency.

BACK

17. A. HMOs have participated in the Medicare program from the very beginning. In the early years, they were paid on a reasonable cost basis as "group practice prepayment plans." Beginning with statutory changes in 1972, HMOs could be paid on a "risk-sharing" basis. After TEFRA passed in 1982, a risk contracting option became available in 1985 and enrollment in Medicare HMOs began to increase in the late 1980s through the late 1990s.

BACK

18. B. Federal law first defined HMOs for the Medicare program in the 1972 Social Security Act Amendments, for the purpose of determining what kinds of organizations could have Medicare risk-sharing contracts. The 1973 HMO Act was intended to foster HMOs in the commercial sector through such means as providing start-up funds, and by requiring employers, if they offered health care coverage that involved an employer contribution, to offer their employees at least one HMO if an HMO in the area met certain conditions.

BACK

19. B. In an effort to improve services to nursing-home eligible Medicaid beneficiaries, who wanted to be continue to live at home, home and community-based service waivers were made available to states.

BACK

20. A. Welfare reform, enacted in 1996, broke the link between AFDC and Medicaid eligibility that had existed since Medicaid was enacted in 1965.

BACK

21. A. The Clinical Laboratory Improvement Amendments of 1988 was enacted to improve the quality of laboratory testing as part of a response to reports about women dying of cervical cancer because of improperly read pap smear tests.

BACK

22. D. Congress expanded Medicaid eligibility to include additional groups of low-income pregnant women and children on numerous occasions in the late 1980s and 1990s.

BACK

23. D. OBRA 1987 was enacted by Congress to address concerns about the quality of nursing home care in the nation. A major Institute of Medicine study recommended a number of new Federal standards to address these problems.

BACK

24. A. After Social Security was enacted in 1935, the Bureau of Old-Age Benefits moved to the Candler Building in Baltimore. The move was to be a temporary one – just long enough for a building large enough to store the million pieces of paper anticipated once the Social Security program started. In 1979, Medicaid staff were transferred from Washington to Baltimore to join Medicare staff, and integrated into a functionally aligned organization called HCFA. HCFA was located in Baltimore office space on the Social Security Administration's Woodlawn campus because the majority of HCFA's staff came from SSA.

BACK

25. A. In 1965, President Lyndon B. Johnson signed H.R. 6675 (The Social Security Act of 1965; PL 89-97) to provide health insurance for the elderly, via Medicare, and the poor, via Medicaid. (http://www.ssa.gov/history/lbjstmts.html#medicare)

BACK

26. A. The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program, a comprehensive health services benefit for all Medicaid children under age 21, was established to find and treat health concerns in children before they become major problems.

BACK

27. D. The Balanced Budget Act of 1997 (BBA) created the State Children's Health Insurance Program (SCHIP), established new managed care options for Medicare beneficiaries, and reduced the rate of growth in Medicare spending.

BACK

28. A. In 1960, the Kerr-Mills program provided Federal grants to States for vendor medical care programs for aged people not on public assistance but unable to pay for needed medical services

BACK

29. B. When Medicare was established, beneficiaries were required to pay a premium covering 50% of the Part B program's cost. As Part B spending grew faster than the Social Security cost of living increase, which constituted a significant share of most beneficiaries incomes, Congress several times changed the beneficiaries share of Part B spending. Currently, the premium is set by law at 25% of Part B program spending.

BACK

30. B. Medicare contractors process about 1 billion fee-for-service claims each year.

BACK

31. A. Medicare covers preventive services where specific authorization by Congress has been provided. Generally, Medicare law only permits coverage of services designed to treat an "illness or injury."

BACK

32. A. Diagnosis-Related Groups is the term used in the Medicare program to describe the relative resource use of hospital patients. A patient receiving a heart transplant has a more resource intensive DRG than a patient hospitalized for pneumonia. In 1972, the Congress gave Medicare the authority to do demonstrations to control the rate of growth in hospital spending. Demonstrations using the DRGs were conducted in several states and then the system was implemented nationally; it has been credited with helping to reduce the rate of increase in hospital spending.

BACK