THE COMMITTEE ON ENERGY AND COMMERCE

MEMORANDUM

February 28, 2014

To: Health Subcommittee Members

From: Majority Committee Staff

Re: "Keeping the Promise: How Better Managing Medicare Can Protect Seniors' Benefits and Save Them Money"

On Tuesday, March 4, 2014, the Subcommittee on Health will hold a hearing entitled "Keeping the Promise: How Better Managing Medicare Can Protect Seniors' Benefits and Save Them Money." The Subcommittee will convene at 10:00 a.m. in 2123 Rayburn House Office Building. Below is background on the hearing.

I. Witnesses

Kathleen King, Director, Health Care, Government Accountability Office;

James Cosgrove, Director, Health Care, Government Accountability Office; and

Robert Vito, Regional Inspector General, Department of Health and Human Services, Office of Inspector General.

II. Background

The Centers for Medicare and Medicaid Services (CMS) is responsible for the oversight of all aspects of the Medicare program. Since the creation of the Medicare program, CMS has utilized a wide array of private sector contracts to assist it in the operation of the program. CMS relies on different contracting partners for different purposes.[1] For example, CMS employs Medicare Administrative Contractors (MACs) to pay provider claims under the hospital (Part A) and physician (Part B) fee-for-service programs, private insurance companies to deliver benefits under Medicare Advantage (Part C), and prescription drug plans and benefit managers to deliver the Prescription Drug (Part D) benefit. CMS also employs a range of contract partners for the purposes of enhancing program integrity and performing additional oversight functions.[2]

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[1] For a broader discussion of the contract types available to CMS, see "Contract Types: A Legal Overview" by Kate Manuel of the Congressional Research Service, available online through the Congressional intranet at http://crs.gov/pages/Reports.aspx?PRODCODE=R41168&Source=search. Federal procurement contracts commonly are divided into two main types—fixed-price and cost-reimbursement—that primarily differ as to whether the government or the contractor assumes the risk of increases in performance costs (e.g., wages, materials).

[2] Binder, Cliff. "Medicare Program Integirty: Activities to Protect Medicare from Payment Errors, Fraud, and Abuse," Congressional Research Service, RL34217, August 3, 2011, available at http://crs.gov/pages/Reports.aspx?PRODCODE=RL34217&Source=search.

The Government Accountability Office (GAO) has consistently designated Medicare as a high-risk program. In 2013, GAO explained the breadth of challenges CMS faces in managing the program: CMS is responsible for "implementing payment methods that encourage efficient service delivery, managing Medicare to provide efficient and cost-effective services to beneficiaries, safeguarding the program from loss, and overseeing patient safety and care."[3] In GAO's view, the sheer size and complexity of the program makes it important for CMS to manage program functions more effectively and better oversee the program's integrity and quality.

Given the scope and complexity of the Medicare benefit, GAO and Office of the Inspector General at the U.S. Department of Health and Human Services (HHS OIG) have produced a number of reports in recent years outlining some of the challenges CMS faces in successfully managing the contractors who are assisting in paying for, delivering, or protecting senior's benefits. For example, a recent report by HHS OIG found that MACs did not meet one in four of the standards CMS reviewed and that CMS had not taken additional corrective actions in a number of areas, despite demonstrated underperformance from some contractors.[4] In the past few months, GAO found that CMS needed to take steps to improve its oversight of program integrity contractors.[5]

One of the key ways CMS can enhance program management is to minimize program vulnerability by reducing waste (like duplicative billing), abuse (like charging too much or misusing codes), or fraud (billing for services not rendered). While there is no official government estimate for dollars lost to fraud, in an April 2012 study, former CMS Administrator Donald M. Berwick and RAND Corporation analyst Andrew D. Hackbarth estimated that fraud and abuse added as much as $98 billion to Medicare and Medicaid spending in 2011.[6] The U.S. Department of Health and Human Services' FY 2013 Agency Financial Report found that $49.9 billion in Medicare payments in 2013 can be considered improper—an increase from $44.3 billion in 2012.[7]

The Subcommittee on Health will examine the role that CMS' contractors play in the management of the Medicare program, and explore options to enhance their overall effectiveness. Successful program management will help make the program more effective and efficient, while reducing waste, fraud, and abuse and protecting seniors' benefits.

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[3] Government Accountability Office, 2013 High Risk Report, available at http://www.gao.gov/products/GAO-13-283.

[4] Office of the Inspector General, U.S. Department of Health and Human Services, "Medicare Administrative Contractors' Performance," January 8, 2014, available at http://oig.hhs.gov/oei/reports/oei-03-11-00740.asp.

[5] Government Accountability Office, "Contractors Reported Generating Savings, but CMS Could Improve Its Oversight," November 25, 2013, available at http://www.gao.gov/products/GAO-14-111.

[6] Donald M. Berwick and Andrew D. Hackbarth, "Eliminating Waste in US Health Care," JAMA. 307(14):1513-1516. Apr 11, 2012, available at http://jama.jamanetwork.com/article.aspx?articleid=1148376.

[7] U.S. Department of Health and Human Services FY2013 Agency Financial Report, available at http://www.hhs.gov/afr/2013-hhs-agency-financial-report.pdf.

III. <u>Staff Contacts</u>

Should you have any questions regarding the hearing, please contact Josh Trent, Robert Horne, or Chris Pope at 202-225-2927.