As the representative voice of 1.1 million mature Americans and senior citizens, AMAC is deeply concerned with the solvency and oversight of Federal legacy programs – such as Medicare and Social Security. Each of these programs provides vital benefits to a growing number of Americans and requires significant supervision to ensure that individuals receive the assistance they need. Approximately 48 million people participate in Medicare – a program that guarantees access to health care for Americans over the age of 65 and those with disabilities.

The Centers for Medicare and Medicaid Services (CMS) is the government agency that has been charged with managing all aspects of Medicare – a tall task that demands efficiency, flexibility, and transparency from CMS' leadership. Over the years however, numerous vulnerabilities have emerged in Medicare, exposing the program's unsustainable nature and the weaknesses in CMS' ability to oversee aspects of this massive program.

AMAC believes CMS can and should take steps to enhance its oversight of Medicare and to strengthen the program for beneficiaries. By **exerting more effective control over contractors**, **reducing program vulnerabilities by fighting waste, fraud, and abuse, and working to modernize its business structure in the process**, CMS can protect the Medicare benefit for mature Americans and seniors and deliver promised health benefits in a more secure and effective manner.

A handful of critical facts require recognition and attention. *The Board of Trustees for Medicare projects that Medicare will be an insolvent program by 2026 – a startling prognosis for a program on which millions of older Americans and AMAC members depend.* Not surprisingly, the Government Accountability Office (GAO) has identified Medicare as a high risk program, making it increasingly more susceptible to fraud and other problems. While the Medicare program itself should undergo fundamental structural reform to protect its legacy for future generations of Americans, CMS can play an integral role in making sure the program functions efficiently and delivers health care benefits to those who need it. CMS has a responsibility to ensure its agencies, contractors, and employees are meeting established standards and accomplishing program goals to ensure the success of the Medicare program.

First, CMS has a history of inadequately managing its contractors. These contractors are employed for a variety of purposes, including, "assisting in paying for, delivering, or providing seniors' benefits."[1] Medicare Administrative Contractors (MACs) are one example of contractors used by CMS. MACs, "pay provider claims under the hospital (Part A) and physician (Part B) fee-for-service programs," yet they often do not meet one quarter of the standards reviewed by GAO. CMS awards billions of dollars to MACs – which, "play a critical role in administering the Medicare program" – but CMS does

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[1] "The Committee on Energy and Commerce Memorandum: Keeping the Promise: How Better Managing Medicare Can Protect Seniors' Benefits and Save Them Money." Feb. 28, 2014, page 1. http://docs.house.gov/meetings/IF/IF14/20140304/101834/HHRG-113-IF14-20140304-SD002.pdf.

not conduct effective oversight over MACs to, "ensure that they are adequately processing claims and performing other assigned tasks."[2]

According to the American Academy of Family Physicians (AAFP), "the sheer number of CMS contractor entities causes confusion" among providers, particularly physicians.[3] This confusion and convolution within CMS – in part – has contributed to the immense growth in CMS' fraud-fighting apparatuses. CMS has had to hire numerous contractors to assist them in tracking down improper, fraudulent payments – which of course adds layers of expense. To account for the vast degree of these fraud-fighting contractors, CMS released an, "*MLN Matters* special article devoted almost entirely to listing and describing for physicians the various entities that 'may contact them with questions and requests for medical records, documentation or other information.'"[4]

Moreover, CMS has done a poor job of eliminating conflicting interests among contractors. For example, GAO reported that, "CMS paid its Zone Program Integrity Contractors (ZPICs) about $108 million in 2012," most of which went to fund investigative staff for fraud case development.[5] ZPICs are responsible for helping restore the integrity of the Medicare program by exposing and curtailing fraud and referring cases to the Office of the Inspector General (OIG) for further scrutiny. Yet, "conflicts of interest among ZPICs are rampant, with as many as two-thirds of these private companies having financial ties to claims processors."[6]

In her article, "OIG: Contractor Conflicts of Interest Weaken Medicare," author Karen Cheung-Larivee describes the conflicting nature of contractors' roles in Medicare:

> During the bidding process, prospective ZPICs (offerors) are supposed to disclose financial interests in other companies that might affect their work. However, OIG found they often failed to provide all the relevant information. And when ZPICs did disclosure potential conflicts, they did it inconsistently. OIG noted that it could be because CMS doesn't have a written policy for reviewing conflict and financial interest information submitted by offerors.[7]

Thus, OIG found that while ZPICs are contracted to protect the Medicare program from egregious abuses, waste, and fraud, ZPICs often had preexisting, "financial relationships with CMS and other offerors – making the federal program vulnerable to conflicts of interest."[8] If CMS continues to permit conflicting interests among contractors to go unfixed or remain inappropriately addressed, the Medicare program will continue to hemorrhage program money, while costing CMS valuable time and resources in their effort to fight fraud and restore trust and accountability between CMS and the American people.

In addition to exerting more effective control and oversight over contractors, it's fully reasonable and appropriate to suggest that CMS get serious about combating waste, fraud, and abuse

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[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.

[3] "Sheer Number of CMS Contractor Entities Causes Confusion." American Academy of Family Physicians. Sept. 22, 2011. http://www.aafp.org/news/practice-professional-issues/20110922cmscontractors.html.

[4] Ibid.

[5] "Medicare Report 2013." Government Accountability Office. http://www.gao.gov/highrisk/medicare_program/why_did_study.

[6] Cheung-Lavrivee, Karen. "OIG: Contractor Conflicts of Interest Weaken Medicare." *Fierce Healthcare*. July 11, 2012. http://www.fiercehealthcare.com/story/oig-contractor-conflicts-interest-weaken-medicare/2012-07-11.

[7] Ibid. http://oig.hhs.gov/oei/reports/oei-03-10-00300.pdf.

[8] Ibid. http://oig.hhs.gov/oei/reports/oei-03-10-00300.pdf.

within the Medicare program – conflicting interests among contractors aside. In 2012, Medicare reported that an estimated $44 billion was spent on improper payments.[9] Writing for *Forbes*, Merrill Matthews says, "Others, including U.S. Attorney General Eric Holder, suggest that there is an estimated $60 to $90 billion in fraud in Medicare and a similar amount for Medicaid" – a frightening management reality for CMS going forward.[10]

AMAC believes it is imperative for CMS to take steps to prevent further fraud and to salvage taxpayer dollars that were subject to improper payments. Not only do we believe it is important to protect taxpayer dollars at all costs, AMAC also feels that CMS will be able to redirect its attention, resources, and efforts to enhancing its own oversight of the Medicare (and Medicaid) program. In fact, preventing or recovering an estimated $120 to $180 billion (including Medicaid) annually would provide CMS with the revenue it needs to develop further efficiencies that could result in higher quality of care which would reduce overall healthcare disbursements.[11] Preserving taxpayer dollars, fighting fraud, and modifying its own administrative and operational goals should be CMS' ultimate goal – and it is a goal that resonates with all Americans who not only want to see Medicare strengthened and improved, but are increasingly concerned about the use of taxpayer dollars.

Time and time again, however, CMS' priorities seem to be misplaced. Fighting fraud and battling wasteful spending appear to be less urgent than other political concerns. Despite repeated assessments by GAO and numerous outside audiences to call attention to the structural failures and systematic problems in Medicare, CMS appears to want to concentrate its efforts, resources, and attention on phantom problems in Medicare that run smoothly, operate cost-efficiently, and provide more than adequate service to American beneficiaries – specifically Medicare Advantage and Medicare Part D. For example, CMS has recently introduced new rules and regulations that would impede these market-based programs from continuing to provide low-cost, satisfactory benefits to consumers. AMAC believes that if CMS were to redirect their resources and efforts toward just a handful of the critical problems that have been identified by Congress and others, then a significant amount of waste, fraud, and abuse could be curtailed and reduced.

Fighting fraud alone will go a far way in shoring up the Medicare Trust Fund, but it will not solve all of Medicare's problems. The fact remains that Medicare is on an unsustainable fiscal road and both CMS and Congress need to act responsibly and promptly to restructure the program so that older and disabled Americans maintain access to the health care they were promised. AMAC believes the market-based structures of Medicare Advantage and Part D programs would serve as effective models of reform for the entire Medicare Program. Choice and competition have enabled these programs to tailor plans to suit the individual needs of beneficiaries and have worked to keep premiums low and stable over time. AMAC strongly feels that Medicare should shift more fully to a competition-driven, market-based structure. Of course, such changes would be implemented over time – but, Medicare Advantage and Part D serve as tangible, time-tested, and instructive examples of how basic principles of market competition can be harnessed to give beneficiaries a better product and service.

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[9] "Medicare Program Report 2013." Government Accountability Office. http://www.gao.gov/highrisk/medicare_program/why_did_study.

[10] Matthews, Merrill. "Medicare and Medicaid Fraud Is Costing Taxpayers Billions." *Forbes*. May 31, 2012. http://www.forbes.com/sites/merrillmatthews/2012/05/31/medicare-and-medicaid-fraud-is-costing-taxpayers-billions/.

[11] Ibid.

Lastly, CMS should work to reduce program vulnerabilities when opportunities arise and seek to reform parts of Medicare that do not function as efficiently as others. On numerous occasions, the public-private partnerships within Medicare Advantage and Part D have proven to be more effective than that of traditional Medicare, despite what some sources indicate. For instance, Medicare claims that their administrative costs are lower than private insurers. While there is some truth to that claim, deeper analysis reveals a more accurate picture; these costs are kept low because traditional fee-for-service Medicare *avoids the expense of utilization and claims review* – an activity that drives up the cost of care in the Medicare program and has the opposite effect for private insurers. Put another way, costs in traditional Medicare are attempted to be controlled at the expense of diligent and thorough oversight – of course, the end result of improper oversight is program leakage and fraud, the final costs of which far outstrip any up-front savings accrued via the ignorance of basic accountability practices.

Also, Medicare does very little in managing the benefits the program provides – which may reduce administrative costs on paper – but may also increase the program's overall spending. Conversely, private insurers use administrative costs they receive to constantly manage their benefit plans in order to seek efficiencies that drive down health care expenditures. Medicare also keeps administrative costs low by not incorporating quality controls that increase the quality of care, as is done with private insurance plans. Spending has a tendency to increase as the overall quality of care decreases.[12]

On the other hand, Medicare Advantage and Part D have proven records of providing high quality of care via myriad plans choices at low costs to the satisfaction of beneficiaries. While there are inconsistent numbers on how much money private sector health insurers lose in fraud, *Forbes* has recently estimated that:

> Private insurers lose perhaps 1 to 1.5 percent in fraud, whereas Medicare and Medicaid may be closer to 10 or 15 percent. One of the primary differences is that the private sector insurers embrace software and other new technologies that help them find discrepancies and fraud in health care claims before they pay the claim.[13]

This private insurance business methodology**, which identifies fraudulent situations before paying the claim**, is standard operating procedure and protects resources while averting a significant amount of payment recovery efforts. While Department of Health and Human Services (HHS) is embracing pre-claims adjudication for ObamaCare, CMS should look to transition fully to this approach as a way to drive down excessive costs in Medicare as well. AMAC believes CMS and Medicare could easily adopt this approach to reduce the impact of fraud on the program.

In conclusion, AMAC encourages CMS to modernize its business model, exert more effective control over contractors, and limit program vulnerabilities by combating waste, fraud, and abuse. It is important to recognize that simply trying to combat waste, fraud, and abuse alone will not fix all of Medicare's problems, and more structural reforms should be pursued. In many ways, the problems of waste, fraud and abuse are a symptom of these deeper issues – for example, waste and fraud are the natural outgrowth of an ineffective contracting system and an outdated business model. As such, working to address these fundamental issues will not only result in a more efficient, responsive, and

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[12] Cannon, Michael F. "Private Insurance Is More Effective Than Medicare – By Far." *The Cato Institute*. Sept. 21, 2012. http://www.cato.org/blog/private-insurance-more-efficient-medicare-far.

[13] Matthew. "Medicare and Medicaid Fraud." *Forbes*. http://www.forbes.com/sites/merrillmatthews/2012/05/31/medicare-and-medicaid-fraud-is-costing-taxpayers-billions/.

cost-conscious program, but it will automatically help reduce and deter fraud as well as de-incentivizing abuse and waste.

Taking swift, meaningful action to improve these areas of CMS' management would enable Medicare to more effectively and efficiently deliver health benefits to seniors. AMAC believes CMS must do a better job of overseeing this complex program, but we also know that Congress must get serious about reforming Medicare if this benefit will continue to be available to older Americans in the future. Reform is key to keeping Congress' promise to seniors, and AMAC urges lawmakers to begin this important discussion now – using the success of Medicare Advantage and Part D to guide that dialogue.