MEDICARE RIGHTS CENTER
266 West 37th Street, 3rd Floor
New York, NY 10018
212.869.3850/Fax: 212.869.3532

Testimony of Stacy Sanders
Federal Policy Director, Medicare Rights Center

Prepared for the
United States House of Representatives
Energy & Commerce Committee, Subcommittee on Health

"Examining Bipartisan Legislation to Improve the Medicare Program"

July 20, 2017

Washington, DC Office:
1444 I St NW, Suite 1105
Washington, DC 20006
202.637.0961

Introduction:

Chairman Burgess, Ranking Member Green, and distinguished members of the Subcommittee on Health, thank you for the opportunity to testify on bipartisan legislation to improve the Medicare program. I am Stacy Sanders, Federal Policy Director of the Medicare Rights Center (Medicare Rights). Medicare Rights is a national, nonprofit organization that works to ensure access to affordable health care for older adults and people with disabilities through counseling and advocacy, educational programs, and public policy initiatives.

Medicare Rights answers nearly 20,000 questions on our national helpline each year, serving older adults, people with disabilities, and those that help them, including family caregivers, social workers, attorneys, and other professionals. Through our educational initiatives, we touch the lives of nearly three million Americans who are seeking an unbiased and trusted Medicare source, whether online or through in-person trainings.

Our commentary draws directly from nearly 30 years of experience serving older adults and people with disabilities who rely on Medicare for basic health security. Problems presented by callers to the Medicare Rights helpline are varied and complex. Year after year, the most common questions heard on the helpline concern three themes: affording basic health care costs, appealing denials of coverage, and enrolling in Medicare. In all of these areas, among others, we see that people with Medicare would benefit from more support.[1]

We applaud the Committee for identifying bipartisan opportunities to improve Medicare for today's beneficiaries and for future generations. We strongly believe that members of Congress should work in a transparent and constructive manner to improve the day-to-day experiences of people with Medicare and to strengthen the program now and into the future.

Combating Medicare Fraud and Exploitation:

The focus of our testimony concerns Medicare fraud and abuse, and particularly the *Medicare Civil and Criminal Penalties Update Act of 2017* (H.R. 3245). This bipartisan legislation was introduced by Congressman

[1] Sutton, C., Bennett, R., Sanders, S., and F. Riccardi, "Medicare Trends and Recommendations: An Analysis of 2012 Call Data from the Medicare Rights Center's National Helpline," Medicare Rights Center (January 2014), *available at:* http://www.medicarerights.org/policy/priorities/2012-medicare-trends/; Morales, S., Bennett, R., and S. Sanders, "Medicare Trends and Recommendations: An Analysis of 2013 Call Data from the Medicare Rights Center's National Helpline," Medicare Rights Center (March 2015), *available at:* https://www.medicarerights.org/pdf/2013-helpline-trends-report.pdf; Morales, S., Schwarz, C. and F. Riccardi, "Medicare Trends and Recommendations: An Analysis of 2014 Call Data from the Medicare Rights Center's National Helpline," Medicare Rights Center (January 2016), *available at:* https://www.medicarerights.org/pdf/2014-helpline-trends-report.pdf; Morales, S., Riccardi, F., Carter, J., and S. Sanders, "Medicare Trends and Recommendations: An Analysis of 2015 Call Data from the Medicare Rights Center's National Helpline," Medicare Rights Center (March 2017), *available at:* https://www.medicarerights.org/pdf/2015-helpline-trends-report.pdf.

Bilirakis and Congresswoman Castor to address penalties for fraud in the Medicare system. Examples of health care fraud include, "billing for services not rendered…making duplicative claims, unbundling packaged services or items, providing excessive or medically unnecessary services, and issuing kickbacks."[2]

Medicare fraud is deeply problematic from two key perspectives—both beneficiary and taxpayer. For people with Medicare, fraud and abuse can lead to exploitation in the form of increased costs, including overcharging for services received or even paying for care that was never delivered. Beneficiaries may also be harmed if they receive unnecessary services, like inappropriate screenings, or if needed care is withheld, such as when a provider accepts a financial inducement to limit care.[3] Fraud and abuse also lead to increased and inappropriate spending of taxpayer dollars.

Over the last year, 6,000 visitors accessed Medicare Rights' free educational content, through the online learning tool Medicare Interactive (www.medicareinteractive.org), on the subject of health care fraud.[4] Further, Medicare Rights regularly fields calls regarding billing inquires, the 4th most common trend on the helpline in 2015.[5] Often times, these cases involve situations where a beneficiary cannot afford excessive cost-sharing or where the beneficiary suspects he or she was overcharged for services received.

For example, one caller reached out to Medicare Rights about a charge for an outpatient procedure that she could not afford to pay. After communicating with the beneficiary and health care provider, Medicare Rights determined that the physician charged the beneficiary cost-sharing over and above the Medicare-approved amount. Medicare Rights is not positioned to assess whether such cases involve a simple billing error versus a fraudulent claim. But when such cases arise, we typically refer our clients to the Senior Medicare Patrol (SMP) or the Office of the Inspector General (OIG).

It is critically important that Congress prioritize policies to prevent and deter the many forms of Medicare fraud and abuse. Existing oversight and enforcement initiatives to combat fraud in federal health programs—including investigative task forces, data sharing and analytics, civil monetary penalties and fines, criminal prosecution, and more—have proven successful. Over the last three years, the U.S. Department of Health and Human Services (HHS) OIG and its partners recovered more than $6.10 for every $1.00 dedicated to health care fraud

[2] *See* Congressional Budget Office (CBO), "How Initiatives to Reduce Fraud in Federal Health Care Programs Affect the Budget," p 3 (October 2014), *available at:* https://www.cbo.gov/sites/default/files/113th-congress-2013-2014/reports/49460-ProgramIntegrity.pdf.
[3] *See* Ibid, pg. 5; K.D., Lind, "Reduce Waste, Fraud, and Abuse in Health Care," AARP (July 2009), *available at:* http://www.aarp.org/health/health-care-reform/info-09-2009/fs158_fraud.html.
[4] *See* Medicare Interactive, "Medicare Fraud and Abuse," Medicare Rights Center (2017), *available at:* https://www.medicareinteractive.org/get-answers/medicare-fraud-and-abuse.
[5] Based on internal analysis of helpline calls; includes almost 1,500 questions.

and abuse investigations.[6] Importantly, these or any enhanced recovery efforts must be implemented carefully so as not to inadvertently curb beneficiary access to care should health care providers come to fear retribution for minor billing errors or honest mistakes.

A continued and enhanced commitment to fraud prevention and recovery can help ensure that people with Medicare are not over-billed or otherwise harmed and that taxpayer dollars are spent efficiently and responsibly. For these reasons, Medicare Rights supports H.R. 3245. This legislation would increase the amount of civil monetary penalties, criminal fines, and sentences allowable for specific instances of Medicare fraud, such as the submission of false claims, acceptance of financial inducements, and willful violation of the terms of assignment, among others.

These administrative sanctions were established in 1981 and last revised in 1996, leading us to believe that these penalties are due for an update. Adding further support for this, in 2011, the OIG testified before Congress that:

> The perpetrators of these [health care fraud] schemes range from street criminals, who believe it is safer and more profitable to steal from Medicare than to traffic in illegal drugs, to Fortune 500 companies that pay kickbacks to physicians in return for referrals…We are concerned that providers that engage in health care fraud may consider civil penalties and criminal fines a cost of doing business.[7]

In addition to efforts like those advanced through H.R. 3542, there is a beneficiary-facing component to preventing Medicare fraud and mitigating the harms of abuse. The federally-funded State Health Insurance Assistance Programs (SHIPs) and SMPs work in concert—in every state and U.S. territory—to educate people with Medicare about how to protect themselves from fraud; to help beneficiaries navigate cost-sharing challenges and billing errors; and to assist beneficiaries with reporting suspected fraud and abuse. As we have learned through the Medicare Rights helpline, potential cases of fraud typically present to SHIPs when a beneficiary is unable to pay a bill. The SHIPs then report cases of suspected fraud to Medicare, often working alongside SMP partners.

As the only on-the-ground resource for people with Medicare, the SHIP and SMP network also plays a vital role in identifying trends and common types of potential fraud and abuse. For example, we recently learned from our SMP and SHIP colleagues to be on the lookout for cases involving stolen Medicare numbers used to submit claims for Durable Medicare Equipment (DME). SHIP counselors are coming across cases where beneficiaries

[6] Office of the Inspector General (OIG), "2016 National Health Care Fraud Takedown" (2017), *available at:* https://oig.hhs.gov/newsroom/media-materials/2016/2016HealthCareTakedown_FactSheetv2_508.pdf.
[7] *See* Congressional Budget Office (CBO), "How Initiatives to Reduce Fraud in Federal Health Care Programs Affect the Budget," p 14 (October 2014), *available at:* https://www.cbo.gov/sites/default/files/113th-congress-2013-2014/reports/49460-ProgramIntegrity.pdf.

are denied DME, because records indicate they obtained that same DME in the past five years. In reality, however, the beneficiaries' Medicare numbers were fraudulently used to bill Medicare for the DME.

Thus, SHIPs and SMPs are vitally important to education and outreach about Medicare fraud and abuse as well as its identification and prevention. And SHIPs fulfill many other essential roles, providing one-on-one, in-depth, and personalized counseling on coverage options, appeal rights, low-income assistance programs, and more.[8] We urge members of Congress to reject attempts to defund the SHIP program. Further, when SHIPs and SMPs identify fraud, it is legislation like H.R. 3245 that is needed to ensure that those defrauding the program are appropriately penalized.

Other Matters before the Committee Supported by Medicare Rights:

- **Eliminating and replacing the therapy caps:** Medicare Rights strongly supports eliminating the Medicare therapy caps for physical, speech, and outpatient therapies. "These arbitrary caps are aimed at federal cost savings rather than providing clinically appropriate service. Further, these caps disproportionately affect the most vulnerable Medicare beneficiaries who require ongoing therapy services," says the Leadership Council of Aging Organizations, a national coalition representing the interests of older Americans, of which Medicare Rights is a member.[9]

  In the absence of full repeal of the caps, Medicare Rights supports an extension of the existing exceptions process, as reflected in the discussion draft made available for today's hearing. We urge the Committee to work towards a bipartisan, permanent solution that will allow people with Medicare to reliably access medically-necessary therapy services.

- **Preserving access to speech-generating devices:** Medicare Rights joins over 60 national and state organizations as well as qualified professionals in support of the *Steve Gleason Enduring Voices Act of 2017* (H.R. 2465).[10] This legislation will ensure that Medicare coverage for speech generating devices (SGD) and related accessories will continue beyond the current law's sunset date of October 1, 2018.

[8] *See* National Council on Aging (NCOA), "Funding for Medicare State Health Insurance Assistance Programs" (2016), *available at:* https://www.ncoa.org/resources/ship-funding-issue-brief-2016/

[9] Leadership Council of Aging Organizations (LCAO), "Medicare Therapy Cap Exceptions Process Should be Made Permanent" (August 2013), *available at:* http://www.lcao.org/files/2013/09/FINAL-LCAO-Therapy-Caps-Exceptions-IB.pdf.

[10] Letter to Congressman Kevin Brady and Senator Orrin Hatch in support of the Steve Gleason Enduring Voices Act of 2017 (April 28, 2017), on file with the Medicare Rights Center.

These unique devices are personally tailored and for many individuals they are the only means of communication available to them. The Committee should advance this legislation to secure access to these essential devices, even when a Medicare beneficiary must reside in a nursing home, hospital, or hospice for an extended period of time.

- **Extending the Independence at Home demonstration:** Medicare Rights is a strong believer in the Independence At Home (IAH) demonstration program, and supports legislation (S. 464) to make the program permanent. If not made permanent, we urge the Committee to advance legislation to extend the program, as reflected in the bill included for today's hearing.

  The IAH model uses interdisciplinary teams to coordinate all medical and social services in eligible patients' homes, providing high quality clinical care and excellent patient experience while reducing total Medicare costs. Over the last five years, this innovative program has provided home-based primary care services to over 10,000 older adults and people with disabilities living with chronic, complex conditions.

Medicare Rights welcomes the opportunity to review other bipartisan bills under consideration by the Committee at today's hearing. We applaud members of the Committee for identifying bipartisan opportunities to limit Medicare fraud and abuse, preserve access to needed therapies and devices, and continue a promising care model for the most vulnerable people with Medicare. Thank you for the opportunity to testify.