**Hearing on Ideas to Improve Medicare Oversight to Reduce Waste, Fraud and Abuse**

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HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS

U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED THIRTEENTH CONGRESS

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C O N T E N T S



**WITNESSES**

Mr. Shantanu Agrawal
Deputy Administrator and Director, Center for Program Integrity,, Centers for Medicare and Medicaid Services, Department of Health and Human Services

Witness Statement [PDF]

Ms. Gloria L. Jamon
Deputy Inspector General for Audit Services, Office of the Inspector General, Department of Health and Human Services

Witness Statement [PDF]

Ms. Kathleen King
Director of Health, Government Accountability Office

Witness Statement [PDF]

# Hearing on Ideas to Improve Medicare Oversight to

# Reduce Waste, Fraud and Abuse

U.S. House of Representatives,
Committee on Ways and Means,
Washington, D.C.

The subcommittee met, pursuant to call, at 1:58 p.m., in Room 1100, Longworth House Office Building, Hon. Kevin Brady [chairman of the subcommittee] presiding. Advisory

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Chairman Brady. This subcommittee will come to order. Good afternoon, everyone.

Every dollar lost to Medicare fraud is a dollar stolen from America's elderly and every dollar lost to improper payments, intentional or not, robs from the solvency of this important program. Today's hearing will examine the issue of Medicare fraud. This is a bipartisan concern shared by our seniors, the Medicare program and lawmakers on this committee.

The Office of Inspector General, which is testifying here today, cites that nearly $50 billion is lost to improper Medicare payments each year. That is an alarming amount. I am most alarmed by how often I open the Houston Chronicle back home to find stunning investigations of Medicare fraud that runs into tens of millions of dollars, involving doctors, ambulance companies, mental health clinics and even patient advocates, those who are tasked with protecting the sick and elderly.

Last Friday brought news of a 13-count indictment of providers in Florida and the Houston area for allegedly billing Medicare for services that were not needed and providing kickbacks for patient referrals. Last Wednesday was the sentencing of a Houston-area woman after her 2013 conviction for defrauding Medicare. These stories are all too frequent in communities around the nation.

To make matters worse, in the past year, the Office of Inspector General has documented evidence that Medicare has paid for services to those who are deceased, in prison, and not entitled to benefits, all this while Medicare's main trust fund is on a crash course with insolvency in a short 12 years.

President George W. Bush established the Federal Medicare Fraud Strike Force in 2007 that changed to a much more aggressive approach to Medicare fraud, and it is starting to bear fruit. In response, the Centers for Medicare and Medicaid have taken strides to address this growing problem. The agency has used its authority to impose a temporary moratorium on the enrollment of certain providers in high-risk areas,

including preventing new ambulance companies from billing Medicare in my home State of Texas; however, more must be done to protect our seniors and taxpayers.

While a moratorium on new providers may very well prevent unscrupulous providers from entering the program, it doesn't stop those who have already enrolled and are improperly billing. More must be done to move from the outdated pay-and-chase approach to a new 21st century approach that stops improper payments before they go out the door.

I am also concerned about the CMS lack of leadership and interest in problems that are especially embarrassing for the Medicare program. Preventing payments for services to those who are dead or are in jail involves a straightforward fix, yet it is still a problem, regrettably still a topic for discussion at this hearing. And that is the focus of this hearing, not merely identifying the fraud and abuses, but identifying what can be done using new technologies and successful strategies to prevent and deter fraud in the future.

First, I commend my colleagues on this committee, members on both sides of the aisle, who have introduced bills to make commonsense changes. For example, my colleagues and fellow Texans, Mr. Johnson and Mr. Doggett, have been working on a legislative fix for nearly a decade to take Social Security numbers off of Medicare cards. And you see bipartisan efforts throughout this subcommittee. It is frustrating that such a simple fix has yet to happen. I look forward to the day when I can tell my seniors in my district that they no longer must worry about having their Social Security number compromised simply by carrying the Medicare card they need to access their health care.

Secondly, we are interested in hearing recommendations from the OIG and the Government Accountability Office. These watchdog entities have identified vulnerabilities and proposed solutions in the areas of improper payments, and CMS oversight of claims paying and fraud fighting contractors. Many of these recommended fixes support bills that members of Congress on this committee are championing.

Thirdly, we will hear from CMS about its program integrity efforts. While we are interested to hear what the agency has done, we are perhaps more interested in what it plans to do going forward.

The written statements from our witnesses make clear that much work is left to be done. Lawmakers have ideas, OIG and GAO have made recommendations, and CMS has its plans. So let's identify the ideas and solve our problems and get to work now to put them in place. It is not important who comes up with these ideas on fighting fraud, waste and abuse. What is important is that we act on these good ideas. It is my intent that we move forward on a bipartisan basis, working with CMS, to protect our seniors, bolster the Medicare trust fund, and ensure appropriate use of taxpayer funds.

Before I recognize the ranking member, Dr. McDermott, for the purposes of an opening statement, I ask unanimous consent that all members' written statements be included in the record. Without objection, so ordered. I now recognize our ranking member, Dr. McDermott, for his opening statement.

Mr. McDermott. Thank you, Mr. Chairman. I want to commend the chairman for having this hearing. I think the controlling of costs as we move forward in health care is going to be the toughest issue we face. This administration has been serious about combating fraud, waste and abuse. The joint effort of Attorney General Holder and Secretary Sebelius through the Health Care Fraud Prevention and Enforcement Action Team, so-called HEAT, there have been measurable results. The team has recovered in excess of $4 billion every single year since 2011. That is real money.

There was a time when a hearing on Medicare fraud such as this would have focused solely on the dollar amounts recouped at the back end after the fraud had been perpetrated, and any money that could have been recouped would have been long spent. Then came the Affordable Care Act, which gave regulators additional new powers to prevent fraud rather than just reactively address it, powers such as expanded payment suspension authority and the requirements to effectively police who gets into the Medicare program, ensuring Medicare participation is reserved for scrupulous providers and suppliers.

So now when we talk about our fraud prevention efforts, we speak a different language than even 5 years ago. We speak of payment suspensions in greater numbers, we speak of high risk or moderate risk providers and suppliers, we are talking about fingerprinting owners of the high risk providers and suppliers, we speak of the fraud prevention system and the predictive analytics designed to monitor for potential fraud on a real-time basis.

Notwithstanding all the efforts that have been made at transforming Medicare and Medicaid into programs that hold participating providers and suppliers accountable, as the chairman has said, much more work needs to be done.

With alternative delivery system models, what does fraud, waste and abuse really look like? With the expanded waiver authority that essentially granted Federal agencies the ability to issue wide-open waivers, what new fraud schemes will emerge?

So our important work in this area is not done. Much more work remains. I know the GAO will continue to play an important role in helping us with our oversight responsibilities, and the OIG and CMS will use their expanded authorities to root out the fraud, waste and abuse to preserve the Medicare and Medicaid programs for the future.

I look forward to working with the chairman on a bipartisan basis on these issues. I yield back the balance of my time.

Chairman Brady. Thank you, Doctor.

Today we will hear from three distinguished witnesses: Gloria Jarmon, Deputy Inspector General for audit services at the Office of Inspector General, the Department of Health and Human Services; Kathleen King, Director of Health at the Government Accountability Office; and Dr. Shantanu Agrawal, deputy administrator at CMS and director of Center for Program Integrity.

We have reserved 5 minutes for each of the opening statements and we will explore the testimony further during questions. Ms. Jarmon, you are recognized.

Ms. Jarmon. Good afternoon, Chairman Brady, Ranking Member McDermott, and other distinguished members of the subcommittee. Thank you for the opportunity to discuss OIG's work related to Medicare oversight and reducing fraud, waste and abuse. We have a lot of work in this area. Today my statement focuses on our recent work related to improper Medicare payments and billings and oversight of Medicare contractors.

CMS needs to continue to take steps to reduce improper Medicare payments and improve its oversight of the various Medicare contractors. Improper Medicare payments cost taxpayers and beneficiaries about $50 billion a year. In recent work, OIG has identified millions in improper payments made on behalf of persons not entitled to Medicare, such as incarcerated, unlawfully present, deceased, or entitlement-terminated individuals. While some progress has been made by CMS in these areas, it needs more accurate and timely information to trigger payment edits and better procedures to detect and recoup these improper payments.

OIG has also uncovered a stream prescribing patterns for hundreds of general care physicians and questionable billings by thousands of retail pharmacies. Medicare also paid millions for prescriptions from unauthorized prescribers, such as massage therapists and athletic trainers. This is especially concerning in light of OIG's increasing investigations into drug diversion. Verification of prescriber authority edits and enhanced monitoring are necessary to safeguard Medicare Part D and ensure patient safety.

Recently we have also reported improper payments to hospitals of millions of dollars related to vulnerabilities we identified as part of our nationwide hospital compliance reviews. In addition, we found that Medicare could have saved about $638 million over just a 2-year period by establishing a hospital transfer-of-payment policy for hospice transfers and strengthening billing requirements. OIG has made specific recommendations to reduce these and other improper payments, but those steps alone will not adequately safeguard Medicare.

CMS must continue its efforts to improve its oversight of Medicare contractors. CMS relies on contractors to administer various parts of Medicare, including claims payment, identification and recoupment of overpayments and benefit integrity functions. Our work has identified vulnerabilities associated with CMS's oversight of contractors.

First, CMS has not fully leveraged data to improve oversight. Part C and Part D plans report fraud and abuse data on merely a voluntary basis. CMS does not mandate such reporting. Under this system, we found that less than half of the Part D plans have actually reported fraud data, and reporting varies significantly from plan to plan. In addition, CMS has made limited use of the data it has received in overseeing Part C plans and has not fully used reported fraud and abuse data for monitoring Part D. As a result, CMS is still missing opportunities to discover and alert plans and law enforcement to emerging fraud and abuse schemes.

Second, we have found that while CMS's performance reviews of Medicare Administrative Contractors, or MACs, were extensive, they were not always timely. If the performance reviews are not performed -- completed and performed timely, the information they contain may not be available to support future contracting decisions.

To improve contractor oversight, we have made several recommendations to CMS that are included in our compendium of priority recommendations on our Web site.

While my testimony focuses on our work to help CMS improve program operations, I would like to make a request that would help OIG better meet our growing oversight responsibilities. OIG is responsible for oversight of about $0.25 of every Federal dollar spent, but our mission is challenged by declining resources at a time when our oversight responsibilities are increasing.

By the end of this fiscal year, OIG expects to reduce Medicare and Medicaid oversight by about 20 percent. During the same time, 2012 to 2014, outlays for Medicare are expected to grow by about 20 percent. To ensure that we can continue to provide needed oversight as these programs expand, we ask for the committee's support of our 2015 budget request.

In summary, we remain very committed to carrying out our responsibilities in the area of improving Medicare oversight to reduce waste, fraud and abuse as comprehensively and effectively as possible with the tools and resources we have available.

Thank you for your interest and support. I would be happy to answer your questions.

Chairman Brady. Thank you.

Chairman Brady. Mrs. King.

Ms. King. Mr. Chairman, Ranking Member McDermott and members of the subcommittee, thank you for inviting me here --

Chairman Brady. Ms. King, is the microphone on there?

Ms. King. I thought -- I had a green -- oh. Sorry.

Chairman Brady. I know.

Ms. King. Thank you for inviting me to talk about our work regarding Medicare fraud, waste and abuse.

CMS has made progress in implementing several recommendations we identified through our work to help protect Medicare from fraud and improper payments, but there are additional actions they should take. I want to focus my remarks today on three areas: provider enrollment, pre and post-payment claims review, and addressing vulnerabilities to fraud.

With respect to provider enrollment, CMS has implemented provisions of the Patient Protection and Affordable Care Act to strengthen the enrollment process so that potentially fraudulent providers are prevented from enrolling in Medicare and higher-risk providers undergo more scrutiny before being permitted to enroll.

CMS has recently imposed moratoria on the enrollment of certain types of providers in fraud hotspots and has contracted for fingerprint-based criminal background checks for high-risk providers. These are all positive steps; however, CMS has not completed certain actions authorized by PPACA, which would also be helpful in fighting fraud. It has not yet published regulations to require additional disclosures of information regarding actions previously taken against providers, such as payment suspensions. And it has not published regulations establishing the core elements of compliance programs or requirements for surety bonds for certain types of high-risk providers, including home health agencies.

With respect to claims for payment, Medicare uses pre-payment review to deny payment for claims that should not be paid and post-payment claims review to recover improperly paid claims. Pre-payment reviews are typically automated edits in claims processing systems that can prevent payment of improper claims.

We found some weaknesses in the use of pre-payment edits and made a number of recommendations to CMS to promote implementation of effective edits regarding national policies and to encourage more widespread use of local pre-payment edits by Medicare administrative contractors, or MACs. CMS agreed with our recommendations and has taken steps to implement them.

With respect to post-payment review, we recently completed work that recommended greater consistency in the requirements under which four post-payment review contractors operate when it can be done without impeding the efficiency of efforts to reduce improper payments. CMS agreed with our recommendation and is taking steps to implement them.

We also recommended to CMS that they collect and evaluate how quickly one type of post-payment review contractor, the zone program integrity contractor, and takes action against suspect providers. CMS did not comment on this recommendation.

We also have further work underway on the post-payment review contractors to examine whether CMS has strategies in place to coordinate their work and whether these contractors comply with CMS's requirements regarding communications with providers.

With respect to vulnerabilities to fraud, we have made recommendations to CMS over the last several years, and CMS has implemented several of them, including establishing a single vulnerability tracking process and requiring MACs to report to them on how they have addressed vulnerabilities; however, CMS has not taken action to address our recommendations to remove Social Security numbers from Medicare cards, because display of these numbers increases beneficiaries' vulnerability to identity theft. We continue to believe that CMS should act on our recommendations, and we are currently studying the use of

electronic card technologies for Medicare, including potential benefits on limitations and barriers to implementation.

Because Medicare is such a large and complex program, it is vulnerable to fraud and abuse. Constant vigilance is required to prevent, detect and deter fraud so that Medicare can continue to meet the health care needs of its beneficiaries.

This concludes my prepared remarks. Thank you, Mr. Chairman.

Chairman Brady. Thank you, Ms. King.

Chairman Brady. Dr. Agrawal.

Dr. Agrawal. Thank you. Chairman Brady, Ranking Member McDermott and members of the committee, thank you for the invitation to discuss the Centers for Medicare and Medicaid Services Program Integrity efforts.

Enhancing program integrity is a top priority for the administration and an agency-wide effort at CMS, and we have made important strides in reducing waste, abuse and fraud with the strong support of this committee and Congress. I know that this also is an area of particular interest to the members of this committee, and I look forward to hearing your input and working with you on strengthening program integrity in the Medicare program.

Before proceeding, I would like to take a moment to introduce myself. I am a board certified emergency medicine physician. For the past several years and concurrently with other positions I have held, I continue to work as an emergency medicine doctor, both in large academic centers and in area community hospitals.

Shortly after completing my medical training, I joined a management-consulting firm, where I had the opportunity to help hospitals, health systems and biotech and pharma companies improve the quality and efficiency of health care delivery.

In 2011, I joined CMS to serve as the chief medical officer of the Center for Program Integrity, where I had the chance to apply both my medical knowledge and private sector health experience to helping CMS fight fraud and ensure quality care for the millions of patients insured through Medicare and Medicaid. I view program integrity through the lens of these experiences and as a physician who fundamentally cares about the health of patients.

Our health care system should offer the highest quality and most appropriate care possible to ensure the well-being of individuals and populations. CMS is committed to protecting taxpayer dollars by preventing or recovering payments for wasteful, abusive or fraudulent services, helping to extend the life of the trust fund, but the importance of program integrity efforts extend beyond dollars and health care costs alone. It is fundamentally about protecting our beneficiaries, our patients, and ensuring we have the resources to provide for their care.

Numerous experts have cited the waste endemic to our system caused by multiple factors, from inefficiencies in care delivery to outright fraud. Underlying the issues and numbers are real patients. We are all too familiar with the stories of a patient getting inappropriate care or services due to the malfeasance of others to defraud our system. When providers and suppliers are influenced by their own financial interests or incentives, this can lead to up-coding or other gaming of Medicare and Medicaid.

Fraud is not merely deception for dollars through falsified billing. It threatens beneficiary health through blatantly unnecessary services, substandard or non-existent care, dangerous prescribing through pill mills, and a host of other schemes.

Examples of such waste and abuse are driving our agency and my team to rethink the way it approaches program integrity. Due to new authorities and resources provided by Congress over the past few years, CMS is changing the program integrity paradigm to one of focus on prevention and collaboration to identify and combat waste, abuse and fraud in our system, and in partnership with other stakeholders.

As deputy administrator, I will continue to lead CMS on this course with three main areas of intention: coordination across the agency and the broader health care system, excellence in program integrity operations, and a clear view towards improving the costs and appropriateness of care.

First, coordination. The Center for Program Integrity is responsible for leading and coordinating agency efforts to reduce waste, abuse and fraud. Collaboration with stakeholders external to the agency is vital to -- as well for the identification of vulnerabilities and increasing our impact. Led by the interagency HHS-DOJ partnership, HEAT, the Federal Government made its highest recovery of funds this past year, $4.3 billion in fiscal year 2013. This resulted in the highest return on investment in the HCFAC program, $8.10 for every $1 invested. We are continuing to build on existing partnerships with private sector pairs, health care organizations and providers through our public-private partnership. Results from the initial data exchanges under the partnership have helped identify fraudulent schemes and specific providers impacting private and public payers, and led to CMS administrative actions such as revocations, as well as law enforcement referrals.

Second, operational excellence. CMS's robust measures of the return on program integrity appropriations, the result of audit and investigation activities, and the impact of advanced data analytic systems, all of which shows strongly positive returns on investment. I intend to build on this foundation by managing performance and strategic decision making based on the areas of greatest risk and return. In particular, CPI's work on provider enrollment and screening has enhanced program integrity while lowering burden for providers.

Finally, the cost and appropriateness of care. CMS has a comprehensive Program Integrity strategy that includes multiple tools and interventions that are used individually and in tandem to tackle specific vulnerabilities. By applying these tools across Medicare and Medicaid in a coordinated way, CMS can impact the overall cost of care. We can and should aim to do even more.

As just one example, CMS has been piloting the use of a fraud prevention system, which is applying predictive analytics technology to all streaming Medicare fee-for-service claims to identify not only potentially fraudulent providers for investigation, but all providers who are billing inappropriately and may require education or medical review.

Thank you for your time and opportunity. I appreciate your support in achieving these goals. I look forward to hearing your ideas on how we can work together as we continue to focus on beneficiaries and strive every day to protect their health and well-being.

Chairman Brady. Thank you, Doctor.

Chairman Brady. Thank you to all the panelists.

Dr. Agrawal, you have highlighted a number of actions CMS has taken to reduce waste, fraud and abuse, and we appreciate them. While your fellow panelists acknowledge that your agency has made progress, the inspector general, General Accountability Office identify a number of areas for improvement. I am particularly troubled by the inspector general's revelation that Medicare pays $23 million for services to those who have died, according to the testimony, $117 million lost to those unlawfully present, and $33 million paid to those in prison. And there is more fraud within the fee-for-service area: overprescribing by physicians, the hospital transfer of payment issue, which is more than half a billion dollars lost to Medicare. These are problems that hurt seniors and erode public confidence in the Medicare program, and to my

mind, reading the testimony, are preventable. I truly believe that preventing fraud is a bipartisan issue and has been a long-standing challenge, and my hope is that we can work collaboratively with CMS.

And since this is your first time before the House and before the committee, can I get a commitment from you that your agency will work with me and our committee to stop the nearly $50 billion in improper payments each year?

Dr. Agrawal. Thank you for the question. Focus on improper payments is absolutely very important for the agency. We appreciate the work of the OIG and the GAO in identifying further vulnerabilities that we can work on. I think we can all agree, and it has been stated, that these are areas that we have made important progress in. That is not to say that we should stop being aggressive on these issues.

I think there are numerous factors in our more recent kind of programs that have provided important progress. So work that we have done on enrollment and screening standards on advanced analytics have, I think, really started to and made significant strides in addressing improper payments as well as the other access -- improper payment issues that OIG and GAO have identified. We will continue to work on those and look forward to working with this committee in doing so.

Chairman Brady. It will go easier if you just start with yes. Just so you know.

Dr. Agrawal. Yes, sir.

Chairman Brady. Doctor, I want to thank you for your willingness to work. As a follow-up on the fundamental challenges that you have and will face is moving CMS from a pay-and-chase fraud-fighting model. I am glad you mentioned it in your written statement, but I am concerned your efforts focus mostly on recouping money that has already gone out the door. Many members on this panel, again, bipartisan, believe we should be copying what private payers are doing already to prevent, detect and deter fraud, stopping payments before they go out the door. And so what actions is CMS taking to move in that direction, and how do we as a committee measure that movement and those results?

Dr. Agrawal. I think that is a very important question. We have taken a lot of steps to both emulate the private sector where appropriate and work with the private sector in our common program integrity challenges. As one example, we have recently completed a demonstration on the use of prior authorization to mitigate improper payments as well as other fraud, waste and abuse issues, and there is language in the President's budget that would allow us to expand that program.

Another example, I think a notable one, is the health care flawed prevention partnership, which specifically brings up private payers together with CMS in order to jointly and in a coordinated manner, detect and prevent fraud. Under that partnership, we have already engaged in numerous data exchanges and also sort of qualitative exchanges around best practices. It has led to some real actions for us.

The way that I think you could measure them is similar to how we measure them. We look at identified savings from HFPP activities as well as other activities and specific outcomes, like revocations and law enforcement referrals.

Chairman Brady. Ms. Jarmon, in her testimony, laid out a number of recommendations, but more importantly what seems to be a fairly simple sharing of data that would have prevented improper payments in a number of areas. Why aren't those being done?

Dr. Agrawal. Well, sir, I think there are multiple examples of where we are sharing data. We are sharing data with State Medicaid agencies, with the private sector, with law enforcement and that -- and all of those examples are really by directional sharing of data, so we are getting data from them and learning from all of these entities as well as providing our data to these other parties.

There is certainly more that we can do, and we continue to expand our data-sharing activities. I am happy to continue to work on those, but I think there are really notable examples in numerous programs where data exchange is central to those programs.

Chairman Brady. Thank you.

Ms. King, I understand GAO generally directs CMS to make or recommend changes with which the agency has administrative authority, and that General Accountability Office recommendations that require legislation are directed to us in Congress. Can you give us -- so that we can track these and so we can measure the progress and know where we need to focus; can you give us a rough percentage of the GAO unimplemented recommendations that CMS has authority to implement, and your sense of why it has not yet acted?

Ms. King. We do track all of our recommendations over time, and we keep them open for a considerable period of time, and I don't have the exact numbers at my fingertips, but our track record is pretty good on whether they have been implemented, and we have supplied to your staff a list of the open recommendations.

Chairman Brady. But approximately how many are there? I am not trying to pin it down. I am just trying to figure out --

Ms. King. Oh, jeez. Off the top of my head, 20 to 30.

Chairman Brady. To put it in perspective, these 20 to 30 recommendations, what potential impact do they have? How important are these recommendations not yet implemented for either stopping improper payments or recouping them once done?

Ms. King. Well, I don't think we make a recommendation unless we think that it is going to have a real effect. We identify a problem and we identify a way that it can be fixed. And some of those recommendations are actually not on the improper payment side, they are for all of Medicare, and some of them go to changes in payment policy and some of them go to changes in management, and others do go to improper payments.

And I think on the improper payment side, I think a good many of those recommendations have been implemented or are in the process of being implemented. And we don't close a recommendation until we are satisfied fully that it has been implemented.

Chairman Brady. Can you share that information with us?

Ms. King. Yes, sir.

Chairman Brady. Great. And we will make sure the committee has it.

Ms. Jarmon, I have introduced legislation with my colleague, Dr. McDermott, to expand your authority to exclude individuals and companies from participation in Medicare and other Federal programs.

Our intent is to prevent individuals who are responsible for fraud from jumping to another company before sanctions are handed down and prevent a company from creating a shell company that could further commit fraud and shield a parent company from liability. That is the intent of the legislation.

I think these situations -- we can all agree need to be prevented. Several types of providers have understandably expressed concern that this expansion could leave companies that serve seniors at serious legal risk, even if they have no role in fraudulent activity exposed to the OIG overreach.

So how do you respond to these concerns?

Ms. Jarmon. Well, we -- well, I would like to note that OIG -- we don't have the resources to actually go -- even go after all of the people who maybe should be excluded. So the chance of us even going broader is very limited.

We do -- we are very careful about how we use the authorities that we have. We have guidance on our website as far as reasonable factors to consider when determining -- when deciding to do an exclusion, which includes the seriousness of the misconduct or the alleged fraud and whether it hurt -- harms beneficiaries or the health plan.

And this exclusion authority is very important to us because we do need the authority to be able to exclude people who actually leave the organization before the citation who have been accused of fraud.

So that was a loophole in the prior legislation that is very important that we fixed so that the wrongdoers would be able to be excluded. So we are very careful --

Chairman Brady. Thank you.

Dr. McDermott and I are very serious about closing this loophole and --

Ms. Jarmon. Thank you.

Chairman Brady. -- and stopping this jumping from company to company, and it -- continues to be a problem.

So now I recognize the ranking member, Dr. McDermott, for 5 minutes for his questions.

Mr. McDermott. Thank you, Mr. Chairman.

Ms. Jarmon, I appreciate your testimony and recognize that you are with the Office of Audit Services component of OIG.

And I have questions that are more appropriately perhaps addressed to the Office of Counsel within OIG; therefore, I want to make a statement and I will submit several questions for the record. I will look forward to the responses from the OIG.

I remain concerned about the application of our current fraud and abuse laws, given our movement to new payment methods. My concern exists on several levels.

First, I believe that Federal regulators have sufficient experience with some models such that these arrangements should not be afforded protection under broad waiver authority, which is unclear exactly how the False Claims Act applies and where whistleblowers can be reticent -- may be reticent to bring qui tam cases.

Instead, regulators should put forth, I believe, an appropriate exception under the self-referral law and make modifications to other laws, including the gain sharing civil monetary penalty laws necessary to provide parameters for such conduct.

As an example, I am aware that OIG has issued no fewer than 15 advisory opinions -- I have read some of them, not all of them -- on various incentive compensation programs between hospitals and patients -- and physicians.

And, Mr. Chairman, I would like to enter into the record these advisory opinions that OIG has issued since 2001 in the area of incentive arrangements between hospitals and physicians.

Chairman Brady. Without objection.

Mr. McDermott. Rather than issue a case-by-case advisory opinion, it seems to me that more structure should be put in place around such arrangements.

This would allow regulators to better monitor these arrangements and would afford participants some level of certainty that participation in such arrangements would not be problematic under the fraud laws.

My bill, H.R. 1487, called the Improved Care of Lower Cost Act of 2013, seeks to require regulators to provide more structure around certain arrangements that regulators have been approving for over a decade on a case-by-case basis to allow broad participation by providers, but also ensure an adequate scrutiny by regulators.

This case-by-case thing -- as we spread the Accountable Care Act over the country, they are going to have endless case-by-case things, and I think it ought to be done systematically.

Secondly, I remain concerned that there are new fraud, waste and abuse schemes that we may not be fully aware of, given the different incentives under emerging payment models. So everyone agrees and usually mentions that we need to be concerned about stinting on care for Medicare beneficiaries.

One of the ways you can save money is don't give care. But what about monitoring whether a few unscrupulous providers would game the system by manipulating quality measures since these measures have taken on an increased importance in this new era of health care?

All a patient would have to say is, "I like the doctor and they have got good quality," but that doesn't mean they have gotten the care they needed.

This conduct seems to me to be much harder to identify than a false storefront, for example. This type of fraud is just as detrimental to our beneficiaries as to the solvency of the Medicare trust fund.

And I will submit these questions in writing to the counsel.

I am also a co-sponsor of a bill, H.R. 2914, the Promoting Integrity in Medicare Act, which would retain, but narrow, the in-office ancillary services exception under the Physician's Self-Referral Act so that the law and implemented regulations would more closely approximate what Congress intended.

CBO has suggested that the change reflected in this legislation would save the Federal Government $3.4 billion over the next 10 years.

Ms. King, can you provide the GAO's key findings related to the in-office ancillary services exception and the existing policy in this area?

Ms. King. Yes. We have done a few reports on that, and what we have found is that, in instances where there is an ownership interest, that the utilization is higher.

And, in our view, the self-referral component of it is one of the primary driving forces behind the higher utilization.

And we have made a recommendation to CMS that they more closely track when services are provided in a self-referral situation, but they did not agree with us on that. And we wish they had and we wish they would.

Mr. McDermott. Could you give us their reasoning that they gave you when they didn't agree with you?

Ms. King. They said that they thought it would be really complicated to track.

Mr. McDermott. It would be complicated to track.

Ms. King. Yes, sir.

Mr. McDermott. And since it is complicated in this day of computers and programming and all the rest, they couldn't figure out how to do it? Is that what you are telling me?

Ms. King. Well, sir, I can't speak for them, but that is, you know, what they responded to us.

Mr. McDermott. Dr. Agrawal, does that make sense to you?

Dr. Agrawal. Sir, I appreciate the question, and I appreciate the issue that you are raising.

I would say that Stark and self-disclosure laws don't actually fall within the activities of the Center for Program Integrity. I am happy to take your comments back and connect you with the right expert at CMS.

Mr. McDermott. All right. If you would, I appreciate it.

Because I think that, when there is this much money on the table as there is in health care today, it is bound to attract some folks who don't have the best interests of the patients or the government or the taxpayers at heart.

And it is going to be difficult for us -- certainly with Medicare, we have got problems already. We are going to have more problems with the Accountable Care Act.

And I think it is important that these fraud laws be updated to move from fee-for-service application, which is what we have had in the past, to now these more complicated other payment arrangements for physicians.

Physicians are hired by hospitals or get into relationships with hospitals. That whole of the fraud thing changes -- or at least it seems to me it changes.

And I want us to look carefully at that and make the kinds of changes we need to so that we don't come here 5 years from now and say, "Here is $100 billion that has been wasted" or 50 billion or whatever. I want us to try and stop it before it starts.

I yield back the balance of my time.

Chairman Brady. Thank you, Mr. McDermott.

Mr. Johnson is recognized.

Mr. Johnson. Thank you.

Mr. McDermott, I agree with you. They refuse to do anything.

Dr. Agrawal, I understand you are now in charge of the CMS Program Integrity mission. Is that true? True or false?

Dr. Agrawal. Sir, I am in charge of the Center for Program Integrity. Yes.

Mr. Johnson. Okay. You may not know, but in recent years, the House has twice overwhelmingly passed bills to take the Social Security number off the Medicare card.

My colleague, Lloyd Doggett, and I have been trying to get this done for years. And it seems to us that CMS, who tells seniors they must carry their Medicare card with their Social Security number in their wallet, refuses to protect seniors from becoming victims of identify theft. And, you know, you talk big about doing things over there, but you guys haven't done anything.

Do you care about protecting seniors from identity theft?

Dr. Agrawal. Unequivocally, yes, sir, we care about protecting seniors from identity theft.

Mr. Johnson. Well, when are you going to do that?

Dr. Agrawal. We have taken a number of actions to do so. We have, for example, beneficiary education activities, campaigns, in order to make them more aware of identity theft issues, given them real tactical solutions and ideas for how to not be victimized by identify theft.

Beyond that, sir, when it looks like somebody has become a victim of identify theft, we have a way of tracking their existing numbers and incorporating that through our compromised numbers database into other analytical work that we have underway.

So we are able to use that information in our activities to help prevent fraudulent billing under their HCCN.

Mr. Johnson. Yeah. But how are you going to stop them from stealing their Social Security number off of your Medicare card?

Dr. Agrawal. Well, I appreciate the issue and I realize its importance to this committee.

I also know that you are very aware of the dialogue that the agency has had with the committee and the operational kind of requirements in order to be able to remove the Social Security number from the card.

I think, given the right resources to be able to do it, we would be very open to further discussion on -- on --

Mr. Johnson. Well, you could at least just put the last four digits on there instead of the whole number.

Does CMS support our bipartisan bill, H.R. 781, the Medicare Identify Theft Prevention Act of 2013? Yes or no?

Dr. Agrawal. Sir, I would have to review the specifics of that bill to give you a --

Mr. Johnson. How long have you been there?

Dr. Agrawal. Pardon me?

Mr. Johnson. How long have you been there?

Dr. Agrawal. 2 months.

Mr. Johnson. Well, you ought to know it by now.

When are you going to do something about it? I would like to know what your plan is and when CMS will try to do the right thing.

Ms. King, GAO told us that CMS has efforts underway to modernize their IT system and that these efforts could be used to remove Social Security numbers off Medicare cards, yet CMS has not included removing Social Security numbers. And you just talked about it.

Is it still true that you agree with that?

Ms. King. Yes, sir, it is. I mean, I think -- CMS' position on that, at least at the time that we did our work, is that they knew that it was really complicated and they had revised their cost estimates, but they believed that they needed additional funding to do it.

Mr. Johnson. Well, I am not sure about that. But I want you to know that both Lloyd Doggett, who is a Democrat, by the way, and I agree that something needs to be done. We have been working on this for what seems like 8 years, and you guys haven't moved off that center.

Thank you, Mr. Chairman. Yield back.

Chairman Brady. Thank you.

Just as a note, the money saved from not paying felons, those who are dead and those who are here undocumented would pay for the implementation of removal of those Social Security numbers.

Mr. Blumenauer.

Mr. Blumenauer. Thank you, Mr. Chairman.

And I do appreciate what you and our ranking member have done in terms of moving forward with this and setting the stage for it, and I share both the sense of the urgency and the potential of doing something.

You may have noticed occasionally we are cranky around here and we don't always see eye to eye, but what has been outlined today and what you are going to hear is an area, I think, of tremendous consensus.

And beyond the consensus, I think there is a commitment and a passion to get something done. It doesn't make any difference about how you feel about the Affordable Care Act or global warming. These are incontrovertible facts. And we are looking at $50-, $60 billion, whatever the number is.

Now, the individual areas in the vast payment scheme are maybe understandable, but the target number needs to be addressed aggressively.

And you are going to hear from some of my colleagues. I am not going to steal their thunder. Just because of the luck of the draw, a couple of my colleagues come after me, and I will let them elaborate on their bills.

But I am happy to have been a co-sponsor of the Prime Act. I think my friend Mr. Roskam and a number of people have zeroed in -- there is about 60 bipartisan co-sponsors with provisions that would probably welcome some refinement, but the essentials there are solid and need to be pursued.

I have been working for several years with Mr. Gerlach on a universal access card. And I think if anything, it started a little timid. It has been -- you know, it has been very careful and calculated to try and move this forward, and I think he is going to weigh forth.

And I couldn't agree more with Congressman Johnson about getting the flipping numbers off the Social Security card. We understand that it takes resources and takes time and you have had a lot going on, but we are into a phase now of implementation of the Affordable Care Act and you have had time.

And I think that there is -- this is something that is not rocket science, and I think people would be open to what needs to happen in terms of some modification of a budget going forward.

But it is going -- these things collectively are going to save far more than they are going to cost, and it speaks to the integrity of the system and the protection of the people that we represent.

Now, Mr. Chairman, I would hope that we could continue with a little deeper dive on some of these proposals. I would hope that these would be at sort of a level.

I have talked with some of my colleagues about what would happen if we took some of -- and we have had this conversation -- we take some of the things that are second- or third-tier issues that don't have to, you know, stop the planet, they -- the leadership doesn't much care in either party, to break some of this stuff loose, be with it on the floor.

Maybe that would be a going-away present -- Mr. Roskam and I talked about this last week -- to Members of Congress, that this would be kind of a wrap-up session that we would have on the Thursday or Friday when we leave, to have one of these specifics on the floor that could bring people together, that would make a difference, that would be a signal to the people out there who are cheating and, more important, to the people that we are representing.

So I will get off my high horse. I won't go any further because you need to hear from the people who are the principal authors and who have put huge amounts of work into it.

But I would respectfully request, Mr. Chairman, that our witness friends could be able to give a little deeper analysis on each of these items that they are going to hear from about how -- about what we need to do to do that.

And the last thing I would recommend is that we think about working with CBO on some scoring mechanisms, because things that actually save money we ought to be able to apply present-value accounting, particularly if we can hold agencies accountable for the savings, that this isn't a pipe dream, but this is something that is beyond theoretical, and that we have the hammer to go back and make sure that they deliver. Then maybe we can cut some slack in terms of CBO scoring.

I appreciate your courtesy, Mr. Chairman. If there is something that my colleagues don't get to, I will submit it to our witnesses in writing. But at this point I will yield back.

Chairman Brady. Thank you, Mr. Blumenauer.

Two comments, if I may.

One, this is a bipartisan concern. This is the first hearing of what we hope will be deeper dives, as you have laid out, and the goal is to begin moving legislation in these areas.

Secondly, I agree with you completely on the scoring challenge. Often very good ideas that we know will work and improve and save money elsewhere are not given the score we think they deserve.

We are eager to work with you and CBO on those issues. So thank you.

Mr. Blumenauer. Thank you.

Chairman Brady. Mr. Roskam is recognized.

Mr. Roskam. Thank you, Mr. Chairman, for your leadership and convening this hearing, and for Mr. Blumenauer and his thoughtful setting of this discussion.

I think most Americans when they hear these numbers are actually scandalized by them. It is very difficult to absorb.

We are in this very clinical, antiseptic setting, but this is a situation that is bad. It has been bad and it is actually getting worse. This is not getting better. And these are the numbers -- these are objective numbers.

So CMS's own numbers in 2010 said that this number, in terms of fraud and abuse and waste and so forth, was $48 billion. A year later, it jumped up, according to GAO, to $64 billion. The latest estimate from the FBI is $75 billion plus and climbing.

So, Doctor, with due respect, in my view, you don't get to use words like "top priority," "robust," and "strongly positive." They should be out of your lexicon. This is a scandal. This is an embarrassment.

And there is an irony in that Ms. Jarmon in her opening statement makes an inquiry of this committee, "Would you please support our request for a budget, an appropriation?" And the irony is you have got all the money already.

So can you imagine the level of confidence that would be buoyant in our country if we were able to come together? And you have brought us together in ways that we have never been brought together before.

As Mr. Blumenauer alluded, we can hardly agree what time it is between the two of our parties. We cannot agree on what day of the week it is. Yet, we are nearly unanimously scandalized by just these big, big numbers.

I have got three inquiries of you. And I recognize you are the new person on the job. You have been there 2 months. So I am measured by that, but here are three legitimate issues that are upon us that have broken through.

One is the Medi-Medi data sharing. This is this whole notion of Medicaid and Medicare being in communication, if there is fraud in one area, communicating that in another area. Right now only 10 States are participating. In my view, that is ridiculous.

What is your remedy to that?

Dr. Agrawal. Thank you.

I think the Medi-Medi program is very important for our activities. It does, as you pointed out, allow us to exchange data with the States so that we can, again, find those providers and schemes that are crossing the line between Medicare and Medicaid and kind of committing schemes against us all.

Expansion is an important element of that, and we have been working to expand the numbers of States that participate in Medi-Medi. This is, I would just point out, a voluntary program, and there are a number of other data exchange activities that the States are engaged in.

We have heard consistently from them that, while they would in some cases value participation, they have to weigh that against other priorities and data exchanges that they have.

So we are very open to more expansion, have actually added more States since that figure of 10. And I could get you a more updated number.

Mr. Roskam. So the next time we meet in a hearing setting so that you can claim those superlatives that I admonished you from using before, what is your plan in terms of the Medi-Medi goal?

Let's say you are back in a hearing in 6 months. There are currently 10 states that are participating. What is reasonable for us to assume. I am not asking pipe dreams.

What is a reasonable number for you to coax, cajole, urge States to participate if only 20 percent of the Nation is participating now?

Dr. Agrawal. I am not sure that I could give you a specific number --

Mr. Roskam. Sure you can.

Dr. Agrawal. -- that would -- you know, to kind of -- for a follow-up hearing.

I think what is important to note is that Medi-Medi is just one of the many activities that we perform with the States.

We also collaborate with them in the Medicaid Integrity Institute, which is all about best practice and knowledge-sharing.

We work with them on specific cases that might fall out of the Medi-Medi context, but are active investigations either that we have initiated or that they have.

So I am not sure that participation alone in Medi-Medi is the best measure of how well that --

Mr. Roskam. Yeah. But it would help. I mean, my Home State of Illinois just paid out $12 million to people who are dead.

Dr. Agrawal. Yes, sir. I -- I also am aware of that.

Do you -- I think I go back to the answer that I had about Medi-Medi. If you are asking specifically about Illinois, I could certainly look into what activities we have with them.

Mr. Roskam. So here is my question: If only 10 States are participating and we are losing $75 billion a year, according to the FBI, doesn't it follow that, if we had every State participating, that this gets better? And don't you play a key role in whether every State participates or not? Am I over-characterizing this?

Dr. Agrawal. I think it is fair to say we, too, want more States to participate. I think --

Mr. Roskam. What is your plan to have that happen? That is my question.

Dr. Agrawal. So we have lots of outreach activities with the States to let them know about the existence of the program, to indicate the sort of portion of the Medi-Medi budget that we are willing and able to handle versus what they would need to undertake, and we engage, you know, with States in numerous different venues in order to be able to do that.

Again, I believe States are under a lot of pressure to also produce data for CMS, including the T-MSIS program. So there will be exchange of data. And I am not sure, again, that Medi-Medi is the singular kind of measure of that collaboration --

Mr. Roskam. But you are not satisfied --

Dr. Agrawal. -- of examples.

Mr. Roskam. You are not satisfied with 10 states, are you?

Dr. Agrawal. Oh, we always want more states to collaborate.

Mr. Roskam. How many more? Next time we meet, how many more is a reasonable number?

Dr. Agrawal. Sir, I am not sure I could give you a particular number.

Mr. Roskam. Okay. Let's switch gears.

Provider legitimacy, this notion of a provider being illegitimate, losing a licensing, being a hustler and so forth, being thrown out of a system and, yet, that doesn't sync up with other systems. There was a ProPublica piece not long ago, I am sure you are familiar with it.

Could you speak to that?

Dr. Agrawal. Sure. And I think that is a great example of data exchange outside of the Medi-Medi program.

So, for example, as a result of the ACA, Medicaid programs are now required to share their termination data with CMS, and we are then able to take relevant action in Medicare, if that provider is indeed enrolled in Medicare, as well as take a reciprocal action in other State Medicaid programs.

I think there are very good examples. We have had compliance in sharing that kind of data increase dramatically since the beginning of the program. We get a lot more information from the States in terminations that they are able to perform.

Now, I would point out licensure decisions are very different from enrollment in Medicare or Medicaid. Those are conducted by non-CMS-affiliated bodies. Those are State licensure boards. They operate very independently of us.

We certainly can take an action if a license is revoked, but we, as such, have no more authority in that process than anybody outside the licensure board.

Mr. Roskam. Okay. We would love to help you.

I yield back.

Chairman Brady. Thank you.

Mr. Kind is recognized.

Mr. Kind. Thank you, Mr. Chairman.

I commend you for holding this important hearing. And it is one that really should be non-partisan and, hopefully, we will have an opportunity to work in a bipartisan way.

You are never going to find any member of Congress defending fraud, waste and abuse, whether it is Medicare or any other Federal program. But I think we need to approach this in the proper context.

It is not just Medicare fraud that we are talking about here. We are talking about system-wide health care fraud, and Medicare is a subset of that.

I would assume that, if we are detecting fraudulent practices, fraudulent billing, in Medicare, it is much larger than that and it involves private payers and those involved in the health care system.

Is that right, Dr. Agrawal?

Dr. Agrawal. Yes. I think that is a very important point.

Part of the reason for the creation of the health care fraud prevention partnership is this very notion that fraud crosses the public-private divide, and the fact that private payers have joined the partnership really does indicate that they face these challenges, too.

Mr. Kind. And that -- the private partnership program right now, how successful do you think that has been working, the collaboration with the private sector and the private payers? And what more do you think could be added to it in order to enhance its success?

Dr. Agrawal. Thank you. I appreciate the question.

It has -- the collaboration has been extensive. For example, next week a number of private payers are going to be coming to the command center at CPI as part of partnership activities.

We have over 30 partners at this point between private payers, national health care agencies, and law enforcement bodies.

We have conducted numerous data exchanges within the confines of the partnership, specific data exchanges, not just qualitative data around best practices, though we have done that as well.

And each of us has then used that data -- each participant has used that data to go and take action wherever appropriate in our own systems, and CMS has been able to do that. So I think the partnership has really continued to mature.

Mr. Kind. Mr. Roskam did point out some startling numbers as far as trend lines, from $48 billion to $75 billion or so. But I also sense there is a little bit of the dial being moved in the right direction as well.

I mean, because of the existing tools now in the Affordable Care Act and some pre-existing authorities, we have got the HEAT strike force that has been out there.

I think, since passage of ACA, over $20 billion has been recouped or recaptured of Medicare fraud, 1,400 individuals have been charged up and criminal charges are pending against.

So there are some instances that we can point to showing some progress is made, but, obviously, there is no reason for a victory lap or satisfaction from any of us here.

My question for you, Doctor, coming from the profession yourself, we just had a huge CMS physician reimbursement data dump recently.

Where do you think this is going to lead as far as looking at over-utilization practices and possible fraudulent detection

Dr. Agrawal. Thank you.

I think that data release was a very important element of the administration's overall approach to transparency and health care data. Since then, we have heard from a lot of external stakeholders about their use of the data, how they would like to leverage it.

I think that kind of innovation, you know, among stakeholders is very important. It also fits into an overall kind of set of programs that we have at the Center for Program Integrity.

Another example that we are implementing now is the Sunshine Act that will allow more transparency into the financial interactions between industry and physicians. I think, you know, all of these programs are designed to give beneficiaries and other stakeholders a view into data.

And one group that we have heard from pretty extensively is the physician community, especially, for example, in emergency medicine where physicians have written back to CMS saying, "Thank you. This is data I did not have before." And it would facilitate their own practice.

Mr. Kind. I think, to be fair to them that was only a small piece of the information out there. What is lacking in that is quality measurements, protocols of care, things of that nature, and the overall success rate and how doctors are practicing medicine.

But, finally, let me ask with the remaining time, from you, Doctor -- and I would also like to hear Ms. Jarmon and Ms. King's opinion -- we are trying to move the system -- the payment system away from fee-for-service and volume-based -- outcome and value-based. And, obviously, we are seeing a lot of effort in bundled payments as well.

What are the implications of that new payment model when it comes to the detection of fraud and how successful? Because, obviously, under the fee-for-service model, there is a lot of reporting and a lot of steps that people are being reimbursed for.

Is this going to make it easier or harder for us to detect fraud, moving to a more bundled form of payment system or a value-based system, ultimately?

Dr. Agrawal. Yeah. Thank you for that question as well.

I think the movement, obviously, towards value is extremely important. It is a central tenet of the ACA. And that movement is important for health care overall.

I think, while I will sort of leave the specifics of new payment models to the experts at CMS who handle the new payment models, what I would just want to clarify is that none of the payment models that are new and innovative preclude us from performing the activities that we already have in place for fee-for-service.

We are still able to conduct the medical review that we conduct. We can still open up investigations and take appropriate actions whether a provider is participating in just traditional fee-for-service or one of the newer models.

So we still have and continue to have the same level of oversight and have the same level of authority. So I think, as the new systems mature, certainly it will be an opportunity for all of us to learn more, but the oversight and the controls are still very much there.

Mr. Kind. Okay. Thank you.

Chairman Brady. Dr. Price.

Mr. Price. Thank you, Mr. Chairman.

And I want to thank the panelists as well. Having practiced medicine for over 20 years before I got here, I think, as I mentioned, often we lose sight of the patients in all of this.

We all want to save money. None of us want to have fraud exist out there, pay for folks that are scamming the system.

But sometimes that money that is taken is taken from folks who are actually trying to provide care and potentially destroying the quality health care for seniors.

And so it is important that we have a feedback mechanism to be able to tell whether or not we are actually doing the right thing.

Ms. King, there was a GAO report that was released earlier this month on the competitive bidding program for durable medical equipment, DME, including home oxygen supply and the like.

These are services that affect real lives, whether or not individuals can actually live a comfortable life or whether or not they live at all. And, again, we all want to hold contractors accountable.

We are into round 2. Nearly 2 years into round 2, the OIG found that there were problems and concerns that they had with round 1 and, yet, CMS went ahead with round 2. GAO said that was a good idea.

Recently your report said that there was decreased utilization of durable medical equipment, there was decrease in suppliers, and no adverse effect to the beneficiaries.

So, you read the top line of that and you jump up and down and you say, "Hallelujah. That is a wonderful thing."

Are you aware of any of the concerns that have been voiced about this by the COPD -- the Chronic Obstructive Pulmonary Disease Foundation?

Ms. King. Not specifically the COPD Foundation, but we have done a considerable amount of work on the implementation of competitive bidding for DME and --

Mr. Price. Did you interview them for your report?

Ms. King. I don't know, but I can get back to you on that.

Mr. Price. How did you decide who you interviewed for your report?

Ms. King. We laid out the methodology in our report -- and we have a very transparent methodology -- and we contacted a number of people in the industry and met with them several times. But I don't recall whether they included the COPD folks.

Mr. Price. I don't think you did. I would encourage you to talk to them. They disagree strenuously with the conclusions that you have made and the recommendations that you provided.

Did you use data that you had or did you use CMS data in your evaluation?

Ms. King. We got claims data from them and did our own analysis.

Mr. Price. Claims data?

Ms. King. Yes, we did.

Mr. Price. No clinical data?

Ms. King. No. They had clinical data and they set up areas --

Mr. Price. They have claims data. They have claims data. Right?

Ms. King. Yeah. And they --

Mr. Price. That is what we are looking at, looking at claims. We are looking at money, which is wise. We need to do that. But oftentimes we don't look at patients.

Did you ask or did you find out or did your data tell you whether or not a patient that fell off, wasn't utilizing the service anymore -- whether they needed the service anymore? Could you tell that?

Ms. King. CMS did their own beneficiary satisfaction work and we evaluated that, and in their work they did not find significant access problems. And we --

Mr. Price. That wasn't what I asked.

I asked: Did you ask whether or not patients fall off? Do they go to self-pay? Do they pay for the service themselves, or have they been transferred to a nursing home? Is there any way to know whether they have been transferred into a nursing home in the data that you used?

Ms. King. Not that I am aware of.

Mr. Price. That is correct.

These are chronic diseases. These are chronic diseases. And CMS says it only tracks data for 120 days. If you don't have a current claim within 120 days, they don't care.

You could have gotten the pennies together in your sofa and paid for the oxygen to keep you alive or you could pull it out of our pocket or you could go to a nursing home. CMS doesn't know.

So I would suggest that we have got a long way to go toward getting the right data when you are talking about quality.

When the Federal Government is defining quality, then anybody that doesn't do what the Federal Government wants to do is fraudulent. I would suggest that is not the right place to define quality.

Let me just touch on -- I have got a few more seconds here.

Ms. Jarmon, you mentioned about the in-office ancillary self-referral increase utilization. You are aware that there are studies in individuals that have been done that demonstrate that that is not the case, that there is no increase in utilization in use of in-office ancillaries.

Are you aware of that?

Ms. Jarmon. No. I was not aware of that.

Mr. Price. All right. Well, we will get that for you, and we will be happy to see the change in the next report.

Ms. Jarmon, talking about the number of counties that have the kind of high incidents of home health outliers, 3,143 counties in the country, 25 counties have the highest incidents.

Wouldn't we do a whole lot better job if we would just concentrate on those 25 counties?

Ms. Jarmon. When we are doing our work, we do try to focus on the areas where there is higher risk. So we do try to focus on those areas in our analysis.

Mr. Price. The work wouldn't demonstrate that, though, because we continue to have that same statistic, that same statistic, year after year after year. So I would encourage you to focus where the real problems are.

Thank you, Mr. Chairman.

Chairman Brady. Thank you.

Mr. Pascrell.

Mr. Pascrell. Thank you, Mr. Chairman.

I am encouraged that we get some bipartisan support. One area that has been of particular interest to me is the hip and knee replacements.

I first became involved in this issue in 2007 when five of the Nation's biggest makers of artificial hips and knees agreed to pay $311 million in penalties to settle Federal accusations that they used so-called consulting agreements, better known as bribes, and other tactics to get surgeons to use their products, regardless of the effect of the product.

So this may be the cost of doing business, but it is serious, because in the next 10 years, if we are going to spend $65 billion on knee and hip replacements, Medicare and Medicaid will pick up most of the cost.

So if we are not concerned in this particular issue in avoiding the debacle that happened just 10 years ago, what are we?

Strong action needed to be taken, and instead of anyone going to jail, no one went to jail. Five companies got deferred prosecution agreements where they simply paid a fine and agreed to be monitored by private firms.

That is not the subject of what I am going to get into today, but let me tell you, your hair would stand up. Go back and read those cases.

I introduced two bills that I believe get at the root of the issues here.

First is the Accountability and Deferred Prosecution Agreements Act, which will require the Department of Justice to establish guidelines for the use of deferred prosecution agreements. I plan to introduce this bill later this week.

And second is the National Knee and Hip Replacement Registry Act, which would establish a registry to help identify failing implants into identified -- we are talking about senior citizens that got shafted over and over again, had to be re-surged because of what we did not do. Make no mistake. Problems with faulty joint implants are no means behind us.

Just last year one of the largest medical device companies agreed to pay $2.5 billion to settle lawsuits filed by thousands of patients who had to undergo -- we are talking mostly seniors. That is what we are talking about. And in the next 10 years, again, we are going to spend $65 billion.

By the way, do you agree that we should have a registry in this country so we know who is stealing from other people?

Dr. Agrawal. Sir, on the hip and knee registry, you know, I think we would be open to reviewing the proposal and offering you any guidance that would be helpful.

I do think that we are aligned in certain other ways already. I alluded earlier to the Physician Payment Sunshine Act.

We will be able to see through that program as just one example of financial interactions between medical device companies and physicians, and I think that will be a level of data transparency that is important --

Mr. Pascrell. Do you believe, Doctor, that collecting patient data in a registry on knee and hip replacements could help us to identify ineffective knee and hip devices so that we can cut down on unnecessary surgery? Do you agree with that or you don't agree with it? It is a pretty simple question.

Dr. Agrawal. I think that we are happy to review any proposal that comes from this committee and help you in the evolution of that proposal.

Mr. Pascrell. Well, it would seem to me, if you know the history -- and I was trying to give it to you in capsule form, unfortunately.

Back in 2007 -- much of it occurred before 2007. And you folks have not -- even though you just came on the job, you folks have not done anything about this, encouraging anything. This is a major part of your budget. This is a major part of the fraud.

It would seem to me that we should be interested in these kinds of things. Correct?

Dr. Agrawal. Yes, sir. I think we are interested. As I have alluded to a couple of times now, I think the Sunshine Act will get at this issue as well.

Mr. Pascrell. Mr. Chairman, I think that, when we speak of trying to make the system better and when we speak about trying to save money -- because there is tremendous amount of fraud and the many people who committed the fraud never went to jail. Okay?

Talk about our system of justice about, when you have a buck in your pocket, you stay out of jail; when you don't have a buck, you sure the hell will go to jail.

And one way to stop this is to look at this registry, which I am talking about here so that one hand knows what the other is doing. And I think it would reduce health care costs, period, not only in this area, but also in other areas.

And I yield back. And I thank you.

Chairman Brady. Thank you, Mr. Pascrell.

Mr. Smith.

Mr. Smith. Thank you, Mr. Chairman.

And thank you to our witnesses here today for sharing your insight. It is a tough job out there that I think you are trying to do.

And it is frustrating from our standpoint. I get especially frustrated when I hear from providers wanting to do the right thing and, yet, it is so cumbersome, it is so complex, that even doing the right thing has become so difficult. And I am afraid that that is just getting worse.

And we know that Medicare is on an unsustainable path. At least that is my opinion. And we need to make some changes.

We did hear about the embarrassing situations of improper payments, Ms. Jarmon.

Any of you, how do these improper payments happen?

What can you tell us is being done to fix this, Dr. Agrawal?

Dr. Agrawal. Sure. One thing I would just want to clarify is certainly the improper payment rate is a huge focus for the agency and we are focused on reducing the improper payment rate. I just want to differentiate that rate from a measure of fraud.

The improper payment rate is not a true measure of fraud. It is really more a measure of perhaps waste and abuse. A lot of the major drivers of the improper payment rate are insufficient documentation, which is often caused by providers sometimes not understanding regulatory requirements. But if we got the documentation that was required, chances are those claims would have been just fine.

Mr. Smith. So services for a dead person, how does that happen?

Dr. Agrawal. Yeah. So there are -- you know, we utilize --

Mr. Smith. Would that be fraud or would that be improper payment?

Dr. Agrawal. It could be either. I think, obviously, you know, establishing fraud depends on establishing intent, and that really is a law enforcement determination. What we do is we look at drivers of improper payment and try to go after the biggest drivers.

With respect to dead beneficiaries or dead providers in specific, we work very closely with the Social Security Administration to get information on their Death Master File to be able to link that information to our own data so that we can stop claims from being paid for those beneficiaries or to those providers.

Mr. Smith. So would you say that current measures are sufficient? More measures are needed? Lack of enforcement? How would you sum up what the current situation is or needs to be?

Dr. Agrawal. Well, I think, if you were to look at the improper payment overall, certainly, you know, there is more that we can do and we are working on various initiatives to decrease the improper payment rate.

Again, because documentation issues drive a huge portion of that rate, we are working with providers to educate them on real documentation requirements.

Some of the other things that drive the rate are medically necessary services, but being provided in the wrong place. So, again, that does come down to education and working with providers.

Mr. Smith. The wrong place, could you elaborate?

Dr. Agrawal. Sure. So there might be a service like a stress test, for example, that is provided in an inpatient setting that could be provided in an office or outpatient setting.

That inpatient claim could potentially lead to an improper payment, you know, depending on how it was documented and all that.

But, you know, nobody is contending necessarily that the service should not have been provided. It should just have been provided in a more medically reasonable location.

So a lot of that, again, does come down to working with providers. I take your point very seriously about provider burden and agree, as a physician myself, that we should do whatever we can to lower burden as feasible while still meeting our obligations to protect trust fund dollars and educating providers as best we can on the front end so mistakes are not made.

Mr. Smith. Well, I would also add, as I have in previous hearings in working on health care issues, especially in rural America, there are arbitrary regulations that I think might be intended for greater efficiencies and, yet, the result is the exact opposite.

And I am afraid patients actually suffer as a result of the Federal bureaucracy supposedly in the name of striving for efficiency, but services are worse. I think it is arbitrary and I would hope that we could have your cooperation as we do move forward on trying to find some efficiency there.

We know that hardworking taxpayers need protection, so to speak, and that we have, I think, many options ahead of us, hopefully, we will pursue that will have the Federal Government step back instead of step forward and into the lives of so many patients because I think it is counterproductive.

Thank you. I yield back.

Chairman Brady. Thank you.

Mr. Gerlach.

Mr. Gerlach. Thank you, Mr. Chairman.

Thank you all for coming and testifying today.

The amount of fraud and abuse in the program is staggering. We all know that. And I relate it back to just where I am from, Pennsylvania. The Commonwealth of Pennsylvania State budget is about $32 billion a year.

So, really, what we are talking about here is fraud and abuse in one program of the Federal Government that has doubled the size of the Commonwealth of Pennsylvania's budget each year. That is staggering.

And I am really concerned that, in the years that I have been on this committee and we have had these kinds of hearings, very little progress has been made to deal with it from the witness side of things, where the same questions have been asked by Mr. Johnson year after year after year, why there are still Social Security numbers on these cards. Still don't have a solid answer as to what you are doing about it.

And, frankly, not to take it personally, you ought to be embarrassed. You ought to be embarrassed for the agency you work for and for the American people. Now, that doesn't mean you are personally responsible for that. So please don't take that as a personal slight to any of you.

But it ought to just remind you, as you sit here today, how important these issues are and how important it is to make progress on these issues. And I hope a year from now you are not back testifying and you are giving the same answers to the same questions and no progress has been made.

A number of us on this committee -- my lead cosponsor, Mr. Blumenauer, and other members of this subcommittee -- have cosponsored H.R. 3024, which will create a smart card program within the Medicare program to deal with this issue, having both a provider and the beneficiary have a card without a Social Security number on it that would be swiped at the time of the medical transaction to try to reduce fraud and abuse and, in particular, deal with fraudulent billing, phantom billing, duplicate billing, dealing with unlawfully present beneficiaries, dealing with deceased beneficiaries, dealing with identity theft.

We think this kind of technology, which is already being used in the Department of Defense to prevent people from getting access to certain buildings of the department or into computer systems, being used by perhaps yourselves -- I understand all Federal employees have a Homeland Security technology card that they use.

Other health care delivery systems around the world are using smart card technology to deal with waste, fraud and abuse. Yet, here in the United States we don't have that as part of our program and we also include the Social Security numbers on our cards.

So a number of us not only here in the House, but, also, on a bipartisan, bicameral basis, have sponsored this kind of legislation to bring smart card technology into the program. And we have asked GAO -- Ms. King, I know you are well aware -- we have asked GAO to do some preliminary background evaluation of the idea.

Ms. King, can you give us an update as to -- the work you are doing in GAO with this particular idea, where you might be in that process and when do – what you think there would be a completion to that so that we can move forward with evaluating that information from you and then move forward legislatively?

Ms. King. Yes. Thank you for that question.

At your request and the request of several other Members of Congress, we are looking at the use of electronic cards in Medicare, and we are looking at several aspects of that.

We want to try and find out what -- the potential benefits and any limitations, if there are any, with the use of them, what issues might be involved in the implementation of smart cards, and we also want to evaluate where they are in use in other settings. And we hope to finish up that work about the end of the year.

Mr. Gerlach. Okay. And then will you come back to us with a report and recommendations relative to the idea?

Ms. King. We will.

Mr. Gerlach. Okay. Doctor, on that same idea, are you currently out of your shop looking at the use of digital technology solutions to more accurately authenticate providers and beneficiaries at the time of the medical transaction rather than continuing this pay-and-chase process we have today, having more front-end verification methods in place, could include smart card technology, could include other types of technology, to, again, address this issue?

Dr. Agrawal. Yes. Obviously, we do look forward to seeing GAO's findings. That will certainly help the agency as well.

We did conduct a little while ago a swipe card pilot with DME ordering. That basically required or allowed providers to swipe an electronic card at the time of the order being placed in the office and then a beneficiary taking that card essentially to a DME supplier to be able to connect the order in the office to the supply that was actually given.

And I think the outcomes of that program have highlighted, you know, some of the challenges that might emerge in this report as well.

Number one; there are obviously some operational constraints that we should be aware of on the part of the provider.

I think we have to be very careful in instituting any kind of alternative technology approach, that we not place too much of a burden on providers, whether it is a resource burden or other kind of technology acquisition burden.

Secondly, I would just highlight or emphasize that, in any new technology implementation, we not get in the way of the physician-patient relationship.

This was actually some specific feedback that we got to our pilot, that certain physicians saw that as an intrusion, having to swipe a card when they were seeing a patient.

Obviously, beyond that, there are other operational constraints of implementation, but I would just ask the committee to keep these things in mind.

Mr. Gerlach. We will look forward to your information. Thank you.

Mr. Blumenauer. Mr. Chairman, just a point of clarification, please.

Chairman Brady. Yes.

Mr. Blumenauer. I would note that this particular project of Mr. Gerlach -- he has unfortunately decided that he is not going to be with us next year. And I am pained with the notion that we are not going to get a report for 6 months.

Is it possible to get some sort of interim report in the next few months that could feed back into the work we are doing here, that we might be able to wrap this up? He has invested years in this very positive idea. Is there some way that we could get a little something sooner?

Ms. King. We are not at the point right now of being able to tell you what our preliminary findings are, but I think we will be before the end of the year.

Mr. Blumenauer. Yes.

And I am just saying respectfully, because we have a different timetable here --

Ms. King. I understand.

Mr. Blumenauer. -- if there is some way -- even not a final preliminary, but something that would give guidance sooner, late in the summer or early in the fall, would make a big difference.

Chairman Brady. And, Ms. King, I imagine every one of us would add our support for that request as well.

All right. Thank you.

Mrs. Black.

Mrs. Black. Thank you, Mr. Chairman. And I do sincerely appreciate the opportunity to participate in this hearing. And I thank you for your leadership on this issue. This is a very important issue in understanding the fraud, waste and abuse in the Medicare program.

Myself and all my colleagues that have spoken here do have serious concerns about the future of Medicare, the program, and appreciate viewing some of the recommendations that have been made by the GAO that has been published in order for CMS to address some of these fundamental structural changes that are facing our growing system.

I think it was our colleague, Mr. Roskam, that made mention of $75 billion. When I think about billions of dollars that potentially cannot be accounted for, it is a tremendous, tremendous amount of money. I certainly appreciate the good work that is done by both the GAOs and the Inspector General as well.

Just recently I sent a letter to Ms. Tavenner on this very topic to understand why CMS has not adopted two recommendations made by GAO to reduce improper payments issued by CMS. One of them goes back pretty far, and we still don't see that there has been a resolution on this.

It goes back to a 2007 GAO recommendation that was a requirement for contractors to develop thresholds for unexplained increases in billing in order to implement the controls under an automated payment system.

And prior to issuing these payments under a fee-for-service, thresholds have not been developed to explain unexpected increases in billing.

And that seems to me to be one that just ought to jump out and ought to be one that takes priority to say, "Why is that happening?" and, "Let's put thresholds there so we can at least catch that," as has already been said by the previous questioner.

Dr. Agrawal, would you be able to help me understand why this still has not been put into place?

Dr. Agrawal. Sure. So we have the fraud prevention system, which is a predictive analytics system that allows us to look at claims in real-time.

One of the models in that system does look at the type of spike billing that you are talking about, essentially, significant changes in billing behavior in a relatively brief period of time.

We also have other models that look at just the absolute dollars that are going out. So, you know, some that look at the change and others that just look at high-dollar amounts.

We could perhaps work with the GAO to close that recommendation, but I do believe we have addressed it.

Mrs. Black. Well, if you have, I think it would be a great idea to work with GAO because it continues to show up, the recommendations.

Dr. Agrawal. Yes, ma'am.

Mrs. Black. And if we go all the way back to 2007 and we see this continue to be a recommendation that hasn't been closed, then there is a question about why that is.

A lot of money is spent with the GAO in trying to get these recommendations to you all. Understanding that you are very busy on administering the program, I think when the recommendations are given, they need to be taken seriously and we don't need to see them being open year after year.

I want to go to just one other one. And I am interested in the recommendation that was made by GAO regarding the home health agencies with known high rates of improper billing. The GAO recommended that the CMS conduct post-payment reviews, and that also seems to have not been done yet.

Can you speak to that?

Dr. Agrawal. Yes, ma'am. So we receive regular reports from our zone program integrity contractors that conduct investigations against various providers that have, you know, risen in priority.

Each one of our zone program integrity contractors does conduct post-pay reviews of home health agencies in their zones. Again, this perhaps may be a recommendation that we could close.

In specific, you know, the committee is aware of the moratorium that we have implemented in home health services in a number of different geographies as a result of those activities and other activities.

As just one example, we have revoked over 100 home health agencies in just Miami alone in the last year, half of them after the moratorium was put in place. So home health care is something that we are closely looking at.

We, in fact, do conduct post-pay audits and payment suspensions and pre-pay reviews just in alignment with our other authorities. So I would be happy to work with them to perhaps close that recommendation.

Mrs. Black. Just an observation that -- you did talk about several of these recommendations that you all are trying to address.

I think that, since you are fairly new with the organization, the agency, that it might be a good change in culture to go back and look at these and be able to report back to this committee in particular, but to Congress in general, to let them know that you are taking these recommendations seriously.

Because, as I say, there is a lot of money that goes into researching these recommendations and giving them to CMS, and I would hope that we would have you close those out.

If you are really doing these, let us know. And let us know, also, how much has been saved. If you can help us to know that, that is very helpful.

Thank you, Mr. Chairman.

Chairman Brady. Thank you, Mrs. Black.

And to the witnesses, thank you for being here.

The bipartisan frustration you hear expressed is not because fraud in Medicare is new. It is not. It is growing as the program is growing. It, at times, seems super human and immortal, and it is not. Much of the fraud and abuse we have seen is preventable.

And so, one, this won't be the last time you are before the subcommittee. We are dead serious about both aggressive oversight to ensure that the recommendations by the Inspector General and GAO are implemented in a timely way by the agency. I appreciate your support and commitment to work with us to do that.

Secondly, the subcommittee hopes to develop and advance a package of legislative bills related to fraud. So if you have views on the legislation that you heard from the Members today, I would encourage you to get with them immediately because we intend to move on the area of fraud.

With that, I would like to thank all of the witnesses for their testimony today. Appreciate the continued assistance getting answers to the questions that are asked by our committee and Members.

As a reminder, any Member wishing to submit a question for the record will have 14 days to do so. Any questions that are submitted, I ask the witnesses to respond in a timely manner.

With that, the subcommittee is adjourned.

[Whereupon, at 3:35 p.m., the subcommittee was adjourned.]

**Member Submissions for the Record**

McDermott Submission 20140430HL

**Public Submissions for the Record**

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