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MEDICARE PROGRAM INTEGRITY: SCREENING OUT ERRORS, FRAUD, AND ABUSE

WEDNESDAY, JUNE 25, 2014

House of Representatives,

Subcommittee on Oversight and Investigations

Committee on Energy and Commerce

Washington, D.C.

The Subcommittee met, pursuant to call, at 10:03 a.m., in Room 2123 of the Rayburn House Office Building, Hon. Tim Murphy [Chairman of the Subcommittee] presiding.

Members present: Murphy, Burgess, Blackburn, Olson, Griffith, Johnson, Long, Ellmers, DeGette, Braley, Schakowsky, Tonko, Green, Upton (ex officio) and Waxman (ex

officio).

Staff present: Clay Alspach, Chief Counsel, Health; Gary Andres, Staff Director; Matt Bravo, Professional Staff Member; Leighton Brown, Press Assistant; Karen Christian, Chief Counsel, Oversight; Noelle Clemente, Press Secretary; Brad Grantz, Policy Coordinator, O&I; Brittany Havens, Legislative Clerk; Sean Hayes, Deputy Chief Counsel, O&I; Robert Horne, Professional Staff Member, Health; Emily Newman, Counsel, O&I; Macey Sevcik, Press Assistant; Alan Slobodin, Deputy Chief Counsel, Oversight; Josh Trent, Professional Staff Member, Health; Tom Wilbur, Digital Media Advisor; Peter Bodner, Democratic Counsel; Brian Cohen, Democratic Staff Director, Oversight and Investigations, Senior Policy Advisor; Lisa Goldman, Democratic Counsel; Elizabeth Letter, Democratic Press Secretary; and Stephen Salsbury, Democratic Investigator.

Mr. {Murphy.} Good morning. I convene this hearing of the Subcommittee on Oversight and Investigations. Today we will be revisiting a subject that every member of this committee believe has gone on for far too long, the fraud, waste, and abuse rampant in our Medicare program.

Last year the Medicare program helped finance the medical services of approximately 51 million individuals and in doing so spent approximately $604 billion. Sadly, a budget that large makes the program a high target for fraud and abuse. Last year the Centers for Medicare and Medicaid Services estimated that improper payments were almost $50 billion. Outside news reports have also pegged the amount lost to fraud as high as $60 billion. This is a shocking amount of taxpayer money to lose every year, especially considering that some experts tell us that we do not even know the full extent of the problem. These financial losses are simply unacceptable.

To someone unfamiliar with the topic, some of the ways the government improperly pays out Medicare funding may seem completely unbelievable. For example, according to the

Department of Health and Human Services Office of Inspector General, just a few years ago the Federal Government managed to pay out $23 million in Medicare funding to dead people. One news story involved an Ohio doctor learning that he was the CEO of a medical practice only when a reporter called him to ask about it, and the practice he was allegedly running. Just a mailbox. Earlier this month news broke about an accusation that one doctor in California was able to help facilitate approximately $22 million in inappropriate Medicare payments for wheelchairs. The economics of this also incentivize abusing the Medicare program as well. Last year the Department of Justice issued a release noting that an individual was able to bill Medicare $6,000 for a wheelchair that cost $900 wholesale.

These are but a few of the more darkly humorous examples. But this is no laughing matter. Quite frankly, it is a national outrage.

It is not only the stories or amounts of money that should shock us all but also the length of time the government has allowed this to continue. Since 1990, 24 years ago, the Government Accountability Office has

designated the Medicare program as a high risk for fraud and abuse, a quarter century of wasted taxpayer dollars. When does it all stop? Think for a moment about a single company in the private sector that could lose this much money, year after year. How could they still be in business today?

We recognize that the administration is attempting to solve this problem. In the past few years CMS has implemented new programs to provide enhanced screening for certain categories of providers. If a provider is servicing an area that typically is more susceptible to fraud, they may undergo additional scrutiny. I hope today to hear about how this is working and the number of fraudulent providers that have been stopped before they even entered the Medicare system.

Meanwhile, the administration testified before the Committee on Ways and Means earlier this year on new collaborations with state governments on ways to combat fraudsters from moving their Medicare or Medicaid schemes from one state to another. I hope to also hear an update on this today.

One of the main problems in the past with Medicare fraud

was that those combatting it often relied on a pay-and-chase model, that is, pay out claims for Medicare, learn of potential fraudulent activity, and then try to stop the fraud. Our government simply must do better. Today I hope to hear about ways the administration is using new methods to use analytics to stop fraud before it happens. With the technological advances that the Medicare program has seen in its lifetime it simply should be much more difficult for individuals to defraud the program.

And one of the easiest ways to prevent fraud on the system and protect Medicare patients is by excluding the bad actors who have committed crimes in the past, that is, make sure there's a pre-approved list of providers. Yet, news reports indicate that doctors who should not be billing Medicare continue to do so. Earlier this year one news outlet reported that several doctors who had a lost a medical license were still able to bill the Medicare program for millions of dollars.

Committee staff has identified more problems as well. At least 14 individuals convicted of FDA-related crimes--health providers that have been debarred by the FDA--do not

appear to be excluded from the Medicare program. Worse, 6 doctors debarred by the FDA actually were paid over $1 million in Medicare payments in 2012.

Finally, today I hope we hear about the steps that can be taken to further combat fraud. GAO has recommended some common sense steps that would reduce fraud, such as removing social security numbers from Medicare cards, but CMS has yet to implement this recommendation.

I want to thank the witnesses joining us. And by the way, I also want to note that last night HHS and CMS finally released their report to Congress on the second implementation of the fraud prevention system. We are pleased we finally got this. We hope that these new technologies can yield even greater returns in the future. And I believe this is a committee that pushed for this, and we are pleased we finally got that. Unfortunately, it was last night, so we haven't had a chance to review it fully. It is 9 months late, and if we are truly serious about combatting Medicare fraud, we can't have these delays.

[The prepared statement of Mr. Murphy follows:]

This is a preliminary, unedited transcript. The statements within may be inaccurate, incomplete, or misattributed to the speaker. A link to the final, official transcript will be posted on the Committee's website as soon as it is available.

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Mr. {Murphy.} But now I would like to recognize the ranking member of this committee, Ms. DeGette, for 5 minutes.

Ms. {DeGette.} Thank you very much, Mr. Chairman. This is the third hearing that the committee has had on Medicare fraud in the last 3 years, and I think it is perfectly appropriate to do that. Medicare fraud wastes money and endangers the care of seniors and the disabled. That is why I think we can work in a bipartisan way, and I am pleased.

We have witnesses today from CMS, the HHS Inspector General and the GAO with us. I appreciate all of you joining us and look forward to hearing your perspective on where we stand and what we need to do to further reduce Medicare fraud, waste and abuse.

The administration has also made some important strides in this area. The Healthcare Fraud Prevention and Enforcement Action, or HEAT Teams, a joint effort between HHS and DOJ, have played a critical role in these efforts. Medicare strike forces are a key component of HEAT, interagency teams of analysts, investigators and prosecutors who can target emerging or migrating fraud schemes, including

fraud by criminals masking as healthcare providers or suppliers. These efforts have produced immediate returns. In fiscal year 2012, the government recovered $4.2 billion in fraud, and from 2009 through 2012, it has returned a record-breaking $14.9 billion to taxpayers, more than doubling returns compared to the previous 4 years. CMS has also implemented many of the new tools provided to the agency under the Affordable Care Act. These new provisions of law have marked a dramatic shift in the way CMS fights fraud, moving from the old pay-and-chase model to the newer and much more effective approach of keeping fraudulent providers out of the Medicare system entirely.

New Medicare providers are screened before they are allowed into the program. Providers in risky programs face additional scrutiny. CMS has embarked on an ambitious project to revalidate the enrollments of all existing 1.5 million Medicare providers and suppliers by 2015. This revalidation effort has deactivated or revoked almost 200,000 providers so far.

The Affordable Care Act also limits the ability of fraudulent providers and suppliers to move from state to

state or program to program by requiring all states to terminate providers whose billing privileges have been revoked by Medicare or have been terminated by another state Medicaid program for costs. And the administration has invested in predictive analytic tools that use algorithms and other sophisticated information technology to identify potentially fraudulent behavior. This technology has resulted in leads for more than 500 new fraud investigations and has provided new information for more than 500 existing investigations.

Mr. Chairman, this is good news, but we also have some unfinished work from CMS that we are going to hear from the IG and GAO about. I am particularly concerned about reports that Medicare Part C and D plans may not be doing enough to identify and report fraud. The private Part C and D providers are popular with many beneficiaries and have become a key and growing part of Medicare, and that is why we need to make sure that they are doing as much as traditional Medicare to fight fraud.

And finally, Mr. Chairman, Congress needs to do our part, especially when it comes to financial support for the

fraud fighters. Sequestration meant that the CMS program integrity funding declined in the last 2 years, and the majority staff official hearing memo describes how funding cuts for the OIG will limit the agency's ability to carry out its mission, forcing staff reductions of over 200 people and forcing the IG to close over 2,000 investigative complaints and cut Medicare and Medicaid oversight by 20 percent. So at the same time we are trying to increase a robust program of oversight, we are cutting the funding for investigations. Now, I think we can all agree, this is penny-wise and pound-foolish. There is bipartisan agreement that we need to do more to wipe out Medicare fraud, and there is bipartisan agreement that every dollar spent to reduce fraud brings back more than a dollar in return.

So we should fix this problem. I know a number of members on this and other committees have discussed bipartisan fraud prevention legislation. We should work diligently on that to give the CMS the tools they need to fight fraud, and we need to make sure that all of the fraud fighters have the funding they need to do this important work. And I yield back, Mr. Chairman.

[The prepared statement of Ms. DeGette follows:]

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Mr. {Murphy.} The gentlewoman yields back. I now recognize the Chairman of the Full Committee, Mr. Upton, for 5 minutes.

The {Chairman.} Well, thank you, Mr. Chairman. I do share my colleagues' frustration on this issue for sure. It was 24 years ago when the GAO first announced the Medicare program was a big high risk for fraud and abuse. The program's financial sustainability has also been under threat for years. This committee has routinely, on a bipartisan basis, conducted oversight of the Medicare program in an effort to eliminate waste, fraud and abuse. Our goal is to save taxpayer dollars and strengthen the program. While rooting out waste, fraud, and abuse cannot alone keep the promise of Medicare, it is an important step that has the potential to benefit both seniors as well as taxpayers.

To our witnesses here today, we have got a simple question. How can the government continue losing tens of billions of taxpayer dollars every year?

For years, the HHS has relied on a pay-and-chase model to recover Medicare losses, learning far too late that

fraudsters routinely tricked the Federal Government into paying them. But today there are some predictive methods that can help the government detect the fraud before the payments go out the door.

I hope that today's witnesses will do more to make these tools work.

We should not pay potential fraudsters a dime, let alone the billions we actually do. All taxpayers, and those relying on Medicare, deserve better.

Thank you for being here.

[The prepared statement of Mr. Upton follows:]

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The {Chairman.} I yield now to Dr. Burgess.

Dr. {Burgess.} I thank the Chairman for yielding and, too, want to welcome our witnesses. I appreciate your being here.

Earlier this year, the CEO of a Texas hospital chain was indicted for defrauding the government of $18 million. The money continued to flow from the Center for Medicare and Medicaid Services despite the hospital's long record of patient safety violations and billing fraud. Conditions at these facilities were bad. Patients died. In 2012, regulators moved to cut off funds, but a few months later at the Center for Medicare and Medicaid Services provided well over $1 million to these hospitals.

This case in Texas raises broader questions about CMS's ability to prevent improper payments to fraudulent or even dangerous providers. Providers that are excluded from one federal program because of improper or illegal conduct can often continue to be paid by other programs. It is my belief that providers that have been banned from federal programs for wrongdoing should be excluded from all federal programs,

period. The incident in Texas prompted me to work with Chairman Upton and Mr. Barton. We sent a letter to CMS and the Office of Inspector General. We asked about the screening of providers receiving Medicare payments and other types of federal funds. Dr. Agrawal was kind enough to come into my office to brief me in response to these letters. They have been very helpful and informative, but you still can't help but be disappointed to learn that little progress has been made in this area over several decades.

Numerous audits have been performed. Recommendations have been made in ways to improve the system. Through the miracle of Google you can find these recommendations going back well over 20 years. But 2 decades later, these recommendations continue to be ignored, and taxpayers continue to lose money. The fact is that the Center for Medicare and Medicaid Services is not doing all they can to prevent this type of fraud and abuse of the system. You have the authority to implement tools to prevent abuse. Yet, you have not done so. We are here today to find out why.

I look forward to hearing from our witnesses today and yield the balance of the time to the vice chair of the Full

Committee, Ms. Blackburn.

[The prepared statement of Dr. Burgess follows:]

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Mrs. {Blackburn.} Thank you, Dr. Burgess, and I want to welcome all of you. You have heard us talk about Medicare fraud, and we know that it is tens of billions of dollars. And it seems like it continues despite RAC audits and ZPICS and CERTS and the additional authorities that you all at CMS have been given, and we still have a permissive approach that allows providers with questionable backgrounds to continue to bill taxpayers. We have heard about doctors enrolled in Medicare who have been convicted of crimes. We have heard about companies that have been found guilty of fraud that are continuing to benefit. They rename themselves. They stay in the process.

People are sick of this. And what we want to hear from you today is what are you going to do about it? If you can't clean it up, let me tell you what. We are going to clean it up. But this is something that just absolutely has to stop. It is not your money. It is not the Federal Government money. It is the money of the taxpayer and they are fed up with the inept attitudes and approaches that are coming out of some of these agencies.

So we thank you for being here. We are concerned about the persistence of this issue, and we look forward to solving it. I yield back.

[The prepared statement of Mrs. Blackburn follows:]

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Mr. {Murphy.} The gentlelady yields back, and now I will recognize the ranking member of the Full Committee, Mr. Waxman, for 5 minutes.

Mr. {Waxman.} Mr. Chairman, I appreciate your holding this hearing today. I care passionately about the Medicare program, and I want to make sure that we are doing everything we can to wipe out fraud. When I was chairman of this committee, we held hearings and passed legislation as part of the Affordable Care Act that gave CMS new authorities, new resources and a whole new approach to reducing fraud.

We are going to hear today about some of the successes of that new approach. We are also going to hear from Members of the Congress' outrage if there is any fraud. Well, it is outrageous to have any fraud, but it is also outrageous for Members of Congress to say this is outrageous, we are going to solve the problem, and then not hear a solution.

We are seeing some progress. We have seen increases in enforcement, recovery for the taxpayers of that money that has been taken by fraud, and questionable providers have been kicked out of the program. CMS is using new, predictive

analytics to sniff out and take action against fraud. And I know the IG and GAO will tell us about the work that CMS still has left to do, and I expect the agency to take additional action to fully implement the Affordable Care Act's anti-fraud provisions and to address other concerns raised by the experts of these two agencies.

I suppose one of the things the Republicans want to do to solve this problem is repeal the Affordable Care Act anti-fraud provisions which they would have done in over 50 times they have tried to get the Congress to repeal the whole law, everything.

We should be working in a bipartisan way in Congress to address anti-fraud funding shortfalls caused by the sequester and close gaps in Medicare law identified by the administration and by GAO and by the IG. There is no reason we can't work together on these issues, unless we just want to use them for talking points in an election year or the year before the next election.

But Mr. Chairman, we need to address Medicare waste, fraud and abuse. We need to look at all three of these areas, and probably the biggest source of waste of taxpayer

funds in Medicare are the high prices that Medicare Part D plans pay for prescription drugs.

Mr. Chairman, last week I wrote a letter to you and Chairman Upton requesting that the committee hold a hearing on the implications of the high cost on the Medicare Part D program of Sovaldi, the new Hepatitis C drug manufactured by Gilead Pharmaceuticals, and I hope we hold this hearing. Sovaldi has been hailed as a breakthrough treatment for individuals suffering from Hepatitis C, but it is costly: $1,000 per ill, or $84,000 for the entire 12-week course of treatment. And there are an estimated 350,000 Medicare Part D beneficiaries with Hepatitis C.

As a result, a recent analysis was done by researchers from Georgetown University and Kaiser Family Foundation that said Medicare Part D will be spending $6.5 billion or 8 percent in 2015 for this one drug.

Mr. Chairman, this problem is exacerbated by the fact that Medicare Part D plans are not able to effectively negotiate for lower prices for Sovaldi or any other drug. While Gilead provides substantial discounts on the drug in other countries, and for the VA and the Medicaid program,

these discounts are not available to Medicare Part D plans.

The result of this inability of Medicare Part D plans to negotiate for lower drug prices is the waste of hundreds of billions of taxpayers' dollars. This is a problem we should solve, at least examine. I hope this committee will hold a hearing, but I have written a lot of letters asking for hearings and if it affects the fossil fuel industry, forget about it. If it affects the pharmaceutical industry, well, they are big campaign contributors. But we ought to look into this issue.

We could be saving money, and we could be doing the Medicare program a great service and we could be doing people who need this drug a great service. At least we ought to look at the problem.

But today's hearing on reducing Medicare fraud is useful. Let us approach it in a constructive manner. I thank the witnesses for being here today, and I yield back the balance of my time.

[The prepared statement of Mr. Waxman follows:]

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Mr. {Murphy.} The gentleman yields back. And I would like to introduce the witnesses on the panel for today's hearing. Dr. Shantanu Agrawal. Did I say that correctly?

Dr. {Agrawal.} That is correct.

Mr. {Murphy.} Thank you. The Deputy Administrator and Director of the Center for Program Integrity of the Centers for Medicare and Medicaid Services. Mr. Gary Cantrell is a Deputy Inspector General for Investigations, the Office of Inspector General at the Department of Health and Human Services. Today Mr. Cantrell is accompanied by Ms. Gloria Jarmon. She is the Deputy Inspector General for Audit Services in the Office of Inspector General at the Department of Health and Human Services. Ms. Kathleen King is the Director of Health Care at the U.S. Government Accountability Office.

I will now swear in the witnesses. You are aware that the committee is holding and investigative hearing and when doing so has the practice of taking testimony under oath. Do any of you have any objections to testifying under oath?

None of the witnesses have indicated that. So the

Chairman advises you that under the rules of the House and the rules of the committee, you are entitled to be advised by counsel. Do any of you desire to be advised by counsel during your testimony today?

All the witnesses decline that. So in that case, would you all please rise and raise your right hand and I will swear you in?

[Witnesses sworn.]

Mr. {Murphy.} Thank you. All of the witnesses said yes, so you are now under oath and subject to the penalties set forth in Title 18, Section 1001 of United States Code.

I will ask all of you to give a 5-minute opening statement summary. Dr. Agrawal, we will begin with you.

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^TESTIMONY OF SHANTANU AGRAWAL, M.D., DEPUTY ADMINISTRATOR AND DIRECTOR, CENTER FOR PROGRAM INTEGRITY, CENTERS FOR MEDICARE AND MEDICAID SERVICES; GARY CANTRELL, DEPUTY INSPECTOR GENERAL, INVESTIGATIONS, OFFICE OF INSPECTOR GENERAL, DEPARTMENT OF HEALTH AND HUMAN SERVICES; AND KATHLEEN M. KING, DIRECTOR, HEALTH CARE, U.S. GOVERNMENT ACCOUNTABILITY OFFICE

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^TESTIMONY OF SHANTANU AGRAWAL

} Dr. {Agrawal.} Thank you. Chairman Murphy, Ranking Member DeGette, and members of the committee and subcommittee, 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. We share a commitment to protecting beneficiaries and ensuring taxpayer dollars are spent on legitimate items and services. I would like to make three major points in my oral remarks this morning. First, our work in implementing new provider

enrollment and screening standards at CMS has had significant, tangible program integrity in face and moved us firmly towards prevention on these issues.

Second, we recognize that further work remains to improve our safeguards, and we are taking specific, proactive steps toward those improvements. And finally, one of our many tools is our advanced predictive analytic system, the fraud-prevention system, which has continued to develop and deliver a positive return on investment in just the second year of operation. That ROI has been certified by the Office of Inspector General.

Thanks in part to the authorities and resources provided by the Affordable Care Act and the Small Business Jobs Act of 2010, CMS is changing the program integrity paradigm towards a focus on prevention to identify and combat waste, abuse and fraud in our system. Our enhanced screening requires certain categories of providers and suppliers that have historically posed the higher risk of fraud to undergo greater scrutiny prior to their enrollment in Medicare.

The Affordable Care Act also required CMS to revalidate all existing 1.5 million Medicare suppliers and providers

under the new screening requirements. We have real, tangible results from these efforts to share. Since March 25, 2011, more than 930,000 providers and suppliers have been subject to these new screening and validation requirements. Over 350,000 providers and suppliers have had their billing privileges deactivated as a result of revalidation and other screening efforts, and over 20,000 providers and suppliers have had their billing privileges entirely revoked. Just since the start of this year, CMS has revoked over 800 providers for lack of appropriate licensure. These deactivations and revocations mean these providers can no longer bill or be paid by Medicare.

Our experiences with provider screening tell us that there is more work to be done to continue to enhance the screening process. We already rely on over 200 databases in our current screening processes, but challenges remain. For example, CMS has historically relied on Medicare exclusion and GSA debarment data to identify relevant felony convictions because there is not a centralized or automated means of obtaining felony conviction data. Using these databases on an automated basis, CMS ensures that individuals

convicted of healthcare fraud, related crimes or other conduct that bars them from contracting with the Federal Government are denied enrollment to Medicare or swiftly removed from the program as part of our routine screening and validation.

However, to address the lack of an off-the-shelf solution for all criminal data, CMS is developing a process to match enrollment data against numerous public and private data sources to ensure receipt of timely conviction data. Additionally, in April 2014, CMS announced that high-risk providers will now be subject to fingerprint-based background checks to gain or maintain billing privileges for Medicare.

We are also applying our enrollment and screening processes more broadly. Just a few weeks ago, CMS issued a final rule to extend enrollment requirements to Part D which prevents revoked or excluded providers from prescribing to Medicare beneficiaries. The same rule also allows us to use data from the Drug Enforcement Agency to ensure prescribers are appropriately licensed to prescribe certain drugs and enable CMS to remove them from Medicare when the DEA has taken an action against an individual's license.

In addition to enhanced provider screening procedures, CMS is using private-sector tools and best practices to stop improper payments of all types. Since June 2012, the fraud prevention system has applied advanced analytics on all Medicare fee-for-service claims on a streaming national basis. In its second year of operations and through over 70 active models in the system, FPS identified or prevented more than $210 million in improper Medicare payments, double the previous year, and resulted in CMS taking action against 938 providers and suppliers. The tool is part of CMS's comprehensive program integrity strategy. For example, the FPS is used as part of an agency focus on home health services in South Florida which includes our screening processes, implementation of an enrollment moratorium, on-the-ground investigations and collaboration with law enforcement.

CMS is expanding the use of FPS beyond the initial focus on identifying potential fraud into the areas of waste and abuse which we expect to increase future savings. While we have made significant progress to address areas of vulnerability, we also know that more work remains to further

refine our efforts and prevent improper payments and fraud in the first place.

I look forward to answering the subcommittee's questions on how we can improve our commitment to protecting taxpayer and trust fund dollars while also protecting, I think very importantly, beneficiaries' access to safe, high-quality care. Thank you.

[The prepared statement of Dr. Agrawal follows:]

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Mr. {Murphy.} Thank you. Mr. Cantrell, you have 5 minutes.

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^TESTIMONY OF GARY CANTRELL

} Mr. {Cantrell.} Good morning, Mr. Chairman, and other distinguished members of the committee. I am Gary Cantrell, Deputy IG for Investigations, and I am joined today by my colleague, Gloria Jarmon, who is Deputy IG for Audit Services.

Thank you for the opportunity to testify about OIG's efforts to fight fraud, waste and abuse in Medicare and Medicaid. OIG utilizes a range of tools in this fight including audits, evaluations, investigations, enforcement authorities and educational outreach. We focus our resources on areas most vulnerable to fraud so we obtain the greatest impact from our work.

OIG works closely with the Department of Justice, CMS and other federal and state law enforcement partners to bring those who commit fraud against our programs to justice. Our Medicare fraud strike force teams, located in nine cities throughout the country, exemplify this approach. The OIG and our partners are committed to fighting and prevent fraud,

waste and abuse.

Our efforts have produced impressive results. In 2013, our work resulted in record numbers of criminal convictions and civil actions, and over the last 5 years, we have recovered more than $19 billion from those defrauding federal healthcare programs, and our return on investment is over $8 for every dollar spent. Perhaps even more important, we are seeing strong indicators of a deterrent effect. When we work together to shed light on program vulnerabilities, put criminals behind bars and CMS takes appropriate administrative actions, our efforts are most successful. We have seen significant declines in Medicare payments across several program areas in strike force cities where we focused our efforts.

For example, following federal enforcement and oversight activities, there have been sustained declines in Medicare payments for DME, home health, ambulance and community mental health centers, or CMHCs. Nationwide Medicare payments for CMHCs have decreased by approximately $250 million annually.

Total Medicare payments for ambulance services in Houston are down approximately 50 percent. Miami area DME

payments have decreased by approximately $100 million annually since the launch of the strike force. And since 2010, home health payments have decreased nationally more than $1 billion annually.

Despite these successes, more needs to be done. Fraud schemes are constantly evolving and migrating, and some of the--top oversight priorities include the rise in prescription drug fraud and schemes involving home base services.

Rarely are these schemes perpetrated by one provider operating independently. There is often a network of individuals including business owners, patient recruiters, healthcare practitioners and sometimes even the patients. Kickbacks in the form of cash or drugs bind these networks together.

The federal forfeitures are a valuable tool to help defund and disrupt illegal activities and can serve as a powerful deterrent. Empowering OIG to execute forfeiture warrants would help curb the profitability of healthcare fraud and exert a deterrent effect. Removing Social Security numbers from Medicare cards could also protect patient data

and disrupt fraud schemes. The theft of patient and provider data underpins many of our cases. In a recent case, criminals perpetrated a $100 million fraud scheme by stealing the identities of doctors and thousands of patients.

In conclusion, I must note that OIG's mission is challenged by declining resources at a time when our oversight responsibilities are growing. OIG is responsible for oversight of about 25 cents of every federal dollar. However, since 2012, we have lost 200 employees and expect to reduce our Medicare and Medicaid oversight by 20 percent by the end of the fiscal year. Now is not the time to reduce oversight in the face of a growing and changing program, and OIG is a proven investment. We would appreciate the committee's support in securing full funding of OIG's 2015 budget request. And thank you for the interest and opportunity to testify. We would be happy to answer any questions.

[The prepared statement of Mr. Cantrell follows:]

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Mr. {Murphy.} Thank you. Ms. Jarmon, I don't think you have a statement, do you?

Ms. {Jarmon.} No.

Mr. {Murphy.} Ms. King, do you have a statement? Thank you. You are recognized for 5 minutes.

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^TESTIMONY OF KATHLEEN M. KING

} Ms. {King.} I do. Chairman Murphy, Ranking Member DeGette and members of the subcommittee, 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 identify 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 background checks for high-risk providers. These are positive steps.

However, CMS has not completed certain actions authorized in PPACA which would also be helpful in fighting fraud. It has not yet published regulations to require additional disclosures of information regarding actions 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 at-risk providers including home health agencies.

With respect to review of claims for payment, Medicare uses pre-payment review to deny payment for claims that should not be paid and post-payment review to recover improperly paid claims. Pre-payment reviews are typically automated edits in claims processing systems that can prevent payment of improper claims. Post-payment reviews are those that are made after the fact and recover payments. We have found some weaknesses in the use of pre-payment edits and have made a number of recommendations to CMS to promote the implementation of effective edits regarding national policies

and to encourage more widespread use of local pre-payment edits by Medicare administrative contractors.

With respect to post-payment claims 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 reducing the efforts to reduce improper payments. CMS agreed with our recommendations 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 contractors, or ZPICS, takes action against suspect providers. CMS did not comment on this recommendation.

We also have further work under way on the post-payment review contractors to examine whether CMS has strategies 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 the 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, such as smart cards, for Medicare cards including potential benefits and 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 needs of its beneficiaries.

I would be happy to answer questions. Thank you.

[The prepared statement of Ms. King follows:]

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Mr. {Murphy.} Thank you. I thank all the witnesses. I will now begin some questions for 5 minutes. Dr. Agrawal, you need to know whether the agency's actions have been successful in reducing fraud and abuse, and one way that the agencies examine the effect on this is by measuring performance as required by the Government Performance and Results Act of 1993 as amended by the GPRA Modernization Act. One of CMS's goals is to fight fraud and work when they've made improper payment. Isn't that right?

Dr. {Agrawal.} We are absolutely focused on the improper payment rate and working to reduce that rate.

Mr. {Murphy.} And isn't it correct that CMS's target improper payment rate for Medicare fee for service for fiscal year 2013 was 8.3 percent? Is that about what the target was?

Dr. {Agrawal.} Yes.

Mr. {Murphy.} Now, that translates to about $36 billion in losses. So what I don't understand is why is it acceptable to have about a $36 billion loss rate that is acceptable?

Dr. {Agrawal.} I don't think it is about acceptability, sir. We are focused on the improper payment rate and reducing that rate as much as feasible.

I will say just two points on the improper payment rate. One is it is not equivalent to the fraud rate. Improper payments do not measure the amount of criminal behavior that is in the Medicare program. That is often an area of confusion I find among stakeholders. Second, what it really does I think show, demonstrate, is the ability of providers to follow our strict payment guidelines and requirements, and most particularly, documentation requirements. So we see for example areas where the improper payment rate continues to rise, like certain institutional providers, DME suppliers, home health services, and we do think--

Mr. {Murphy.} It went up for 2013 for you to 10.7 percent, I think.

Dr. {Agrawal.} Well, I think what we have done is institute a lot more specific requirements in those areas in order to reduce fraud, waste and abuse. Those requirements can take time for providers to catch up with, and what we see is documentation lags and the improper payment rate goes up.

Mr. {Murphy.} I guess I am concerned about that you went from 8.5 percent to 10.7 percent which says it is getting worse.

Dr. {Agrawal.} Again, I think it is an outcome of our more stringent requirements. I think this shows the balancing act between trying to be very strong on program integrity which is really enforced by strong rules and regulations and then those rules and regulations being difficult for providers to follow.

Mr. {Murphy.} The bottom line up front, though, is you didn't meet your goals and it is getting worse.

Dr. {Agrawal.} Correct. Well, we did not meet our goal, and we have taken proactive steps to, you know, help reverse that trend. One is we work very closely with providers to help educate them on our rules to make sure that they are able to follow our rules, follow our documentation requirements. We have instituted, you know, sort of point audits that allow us to look at specific--

Mr. {Murphy.} I get all that. I am just saying bottom line for taxpayers is the amount of money that has been done in improper payments is greater than the entire budget of the

State of Pennsylvania. So I hope you will improve that.

Let me ask this. I am trying to find ways that can facilitate you on this because you are probably familiar with that old quote from the bank robber Willie Sutton while he robbed banks, and he says because that is where the money is. So with a $600 billion in Medicare spending, that looks like a ripe target for a lot of people. So the fact that he was convicted as a bank robber, I believe the way the laws and regulations are written right now, those type of criminal convictions wouldn't prevent you from giving someone Medicare payments, am I correct? They could still slip through the system?

Dr. {Agrawal.} Certain convictions we can revoke from the Medicare program for--

Mr. {Murphy.} Would bank robbery be one of them?

Dr. {Agrawal.} Felony convictions? So I am no lawyer. I assume bank robbery is a felony conviction.

Mr. {Murphy.} A felony conviction.

Dr. {Agrawal.} If it is a felony conviction, then yes, we can kick people out of the Medicare program.

Mr. {Murphy.} I just want to be sure. Mr. Cantrell,

would you know if someone with some felony--we are trying to improve this. So I am thinking if--so if it is not there, I would like to know. Insurance fraud, auto insurance fraud, tax fraud. I believe tax fraud is still acceptable, that they wouldn't be kicked out of the program. Do either of you know that?

Mr. {Cantrell.} As it relates to our exclusion authority?

Mr. {Murphy.} Yes.

Mr. {Cantrell.} There are requirements that link it to in connection with the delivery of healthcare item or service.

Mr. {Murphy.} But if it is not healthcare. So if someone was involved with auto insurance fraud or assault or convicted of clinical research fraud, if it is not health, right, they can still be a Medicare provider, am I correct--

Dr. {Agrawal.} We have--

Mr. {Murphy.} --the way the law is currently written?

Dr. {Agrawal.} We have very proscribed guidelines for what we can revoke for. They are four types of felony convictions.

Mr. {Murphy.} I am trying to help you so--

Dr. {Agrawal.} These are not--

Mr. {Murphy.} If you would like it stricter, we need to know this. So if someone has a history of criminal fraud, criminal felony behavior, and you can't exclude them, I think one of the best predictors of future problems is past. And if someone has a pattern of this, can they still slip through and be a provider for Medicare?

Dr. {Agrawal.} Yeah, I think the agency agrees with you, sir. In fact, we have taken steps in the last year to put out a proposed rule that would actually expand our use of this felony conviction.

Mr. {Murphy.} Well, we would like to work with you on that. Let me ask one other thing. Can someone with a foreign address or just a box number also be a Medicare provider? Do you go through and check those records?

Dr. {Agrawal.} We do check records. We have automated checks for, you know, addresses as well as the ability to conduct on-site visits to make sure that these are legitimate places of business.

Mr. {Murphy.} Can someone with a foreign address be a

Medicare provider?

Dr. {Agrawal.} I would have to check I think specifically on that, but I believe the answer is no.

Mr. {Murphy.} Okay. We will find out. Ms. DeGette, you are recognized for 5 minutes.

Ms. {DeGette.} Dr. Agrawal, in your testimony you discussed how taxpayers get a significant return on investments to reduce Medicare fraud, is that right?

Dr. {Agrawal.} Yes.

Ms. {DeGette.} And I have been told for each dollar we spend, we save more than a dollar. Is that right?

Dr. {Agrawal.} Yes.

Ms. {DeGette.} Why is that true?

Dr. {Agrawal.} Our activities are having impact. I think we have clearly--

Ms. {DeGette.} But why for each dollar that we spend do we save more than a dollar?

Dr. {Agrawal.} I think our activities have a cumulative effect, so they can actually prevent dollars from going out the door in the first place. They have sentinel effects where we see impact beyond just the specific providers and

suppliers that we are looking at. I think all those things cumulatively lead to that higher ROI.

Ms. {DeGette.} It is a systemic issue?

Dr. {Agrawal.} Correct.

Ms. {DeGette.} Okay. And what are the sources of funds for CMS program integrity efforts?

Dr. {Agrawal.} We have a variety of funds. We have both Medicare and Medicaid funds. We have Small Business Jobs Act funds that are connected, for example, to the FPS, HCFAC funds.

Ms. {DeGette.} How much will CMS spend this year on Medicare and Medicaid program integrity efforts?

Dr. {Agrawal.} I would have to come back to you with a specific number. I am not sure about--

Ms. {DeGette.} I would appreciate it--

Dr. {Agrawal.} --the total application--

Ms. {DeGette.} --if you would supplement your response.

Dr. {Agrawal.} Absolutely.

Ms. {DeGette.} Do you remember how much you spent in 2012?

Dr. {Agrawal.} No, ma'am.

Ms. {DeGette.} Okay. Do you know if there has been an increase or a reduction in funding for fighting fraud over the last 2 years?

Dr. {Agrawal.} Well, we have experienced between the sequester and then sort of flat-funding a general flattening out of our funding, you know, and that has forced us to make certain budgetary decisions about what programs and tools to focus on.

Ms. {DeGette.} Now, you mentioned the layoffs, and I talked about that in my opening statement. What other programmatic adjustments have you made?

Dr. {Agrawal.} Well, I might just point out that the layoffs most significantly impacted the Office of Inspector General--

Ms. {DeGette.} Okay.

Dr. {Agrawal.} --which we take seriously obviously as well.

Ms. {DeGette.} So Mr. Cantrell, maybe you can answer that.

Mr. {Cantrell.} Sure. Our budget is primarily funded--our healthcare oversight is primarily funded by the

Healthcare Fraud and Abuse Control Act, and that fund is--we get about $300 million a year. But with sequestration, it takes about $14 million out of that healthcare oversight fund. We have another funding stream that we call our discretionary fund that funds all of our other activity related to the Department of Health and Human Services but not the Medicare and Medicaid program.

Ms. {DeGette.} Have you made programmatic adjustments to account for the budget cuts or have you just laid people off?

Mr. {Cantrell.} We haven't laid people off. We have lost people through attrition.

Ms. {DeGette.} Okay.

Mr. {Cantrell.} We have reduced investments in things like training, equipment--

Ms. {DeGette.} Now you have fewer people doing the job.

Mr. {Cantrell.} That is correct.

Ms. {DeGette.} Right?

Mr. {Cantrell.} That is correct.

Ms. {DeGette.} So are you trying to make them figure out how to do the job more efficiently?

Mr. {Cantrell.} We do. We are trying to focus our work on the areas where we can have the greatest impact. So the biggest thing we are doing is picking our work. There is much more work in this program than we have the ability to do. So we are being very strategic about the work that we select, and placing our resources in areas where they can have the greatest impact is our strategy here.

Ms. {DeGette.} So this is really a situation. If we adequately funded you, then you could actually do more investigations and pick more cases, correct?

Mr. {Cantrell.} Absolutely.

Ms. {DeGette.} Now, for either one of you who know the answer to this, while we have been having a slight reduction in the funding, at the same time, the Medicare population has increased and Medicare expenditures have increased. Is that correct, Dr. Agrawal?

Dr. {Agrawal.} That is correct.

Ms. {DeGette.} You know, Mr. Chairman, I think that there are some things you can do by efficiencies and by being smart and so on. But when you cut $30 million from CMS's integrity efforts, I am not sure how much you can make up for

that.

Dr. Agrawal, the administration has asked for significant increase in program integrity funding for fiscal year 2015, over $400 million. Is that correct?

Dr. {Agrawal.} Yes.

Ms. {DeGette.} And what would you do with that funding?

Dr. {Agrawal.} That funding would really allow us to expand programs that we know have impact. As an example, our prior authorization demo could be expanded nationally into program areas that it doesn't currently cover. We know that that could have impact.

Ms. {DeGette.} Do you think that would assist you?

Dr. {Agrawal.} Absolutely.

Ms. {DeGette.} Perhaps you can also add to your supplement, to your testimony, some of the things, some of the plans for this money if Congress appropriates the money.

Dr. {Agrawal.} I will do that.

Ms. {DeGette.} Okay. Thanks. Mr. Cantrell, let us see, what would you be able to do with the funding if we adequately funded your agency?

Mr. {Cantrell.} Well, first we would hire more

investigators, auditors, evaluators, attorneys to support the work that we are doing and actually have more boots on the grounds performing this type of oversight work. We also need investments in technology. As we deploy electronic health record systems throughout the country and that becomes a greater adoption of HER, that creates digital evidence that we have to collect, store, maintain and sort through. So we need investments in technology to maintain, to kind of stay above water here in this area that continues to evolve.

Ms. {DeGette.} Thank you. Thank you, Mr. Chairman. I yield back.

Mr. {Murphy.} Thank you. Now I recognize Mr. Burgess, or Dr. Burgess, for 5 minutes.

Dr. {Burgess.} Thank you, Mr. Chairman. So again, I appreciate everyone being here this morning. If I understood your testimony correct, we are doing a great job. If you just give us a little bit more money, we will do a better job, and yet the problem continues. Year after year after year we are here having these same hearings.

Let me just ask--I have got questions that I must ask, but at the same time, I feel obligated to make the statement

that, yes, I supported the sequester. It was a policy that I supported, but it was the President who signed it into law. Now, we all knew after the President signed it into law that it was going to affect the Department of Health and Human Services significantly at a time when the President's healthcare law was being implemented. So I had asked repeatedly for someone, the Secretary of HHS, to come to this committee and talk about how you were going to deal with an 8- to 10-percent reduction in across-the-board funding, how were you going to prioritize. I would think, Mr. Cantrell, you would prioritize your department. I don't know why you would prioritize money going to build and exchange that you then had to reinvest when they didn't build the exchange the right way. But I am not the head of HHS, so I don't make those decisions. So please forgive me if I am a little bit circumspect about people coming in here and saying more money for my agency, more money for my agency, when my God, you have wasted so much money in that agency in the last 4 years that it is just absolutely astounding.

Now, let us get to the reason why we are here. Mr. Cantrell, do you have recommendations, your office, the

Office of Inspector General, have recommendations and have you made recommendations to the Centers for Medicare and Medicaid Services relating to improvements in the screening of providers that have not been adopted?

Ms. {Jarmon.} I can answer that question. We have several recommendations. In fact, we posted in March 2014 a compendium of priority recommendations that are unimplemented, and that has over 100 recommendations to CMS, many related to Medicare and Medicaid payment and process issues and some related to quality of care. So we do have several recommendations that we have been working with CMS, and they have been unimplemented but--

Dr. {Burgess.} Let me just ask--

Ms. {Jarmon.} --we are still working with them.

Dr. {Burgess.} --the question, Dr. Agrawal or Mr. Cantrell. What is the status of the implementations of those recommendations from the Office of Inspector General?

Dr. {Agrawal.} You know, we have appreciated the recommendations that are provided to us, both by the OIG as well as GAO. We work diligently to implement those recommendations based on our, you know, ability to do so, you

know, budgetary and other resource constraints.

Since January 2013, we have completed or closed out over 60 recommendations provided to us by GAO and OIG. We continue to work through the remaining recommendations in order of priority based on their potential impact on our program. But we do appreciate those recommendations.

Dr. {Burgess.} Will you provide to the committee a list of those recommendations that have been made which have not yet been implemented? Are you able to do that?

Dr. {Agrawal.} I can do that.

Dr. {Burgess.} And the committee would appreciate that information.

There was an article in Bloomberg not too terribly long ago talking about individuals who--doctors who have lost their licenses and continued to get paid by Medicare. I mean, I always lived in fear--as a practicing physician, I always lived in fear of getting a bad mark at the National Practitioner Data Bank. I would assume that all of these doctors have recorded activity in the National Practitioner Data Banks. Dr. Agrawal, do you query the National Practitioner Data Bank when you authorize or when you permit

someone to bill the Medicare system?

Dr. {Agrawal.} Yes. So I--and I share your feelings about my medical license as well, Dr. Burgess. It is something that I guard very carefully and want to make sure is untarnished.

We access a lot of different data sources including the NPDB and over 200 other data sources to check things like licensure. As I said in my opening remarks, we revoked over 800 providers just since the beginning of this year for licensure issues. This was an area of vulnerability for us, even a couple of years ago, that we have really worked hard to close by getting access to all the right data at the state level so that we can do automated checks on licenses literally every week and revoke any providers that don't have appropriate licensure.

Dr. {Burgess.} You know, a lot of the substance of this hearing came about because of the local article in the newspaper back home where you had a doctor, a CEO of a hospital chain, who had received $17 million from the stimulus to improve medical records in his system. And then it was found that the medical records were boxed up and

sitting in the basement being eaten by rodents. So I guess you would classify that as meaningless use of health information technology. But yet, at the same time, with this bad and egregious an offense, he continues to get paid by CMS. Is this just a one-off or are there other such stories out there in the country?

Dr. {Agrawal.} I think it is a notable case. It is one that I know well personally. I can tell you that we have a lot of checks in place to ensure that that kind of thing does not happen both before payments are made and after.

Dr. {Burgess.} But it did happen.

Dr. {Agrawal.} I agree that it did. I think in part, you know, this person was providing misleading information to the agency, and we were also made aware by, you know, about law enforcement concerns well into their process. And I think, you know, IG would agree here that early collaboration between our agencies is very helpful. That allows us to take the actions that we can take very quickly, and we can work with law enforcement to facilitate their actions as well.

Dr. {Burgess.} Then do it.

Dr. {Agrawal.} Thank you.

Dr. {Burgess.} Early collaboration is the key. I yield back, Mr. Chairman.

Mr. {Murphy.} Just a quick question. When you are getting that clarifying data for the committee with regard to recommendations you have made that have not been implemented, if they have not been implemented, could you let us, with each one, explain some reason of why that is, if it is some federal action, if there is any state action, if states are not sending you data. That is extremely important. We want to help you, but we need to have that thorough report.

I now recognize the gentleman from Texas, Mr. Green, for 5 minutes.

Mr. {Green.} Thank you, Mr. Chairman, and ranking member. Dr. Agrawal, can you tell me more about how the Affordable Care Act helps CMS in fighting Medicare fraud? Specifically, can you expand a little on CMS's provider enrollment and screening process?

Dr. {Agrawal.} Absolutely, and thank you for the question. The Affordable Care Act has had significant impact on our ability to safeguard the program and particularly in the area of provider enrollment and screening. Without the

ACA--the ACA really required us to, for the first time, categorize providers based on the risk of fraud and subject higher risk providers to greater levels of scrutiny. That includes automated checks, site visits, fingerprinting. All of that was made possible by the Affordable Care Act.

In addition, our moratorium authority, our requirement to revalidate all providers on a cyclic basis, again, comes out of the ACA.

Mr. {Green.} Okay. I appreciate it because some of the savings from the ACA was actually giving CMS the tools to go after the fraud. We would prefer not to read it on the front page of the papers before we can get to you.

The health reform bill includes the authority for CMS enact moratorium on enrolling new providers. Has CMS used this new tool yet?

Dr. {Agrawal.} We have. So we implemented the first moratoria last summer in July. We now have a total of--we have moratoria in two different provider categories, ambulance services and home health services in seven different metropolitan areas and are closely monitoring the impact of that moratorium.

I should also say while the moratorium is in place, we have really stepped up our activities to make sure that we are taking action on the providers that are already in the moratoria area.

Mr. {Green.} Okay. Good. Because I represent the Houston area, and it seems like we are ground zero for some of the fraud, and I appreciate that. How does the moratorium help fight the fraud?

Dr. {Agrawal.} Well, what the moratoria really allows us to do is essentially close the door for enrollment, in this case, for new ambulance services as in Houston or home health agencies in other parts of the country. That gives us an opportunity to clean up the providers or suppliers that are already there and work very closely with law enforcement. We actually work very closely with them in identifying these areas for the moratoria and then in the stepped-up activities to make sure that we are cleaning up those areas before, you know, eliminating the moratoria.

Mr. {Green.} Okay. The Affordable Care Act required Medicare providers to report and return overpayments once they are identified. Failing to do so would constitute a

federal crime under the False Claims Act. Was this requirement necessary and have you seen evidence of providers complying with this requirement and is it being enforced?

Dr. {Agrawal.} I am sorry, Mr. Congressman. I missed the beginning part of your question.

Mr. {Green.} The Affordable Care Act required Medicare providers to report and return overpayments once they are identified, and failing to return those payments would constitute a federal crime under the False Claims Act. I was wondering how--if this is being enforced and how it is working.

Dr. {Agrawal.} Yes, we are looking to--we published a proposed rule on this, and we are looking to finalize that. We do see providers actually taking just the statutory authority seriously itself and actually returning overpayments voluntarily. We have also promulgated another proposed rule that would actually have overpayments follow providers if they try to close down one location and open up another one. They will have to pay the overpayment before they can get into the program again.

Mr. {Green.} Okay. Ms. King, do you have a view on how

CMS is doing at implementing the broad range of new Affordable Care Act anti-fraud positions? And after you, I would like to give Dr. Agrawal a chance to respond.

Ms. {King.} Yeah, we view the new provisions in the Affordable Care Act as a positive step because we are in favor of keeping people out of the program who shouldn't be in the program, and right now our investigative team has work under way to determine whether people are being kept out of the program as they should be and whether people who have committed bad acts and should be thrown out of the program are being thrown out. And we should be able to report on that by the end of the year.

Mr. {Green.} Okay. Thank you. Dr. Agrawal, do you have a comment on that, how CMS is doing with the GAO?

Dr. {Agrawal.} Sure. And again, I appreciate Ms. King's comments and agree that their recommendations are very important. We have done a lot based on their recommendations to strengthen our program in Part D, in basic provider enrollment and screening. There are other recommendations that we continue to work through, but they are very helpful to us.

Mr. {Green.} Okay. Thank you, Mr. Chairman. I yield back.

Mr. {Murphy.} Thank you. Now I recognize Ms. Blackburn for 5 minutes.

Mrs. {Blackburn.} Thank you, Mr. Chairman. Dr. Agrawal, I want to come to you. You mentioned in your testimony that since 2011, 20,000 providers and suppliers had their participation in Medicare revoked and some from felony convictions and some from administrative actions. And also, you mentioned that CMS has issued a proposed rule that would clarify the list of felony convictions that may result in a denial of participation. And yet, I have heard from constituents that some of these bad actors that are out there continue to do business because they change their names and they start a new business. But it is the same bad group of people. And we have seen this time and again, and I know the chairman, a couple of years ago, had a piece of legislation that went through judiciary, didn't get very far at the time. We need to bring it back. It would say if you have ever been convicted, you can in no way participate and benefit.

GAO has recommended that CMS could potentially thwart

this type of behavior by strengthening enrollment procedures as is currently authorized, and CMS could require additional disclosure information on the front end. And yet, according to GAO, it hasn't been done. My question to you is this. After 20 years after being on a fraud high-risk list, when can the taxpayers expect to see results from common-sense activity in this arena?

Dr. {Agrawal.} Well, I think we clearly are seeing results, and I think you saw that in the testimony that I provided to the committee this morning that there are clear results of our activities. Now, I, too, am frustrated by the kind of case that you are identifying. If there are cases like that specific ones that we can work on with your office, I would be happy to do that.

Let me just say that we are working toward strengthening disclosure requirements. We actually have a proposed rule that would require far more disclosure from--you know, to resolve issues just like that so that we can actually prevent people from entering the program that are just, you know, changing names and switching from company to company. I think that kind of approach is indeed very frustrating, and

we are working to expand our authorities to get greater clarity.

Mrs. {Blackburn.} Well, you are not giving me the granular level that I am seeking. Tell me specifically what you are going to do because when I talk to my constituents, they say we want to know specifically what is going to be done about this. It is our money, and you are wasting it.

Dr. {Agrawal.} Well, beyond the overall approach that I have described, there are two things that I think will affect the situation. One is we are expanding our ability to actually revoke or deny enrollment for a broader list of felony convictions than we are currently are authorized to do, and second, we are requiring greater transparency at the time of attempted enrollment so that if there are overpayments from other enrollments that that provider had, we can actually deny enrollment until those overpayments are recovered. Those are two very specific things that I think will go directly at the cases that you are talking about.

Mrs. {Blackburn.} But why did we let them in the program in the first place?

Dr. {Agrawal.} Well, you know, again, historically, I

think Medicare has had a more open enrollment process than it has had since the passage of the Affordable Care Act. So we are working very diligently every day to clean up those records and hence, the numbers that you have seen of over 300,000 deactivations and over 20,000 revocations --

Mrs. {Blackburn.} Okay. Does CMS give bonuses?

Dr. {Agrawal.} Pardon me?

Mrs. {Blackburn.} Does CMS give performance bonuses to employees?

Dr. {Agrawal.} I am not sure. I don't really manage our HR function. I don't know what kind of bonuses--

Mrs. {Blackburn.} Do you get a performance bonus?

Dr. {Agrawal.} --that we do. I joined the agency in this role 3-1/2 months ago.

Mrs. {Blackburn.} Okay.

Dr. {Agrawal.} I haven't qualified for bonuses.

Mrs. {Blackburn.} Mr. Cantrell, did you get a performance bonus?

Mr. {Cantrell.} We do pay performance bonuses in OIG based on our ranking of record.

Mrs. {Blackburn.} Okay. Ms. Jarmon, HHS, do they do

performance bonuses?

Ms. {Jarmon.} I am in the same office with Mr. Cantrell. There are performance bonuses based on performance.

Mrs. {Blackburn.} Okay. All right. Let me come back, Mr. Cantrell and then also--let me talk to you about this issue. I have got a prop back here.

[Chart]

Mrs. {Blackburn.} Identity theft and privacy is a huge issue, and this is something we have tried repeatedly to get cleaned up. This is a copy of a Medicare card. Now, what we have that is a problem with identity theft, you have got the program, the health insurance program it is in, Medicare. You have got the name. And this Medicare claim number is the Social Security number. When are you going to delink these and make certain that a Social Security and a name do not appear on this card? When are you going to change that?

Dr. {Agrawal.} I think you are probably asking me, not Mr. Cantrell. So we have--

Mrs. {Blackburn.} I am sorry. I thought I called for you and then I would like to know from Ms. King, has GAO

recommended doing this?

Ms. {King.} We have.

Mrs. {Blackburn.} Okay. Back to you, Doctor.

Dr. {Agrawal.} So this is an area--

Mrs. {Blackburn.} Why not?

Dr. {Agrawal.} --we have looked at. We have appreciated the recommendations. We are not, as an agency, opposed to the idea. It is, however, a challenging idea that requires a lot of sort of rigor to implement--

Mrs. {Blackburn.} Do something. Take an action. Be brave.

Dr. {Agrawal.} I think we need to be adequately resourced--

Mrs. {Blackburn.} I yield back.

Dr. {Agrawal.} --by the Congress to be able to do that. But yes, we appreciate the ability.

Mr. {Murphy.} Dr. Agrawal, do you have the authority to make that decision to eliminate the Social Security number from the cards?

Dr. {Agrawal.} I think we as an agency could do that. Again, however, as we have discussed this with the GAO,

making this change would require changes to over 70 systems that CMS has. It would also require changes to state Medicaid agency systems, private insurers that deal with us in Part C and D as well as even potentially on the provider side. So there is quite a bit of burden across the healthcare community to make this change. Again, we are not opposed to it. I think as an agency we just need to be adequately resourced to be able to take on that challenge.

Mr. {Murphy.} Just don't hire the same company that did the Obamacare rollout. You can do better. Ms. Schakowsky first.

Ms. {Schakowsky.} I would like to talk a little bit about fraud and the Medicare Part D program. Dr. Agrawal, CNS released a Medicare Part D proposed rule in January of 2005. What steps did that rule take to reduce fraud in Medicare Part D?

Dr. {Agrawal.} So just to clarify, this is the rule that we finalized now 3 weeks ago or roughly 3 weeks ago, is that correct?

Ms. {Schakowsky.} Yes.

Dr. {Agrawal.} Yeah. I think that rule is going to

have really important impact for us in Part D. One thing is it extends our controls and safeguards in Parts A and B to Part D. It will actually require an enrollment of providers in the Medicare program to--even if all they do is prescribe in the Part D program. So we will have much more transparency into who those providers are, and I think importantly, we can keep revoked and excluded providers out of the Part D program so they can no longer prescribe.

A second big impact is that it will allow us for the first time to go after abusive prescribing. So this will be not just those prescribers that have actually committed fraud but will allow us to go upstream of the problem and be actually much more preventive to make sure that prescribers that are endangering the safety and health of our beneficiaries, for example, can be taken action against and we can actually kick them out of the program.

Ms. {Schakowsky.} So it is a financial issue, but also a health issue for a patient?

Dr. {Agrawal.} Absolutely.

Ms. {Schakowsky.} Okay. So I appreciate these steps. Fraud in Part D appears to be a problem that is increasing,

and it is important that CMS act quickly to nip this fraud in the bud.

Mr. Chairman, fraud is not the only problem with Medicare Part D. Waste and abuse is also a problem. In particular, taxpayers and beneficiaries are forced to pay too much for prescription drugs because Medicare Part D plans are not able to negotiate for lower prices. The poster child for high Medicare Part D prices will soon be Sovaldi which Mr. Waxman was talking about, the Hepatitis C drug manufactured by Gilead. The company charges $84,000 for a course of treatment. A recent analysis by researchers from Georgetown University and the Kaiser Family Foundation found that Medicare Part D coverage for Sovaldi alone would increase Medicare drug spending by $6.5 billion, or 8 percent, in 2015 which is an astounding amount of money for one drug. While Gilead provides substantial discounts on the drug in other-- on this same drug in other countries and for the VA and the Medicaid program, these discounts are not available to Medicare Part D plans. According to the studies' authors, ``It is likely to be hard for Part D plans to have an impact on the price in the case of Sovaldi. Part D sponsors have

little negotiating power.''

Mr. Chairman, Sovaldi is not unique. Part D plans are not able to obtain significant discounts on many expensive drugs. So Mr. Cantrell, the Inspector General has conducted analyses of Part D drug prices and compared prices charged for the same drugs on Medicaid. Can you tell us what those investigations have found?

Mr. {Cantrell.} I can tell you that Part D drug prices are higher. We are paying more in Medicare than we are in Medicaid, and our work has come out of the Office of Evaluation and Inspections and somewhat from the Office of Audit Services. So I will pass onto Ms. Jarmon.

Ms. {Schakowsky.} Okay.

Ms. {Jarmon.} One of the things we have looked at are rebates for the rebates that are actually--the Part D prices were higher than Medicaid prices because Medicaid received higher rebates. Average rebates for Medicaid drugs were 45 percent of the cost while average rebates from Part D drugs were only 19 percent of cost. And in the compendium on implemented recommendations, we actually have several recommendations related to payment policies, looking at lab

costs, also differences between Medicare and Medicaid prices for these same services.

Ms. {Schakowsky.} And how much would the--so you are saying that there is an administration proposal that would end the waste and require higher rebates for Part D drugs, is that right?

Ms. {Jarmon.} I am not sure if there is a proposal.

Ms. {Schakowsky.} Dr. Agrawal?

Dr. {Agrawal.} There is. There is an item in the President's budget that would put Medicare payments on par with the Medicaid rebates.

Ms. {Schakowsky.} And how much would that proposal save taxpayers?

Dr. {Agrawal.} I would have to look back at the O Act estimation. I can get back to you about that.

Ms. {Schakowsky.} Okay. What I--the number I have heard, and you can confirm it, is about $150 billion would be saved by that one change.

Dr. {Agrawal.} Right.

Ms. {Schakowsky.} And I would certainly support that change. Thank you, and I yield back.

Mr. {Murphy.} Thank you. Now I recognize Mr. Olson for 5 minutes.

Mr. {Olson.} I thank the chair for having this hearing that is required by our rules. Welcome to all the witnesses. Before I get to my questions, I want to tell you about how Medicare fraud looks like back home in Texas 22, in Houston in particular. These are some stories that have been in local papers. January 24, 2014, ``Houston medical device supplier charged with $3.4 million in Medicare fraud.'' February 2, 2 weeks later, Houston psychiatrist indicted for $158 million in Medicare fraud. February 29, Houston physician arrested in healthcare fraud conspiracy. In that case, CMS missed the fact that one person had been tested 1,000 times and billed those tests over a 3-year period. April 3 of 2014, ``Houston businesswoman convicted of $1.5 million in Medicare fraud.'' April 24, 3 weeks later, ``$70 million alleged healthcare scam busted in Texas.'' And finally, June 4 of 2014, ``Houston physician and four others indicted for $2.9 million in healthcare fraud in state and federal case.'' That is 6 months and $200 million in fraud in Houston. And that is what we have known. That is what

has been charged, what has been put in the press. We know that it is much, much worse in Houston and all across America.

One area of abuse is billing Medicare for ambulance services that aren't given or provided or needed. As was mentioned by some of our witnesses, Houston is one of seven cities in America that have a moratorium on new ambulance services under Medicare. And I believe, Mr. Cantrell, in your testimony you said that because of the moratorium, Houston's costs have gone down 50 percent since 2010. Is that correct?

Mr. {Cantrell.} I am not linking it directly to the moratorium, sir, but based on our collective efforts, yes, our enforcement efforts and administrative efforts.

Mr. {Olson.} You anticipate my question. So it is not due moratorium. It may be due to putting people in jail as opposed to some sort of combination thereof?

Mr. {Cantrell.} Absolutely. We think putting people in jail who commit these crimes is paramount to success in this area.

Mr. {Olson.} Can you get us that data, separate the

moratorium from actually putting people in jail? Is that possible?

Mr. {Cantrell.} We haven't studied that, the impact of the moratoria. I don't know if Dr. Agrawal--

Mr. {Olson.} Dr. Agrawal, any possibility of having that information?

Dr. {Agrawal.} Well, we are monitoring the, you know, certain measures like utilization and cost in the moratoria area. I think statistically it is very hard to desegregate all the work that we are doing from the moratorium alone. In fact, you know, we bring a package of activities between us and the Office of Inspector General that allow us to attack these problems head on. The moratorium is one component. We also have, as you saw the report, the fraud prevention system enrollment requirements. So I think all of those things together clearly have impact. It is very hard to desegregate and say that this is the impact of one of those things.

Mr. {Olson.} Do you plan to expand the moratorium?

Dr. {Agrawal.} Pardon me?

Mr. {Olson.} Do you--expand the moratorium with the seven cities, making it longer?

Dr. {Agrawal.} Well, what we are doing currently, since this is a new authority and the first time that CMS has really implemented it, is that we are studying it to see what impact it does have, making sure that it plays a useful role in our toolbox and that it allows us to, you know, take action against providers that are already in those areas.

So until we know the answers to those questions I think, you know, given that it has a real impact on even potentially legitimate providers, we want to be careful about expanding that authority until we really have a sense of what it does for us.

Mr. {Olson.} Any idea of when that timeframe will come out and when you can tell us this is working, we will expand it in a year, 2 years, 3 years, 4 years?

Dr. {Agrawal.} Well, we are required by the statute to publish a federal register notice every 6 months in order to continue the moratorium or eliminate it or implement new ones. So we will be looking forward to publishing a notice within the next month with that decision.

Mr. {Olson.} So if you expand it to the seven cities currently involved in the moratorium that you will take more

cities, 12, 14, 15, 20, 25 to see if it is working? It seems to be working. Costs have gone down 50 percent since 2010. Let us go forward.

Dr. {Agrawal.} Yeah, again, I think we are very open to using this authority more. I think we just want to be able to know what its impact is and make sure that we are not negatively impacting legitimate providers or beneficiary access to care. I think that is really paramount for us as an agency.

Mr. {Olson.} Thank you, and I have 47 seconds left. Mr. Burgess, would you like my time or--

Dr. {Burgess.} Yeah, let me just ask a question on the predictive modeling issue. Prior to the passage of the Affordable Care Act, was there any prohibition on using predictive modeling?

Dr. {Agrawal.} Well, sir, in fact the predictive modeling became a requirement from the Small Business Jobs Act which preceded the ACA. There was no prohibition. I think what the Small Business Jobs act really gave us was the necessary funding to be able to implement this kind of advanced technology.

Dr. {Burgess.} But predictive modeling has long been known, particularly among the credit card agencies. I mean, I don't know how many years they have used this, but it has been some time. It is a reliable way to cut down on fraud. One of the things I have never understood is why CMS has been so slow to embrace it. I will yield back.

Mr. {Murphy.} Thank you. I now recognize Mr. Tonko for 5 minutes.

Mr. {Tonko.} Thank you, Mr. Chair, and welcome to our panelists. Yesterday the Second Annual Fraud Prevention System Report to Congress was released which detailed some of the accomplishments of CMS in the fiscal year 2013 to identify bad actors and again protect Medicare. If we could just visit those report findings for a moment, for starters, Dr. Agrawal, can you just give us a basic description of what the fraud prevention system is and just how it works?

Dr. {Agrawal.} Sure. So the fraud prevention system is an advanced piece of technology. It allows us to perform predictive analytics and other kinds of analytics on claims in Medicare as they are streaming through the system in real time. So the Medicare program sees about 4.5 million claims

per day. This allows us to more quickly and specifically identify those claims that need to be evaluated by our investigators, you know, and further develop to see if they represent aberrancies or even fraud.

Mr. {Tonko.} And beyond that, are there other things that enables your office to do that that was not previously available? Are there new opportunities here with that system?

Dr. {Agrawal.} Yeah. I think the system itself is a great piece of technology that allows us to, again--you know, it would be impossible for a human being to lay eyes on all 4.5 million claims per day. The fact that we have an automated system to pull out those claims and those providers that are really problematic is an amazing step forward for us.

In addition to that, it allows us to do certain things as well like simply deny claims that don't meet payment requirements which is an ability that the agency had before but the FPS allows us to do it more flexibly and quickly.

Mr. {Tonko.} And what kind of investment has been made by CMS in the prevention system?

Dr. {Agrawal.} The Small Business Jobs Act came with about $100 million of funding for the fraud prevention system that we have been utilizing in its implementation. You know, as I think we have pointed out earlier, we implemented the system on a very rapid timeframe and actually exceeded the expectations of the statute by going to a national view as opposed to a regional view which the statute required initially. We have also shown good progress in the implementation, going from a 3-to-1 ROI to now this year a 5-to-1 ROI that I would point out has actually been certified by the Office of Inspector General.

Mr. {Tonko.} So any expanded opportunities there in terms of fiscal impact? You see it improving even beyond that?

Dr. {Agrawal.} Yes. We have undertaken various measures to increase the value and return of the FPS. We are, for example, applying it against a wider spectrum of program integrity issues, actually using it to identify providers for medical review, as one example, being able to implement those automated edits as another example. We do look forward to the value of this program increasing.

Mr. {Tonko.} Okay. Thank you. And Mr. Cantrell, are you familiar with the FPS system and with the results that were released yesterday?

Mr. {Cantrell.} I think Ms. Jarmon is the person to answer that question, if you don't mind.

Mr. {Tonko.} Ms. Jarmon?

Ms. {Jarmon.} Yes. It is not a part of Office of Investigation--the OIG office that actually did the work in looking at the fraud prevention system the second year. The first year we weren't able to certify the information because of inconsistencies, and the second year we were able to certify both the unadjusted number, the number before adjustments, to reflect what actually gets returned to the Medicare trust fund. We were able to certify both numbers in the report that went out late yesterday, the larger number being $210 million of unadjusted projected actual and projected savings, and the adjusted number of 54.2 is a 1.34-to-1 return on investment.

Mr. {Tonko.} And basically what is the significance of the certification?

Ms. {Jarmon.} The significance is that the auditors

actually looked at supporting documentation. They actually did similar to financial audit work to determine the reasonableness of the numbers. So the numbers actually started out as the larger number, and we worked closely with CMS on any concerns we had if we couldn't directly associate these savings to the fraud prevention system so we got comfortable with the--really got comfortable with the unadjusted number. Like I said, it started out as a larger number. So it was the audit work that was done to make us feel comfortable that we could certify the numbers this year.

Mr. {Tonko.} Thank you. And earlier you were quizzed as a panel about the legislative recommendations for further improvements in anti-fraud. Could any of you highlight which of those recommendations would be your top priority?

Mr. {Cantrell.} From a law enforcement perspective, our ability to have asset seizure authority is important to OIG, but also removing the Social Security number from the Medicare beneficiary card is important from an identity theft perspective, preventing identity theft.

Mr. {Tonko.} Do you all share that same priority?

Ms. {King.} Yes. I think from our perspective the

removal of the Social Security number from the cards is a very high priority.

Mr. {Tonko.} Okay, and Dr. Agrawal?

Dr. {Agrawal.} Well, being from the agency that I am, I don't get to make the recommendations. I get to implement them. So you know, again, we look at all of them. There are others that I think have very high priority because of their impact on our enrollment and screening work. The SSN issue is one that we have looked at specifically. Again, we are open to that recommendation, just--but need to be resourced appropriately to meet its requirements.

Mr. {Tonko.} Thank you very much. I yield back.

Mr. {Murphy.} Thank you, Mr. Tonko. I would like to get some clarification on something the gentleman asked you. On page II of the Executive Summary of this document you released last night, the Report to Congress, Fraud Prevention, you indeed say in this little blue box, ``The results are a 5-to-1 return on investment almost double the value of the FPS in the first implementation year.'' But then when we get into the meat of the text on--it also says in here, what we found, it says Medicare fee for service

program and return on investment on--it is only $1.34 for every dollar spent on the FPS. Can you justify for us what that distinction is?

Dr. {Agrawal.} Sure. So number one, let me just say, either number, both numbers, demonstrates that the fraud prevention system has had a positive ROI. The two numbers, you know, are something that Ms. Jarmon alluded to. There is an unadjusted savings number and then an adjusted savings number. We believe in the agency that the unadjusted savings number most directly measures the impact of the fraud prevention system.

Mr. {Murphy.} In which one of those, the $5 or the $1.34?

Dr. {Agrawal.} The 5-to-1 ROI. And the reason for that is because the FPS is a piece of technology, again, as I have pointed out earlier that points to those claims and those providers that need further investigation. What the adjusted number gives you is the downstream impact of all of a series of work. So not only the outcomes of the investigation, the outcomes of any administrative processes, any recovery processes and the work of law enforcement referrals.

So it reflects dollars returned to the trust fund, but the FPS was not designed to impact the entire downstream process.

Mr. {Murphy.} Ms. Jarmon and Mr. Cantrell, then he is saying your numbers aren't accurate. Is it $1.34 or is it 5-to-1?

Ms. {Jarmon.} Well, both numbers show again the positive effect of the fraud prevention system.

Mr. {Murphy.} Sure.

Ms. {Jarmon.} But in Office of Inspector General, we feel more comfortable with the adjusted number which shows the return on invest of 1.34-to-1 because that reflects the actual amount that is expected to be returned to the Medicare trust fund. The larger number is the number before adjustments. In some cases assets were not there to be collected. So the larger number--while it was identified by the Medicare contractors, what actually is going to come in is the adjusted number with the expected return of investment of 1.34-to-1.

Mr. {Murphy.} Thank you. I appreciate that. I now recognize Mr. Johnson of Ohio for 5 minutes.

Mr. {Johnson.} Thank you, Mr. Chairman, and I thank the panel for being with us today. You know, one of the ways that has been suggested to fight fraud is increase disclosure of prior actions against providers and suppliers that were enrolling or revalidating their Medicare enrollment. So Dr. Agrawal, has CMS issued a rule on increasing disclosure of prior actions?

Dr. {Agrawal.} So we have put out or--yes, we have actually put out a proposed rule that will allow for more disclosure. But one thing I would point out is, again, disclosure is one aspect of a program integrity approach. If these are really criminals, then they probably won't have much of a problem lying on an application. So we have a lot of other resources at our disposal that include data checks that go beyond anything that somebody puts on an application. And those I think data checks have had significant impact on our ability to keep people out of the program or remove them if necessary.

Mr. {Johnson.} Okay. Mr. Cantrell, Ms. Jarmon, would, in your opinion, would such disclosure help fight fraud, for instance? Would contractors that CMS currently works with,

say Medicare Advantage and drug plan sponsors, be better able to identify fraudulent providers up front if they had access to such information?

Mr. {Cantrell.} Well, I think for one thing, if they lied on the application, it would be a means for us to charge them with that actual crime. So we like that attestation by the provider or whoever is attesting to the facts on the application so that we--or in this case, someone might withhold some information, to use against them as evidence if you will of intent to commit fraud. So I think it would help our efforts on the prosecution and enforcement side.

Mr. {Johnson.} Okay. Ms. Jarmon, any comment?

Ms. {Jarmon.} Yes, and it is in line with what we have also been recommending that the Part C and Part D contractors report fraud also so that they can use that information to try to make sure the bad actors are not in the program.

Mr. {Johnson.} Okay. Ms. King, are Medicare contractors able to share such information with each other? For instance if a patient or provider is suspected of fraud and they change plans during open enrollment, would a plan a beneficiary is leaving be able to communicate with a plan

they are joining about the suspected fraud?

Ms. {King.} I am not sure of the answer on that. Let me get back to you.

Mr. {Johnson.} Can you take that for the record and get back--

Ms. {King.} I don't believe they can, but I am not positive.

Mr. {Johnson.} Okay. All right. Well, certainly it would be good if they could, right? Okay. Also for Ms. King, Medicare administrative contractors known as MACs, MACs were created about a decade ago. Today they serve as the primary bill payers for Medicare claims. Given that the bulk of Medicare reimbursements are processed by MACs, the bulk of improper payments are also made by MACs. I know GAO is currently wrapping up work examining the work of the MACs. Do you have any early observations on your work that you can share with our committee?

Ms. {King.} Not from the work that is ongoing, but we did release some work recently that looked at a lot of their requirements. There are different types of contractors that do post-payment review for fee-for-service claims, and we

found a lot of variety among the requirements that they are subject to which is a source of confusion for providers. And we recommended that the CMS take steps to align those requirements where it wouldn't hurt program integrity efforts.

Mr. {Johnson.} Okay.

Ms. {King.} So streamlining--not streamlining but making the requirements more consistent across contractors we think would be helpful.

Mr. {Johnson.} Okay. And then a follow-up, Ms. King. GAO has conducted work looking at CMS's management of all program integrity contractors. GAO made several interesting findings including the fact that CMS did not standardize its requirements for all contractors. One of the consistent findings from GAO's work over the years is that CMS will often sign a contract for a program integrity function but either fail to measure the right functionality and activities from the contractor or failed to assess progress as the contractor conducts the work.

So in what ways do you think the current contracting mechanism that CMS uses, which is subject to the federal

acquisition rules or the FAR, might hinder CMS's flexibility to manage the program well?

Ms. {King.} Are you referring to the MAC's or the program integrity contractors, if I might ask a clarifying question?

Mr. {Johnson.} I think we are talking about management of all program integrity contractors.

Ms. {King.} Okay. We did some work recently that evaluated the program integrity contractors that are called ZPICs, and we did find that they had a positive return on their investment. And they are FAR contracts subject to the FAR and they are cost plus award fee contracts. The one--we made some recommendations to CMS that they could further link the program integrity contracts with their higher goals in the GPRA Act so that the goals from the top of the agency flow down through the program integrity contractors.

Mr. {Johnson.} Okay. So do you think that the current contracting mechanism that CMS uses would hinder their flexibility to manage the program well?

Ms. {King.} I don't have reason to believe that it does.

Mr. {Johnson.} I yield back, Mr. Chairman.

Mr. {Murphy.} Thank you. I now recognize Mr. Long for 5 minutes.

Mr. {Long.} Thank you, Mr. Chairman, and thank you all for being here today. Ms. King, I want to direct my questioning toward you, and in my questioning I would like to focus on the issue of post-payment audits within the Medicare program and the effect they are having on hospitals and small businesses across the State of Missouri.

In the Dallas airport last Friday I ran into a fellow that happened to be one of my constituents. We both happen to be flying back to Springfield, and he owns a prosthetics and orthotics company. If you go to Google and look that up, O&P, it is the evaluation, fabrication and custom fitting of artificial limbs and orthopedic braces. I am sure you know that--but custom fitting. He sat and told me that Medicare is sitting on a quarter million dollars or better in these RAC audits. And so as I go through this little line of questioning that I have here, I want you to keep in mind that fellow. It is him and his wife and his son. They own a little O&P business in my district, and think about a small

businessman that is sitting around waiting for a quarter million dollars and when he might see that money.

But as you know, Medicare currently contracts with private vendors referred to as recovery audit contractors, RACs, to perform these payment audits. These contractors are paid on a contingency fee basis receiving a share of the improper payments they identify, and they are not penalized if the alleged improper payments are overturned on appeal. So they are going to hold this money and try and prove-- because they are going to benefit if they are going to make money by proving that these were paid when they shouldn't have been paid. But if they are wrong and they hold this guy's money forever and put him out of business, if it is overturned on appeal, there is no penalty for those companies. As a result, the demands with the contractor for medical billing, for medical and billing records, have nearly doubled since 2012. Ultimately this has resulted in administrative quagmire where the Office of Medicare Hearings and Appeals has suspended the ability for providers to appeal their decisions due to the backlog of almost 357,000--357,000 cases they are backlogged. So they have suspended him.

I recognize that the post-payment audits are an appropriate tool for HHS to employ and have also successfully recovered millions from genuine bad actors in the system. But there are a lot of small business people just like my constituent that are out there waiting for this money. Now it has been suspended. The people that are doing the audits are getting paid for what they find, and even if it is overturned on appeal there is no penalty for those people.

So one question I have is do you believe that the current structure of the system is designed in such a way that it incentivizes quality--or excuse me, quantity over quality of these audits?

Ms. {King.} Let me answer your question in several parts. You are correct that the RACs are paid on a contingency fee basis, and they are paid differently from all the other post-payment review auditors who are paid on a cost basis. And initially, the RACs were not penalized if payments were overturned on appeal, but now they are. So if they lose on appeal, they have to--

Mr. {Long.} Okay. I--

Ms. {King.} There is a penalty there.

Mr. {Long.} I had incorrect information on that, ma'am.

Ms. {King.} It was initially correct. The volume of audits done by the RACs has increased substantially over the last several years, and they do by far--

Mr. {Long.} Have they doubled since 2012?

Ms. {King.} Oh, more than that. Well, not since 2012 but probably since 2010 or 2011. And like for example--

Mr. {Long.} My information says 2012, but okay.

Ms. {King.} They have gone up a lot and your--

Mr. {Long.} Are there 357,000?

Ms. {King.} Yeah, they are--out of the--

Mr. {Long.} Backlogged?

Ms. {King.} Of the $2.3 million of--2.3 million post-pay audits in 2012, about 2.1--

Mr. {Long.} Those are audits, not dollars, right?

Ms. {King.} Audits, yes.

Mr. {Long.} Okay.

Ms. {King.} 2.1 million of them were done by the RACs. There is--you are also correct that there is a huge backlog in appeals, and we have--

Mr. {Long.} What do you do for a small business guy

like mine? He and his wife and his son are trying to make a living in a custom-fit part that is not returnable. Nobody else can use that. If they say, oh, you shouldn't have got that part, we should not reimburse you for that part, what do you do in that situation? I mean, what can we do?

Ms. {King.} Well, I think there are a few things. You know, one is that I would be curious to know what the reason is for the payment being declared being improper. If it is a documentation error--

Mr. {Long.} But the company that is declaring it is going to get compensated if they can prove that it is, whether it is or not.

Ms. {King.} No. But there--

Mr. {Long.} Maybe you can correct me on this, too.

Ms. {King.} There--

Mr. {Long.} Excuse me, ma'am.

Ms. {King.} Oh, I am sorry. It is my understanding that like it is 93 and above, maybe 97--93, 97, somewhere in that range of these 357,000 cases are going to be adjudicated have been fine in the first place, and the small business guy should have been paid his money. Is that correct? Is it

over 90-some percent that were--

Ms. {King.} I don't know the numbers on that.

Mr. {Long.} --proper in the first place and they were holding this money?

Ms. {King.} I don't know. I don't know the numbers on that but--

Mr. {Long.} Okay. Well, can you find out for me and see if that is accurate, if it is above 90-some percent that they say, oh, yeah, we should have paid you months and months and months ago, maybe after he's out of business?

Ms. {King.} Well, I have been asked to look at the appeals process and look at the backlog and determine what some of the underlying reasons are and to figure out whether we have any recommendations for solutions.

Mr. {Long.} Has the GAO ever made any recommendations and more efficiently review claims after payments were made?

Ms. {King.} We have made some recommendations to improve the consistency of the requirements that the post-payment review audit contractors are subject to, and we have further work under way that is looking at the post-payment review process, and that should be out later this summer.

Mr. {Long.} Okay.

Mr. {Murphy.} Gentleman's time has expired.

Mr. {Long.} Thank you. I yield back.

Mr. {Murphy.} Now I recognize Ms. Ellmers for 5 minutes.

Mrs. {Ellmers.} Thank you, Mr. Chairman, and thank you to our panel. I have a number of questions, so I would really like to get right into my questioning. And I just want to start by saying, you know, just as my colleague, Mr. Long--I also, as we all do, have constituents who are very, very concerned about this issue. They are small business owners. They are medium-sized business owners. They are taking care of our patients. They are taking care of Medicare patients.

Now, I just want to outline for you just how ridiculous this process is in relation to the MAC, both RAC and MAC, absolutely ridiculous.

Oxygen, CPAP, hospital beds. They outline for me over a year time--we are talking about 2,600 of those filled. Of those, they have 1,228 audits. That is 46 percent. Why would any business have to be audited 46 percent? Dr.

Agrawal?

Dr. {Agrawal.} Thank you for the question. I think you highlight a really important and complex topic, so I think what this highlights is--and we try to achieve a balance every day between not being burdensome on providers, making sure that beneficiaries can get access to the services that they need, and yet being fiscal stewards of the trust fund as required by law.

Mrs. {Ellmers.} And--

Dr. {Agrawal.} And these are areas--just to complete the thought, if you don't mind. DME supplies, orthotics and prosthetics are areas that the OIG has identified as being very high for improper payment rates.

Mrs. {Ellmers.} Okay. I am going to stop you right there--

Dr. {Agrawal.} 70 percent of DME alone.

Mrs. {Ellmers.} --and reclaim my time because the issue here is they are not getting paid. The product has gone out to the patients, to the family that is taking--the caregivers who are taking care of this patient. This patient has oxygen, this patient has a hospital bed. But they have not

been paid. And the timeline, the ridiculous timeline. You know, we are talking about the process of the audit, and then we have the redetermination period. Then we have the reconsideration period, and now the Administrative Law Judge, they are coming in and saying, you know what? We can't even take anymore new appeals. You know, there is going to be a 2-year waiting just to get a hearing. How can anyone run a business if they are not going to get paid for some of the most basic--I am a nurse. These are basic items that our seniors need and use every day. How can these gentlemen that run this business in my district continue to keep their doors open when they are not getting paid? Can you please just tell me how that can be possibly addressed?

You--now, let me back up also. One of the issues in talking about the fraud--and this is what I see here. There is fraud. We all know that there is fraud and abuse of the system. But you are going after the good guys to make up the dollar difference. You are not addressing the real fraud issues that are there. You are not taking recommendations and applying them. Your own recommendations--let me ask a question, Dr. Agrawal. As far as the audit system, if the

provider is found to, you know, have a low denial rate, why are we not rewarding them? Why are we not saying, look, you are in this category, you know, whether you want to score them, you know, grade them. Why are we not rewarding them?

Dr. {Agrawal.} I think that is a great point and idea. In fact, that is something that we got from the provider community and we are actually implementing in the next round of RAC contracts.

Mrs. {Ellmers.} And when will that round be?

Dr. {Agrawal.} Well, we have been engaged in that procurement for a while now, but the procurement itself has come under protest. So we would have looked forward to actually having it completed by now. But it is currently in that protest process.

Mrs. {Ellmers.} And who is protesting it?

Dr. {Agrawal.} Other contractors.

Mrs. {Ellmers.} So these folks, my constituents and every other provider is just left in limbo right now, not getting paid?

Dr. {Agrawal.} Well, I would point out--

Mrs. {Ellmers.} You know, being good actors, you know,

playing by the rules, doing everything they can. They are not getting paid, and we are waiting because someone is protesting?

Dr. {Agrawal.} Let me just say that these audits are required by law. The contingency fee structure was set up in statute. This is not typically the way that--you know, most of our other contractors are not paid that way, either. They also post-pay audit, so they did in fact get paid. These are--and just to differentiate sort of improper payments from fraud, these are tools that we actually utilize to lower the improper payment rate, which this committee has identified as a priority, I think we can agree. And you know, the areas that the RACs have gone after are areas where there is high cost and high improper payments. The DME supplies I just pointed out--

Mrs. {Ellmers.} Well, how is it--

Dr. {Agrawal.} --are those areas--

Mrs. {Ellmers.} How does the RAC auditor--how do they determine--what is it that makes them, that puts the red flag up that they need to go in and audit? What is it?

Dr. {Agrawal.} I think one of the best early indicators

is where the improper payments are based on our CERT audits that are also required by law. So the CERT audits pointed out for example that the improper payment rate in DME is about 70 percent so--

Mrs. {Ellmers.} Okay. But why--okay. So--

Mr. {Murphy.} It was in--

Mrs. {Ellmers.} --XYZ provider now has auditors, and what is it that they did that alerted the RAC auditor to come in?

Dr. {Agrawal.} Oftentimes it is the area in which they operate. Again, the areas of high--

Mrs. {Ellmers.} What do you mean the area?

Dr. {Agrawal.} So if they are a DME supplier and 70 percent of DME payments are improper, then you are obviously going to go--

Mrs. {Ellmers.} So DME provider is just subject to a random audit at any given time?

Dr. {Agrawal.} It is not typically random. It is based on real analytical work to see where improper payments could reside among the specific suppliers. In addition, as I mentioned to you, we are very interested in rewarding those

that have low denial rates so that they get audited less frequently and at less volume.

Mrs. {Ellmers.} But we don't know when that will happen because we are in a protest.

Dr. {Agrawal.} We are as--you know, we want to get the RACs up and running as quickly as anybody else.

Mrs. {Ellmers.} Okay. Thank you, Mr. Chairman, for indulging me. I am over my time, but I would like to submit for the record and ask unanimous consent, there is a memorandum to OMHA Medicare appellants on the time, the length of time for the Administrative Law Judge hearings on the claims and entitlement appeals.

Mr. {Murphy.} Thank you. Any objections?

Ms. {DeGette.} Let me see that document.

Mr. {Murphy.} Could you send that document over here for a second. Thank you. While that is being looked over, let me just ask a question here that I think is important, too. When people get caught for Medicare fraud--is that acceptable? Do they--that is acceptable for the record.

[The information follows:]

This is a preliminary, unedited transcript. The statements within may be inaccurate, incomplete, or misattributed to the speaker. A link to the final, official transcript will be posted on the Committee's website as soon as it is available.

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Mr. {Murphy.} When people get caught for Medicare fraud, are they going to jail? Are you fining them? What kind of examples can they be made of, if I can end with a preposition there? So are there current penalties that are incurred upon folks who are involved with Medicare fraud? Mr. Cantrell?

Mr. {Cantrell.} They are going to jail more and more. The DOJ reported in strike force cases over 2013, the average length of sentence was 52 months. And that is a fairly substantial time for this kind of crime, and that is an average from 2013. Over the last several years the average has been since the implementation of strike force, 47 months. So they are going to jail. There are criminal fines. There are criminal forfeitures that are applied, and that is the result--that is the work that results in the recoveries that the government has received.

Mr. {Murphy.} So can I ask then, of those who are--when you catch someone, the likelihood that they will serve time, they will pay a fine, any idea what those numbers are like?

Mr. {Cantrell.} I don't have the percentage, sir.

Mr. {Murphy.} That would be important if we get those--

Ms. {King.} I believe that we have some information on that, sir.

Mr. {Murphy.} Yes? You do, Ms. King? If you can get that to us--

Ms. {King.} We do.

Mr. {Murphy.} Do you know anything offhand or can you get those to us?

Ms. {King.} I don't remember off the top, but I can tell you that most of the people--we did some work on 2010 data that came out I think in 2012. Most of the people who are investigated for fraud, both criminally and civilly, those actions do not go forward. On the criminal side, only about 15 percent of the investigations actually result in the action going forward.

Mr. {Murphy.} What is that percent?

Ms. {King.} 15 percent.

Mr. {Murphy.} 15 percent? Only 15 percent actually go forward to some criminal prosecution?

Ms. {King.} Yes.

Mr. {Murphy.} Are the rest somehow settled or does that

mean you have an 85 percent chance of getting away with it?

Ms. {King.} No, that is the settlements. You know, some investigations just do not go forward for a host of reasons.

Mr. {Murphy.} Okay. So for example, they are not really guilty of fraud or if there is no fraud charges there. Is that what that is--am I correct in that?

Ms. {King.} Well, there are no fraud charges finally brought or there is no settlement.

Mr. {Murphy.} I guess what we want to know, if someone is--there is a fraud charge, what is the likelihood they are going to see the inside of a prison cell or pay a fine? The rate of success?

Ms. {King.} I believe we have some high-level data on what the results are not bound to the length of the sentence but the types of penalties imposed.

Mr. {Murphy.} We would like to--Ms. DeGette, do you have a quick question?

Ms. {DeGette.} I just have a follow-up. Mr. Cantrell, the IG identified problems with Medicare C and D plans not reporting data and recommended that the CMS make the

reporting mandatory. Is that correct?

Mr. {Cantrell.} That is correct.

Ms. {DeGette.} And Dr. Agrawal, has CMS done that?

Dr. {Agrawal.} Well, we have taken a number of steps to better align Medicare C, D and you know, the fee-for-service programs. I talked earlier about the Part D rule that was going to allow us to require provider enrollment in Part D.

We are also working on other activities like the healthcare fraud prevention partnership that actually allows us to exchange data and best practices directly with the private sector so that we can jointly, you know, work to detect and prevent fraud.

Ms. {DeGette.} Right. So I am going to take that answer as a no, you have not made it mandatory, is that right?

Dr. {Agrawal.} We have currently not yet made it mandatory.

Ms. {DeGette.} Yeah. Thanks. I think frankly, Mr. Chairman, I think CMS needs to do that because we know there is a lot of fraud in those Part C and Part D programs. I appreciate the efforts that the agency has made on those

other ends, but I think making it mandatory would really help. And I appreciate your indulgence, Mr. Chairman.

Mr. {Murphy.} Thank you. Mr. Long and Ms. Ellmers have each asked for 1 minute.

Mr. {Long.} Just a quick follow-up, Dr. Agrawal. When you were answering Congresswoman Ellmers' questions, you said 70 percent. Are you talking about O&P or are talking about prosthetics? That business? 70 percent of them are not correct on their billing?

Dr. {Agrawal.} No, what I was identifying was that there is a high improper payment rate for DME, but there is also a high improper payment rate in orthotics and prosthetics.

Mr. {Long.} Okay.

Dr. {Agrawal.} Those are reports that the OIG has also published.

Mr. {Long.} Okay, because if what my constituent is telling me is accurate, isn't it 93 or 97 percent they go ahead and pay eventually, some time, a couple years from now. The 70 percent didn't match. So I just wanted a clarification on that.

Dr. {Agrawal.} Well, if I could clarify on that point, sir, so of all of the RAC overpayment determinations, only 7 percent are actually overturned on appeal. That is 7. So of all the overpayments that the RACs actually get from providers, 7 percent go onto appeal and at any level of appeal--

Mr. {Long.} Yeah, but we are talking apples and oranges. We are talking about how many were not improper in the first place is what my question is, not how many were overturned on appeal.

Dr. {Agrawal.} Okay. Got you, sir.

Mr. {Murphy.} Thank you. Ms. Ellmers, 1 minute.

Mrs. {Ellmers.} Thank you, Mr. Chairman. Dr. Agrawal, I have a question, too, about what is the period of time--a provider has an audit and maybe they haven't been educated. I know that you said that there is an effort to educate. Is there a grace period? Is there a time? What time limit from a change that is made to the time that the auditor goes in are we looking at? If something is flagged to, you know, for an audit?

Dr. {Agrawal.} So if I am understanding the question, a

change in payment policy that would then--

Mrs. {Ellmers.} Right.

Dr. {Agrawal.} --downstream be enforced?

Mrs. {Ellmers.} Yeah. So a change is made. The provider may or may not have had time to--what is that--what does CMS consider a reasonable time that that provider should know that a change has occurred?

Dr. {Agrawal.} Sure. So I don't think there is a set time period, you know, the kind of set time period that you are identifying. I will point out that a lot of the audits--

Mrs. {Ellmers.} So the change could be made and the next day the auditor can be in the office?

Dr. {Agrawal.} It is typically not like that. The majority of audits that we conduct are around rules and policies that are very well known by the provider community. So the high improper payment rates in DME for example are based on documentation requirements that have been around for a while.

Mrs. {Ellmers.} Okay. So that is not what I am hearing from my constituents. My constituents are looking at the situation. They are saying, look, we weren't even aware of

that change. Ms. King, would that be--you know, is that something GAO has recommended, that there be a grace period time or anything like that?

Ms. {King.} It is not an issue that we have looked at.

Mrs. {Ellmers.} Okay.

Ms. {King.} But you raise an interesting question about education of providers about the documentation requirements and the rules.

Mrs. {Ellmers.} One last question, Dr. Agrawal. You did say that one of the things that you are suggesting in the change in the next RAC audit time period is, you know, the idea that those are rewarded. What would you say the percentage, if you have got a low denial rate? Throw out a number.

Dr. {Agrawal.} I don't have a specific number. You know, we can actually get that for you based on the--

Mrs. {Ellmers.} Well, I would like to work with you--

Mr. {Murphy.} Thank you.

Mrs. {Ellmers.} --on that. Thank you so much, and thank you, Mr. Chairman.

Mr. {Murphy.} Dr. Burgess, you have some concluding

questions?

Dr. {Burgess.} Thank you, Mr. Chairman. Okay. Well, I want to go back for a minute to the article, the Bloomberg article, that I referenced that was published on April 28th of this year. Doctors get millions from Medicare after losing their licenses. And this article goes through sometimes in rather painful detail of how a doctor would lose their license in one state and then be able to bill Medicare in another state. I realize that states have a responsibility here as well. But you as the payer for Center for Medicare and Medicaid Services, you ultimately have the responsibility about those dollars going out, and even though New Mexico may have erred in not checking a database for someone who lost their license in Ohio, which was the case of one of the doctors that was referenced here, Medicare paid that doctor an additional $660,000 for that doctor to treat patients in New Mexico. You know, the question is, why won't CMS at least do the basics on checking with the National Practitioner Data Bank to see if there is a problem with this doctor's license?

Dr. {Agrawal.} Congressman, it is not a question of

will, it is a question of authorities. So loss of licensure is one of the best triggers that we have for removing somebody from the Medicare program. If a provider loses their license in one state, however, and they have a license that is active in another state, we are bound by limits of authority about, you know, whether or not we can revoke that person across the entire Medicare program. We can certainly revoke or eliminate any enrollment in the state in which they lost their license. But loss of licensure in one state is not in and of itself a basis for losing enrollment nationally.

Now, if there was something underlying the licensure loss--

Dr. {Burgess.} I have to stop you there. I find that absolutely incredulous. A guy loses his license, and some of these doctors were charged with fairly serious crimes. And because they had good lawyers, they were able to keep their license in another state. But I mean, does that at least not trigger some sort of basic curiosity on the part of CMS as to why the doctor lost their license in a given state, what was the crime of which they were accused and should we keep

sending them checks for $660,000?

Dr. {Agrawal.} Of course, and I, again, as a physician am very frustrated when loss of licensure in one state is not followed by loss of licensure in all states. We do look at those providers, you know, to you know, investigate or understand what they have done. But again, this comes down to due process. If there is just not an authority that we can, you know, trigger to cause the revocation, then we simply can't do it. I mean, these are the constraints that are placed on us, you know, rightfully by taxpayers to make sure we don't go too far.

Dr. {Burgess.} I don't want you to go too far, and we have certainly heard from other members about some of the problems when you go too far. But should this at least--at the very least, should this not trigger some type of heightened scrutiny on the bills that are coming in from a doctor who has lost their license in another state because of the death of a patient or because they are charged with a serious crime?

Dr. {Agrawal.} It can absolutely be a risk factor. I don't think that that is what is under contention. I think

the real issue is whether we can just revoke summarily across the country for loss of licensure in one state, and that is where there are significant restrictions or limitations in our authority.

Dr. {Burgess.} Do you not have the authority for heightened scrutiny? I mean, you paid this guy $660,000. Apparently we weren't scrutinizing very highly.

Dr. {Agrawal.} That may or may not be true. I don't know about the, you know, the data on that particular case or what the report was. But we can subject folks to--you know, providers to medical review based on a multitude of factors. We can certainly do that in these kinds of cases. But again, providers can--as you know as well as I do, providers can lose their licenses for a variety of reasons, some of them having nothing to do with healthcare fraud or, you know, the extent of our authorities and concern.

Dr. {Burgess.} Yeah, but it just raises or begs the question, should the Medicare system be paying those doctors? I mean, should they even be taking care of Medicare patients? The fundamental question, is there a way that you have of debarring someone who has been accused of or been convicted

of a fairly serious allegation and lost their license as a consequence?

Dr. {Agrawal.} So we have a specific revocation authority that we utilize on a consistent basis. The OIG has an exclusion authority. GSA has a debarment authority. We utilize as triggers for our actions the GSA debarment list as well as the OIG exclusion list.

Dr. {Burgess.} Is that the exclusion list here?

Dr. {Agrawal.} Yes.

Dr. {Burgess.} I mean, one of the permissive exclusions is license revocation or suspension. One of the mandatory is conviction on three or more occasions of mandatory exclusion offenses. I mean, what have you got to do? What have you got to do to lose your ability to bill Medicare and have you guys pay?

Dr. {Agrawal.} Well, I would have to defer exclusion questions to the OIG since we don't put people on the exclusion list.

Mr. {Murphy.} The gentleman's time is expired.

Dr. {Burgess.} Can we let Mr. Cantrell answer the question?

Mr. {Murphy.} Mr. Cantrell?

Mr. {Cantrell.} We also have a variety of limitations to our exclusions authority. There are situations--often it is the underlying crime or offense that resulted in the loss of license. But the real I think vulnerability that we face is we don't have 100 percent of the data that we would need to implement exclusions in 100 percent of the cases where we would have the opportunity and the authority. We have a voluntary reporting system to the OIG from the state boards, from other federal agencies, and so that is an area where we know we have incomplete information. But we get--we currently have 57,000-plus entities in--who are excluded, and we exclude over 3,000 every year. So there is a lack of complete data that we have access to, but there is still a great number of exclusions that occur.

Dr. {Burgess.} I just have to ask you. Can you not query the National Practitioner Data Bank? Can you?

Mr. {Cantrell.} I believe that we can. There were some restrictions on law enforcement access to the National Practitioner Data Bank. I can't speak to whether that is actually a continuing concern or not.

Mr. {Murphy.} Let me--

Dr. {Burgess.} Can you get--find out and get me that information, please?

Mr. {Cantrell.} Certainly.

Mr. {Murphy.} Let me ask in general for that for this committee if Dr. Agrawal, Mr. Cantrell and Ms. King, to the extent you can, you have heard a number of things there. We recognize also that you are aware that there is more information that would be valuable to you to help prescreen out people who have some tendency towards crime. The example I gave before, if someone has robbed a bank or involved with some other fraud that is not Medicare fraud, they can still be involved in this I think raises all of our questions, and Mr. Cantrell, you just said you don't have a lot of data.

If you would please in a timely manner get that data back to the committee, as I was talking to Ms. DeGette, too, as I think this is something I think this committee would be interested in moving forward on some legislation to assist you in that rather than just pay and chase moving forward.

I am going to ask unanimous consent that the members' written opening statements be introduced in the record, and

without objection, the documents will be there. Also in conclusion, I thank all the witnesses and members who participated in today's hearing. I remind members, I am sure many people have some other follow-up questions for you. They have 10 business days to get them to you, and I do ask that you do all agree to respond promptly to the questions. So with that, this committee is adjourned. Thank you.

[Whereupon, at 12:00 p.m., the Subcommittee was adjourned.]