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ONE HUNDRED THIRTEENTH CONGRESS

Congress of the United States

House of Representatives

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July 18, 2014

Mr. Gary Cantrell
Deputy Inspector General for Investigations
Office of Inspector General
Department of Health and Human Services
330 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Mr. Cantrell:

Thank you for appearing before the Subcommittee on Oversight and Investigations on Wednesday, June 25, 2014, to testify at the hearing entitled "Medicare Program Integrity: Screening Out Errors, Fraud, and Abuse."

Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for ten business days to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your answer to that question in plain text.

Also attached are Member requests made during the hearing. The format of your responses to these requests should follow the same format as your responses to the additional questions for the record.

To facilitate the printing of the hearing record, please respond to these questions and requests with a transmittal letter by the close of business on Friday, August 1, 2014. Your responses should be mailed to Brittany Havens, Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, D.C. 20515 and e-mailed in Word format to brittany.havens@mail.house.gov.

Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,

Tim Murphy
Chairman
Subcommittee on Oversight and Investigations

cc: Diana DeGette, Ranking Member, Subcommittee on Oversight and Investigations

Attachments

Attachment 1—Additional Questions for the Record

The Honorable Tim Murphy

1. CMS says the Fraud Prevention System (FPS) "prevented more than $210 million in improper Medicare fee-for-service payments, double the previous year." But according to the OIG's comments in the report, OIG only certified $54.2 million of actual savings in the Medicare program. Can you please explain why CMS is claiming higher numbers than OIG says may be verifiable?

2. At the end of the OIG's report on the FPS, there is some extended discussion between CMS and OIG regarding two issues: (1) contractors being given written instructions to determine when savings from an administrative action should be attributed to the FPS, and (2) requiring contractors to maintain documentation supporting the claim that an FPS lead contributes to an administrative action. Can you briefly outline your recommendations, CMS's perspective, and what you think should happen now?

3. Some reports have noted that CMS has not published a proposed rule that would permit more disclosure of prior actions against providers and suppliers that were enrolling or revalidating their Medicare enrollment. How would such disclosure help fight fraud? For instance, would contractors that CMS currently works with – including Medicare Advantage and drug plan sponsors – be better able to identify fraudulent providers up front if they had access to such information?

4. The Centers for Medicare & Medicaid Services has agreed to postpone awarding the new round of Recovery Auditor Contractor (RAC) contracts until at least Aug. 15 because of pending litigation. This delay comes after numerous administrative changes and delays to the statutorily mandated program. Given the RACs record of recovering hundreds of millions, even billions, of dollars for the Medicare Trust Fund, does GAO have any concerns regarding the impact further administrative or legal delays may have on the effectiveness of the recoveries for the Medicare Trust Fund from this statutorily mandated program?

5. Do you believe the Medicare program would be more protected than it currently is if HHS OIG were given the authority to exclude a supplier/provider from federal health care programs once that individual has been convicted, instead of waiting for sentencing?

6. Do you think it makes sense, from a program integrity perspective, for Congress to give HHS OIG or CMS more latitude to suspend, terminate, or otherwise exclude a supplier/provider from federal health care programs if that individual has been convicted of a felony?

7. What do you believe are the top five vulnerabilities with regard to the integrity of Medicaid payments?

The Honorable Michael C. Burgess

1. What recommendations has the OIG made to CMS relating to improvements in the screening of providers or fund recipients that have not been adopted? Which ones have not been adopted? Has CMS given reasons for not adopting certain recommendations? What are those reasons?

Attachment 2—Member Requests for the Record

During the hearing, Members asked you to provide additional information for the record, and you indicated that you would provide that information. For your convenience, descriptions of the requested information are provided below.

The Honorable Tim Murphy

1. What additional data would be valuable to help you prescreen for Medicare fraud?

The Honorable Michael C. Burgess

1. Do you have the ability to get a query of the National Practitioner Data Bank?