DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

FEB 07 2012

The Honorable Tom Coburn
United States Senate
Washington, DC 20510

Dear Senator Coburn:

Thank you for your letter regarding the Centers for Medicare & Medicaid Services' (CMS') oversight interest and support of the Medicare and Medicaid programs. We appreciate your interest in our program integrity efforts, and we are pleased to have the opportunity to report on the innovative solutions to curb fraud, waste, and abuse that CMS has implemented in the last 18 months.

CMS has taken a new approach to address fraud, waste, and abuse in the Medicare and Medicaid programs. The first strategic action was the creation of the Center for Program Integrity (CPI) in April 2010, which consolidated the Medicare and Medicaid program integrity groups under one management structure. This change strengthened existing and planned fraud, waste, and abuse activities, and demonstrated the Administration's commitment to a coordinated approach to fighting fraud, waste, and abuse in Federal health care programs. In February 2011, CPI realigned into five functional groups: Data Analytics, Provider Enrollment, Program Integrity Enforcement, as well as the Medicare and Medicaid program integrity groups. This targeted approach has enabled CMS to pursue a more strategic and integrated set of program integrity policies and activities across Medicare, Medicaid, and the Children's Health Insurance Program. Since then, CPI has implemented a number of innovations to modernize the Agency's anti-fraud and abuse efforts. For example, CPI implemented the new predictive analytic technology that has demonstrated effectiveness in reducing fraud losses by several orders of magnitude in the private sector, while reducing required operations resources by more than half. CMS described many of our early successes and results of the state-of-the art predictive modeling system in response to your December 19, 2011, letter.

I appreciate your commitment to fighting fraud and abuse in the Medicare and Medicaid programs, and look forward to continuing working with you on this important issue. Enclosed is information that responds to your questions. I will also provide a copy to the cosigner of your letter.

Sincerely,

Marilyn Tavenner

Marilyn Tavenner

Enclosures

Responses to January 9, 2012 Questions

1. Now that you are Acting Administrator of CMS, what existing unimplemented HHS OIG or GAO recommendations is CMS considering implementing to reduce fraud, what steps is CMS currently taking to implement those recommendations, and when will they be implemented?

CMS provides the Department of Health and Human Services' Office of Inspector General (OIG) and Government Accountability Office annual updates on the status of unimplemented recommendations, including those aimed at reducing fraud. OIG considers a recommendation "unimplemented" when a corrective action has not been completed. This means that while CMS may be working to implement various OIG recommendations, the status is deemed open even while CMS' implementation efforts are ongoing. The OIG publishes a compendium of unimplemented recommendations every spring. We are also providing as an enclosure to this letter, an overview of OIG recommendations that CMS is working to implement to reduce fraud. The GAO publishes an update to the High Risk series in the late winter/early spring. The most recent version of CMS' summary of plan for improvement in the GAO High Risk Area is included in the FY 2012 Online Performance Appendix which is enclosed, and available at http://www.cms.gov/PerformanceBudget/Downloads/CMSOPAFY2012.pdf

2. What number of Medicare and Medicaid program integrity staff or contractors use Google Earth to match supplier or provider addresses against actual physical locations before bills are paid to prevent fake shell companies from bilking the program?

During the Medicare enrollment process, there are several ways that CMS is ensuring and verifying that practice locations are operational and legitimate. CMS implemented a new Automated Provider Screening (APS) solution in December 2011 that uses information contained in numerous public and private databases to automatically verify information submitted via a provider Medicare enrollment application. The screening solution includes identity and address verification to ensure legitimate providers and suppliers are enrolling in Medicare. For example, the provider's service address will be checked to identify addresses not suitable for Medicare providers such as campgrounds and mail receiving services. Additionally, service addresses in the system will soon be geo-coded with the latitude and longitude to the roof-top-level to ensure the address is a legitimate address. Given the scale of the Medicare provider community, we believe this approach is a highly effective use of investigative resources.

The APS also monitors all providers and suppliers to ensure that they continue to meet Medicare enrollment requirements, such as licensure. The APS also monitors felony convictions, death, and exclusions from other Federal programs, for the duration of a provider's or supplier's enrollment. APS will replace the time- and resource-intensive process of manual review of the enrollment application. The new process will decrease the application processing time, enable CMS to continuously monitor the accuracy of enrollment data, and assess applicants' risk to the program using standard analyses of provider data.

Site visits are required for categories of providers and suppliers in the "moderate" and "high" screening levels prior to enrollment, upon revalidation, and when a new practice location is added, consistent with our recent regulation, "Medicare, Medicaid, and Children's Health Insurance Programs; Additional Screening Requirements, Application Fees, Temporary Enrollment Moratoria, Payment Suspensions, and Compliance Plans for Providers and Suppliers" (76 FR 5862), implementing the Affordable Care Act requirement to establish new levels of screening according to the risk of fraud, waste, and abuse. CMS also has authority to conduct a site visit at any time for any provider or supplier to verify compliance with Medicare enrollment requirements. Site visits can be announced or unannounced, and are the best way to verify whether a practice location is legitimate.

While Google Earth may provide interesting anecdotal data, CMS is unable to identify how many Medicare program integrity staff or contractors rely on Google Earth to identify potential false store fronts, as Google Earth is neither a required nor prohibited source for staff or contractors to use as a resource for determining the legitimacy of provider locations. While Google Earth or other geospatial analysis may indicate that a provider's or supplier's location appears to be a false store front, CMS cannot act on any such information from Google Earth without undertaking additional validation. CMS is implementing a new national site visit contract that will facilitate efficiency and increase capacity for additional announced and unannounced site visits when required or needed. In addition, CMS does not have data on Medicaid enrollment processes as Medicaid provider enrollment is managed by the States.

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FY 2012 Online Performance Appendix