DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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CMS/

CENTERS for MEDICARE & MEDICAID SERVICES

Center for Program Integrity

JAN 2 7 2012

The Honorable Tom Coburn
United States Senate
Washington, DC 20510-6250

Dear Senator Coburn:

I am responding to your December 19, 2011, letter regarding the Centers for Medicare & Medicaid Services' (CMS) implementation of the predictive analytics program designed to prevent waste, fraud, and abuse in Medicare. CMS is strongly committed to protecting the health of all Americans and aggressively combating fraud, waste, and abuse in its programs. I appreciate this opportunity to elaborate on CMS' advanced technological initiatives and I look forward to working with you as we continue to protect the integrity of Federal health care programs and safeguard taxpayer resources.

Following the passage of the Small Business Jobs Act of 2010, CMS deployed predictive analytics technology to review all Medicare fee-for-service claims. The Fraud Prevention System (FPS), a part of CMS' National Fraud Prevention Program (NFPP), was launched prior to the statutorily mandated implementation date of July 1, 2011. With the FPS, predictive analytics are now being used to review all Medicare Part A, Part B, and durable medical equipment (DME) claims prior to payment. For the first time, CMS has a real-time view of fee-for-service claims across claim types and the geographic zones of its claims processing contractors. CMS can now more easily identify fraudulent providers by detecting patterns and aberrancies. The FPS prioritizes leads in real-time for the Zone Program Integrity Contractors (ZPICs) and Program Safeguard Contractors (PSCs) who then investigate the providers and suppliers and take appropriate administrative actions, including referrals to our partners at the HHS Office of the Inspector General (OIG) and the Department of Justice (DOJ).

As a key component of our National Fraud Prevention Program, the FPS is significantly changing the way we approach fraud detection and analysis here at CMS. The FPS has greatly increased collaboration among our fraud contractors, OIG investigators, Federal Bureau of Investigations (FBI) agents, and DOJ prosecutors. These stakeholders have met routinely with CMS to provide valuable input into developing predictive models, detecting fraud, and investigating specific cases.

I agree that performance metrics are critical to the success of our new predictive analytics technology and I share your interest in tracking our operations in this manner. We are pleased to report on the early success of the FPS and have provided responses to your specific questions below.

1. When will CMS have in place metrics for determining the relative successes or failures in operating predictive analytics?

CMS has metrics in place for measuring the outcomes of predictive analytics and is continuing to develop additional metrics to track the effectiveness of the system. The FPS, a key component of the National Fraud Prevention Program, is significantly changing the way CMS approaches fraud detection and analysis. As part of this strategy shift, CMS is adjusting and strengthening its relationships with its fraud contractors and law enforcement partners so as to better leverage the new predictive analytic technology in support of the entities' shared mission. During the first six months of implementing the FPS, we have focused on establishing and streamlining work processes for our data analysts, the ZPICs/PSCs, OIG investigators, and DOJ to ensure the FPS generates the types of information and data needed to support decisions to stop payment, investigate cases, and make referrals as quickly and efficiently as possible. The FPS is a significant departure from how CMS had previously conducted fraud prevention activities and has required considerable education and outreach to train the ZPICs/PSCs and our law enforcement partners at OIG, FBI, and DOJ.

ZPICs/PSCs now report detailed provider-level information on investigation activities and administrative actions directly into the FPS. CMS has a real-time, interactive dashboard that tracks the activities and outcomes related to the providers identified as high risk by the predictive analytics. After a thorough investigation, possible administrative actions include payment suspensions, auto-denial edits, prepayment edits, provider and supplier revocations from our programs, and referrals made to law enforcement. ZPICs/PSCs also track and report the monetary value of their reported administrative actions. The FPS enables CMS to generate reports that help the Agency to measure outcomes, analyze results, and refine the predictive models. CMS anticipates that it will establish additional metrics in the future so we are able to effectively monitor the success of the FPS.

2. When will CMS have in place a complete system for stopping claims before they are paid that are determined to be improper or for which there is credible evidence of fraud?

CMS has a process in place for stopping claims determined to be improper and for which there is credible evidence of fraud. This process will continue to evolve over the next year as CMS pursues its dual goals of preventing fraudulent payments while not interfering with payment of legitimate claims. As stated above, the FPS is reviewing claims for potential fraud early, before the payment is made, to the providers and suppliers while it also tracks the number and type of alerts for each provider and prioritizes the leads. ZPICs/PSCs use the various existing claim-level and provider-level data to initiate administrative actions to stop payment in appropriate situations. Upon a thorough investigation, CMS and its contractors can take various administrative actions to prevent payments for providers identified in the FPS, including payment suspension, auto-denial edits, prepayment edits, and revocation of Medicare program billing privileges.

In addition to the specific provider-focused actions taken by the program integrity contractors, CMS and its Medicare Administrative Contractors can use the FPS findings to implement national auto-denial edits. In fact, CMS recently implemented a national auto-denial edit based on vulnerabilities identified in the FPS. Last year, Medicare made over $3.3 million in payments to providers and suppliers associated with these vulnerabilities; because of the auto-denial edit, these claims will no longer be paid. In late 2012, CMS intends to expand its ability to prevent payment of claims determined to be improper by adding a communications channel between the FPS and the payment systems. Through this new enhancement, the FPS will assist CMS to deny claims when appropriate.

3. What amount and number of recoveries has CMS made directly related to the predictive analytics technologies?

As of November 30, 2011, the ZPICs/PSCs investigated FPS-generated leads that resulted in 9 overpayment determinations, valued at a total of $2,196,369. An overpayment determination is made when it is found that a provider, supplier, or beneficiary received Medicare payments in excess of amounts due and payable under the statute and regulations. While CMS has the ability to track the administrative actions through the FPS dashboard in real-time, there is a lag between the reporting of the actions and the reporting of the associated dollar values. Consequently, administrative actions and associated dollar values have been provided through November 30, 2011, the latest date for which both the administrative actions and corresponding values are available.

As of December 31, 2011, ZPICs/PSCs have opened 437 new investigations based on leads from the FPS and had 351 existing investigations that are supported by real time information in the FPS. These investigations are ongoing and we expect to see additional administrative actions and referrals as the investigations mature. Additionally, we expect this tool to directly aid law enforcement investigations and prosecution efforts.

4. What amount and number of losses has CMS prevented due to the predictive analytics technologies?

As of November 30, 2011, the FPS has enabled CMS to prevent $1,577,563 in Medicare payments to providers and suppliers by implementing 284 prepayment and auto-denial edits. These edits are in addition to more than 30,000 system edits through which FFS claims pass to ensure Medicare pays only valid claims. CMS also began implementing payment suspensions based on FPS leads in December 2011. While CMS has the ability to track the administrative actions through the FPS dashboard in real-time, there is a lag between the reporting of the actions and our ability to report the associated dollar values. Consequently, administrative actions and associated dollar values have been provided through November 30, 2011, the latest date for which both the administrative actions and corresponding values are available.

5. What changes in provider and supplier behaviors, if any, has CMS measured due to the implementation of predictive analytics technologies?

It is too early to report any measureable results in this area; however, CMS anticipates changes in behavior due to the success of this program. As we begin to take more administrative actions based on the results of the FPS we expect to see changes in claims submissions and billing patterns over time. We also anticipate noticeable, if not quantifiable, sentinel effects resulting from the expanding scope of CMS predictive analytics. CMS is working to identify other measures that could capture evidence of these shifts in behaviors.

6. What is the process CMS uses when a suspect claim is identified, including the referral to contractors, the Department of Health and Humans Services Office of Inspector General (HHS OIG), or other entities for further investigation? How many such referrals have been made, and what is the total value of the associated claims?

The ZPICs/PSCs have direct access to the FPS and have a prioritized view of the providers with the most suspect behavior in their jurisdiction. CMS requires that ZPICs/PSCs work the highest priority leads using their current investigation processes. If a ZPIC/PSC determines that a lead likely involves Medicare fraud, the contractor refers the lead to law enforcement. As of November 30, 2011, ZPICs/PSCs have made 9 such referrals of FPS-generated leads, with a total value of $9,149,531, to law enforcement. Please note that the total value of the associated claim lines of interest (dollars at risk) represents an estimate calculated at the point in time when the referral to law enforcement was made. The dollars at risk may fluctuate over time as the investigation and/or case progresses.

In addition to identifying new leads, the FPS is currently providing near real-time data for 255 providers and suppliers that are subjects of existing law enforcement cases. Prior to the implementation of FPS, such data would have been collected via a labor intensive manual process that produced only a static snapshot of the provider or supplier's billing activity. Now the FPS automatically links related data by provider, beneficiary, and service location so that changes in behavior or new billings can be spotted almost immediately.

7. Has CMS identified suspected overuse of timed codes, that is, providers or suppliers billing for more services in a day than is humanly possible? If so, how many and for what total value of the associated claims? If not, why or why not?

CMS has identified 93 suspect providers that are billing for more timed services than would be humanly possible to perform in a day. The value of the claims associated with these cases is $13,809,989. The providers implicated by these alerts are actively under investigation by the ZPICs/PSCs. In each case, CMS and the ZPIC/PSC are taking appropriate action based on the investigation.

8. Has CMS suspended payments for any providers or suppliers based on the use of predictive analytics technologies? If so, how many providers, for what categories of providers, and for what total value of associated claims?

The first payment suspension resulting directly from an FPS lead was reported during the week ending December 21, 2011. This payment suspension was supported by reliable information that an overpayment existed or that payments to be made may not be correct. As of January 6, 2012, $7,591 in payments have been suspended and we expect that number to increase as more claims are submitted. In addition to payment suspension, CMS is evaluating whether other administrative actions are warranted.

9. Has CMS referred any cases to the HHS OIG or other entities based on the use of predictive analytics technologies? If so, how many and for what total value of associated claims?

Please refer to our response to #6.

10. Has CMS excluded providers or suppliers from billing Medicare based on the predictive analytics technologies? If so, how many?

CMS has used its revocation authority, not its exclusion authority, to revoke Medicare billing privileges and has initiated 26 revocation actions against providers and suppliers based on leads generated by the FPS as of November 30, 2011. These providers were paid $7,366,974 in 2011.

If you have any further questions, please feel free to contact me at (202) 205-9321.

Sincerely,

Peter Budetti, M.D., J.D.
Deputy Administrator for Program Integrity