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United States Senate

COMMITTEE ON FINANCE

WASHINGTON, DC 20510-6200

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July 31, 2012

Via Electronic Transmission

Marilyn Tavenner, Acting Administrator
Centers for Medicare & Medicaid Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Acting Administrator Tavenner:

As Members of the Senate Finance Committee, it is our responsibility to conduct oversight over the Administration's implementation of a range of policies impacting the Medicare program. Accordingly, we appreciate the demonstrations your staff has given to our offices of the new Fraud Prevention System (FPS) as part of the National Fraud Prevention Program (NFPP) which was adopted by the Center for Medicare & Medicaid Services (CMS) fulfilling the mandates in the Small Business Jobs Act of 2010.

We support the predictive analytics provision of the Small Business Jobs Act, which was enacted to enable and accelerate CMS' use of predictive analytics tools to reduce waste, fraud, and abuse in the Medicare program. The FPS system holds significant potential if CMS is timely, transparent, and targeted in its implementation of the system.

As you know, the Medicare program currently loses an estimated \$60 billion dollars each year to waste, fraud, and abuse. This is unacceptable. The hemorrhaging of taxpayer dollars due to waste, fraud, and abuse is ultimately a virtual invisible tax on taxpayers. This invisible tax effectively increases program costs and further erodes the financial solvency of the program. While no health coverage payment system is perfect, for years the acute program vulnerabilities and severe inefficiencies of the Medicare program have been well-documented by the Government Accountability Office (GAO) and Department of Health and Human Services (HHS) Office of the Inspector General (OIG), along with law enforcement, health providers, and the media among others.

For some time, we have heard a growing chorus of concerns from a wide range of credible entities who have expressed concerns about the FPS. Today we are writing to express our increasing concerns about three specific categories of concerns related to the FPS: the performance metrics to assess the effectiveness of FPS, the targeting of claims for reviews, and transparency about results from the system.

FPS Performance Metrics

While some have argued the FPS is still “new” and evolving, the system has now been in place and operating for a year. In fact, earlier this year, CMS explicitly stated that “the FPS will become mature in June 2012.”¹ Therefore, it is not too early for Congress, the taxpayers, and other stakeholders to more closely inspect how the FPS has been implemented and whether or not it is on track to significantly reduce fraud and improper payments in the Medicare program.

Given the myriad array of Medicare systems and processes, implementation of the FPS was a challenging task. It is notable that CMS was able to bring the FPS system up so quickly and well in advance of the statutory timeline in spite of having to navigate the complexity of the Medicare program. However, if the system truly holds the potential that CMS asserts it does, demonstrating the effectiveness of the system should also be a top priority. In fact, CMS rhetorically seems to agree with this. In an announcement earlier this year, CMS said that “reversing the traditional pay-and-chase approach to program integrity is the main goal of the National Fraud Prevention Program (NFPP).”²

Despite this rhetorical commitment, CMS has not been fully transparent regarding what progress the agency is making in implementing the system and how successful the efforts of the system have been to date. In hearings, meetings, and public letters over the past several months, our offices have repeatedly pressed CMS for a set of specific metrics and timelines for the implementation of the FPS and the metrics for measuring its performance, including the agency’s view on “what determines success.” The responses have been polite, but vague and largely qualitative. This is concerning, because the old adage is true: “one cannot manage what one cannot measure.”

Without a specific set of performance goals for the FPS and a detailed implementation timeline, Congress has no systemic measures by which to evaluate the program’s implementation, and is forced to rely on impressionistic anecdotes and unnuanced claims from the Administration. As Senators who want to see this predictive analytics effort succeed, the lack of specificity regarding metrics for success is disappointing.

Targeting Claims for Review

CMS should improve how it currently targets claims for pre-payment review. While in one sense, it is understandable that CMS has undertaken implementation of the FPS with some caution (it is not in anyone’s interest for CMS to take enforcement actions based on conclusions from misleading or incomplete data), yet in another sense, graduation caution should eventually yield to robust operations.

After our offices saw a live demonstration of the FPS, we have concluded there is a significant disconnect between the rhetorical claims made by the Administration and the system’s actual current operational status. CMS has acknowledged the system is “mature” and has spent \$77 million taxpayer dollars to procure the contract for FPS, yet the number of predictive analytic

¹ <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2012-Transmittals-Items/R1089OTN.html>

² <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2012-Transmittals-Items/R1089OTN.html>

algorithms, or “models,” being applied to the live payment stream are underwhelming at best. CMS should have hundreds of models in operation, but instead there is a handful, and even the contract fulfillment only requires a few dozen.

Moreover, at the time we viewed the system, very few models were specifically designed to target procedures, services, or supplies that are known to have a significant profit margin or are known areas of high risk for the Medicare program. CMS needs to do a better job prioritizing what claims are under review and how those claims are reviewed. Rather than merely prioritize the “top 10” possible fraudulent claims or schemes, CMS should maximize its efforts with law enforcement and its contractors to review dozens, even hundreds, of flagged claims concurrently.

CMS should be more targeted in its design and adoption of models to review live claims. There are a wide range of recommendations and from GAO, OIG, Recovery Audit Contractors (RACs) and other program integrity contractors that can inform the process moving forward. It is my hope that CMS will adopt an institutionalized mechanism of some form to distill findings from these sources, and translate them into dozens and dozens of models that can be utilized to *prevent* fraudulent bills from being paid.

Transparency in Accounting for Results

There is strong bipartisan support for increasing program integrity in Medicare, but there remain significant unanswered questions about CMS’ activities to achieve effective program integrity. Members of Congress – on both sides of the aisle, in both chambers of Congress – want to see efforts succeed to reduce waste, fraud, and abuse. Congress has a right, even an obligation, to conduct oversight and understand the details of program operation. Accordingly, CMS should be more transparent in its reporting to Congress and the public about efforts to reduce waste, fraud, and abuse through the FPS and NFPP.

According to media reports, at a public appearance in May you apparently made comments that indicated CMS was considering how to test new audit methods.³ Certainly, a number of GAO and OIG reports have identified lingering challenges with some elements of CMS’s program integrity strategy – most notably of late, the Medicaid Integrity Group – but no details have been shared with Congress about possible changes that may lie ahead. Related, other than repurposing the Zone Program Integrity Contractors (ZPIC), CMS has not fully outlined a comprehensive vision for how the FPS will be integrated into the current constellation of program integrity work.

As CMS moves forward to improve program integrity efforts in a transparent manner, it is very important the agency do a better job institutionalizing accountability. A number of reports from GAO have shown that CMS struggles to effectively and efficiently manage its contractors. Too often, contractor performance is evaluated on outputs, rather than outcomes. For example, recent GAO analysis of another agency in HHS revealed that individuals are not accountable for their contribution toward the institutional goals and commitments of the agency in which they work. Moving forward, CMS should carefully assess how to most appropriately incentivize individuals

³ <http://insidehealthpolicy.com/201205082398185/Health-Blog/The-Vitals/cms-to-develop-new-audit-programs/menu-id-214.html>

and hold them accountable their contribution toward institutional performance standards. Increasing accountability in this way, in a transparent manner, could help strengthen overall program integrity efforts.

CMS can be more transparent with how it is handling the resources it has been allocated for the purposes of enhancing program integrity. For example, OIG and GAO have made a number of recommendations about how CMS can improve program integrity and reduce the loss of taxpayer dollars to waste, fraud, and abuse. Many of these recommendations still have yet to be implemented, but our offices have received reports that CMS has spent several hundred thousand dollars for a large new screen for its multi-million dollar “command center” as part of the FPS. Institutionalizing relationships through establishing a center may be useful, but if huge sums of money have indeed been spent on a video screen while other common-sense recommendations may have not been implemented due to “resource concerns,” this seems to be a case of misplaced priorities. If these and other questionable expenditures did occur as reported, they may effectively undermine legitimate request for additional resources for enhanced program integrity efforts.

Data Request

Finally, to ensure the FPS effort is successful, to safeguard taxpayer dollars, and to increase transparency and accountability, please provide my office with the following information outlined below:

Metrics for Implementation

- A work plan for the FPS for the next six quarters, outlining specific goals, deliverables, timeframes, and metrics for evaluation.
- An explanation of how the “One PI” (One Program Integrity –an effort to coordinate all PI pieces adopted by CMS in recent years) fits with FPS and NFPP.
- An explanation of how the Integrated Data Repository and One PI efforts are now funded.

Targeting Claims for Review

- An explanation of the need for the “command center” in Baltimore to run the FPS, as well as an account of the expenditures and staffing associated with the new “command center.” Please clarify the role and integration of the ZPIC staff with regard to the new center and what is different about the new center that requires its establishment.
- A specific explanation of how the fraud referrals from the 1-800 Medicare hotline –some of which have reportedly already been examined by the ZPICs and discarded —are now being integrated into the FPS.
- An explanation of the additional steps CMS must take if contractors identify false store fronts for Medicare billing addresses using technologies like Google Earth.⁴

⁴ http://www.coburn.senate.gov/public/index.cfm?a=Files.Serve&File_id=62eace4b-2ea6-4a2e-b8b4-ed200b05b8a8

- A detailed explanation of the institutionalized feedback mechanisms CMS has in place to develop new models based on the experience, insight, and advice of all of its program integrity contractors.

Transparency in Accounting for Results

- An explanation of how CMS handles cases of alleged or possible fraud that law enforcement declines to pursue.
- A timeframe for when CMS will comprehensively outline how it will assess the success of the FPS system.
- An explanation of what other possible revisions or modifications CMS may be considering to current auditing procedures, including changes to the scope of work for various CMS contractors.
- A detailed breakdown of all costs associated with FPS and the NFPP including administrative, implementation and operational costs. Please include specific information about how the \$77 million paid for the FPS contract is being divided amongst the various contractors and subcontractors working on FPS as well as detailed accounting of all costs, including staffing, for the FPS command center in Baltimore.
- An explanation of why CMS has not to date, been able to solely use FPS to stop any claims before they are paid.
- An explanation of why CMS has not used its exclusion authority to prevent fraudulent providers from continuing to bill the Medicare program.⁵
- A detailed breakdown of what dollar amount has been recouped as a direct result of enforcement actions taken against providers or suppliers who were first identified as problematic through FPS.
- A detailed explanation of what actions CMS took in response to our identifying more than three dozen physicians and non-physician practitioners with felony convictions or guilty pleas who have retained their Medicare billing privileges and/or the ability to order and refer in the Medicare program in November of last year. Please details when actions were taken with regard to each individual.⁶

New Public-Private Partnership

We noted with interest the announcement by HHS of the new public-private partnership between the Administration and private insurers to share information in order to share information and best practices as well as improve detection and prevent payment of fraudulent health care billings. We are supportive of the goal to reveal and halt scams that cut across a number of public and private payers and think this is an effort which is long overdue.

In reading the various pieces of information released regarding this new partnership, it was not immediately apparent how the partnership will work, what entity will be overseeing the process and which contractor or “trusted third party” would be analyzing the data. To that end, we would like to request the following information about this new initiative:

⁵ http://www.coburn.senate.gov/public//index.cfm?a=Files.Serve&File_id=f44ef932-dc16-4ad6-86d1-2a3c04fde387

⁶ <http://blogs-images.forbes.com/aroy/files/2011/11/11-29-11-Sebelius-Sept-27-follow-up-no-attachment.pdf>

- Specifics regarding exactly how this collaboration will work including what entities will be involved, whether HHS/CMS or another entity will be overseeing the effort and a timeline for expected key milestones of the effort.
- A step-by-step explanation of how the information will be shared (e.g., what systems will be used to transmit the data), what authorities allow the exchange of information, what impediments exist to sharing information (e.g., statutory language) and where the information will be stored/analyzed.
- A description of the third party who will be analyzing the data, as well as an explanation of how that entity will be selected and what their capabilities are to integrate and analyze such a large amount of information.
- Specifics regarding what will happen when leads are identified, how that information will be disseminated, and what the process will be for following up on those leads.

We respectfully request your office's response to these important, common-sense questions by August 31, 2012. If you have any questions about this request please contact Kimberly Brandt at 202/224-4515 or Josh Trent at 202/224-5754. Thank you for your attention to this matter and we are committed to working with you and others interested in reducing waste, fraud, and abuse in Medicare.

Sincerely,



Tom Coburn, M.D.
U.S. Senator



Orrin G. Hatch
Ranking Member

CC: Dr. Peter Budetti, CMS Deputy Administrator for Program Integrity