United States Senate
COMMITTEE ON THE BUDGET
WASHINGTON, DC 20510–6100

July 1, 2014

The Honorable Marilyn Tavenner
Administrator
Center for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Administrator Tavenner:

The Medicare Integrity Program ("MIP") at the Center for Medicare and Medicaid Services ("CMS") is charged with detecting and preventing improper Medicare payments. One of the goals of the MIP should be to detect fraud or improper requests for payments upfront, rather than attempting to recover funds once they have been improperly paid. CMS must make more progress with anti-fraud tools in order to shift beyond a "pay and chase" approach to a more effective strategy that identifies fraud before payments are made. Although CMS has implemented the Fraud Prevention System (FPS), with predictive analytics technology designed to identify and prevent the payment of improper claims in the Medicare fee for service program, the impact of FPS is uncertain.

In FY 2013, the nation spent over $580 billion in Medicare-related costs. Substantive evidence suggests that many of these costs are not warranted. According to the latest available data from the Office of Management and Budget, Medicare issued more than $36 billion in improper payments between July 1, 2011, and June 30, 2012. In its Spring 2014 Semiannual Report to Congress, the U.S. Department of Health and Human Services Office of Inspector General ("OIG") identified expected recoveries of more than $3.1 billion. In other words, only about 10 percent of identified improper payments will be recovered by the government. This is perhaps one reason why the Government Accountability Office has designated Medicare as a high risk program.

Numerous cases have been identified where physicians are over-diagnosing or intentionally misdiagnosing patients for the purpose of inflating Medicare billings. The OIG issued a report in March 2012 raising concerns about independent diagnostic testing facilities and recommended that CMS, among other things, compare billing

patterns of certain facilities and look for identifying characteristics in certain claims. In December of 2013, the OIG issued another report recommending that CMS establish a cumulative payment threshold and identify timely procedures for review of clinicians who reach that threshold. I agree with the OIG's recommendations.

Additionally, the OIG provides listings of unimplemented recommendations that could have detected improper payments before they were made, if corrective actions had been taken when first proposed. The Congress needs to know the steps that you are taking to reconcile these problems. To that end, please respond to the following:

1. Has CMS acted on the OIG's recommendations and established a cumulative payment billing threshold that triggers a review for service providers (e.g., clinicians, physicians, etc.) who reach that threshold? If so, please provide the threshold amount and the review process model. Also, could you please inform me on where CMS stands on developing these thresholds based on specialty? Is CMS considering other threshold-related models, such as an average payment per beneficiary which could indicate, for instance, the extent of services and procedures a physician performs in comparison to his/her peers for each Medicare beneficiary treated?
2. It is my understanding that CMS utilizes the relative value units (RVU) developed by the AMA as a basis for payments for physician services. I also understand that the Board that develops the RVUs is dominated by physician specialists. How does CMS monitor the development of the RVUs?
3. Has CMS considered reducing the payment for claims for which physicians have exceeded the number of procedures allowed in a daily average? How effective are CMS controls for identifying when a physician is providing the service, as opposed to a nurse practitioner or physician's assistant? How much of any given procedure does a physician actually have to perform to be identified as the "rendering" provider for a claim?
4. What actions is CMS taking with the data released this year to safeguard its Medicare programs? Is CMS partnering with, or planning to partner with, insurance companies or agencies in the Medicare arena in an effort to receive assistance in analyzing data or identifying fraudulent activities? Has CMS had any outreach with private insurers on how to interpret and use the data? Because many of the established edits in CMS' claims processing systems are based on volume of services, would CMS be able to strengthen these edits if it had access to complete provider billing and payment data from all payers?
5. The primary purpose of the FPS is to identify improper claims submitted for reimbursement and prevent payment for those claims rather than paying the claim and "chasing" the overpayment. How effective has the FPS been in terms of preventing fraud so as to diminish pay and chase in favor of prevention? Where does CMS stand on establishing specific performance measures to

evaluate the effectiveness of the FPS as recommended by the GAO? How much has the FPS identified that was actually prevented payments, not overpayment recoveries? What is the rate of return for the FPS based upon prevention only, not the overpayment recoveries?

6. There are significant Medicare payments that the fraud contractors identified as overpayments. But the OIG has found that, even once overpayments were identified, many did not result in recovery. What steps is CMS taking to prevent these overpayments from occurring and to collect the overpayments once they have been identified by the fraud contractor?
7. For 2013, the national error rate for Medicare fee-for-service claims was about 10 percent but the improper payment error rate for HHA claims was estimated at over 17 percent. An undetermined percentage of the national and HHA improper payments was due to fraud. CMS' identification of fraud schemes and patterns is critical towards establishing effective fraud deterrents. To this end, please provide the results-to-date of CMS' HHA Probable Fraud Measurement Pilot, and please detail any efforts to expand the pilot to other types of providers.
8. Does CMS investigate variations between high volume and low volume service providers? What have you found regarding these variations and how are you addressing any issues identified? Please explain the process in detail.

A number of problems related to Medicare fraud might not require congressional action. Instead, CMS could have the necessary tools, through incoming and recently released data, to prevent a substantive number of improper payments. The information requested will help us as we make that determination.

Please have your staff provide this information both in hard copy and in an electronic, searchable format no later than August 5, 2014 to William Smith on the Senate Committee on the Budget. If you have any questions, please contact me or have your staff contact Mr. Smith at (202) 224-0642, or william_smith@budget.senate.gov.

Very truly yours,

Jeff Sessions
Ranking Member