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United States Senate
COMMITTEE ON FINANCE
WASHINGTON, DC 20510–6200

October 15, 2012

Marilyn Tavenner, Acting Administrator
Center for Medicare & Medicaid Services
200 Independence Avenue, S.W.
Washington, DC 20201

Dear Acting Administrator Tavenner:

We are writing once again to express our continued concern over the continued lack of information provided by the Centers for Medicare & Medicaid Services (CMS) to repeated Congressional requests for information on CMS' fraud prevention system (FPS). As Members of the Senate Finance Committee who are charged with ensuring that public funds are being put to the best possible use, the large amount of dollars being spent on this project are of great interest as are the purported results. We have two serious concerns: the lack of specificity in responses to inquiries about FPS, as well as the fact that CMS has now missed a milestone in federal law that required a public accounting of the FPS system.

First, while we appreciated your response of August 27, 2012, to our earlier letter requesting information about the FPS, it was a far from complete response. We had initially requested very detailed and specific information answering a number of questions regarding the metrics and costs of FPS and other related CMS initiatives. Instead of a comprehensive response, we received a generic reply that was not truly responsive to our specific questions.

Second, you noted in your response that Section 4241(e) of the Small Business Jobs Act of 2010 (Pub. Law 111- 240) requires CMS to report, no later than 3 months after the completion of the first implementation year, on the use of predictive analytics in the first year, and to obtain certification from the Department of Health and Human Services' (HHS) Office of Inspector General (OIG) on the actual and projected savings to the Medicare fee-for-service program from use of this technology. According to this deadline specified in federal statute, we were expecting to receive the report by the statutory deadline of October 1, 2012.

We were disappointed that we did not receive the report. Instead, all our office received in response to staff inquiries about the status of the report was an email stating that CMS was "working diligently to finalize our report which will detail the government's pioneer efforts in using advanced predictive analytics to identify and fight fraud." However, given specific verbal

and written[1] comments by both you and your staff acknowledging the October 1, 2012 deadline, we have not yet received the report mandated under federal law. In fact, given the detailed statements by CMS staff in public speeches about the results of the FPS, it seems odd that specific details can be shared in public remarks yet you seek to keep the Congressional committee of jurisdiction in the dark.

For example, an October 1, 2012, article cited the following remarks about FPS results made by a CMS staffer who ". . . shared two success stories involving the FPS, including one about a provider who was detected under the system billing for a number of compromised Medicare beneficiary identities. The staffer said that CMS revoked the provider's Medicare billing privileges,

> "and as we looked further, we found additional leads and are now investigating other entities linked to the scheme. In the other example, the FPS flagged a situation where 80 percent of a provider's claims were for highly suspicious services. CMS suspended the provider's payments, and eventually revoked Medicare billing privileges."[2]

This is precisely the sort of information we have been requesting for months now but have yet to receive. It is incomprehensible to us why CMS has been unable to provide Congress with the statutorily mandated report when clearly there are results from the FPS project that are reliable enough to use in public speeches.

To exercise responsible Congressional oversight and ensure accountability for taxpayer dollars, we once again reiterate our request to receive the FPS report immediately. It is critical Congress can see how the significant resources allocated for FPS have been spent and whether or not the results justify continued investment with the same methodology.

We also think it appropriate to again express our concerns about the provider screening system, which was implemented in December 2011. According to remarks made by a senior CMS official at a conference last month,

> "CMS has already been used to perform licensure checks on the 800,000 physicians who are in the Medicare Provider Enrollment, Chain, and Ownership System (PECOS). Complete screens have also been performed on all 1.5 million Medicare providers and suppliers to establish a baseline and the screening system uses several different databases

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[1] August 27, 2012, letter from Acting Administrator Tavenner to Senators Hatch and Coburn stating "CMS would be issuing a report to Congress and the public by the end of September detailing the program's results."

[2] "Using Multiple Models Critical to Anti-Fraud Predictive Modeling Effort, CMS Official Says," James Swaan, Bloomberg BNA Health Care Fraud Report, October 1, 2012.

to analyze provider risk, including the compromised numbers checklist, which contains beneficiary and provider Medicare numbers that have been stolen."[3]

As we have previously articulated, our concern is that despite these efforts, *numerous individuals continue to bill the Medicare program despite having been convicted of felonies or other offenses that should render them ineligible to do so*. For example, just last month, a Los Angeles doctor who was already incarcerated for his participation in a narcotics scheme was convicted of healthcare fraud for submitting almost $1 million dollars in fake claims to Medicare in just seven months.[4] In prior letters to CMS, we have identified numerous other examples of individuals with felony convictions who continue to bill the Medicare program and remain very concerned that the enhanced screening efforts are not catching these individuals. The responses we have received to prior inquiries on this topic indicated CMS was working on the issues identified, but to date it appears that the issues are far from resolved as the most recent case in Los Angeles illustrates.

We remain very concerned about the effectiveness of these tools if CMS continues to be unable to provide valid, reliable results from either of these resource intensive efforts. We share your goal of protecting the Medicare program and want to ensure that taxpayer funds are being well utilized as CMS continues to enhance its program integrity efforts. However, the continued lack of information provided by CMS about the programmatic results casts a pall over whatever results may be eventually received. The longer the delay, the more questions there will be about the reliability and validity of those results.

In the interest of being transparent to taxpayers and stakeholders, and accountable to Congress, we request you publicize the report and reply to our concerns about provider enrollment within business 3 days. The American people deserve a CMS that abides by federal statute and is more candid about its programmatic operations.

Respectfully,

Tom Coburn, M.D.

Orrin G. Hatch

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[3] "CMS Committed to Using Data Analytics To Prevent Medicare Fraud, Budetti Says," James Swann, Bloomberg BNA Health Care Fraud Report, September 18, 2012.

[4] http://latimesblogs.latimes.com/lanow/2012/09/los-angeles-doctor-convicted-of-medicare-fraud.html.