Congress of the United States
Washington, DC 20515

September 12, 2016

Mr. Andrew Slavitt
Acting Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Mr. Slavitt:

The billions of dollars lost to Medicare fraud each year underscore the importance of stopping potentially fraudulent payments before they are made. Historically, the Centers for Medicare & Medicaid Services (CMS) has paid claims and then, after the fact, investigated whether the claims were proper, a concept known as "pay and chase." Over the past several years, however, CMS has taken steps to stop payments before they go out the door. These efforts include the deployment of the Fraud Prevention System (FPS), established through the Small Business Jobs Act of 2010, which uses predictive analytics to identify claims and providers that present a high fraud risk to the Medicare program.[1] Even so, we remain concerned that in spite of the steps taken, CMS still relies too heavily on investigating claims after the payments have been made rather than preventing them in the first place.

Improper payments remain an enormous problem for the Medicare Program. In 2015, the Medicare Fee-for-Service Program had an error rate of 12.1 percent, or $43.3 billion dollars.[2] In other words, 12 cents out of every dollar was misspent. On March 24, 2015, the Committee on Ways and Means Oversight Subcommittee held a hearing on the use of data analytics in combatting Medicare fraud. As members noted, each dollar lost to fraud is a dollar that is not used to benefit patients. This represents a significant burden on the program and taxpayers. As Representative Susan Brooks remarked during a Committee on Energy and Commence Oversight and Investigations Subcommittee hearing on improper payments on May 17, 2016 "[I]t truly is astonishing that after 10 years of albeit thoughtful reports — many reports — we've continued to allow our nation's largest health insurance programs to run really with this much fraud for this long of a period of time."

According to Dr. Shantanu Agrawal, Director of the CMS Center for Program Integrity, "[s]ince its June 2011 inception, the FPS has identified significant savings by running sophisticated

[1] Small Business Jobs Act of 2010, Pub. L. No.111-240, Sec. 4241, 125 Stat. 2504 (2010).
[2] High-error Programs, https://paymentaccuracy.gov/high-priority-programs.

analytics on 4.5 million Medicare claims on a daily basis, prior to payment."[3] Over the past several years, the FPS has produced some savings to the Medicare program. For example, in the program's third year, the Department of Health and Human Services' Office of Inspector General (OIG) certified approximately $86 million in savings from the FPS, representing a return on investment of $2.84 dollars to one.[4] This result is up from a return on investment of $1.34 to one reported the year before.

We remain supportive of CMS' efforts to implement the FPS, but are concerned that the FPS continues to rely primarily on outdated "pay and chase" activities rather than focusing on preventing potentially fraudulent dollars from going out in the first place. To assist our Committees in understanding CMS' work implementing the FPS, please provide the following information, no later than September 26, 2016:

1. A breakdown on the types of schemes and impacted Medicare programs identified in the FPS referrals for Zone Program Integrity Contractors (ZPICs) in each of the past three years. Please specify:
    a. The top ten allegation categories (e.g., upcoding and billing for services not rendered) and top five impacted Medicare services (e.g., Home Health, Managed Care, Hospice) identified by the FPS leads.
    b. The number of FPS leads that lead to the creation of new ZPIC investigations. Did these investigations result in any actions taken by CMS? If so:
        i. How many investigations resulted in actions by CMS?
        ii. What actions were taken?
        iii. What was the dollar amount involved?
    c. The number of FPS leads that aided existing ZPIC investigations. Did these investigations result in any actions taken by CMS? If so:
        i. How many investigations resulted in actions by CMS?
        ii. What actions were taken?
        iii. What was the dollar amount involved?

2. How many total investigations were conducted by ZPICs over the past three years? Please specify:
    a. What percentage of ZPIC investigations were supported by FPS leads?
    b. How many actions were taken by CMS resulting from ZPIC investigations? Please include: the number of investigations that resulted in actions by CMS, the types of actions, and the dollar amounts involved.

---

[3] Dr. Shantanu Agrawal MD., Raymond Wedgeworth, and Kelly D. Bowman, Commentary: Medicare's 'big data' tools to fight and prevent fraud yield over $1.5 billion in savings, Modern Healthcare (May 24, 2016), http://www.modernhealthcare.com/article/20160524/NEWS/160529960/commentary-medicares-big-data-tools-to-fight-and-prevent-fraud-yield.

[4] Department of Health and Human Services, Office of Inspector General, The Fraud Prevention System Increased Recovery and Prevention Of Improper Medicare Payments, But Updated Procedures Would Improve Reported Savings (June 2015).

3. The types of edits and/or filters that have been put into place as a result of the FPS over the past 3 years? Please specify:
    a. The various edit/filter categories for existing edits/filters.
    b. How many improper claims have been stopped due to these edits and what are the dollar amounts involved?
    c. For edits established by contractors other than the FPS contractors, please explain how the FPS contributed to the edit put into place.
    d. How many claims in the past 3 years have been stopped by algorithmic models and not pre-pay edits and denied before payment was made?

4. With guidance from the OIG, CMS developed adjustment factors to identify amounts saved or returned to the Medicare trust fund. What is the adjusted savings for the FPS in its 4th year using this methodology? Please provide the specific adjustment factors used in making this determination.

5. The total amount obligated over the past 3 years for FPS and the ZPICs.

6. A description of the process currently in place to monitor the effectiveness of the FPS models. How does CMS verify that models in the FPS are working as intended?

Thank you in advance for your assistance in this matter. If you should have any questions, you may contact Meinan Goto, staff for the House Committee on Ways & Means at (202) 225-9263, James Paluskiewicz, staff for the House Committee on Energy and Commerce at (202)225-2927, or Kim Brandt, staff for the Senate Committee on Finance at (202) 224-4515.

Sincerely,

Orrin G. Hatch
Chairman
Committee on Finance

Kevin Brady
Chairman
Committee on Ways and Means

Fred Upton
Chairman
Committee on Energy and Commerce

Peter J. Roskam
Chairman
Committee on Ways and Means
Subcommittee on Oversight

Tim Murphy
Chairman
Committee on Energy and Commerce
Subcommittee on Oversight and Investigations

Pat Tiberi
Chairman
Committee on Ways and Means
Subcommittee on Health

Joseph R. Pitts
Chairman
Committee on Energy and Commerce
Subcommittee on Health

cc: The Honorable Sander Levin, Ranking Member, Committee on Ways and Means
The Honorable Frank J. Pallone, Ranking Member, Committee on Energy and Commerce
The Honorable Ron Wyden, Ranking Member, Committee on Finance
The Honorable Jim McDermott, Ranking Member, Subcommittee on Health
The Honorable John Lewis, Ranking Member, Subcommittee on Oversight
The Honorable Diana DeGette, Ranking Member, Subcommittee on Oversight and Investigations
The Honorable Gene Green, Ranking Member, Subcommittee on Health