Congress of the United States
House of Representatives
COMMITTEE ON WAYS AND MEANS
WASHINGTON, DC 20515

SUBCOMMITTEE ON OVERSIGHT

April 25, 2012

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

Dear Acting Administrator Tavenner:

As the Chairman of the House Committee on Ways and Means Subcommittee on Oversight, it is my responsibility to conduct oversight of the Centers for Medicare & Medicaid Services (CMS) and its program integrity activity. The Government Accountability Office (GAO) estimates that nearly $48 billion in Medicare payments were subject to fraud, waste, or abuse during fiscal year (FY) 2010, with an estimated $34.3 billion in Medicare fee-for-service alone.[1] Today I write to request specific information regarding CMS's program integrity efforts and the performance, effectiveness, and evaluation of Medicare contractors.

The Health Insurance Portability and Accountability Act of 1996 established the Medicare Integrity Program (MIP), under which CMS oversees program integrity efforts such as fraud detection, provider audits, medical reviews, provider education, coordination with law enforcement, and other actions. These activities are performed through a variety of private contractors, including: Medicare Administrative Contractors (MACs), which process and pay Medicare claims, enroll and audit providers, and identify and recover improper payments; Zone Program Integrity Contractors (ZPICs) and Program Safeguard Contractors (PSCs), which are assigned geographic regions to detect and investigate potential fraud and abuse and refer cases to law enforcement; Recovery Audit Contractors (RACs), which are paid on a contingency basis to identify and recoup overpayments; and the National Supplier Clearinghouse (NSC) Contractor, responsible for reviewing enrollment applicants from suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) through on-site visits and other activities.

[1] GAO, Medicare Integrity Program: CMS Used Increased Funding for New Activities but Could Improve Measurement of Program Effectiveness (July 2011), GAO-11-592.

As program integrity efforts are critical to the protection of Medicare Trust Funds, it is essential that Congress conduct oversight to ensure CMS is engaging in these efforts effectively and that taxpayers are getting value for the over $1 billion that is spent on MIP activities annually. I therefore ask that you provide the following information by no later than May 25, 2012. This information will assist the Committee on Ways and Means in its review of CMS's program integrity efforts and contractor performance. When responding to this request, restate the question prior to each response. The relevant date range for all requests is October 1, 2008, to the present.

1. A list of all program integrity contracts in effect across CMS. This includes but is not limited to all current MAC, ZPIC/PSC, RAC, NSC, Comprehensive Error Rate Testing, Payment Error Rate Measurement, and Risk Adjustment Data Validation contracts. This information should also include the name of the contracting entity, the effective dates of the contract, a brief description of the contract terms, and dollar value of the contract (including both past and anticipated payments).

2. The following information and documents:

    a. For MACs, include:

        i. All Statements of Work;

        ii. The total number and amount of suspected overpayments referred to each MAC by a ZPIC/PSC and the amount the MAC has actually recovered; and

        iii. A description of how CMS evaluates MAC performance and all performance reviews, evaluations, and performance-related findings performed by CMS or an outside party at CMS's direction.

    b. For ZPICs/PSCs, include:

        i. A description of how CMS evaluates ZPIC/PSC performance and all performance reviews, evaluations, and performance-related findings performed by CMS or an outside party at CMS's direction;

        ii. All Statements of Work, task orders, and procurement award details for each ZPIC/PSC;

        iii. A list of all case referrals the contractor has made to the HHS Office of Inspector General (OIG), the Department of Justice (DOJ), or other law enforcement entity;

iv. The total number of Medicare beneficiaries, the number of paid claims, and the dollar amount of paid claims provided per year within each ZPIC/PSC zone;

v. For each ZPIC or PSC, provide the following monthly workload statistics from the CMS Analysis, Reporting, and Tracking System: 1) Benefit Integrity template (including but not limited to new investigations and cases, amount of overpayments referred to and recovered by MACs, and administrative actions initiated), 2) Request for Information template, 3) Quality Assurance and Improvement template, and 4) Quarterly Requests for Information reports; and

vi. The return on investment for each contractor for each fiscal year.

c. For RACs, include:

i. Total overpayments collected and underpayments returned by region;

ii. The total fees paid to each RAC;

iii. The percent of each RAC's overpayment determinations that were appealed by providers, and the percent of these overpayment determinations that were overturned on appeal; and

iv. A description of how CMS evaluates RAC performance and all performance reviews, evaluations, and performance-related findings performed by CMS or an outside party at CMS's direction.

d. For NSC, include:

i. The number of unannounced site visits conducted by month;

ii. The number of DMEPOS suppliers that have had enrollment applications approved or rejected in FYs 2010 and 2011;

iii. A description of how CMS evaluates NSC performance and all performance reviews, evaluations, and performance-related findings performed by CMS or an outside party at CMS's direction; and

iv. The Balanced Budget Act of 1997 amended the Social Security Act to require DMEPOS suppliers to provide a surety bond as a

condition of enrollment in Medicare. CMS eventually promulgated a final rule in January 2009, which became effective on March 3, 2009. Provide all written procedures outlining how DMEPOS overpayments are recovered through surety bonds, as well as a list of all DMEPOS overpayments that have been recovered through surety bonds since March 2009.

3. Describe how CMS oversees contractor conflicts of interest both during the contract award process and through the period of performance.

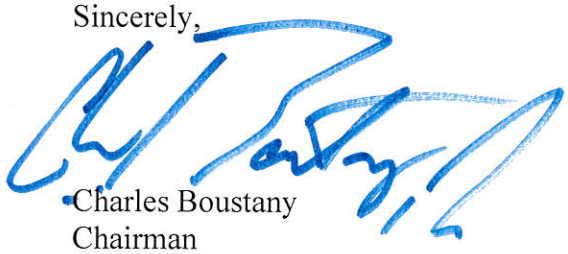
4. Provide the methodology CMS uses to calculate costs, savings, and return on investment for program integrity contractors.

5. The annual and cumulative funds CMS has collected through provider application fees, as well as detailed information of how the funds were used.

6. Earlier this year, GAO identified weaknesses with the data CMS uses to calculate ROI. This included a failure to include updated submissions and corrections from contractors that can occur up to two years after the end of the fiscal year. At the time of the report, CMS reported that the agency was aware of the issue and making changes to its data collection system to correct this problem. Please provide information detailing how the agency has implemented corrective changes, or if it has not, an estimate of when they will be completed.

I thank you in advance for your cooperation in this important matter. Should you have any questions regarding this request, please contact Chris Armstrong at (202) 225-5522.

Sincerely,



Charles Boustany
Chairman