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

November 12, 2015

VIA ELECTRONIC TRANSMISSION

The Honorable Andrew M. Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
200 Independence Ave, S.W.
Washington, D.C. 20201

Dear Mr. Slavitt,

I am writing to you about my serious concerns regarding a Technical Direction Letter (TDL) recently issued by the Centers for Medicare & Medicaid Services (CMS) to the Recovery Audit (RA) contractors placing a 0.5 percent limit on record requests for all providers for Part A claims. This limit is significantly lower than what has historically been the record limit for RAs and appears to significantly curtail the ability of the RAs to operate as Congress intended them to.

This guidance and its impact is especially troubling as in recent testimony before the Finance Committee, Comptroller General of the United States Gene Dodaro testified that in fiscal year 2014, Medicare financed health services for approximately 54 million elderly and disabled beneficiaries at a cost of $603 billion and reported an estimated $60 billion in improper payments. It is both astonishing and unacceptable that one in every 10 dollars spent on the Medicare program is spent improperly.

Mr. Dodaro also testified that for fiscal year 2014, the Department of Health and Human Services (HHS) reported an estimated error rate of 12.7 percent for Medicare Fee-for-Service. This represents a significant increase from the already high 10.1 percent error rate in the previous year. Some components of this estimate—such as durable medical equipment and home health claims—have estimated error rates in excess of 50 percent, meaning that most payments for these items and services were estimated to be improper.

Last month, CMS issued the Fiscal Year 2014 Recovery Audit Program Report to Congress. This report shows that in fiscal year (FY) 2014, RAs collectively identified and

corrected 1,117,057 claims for improper payments that resulted in $2.57 billion in improper payments being corrected. The total corrections identified include $2.39 billion in overpayments collected and $173.1 million in underpayments repaid to providers.

These recovery levels, while appreciated, are just a drop in the bucket compared to the waste, fraud and abuse identified by the Government Accountability Office (GAO) and more must be done. The Finance Committee is doing its part to enhance an operational program integrity system by advancing appeals legislation to ensure that a functional system allows contested audit findings to be independently reviewed and resolved in a timely manner.

CMS must do its part as well. In 2014, CMS reported $45.8 billion in improper payments for the Medicare fee-for-service program; this represents the highest level of improper payments for all government programs. I am concerned that rather than vigorously going after waste, fraud and abuse in Medicare, CMS is further restricting claims subject to audit and review. On May 20, 2014, at a hearing before the House Oversight and Government Reform Subcommittee on Energy Policy, Health Care and Entitlements, a representative from GAO and Dr. Shantanu Agrawal, Deputy Administrator and Director, Center for Program Integrity, testified that CMS reviews less than one percent of the claims it receives. Given the high error rate and the fact the Medicare program loses more money to improper payments than any other government program, a review level of less than one percent appears to be too low.

Additionally, while the RA recoveries historically have been high, RA recoveries in FY 2015 are significantly lower—between 85 and 90 percent lower—than those for FY 2014. In the first three quarters of FY 2015, RAs corrected $309.15 million in improper payments (overpayments and underpayments) and recovered $224.23 million. During the first three quarters of FY 2014, RAs corrected over $2.21 billion in improper payments and recovered over $1.95 billion in overpayments. I understand and appreciate the complexities CMS must navigate to resolve the challenges associated with hospital short stay policies, but I believe that CMS should be stepping up a vibrant oversight presence in the program more broadly. With the recent moratorium on RA reviews of inpatient claims, I would not expect CMS to further limit reviews of non-inpatient claims, especially since these are the very areas that have some of the highest error rates. A 12.7 percent or potentially even higher program error rate is unsustainable and not in the best interest of the Medicare program.

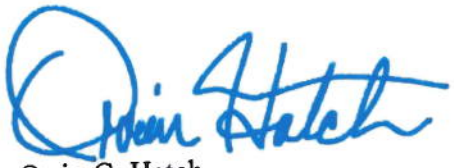
To that end, I would like to see a detailed plan from CMS to bring that level down, fully utilizing the resources at your disposal on behalf of taxpayers by December 4, 2015. That plan should include:

- A serious review of the TDL issued to the RAs to assess if this new lower limit is indeed appropriate;
- A broad look at the RA program generally to ensure CMS is best using the RA contractors to the full extent of their capabilities;
- CMS's target for recoveries in the RA program for the current and future RA contracts; and

- An explanation of CMS's plans to, and targets for, broadening the types of improper payments for recovery, or if CMS does not have such plans, an explanation of why it does not.

Thank you for your prompt attention to this critical issue. Please do not hesitate to contact Kim Brandt of the Finance Committee staff at 202/224-4515 if you have any questions regarding this request.

Sincerely,



Orrin G. Hatch
Chairman
Committee on Finance