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

September 27, 2011

Donald Berwick, M.D., M.P.P.
Administrator
Centers for Medicare & Medicaid Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Administrator Berwick:

The United States Senate Committee on Finance (Committee) has jurisdiction over, among other things, the Medicare program and the Patient Protection and Affordable Care Act (PPACA). As Members of the Committee, we have a responsibility to conduct oversight and ensure that the appropriate steps are taken to protect the Medicare program from fraud, waste, and abuse. We are writing to outline several concerns that have come to our attention and request your response to ensure taxpayer dollars are carefully stewarded.

A number of issues have come to our attention, which raise questions about the Centers for Medicare & Medicaid Services (CMS) oversight of its fee-for-service contractors with respect to implementation of the provider enrollment provisions of PPACA and actions to ensure the appropriate enrollment of legitimate practitioners in the Medicare program by CMS. Some of the questions raised are:

1) CMS Oversight and Implementation of Surety Bond Requirement for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Suppliers

The Department of Health and Human Services Office of Inspector General (HHS-OIG) issued an Early Alert Memorandum Report on September 12, 2011, reporting on a number of findings the HHS-OIG identified regarding CMS' failure to finalize procedures related to the recovery of overpayments made to DMEPOS suppliers through surety bonds. These findings stated that CMS' failure to finalize these procedures or recover any DMEPOS overpayments through surety bonds since March 2009 left Medicare vulnerable to losses from fraudulent DMEPOS suppliers. This is of particular concern given the issues attributed to fraudulent DMEPOS suppliers identified by HHS-OIG in the past which resulted in billions in Medicare improper payments. Ancillary information we have received indicates other potential issues such as an increase in the number of DMEPOS suppliers and that the surety bond requirement has not been uniformly applied to all new DMEPOS suppliers.

To address these concerns, please provide us with the following:

- Copies of all draft and final instructions and/or technical direction issued to CMS contractors regarding identification and collection of DMEPOS overpayments;

- Copies of all draft and final instructions and/or technical direction issued to CMS contractors regarding enforcement of the DMEPOS surety bond requirement related to the enrollment of new and existing DMEPOS suppliers; and

- The number of DMEPOS suppliers currently enrolled in the Medicare program as of October 1, 2011, and the number of DMEPOS suppliers enrolled in the Medicare program as of January 1, 2010, and January 1, 2011.

2) Ability of Convicted Felons and Unlicensed Practitioners to Potentially Receive Medicare Payments

Based on our review, it appears that CMS' Medicare fee-for-service contractors are not taking the necessary steps to review and, as appropriate, revoke Medicare billing and referring privileges for physicians and non-physician practitioners despite felony convictions or plea agreements to such crimes as tax evasion, health care fraud, and lewd and lascivious conduct. By not taking the appropriate administrative action against providers and suppliers who are convicted or who have pled guilty to financial crimes and other felonies detrimental to the Medicare program, CMS is abdicating its fiduciary responsibilities and placing Medicare beneficiaries at increased risk of poor quality health care. Equally troubling is the apparent lack of meaningful coordination and communication between CMS and the Department of Justice (DOJ), the Internal Revenue Service (IRS), HHS-OIG, State officials, and contracted Medicare Advantage Organizations (MAOs).

We request that CMS:

- Investigate and determine if a Medicare revocation and/or overpayments are appropriate for the individual practitioners and/or health care entities contained in the document provided separately; and, provide us with a report on CMS' findings, and the steps that CMS will take to prevent these types improper payments or referrals in the future;

- Provide us with copy of the Interagency Agreements, including any performance measures, between CMS and DOJ, IRS, HHS-OIG and State officials (e.g., State Attorney General or State Insurance Commissioner) to ensure that CMS is made aware of felony indictments and/or convictions in a timely manner;

- Explain the process improvement actions that CMS takes after the DOJ obtains a conviction or an individual pleads guilty to health care fraud. Specifically, provide the CMS review protocol used to review, analyze, and implement changes to the Medicare program based on DOJ felony indictments and/or convictions; and,

- Provide a copy of the procedures used by CMS to notify contracted MAOs when a physician or non-physician practitioner or health care entity Medicare billing privileges are revoked.

We are also concerned that CMS' fee-for-service contractors may be failing to investigate and, where appropriate, revoke the Medicare billing and referral privileges of physicians and non-physician practitioners who continue to bill the Medicare program even though the individual

practitioner's medical license has been suspended or revoked by the applicable State licensing board. It is not acceptable to allow unlicensed physicians and non-physician practitioners to continue to bill the Medicare program for services furnished or referred to Medicare beneficiaries. Accordingly, we request that CMS:

- Explain how it verifies that its Medicare contractors are taking the appropriate administrative action when an individual practitioner's medical license is revoked or suspended by a State medical board;

- Investigate and determine which Medicare contractors are not revoking Medicare billing privileges when an individual practitioner's medical license is revoked or suspended by a State medical board and take the appropriate contract action to address this deficiency; and,

- Provide a list by contractor with the names of the physicians or non-physician practitioners continuing to participate in the Medicare program with invalid State medical license (i.e., medical license revoked or suspended by a State or voluntarily surrendered by the practitioner). For these providers, describe the CMS administrative action and amount of overpayments assessed for each.

3) Payments to Undefined Provider and Supplier Types

It has recently come to our attention that, despite the increased scrutiny on providers and suppliers mandated under PPACA, CMS continues to reimburse some providers and suppliers that have previously enrolled as an "undefined" or "other" provider or supplier types and that these providers and suppliers continue to bill the Medicare program with little or no oversight activity by CMS. Therefore, we request that CMS:

- Investigate and determine whether providers and suppliers that enrolled as "undefined" or "other" are licensed and eligible to participate in the Medicare program; and for each "undefined" or "other" practitioner medical specialty enrolled in the Medicare program provide the following:
    - Name of provider or supplier,
    - Location (State) of provider or supplier,
    - Original provider or supplier specialty type listed on the Medicare enrollment application,
    - Newly assigned provider or supplier specialty type, if changed, and
    - Whether a site visit was conducted prior to enrollment or during the revalidation process.

4) Review and Action on State-Imposed Sanctions for Medical Documentation Failures

Many States impose sanctions on physicians and other practitioners when these individuals do not maintain the appropriate documentation for services furnished to patients. Since the lack of medical documentation is a significant factor in the Medicare error rate, what efforts, if any, does

CMS undertake to review State licensing board disciplinary actions to identify physicians and other practitioner disciplined by the state for documentation errors?

5) Implementation of Claims Edits to Protect the Medicare Program

It is also troubling that CMS has failed to implement edits or has suspended edits to ensure patient safety and protect the Medicare Trust Funds from improper payments. To date, it appears CMS has not implemented: (1) systematic ordering and referring claims edits to prevent, waste and abuse and reduce improper payments, or (2) provisions found in the PPACA (see Section 6401(a)(3)) to establish a provisional period of enhanced oversight for new providers and suppliers. In addition, while the Government Accountability Office (GAO) and HHS-OIG have recommended that CMS adopt a deactivation process for unused Medicare billing privileges, it appears that that CMS suspended its successful deactivation process for Part B suppliers.

Accordingly, we request that CMS:

- Explain why CMS has not implemented systematic ordering and referring edits for home health agencies, DMEPOS suppliers, clinical laboratories and independent diagnostic testing facilities and provide a timeline of when CMS will implement these edits;

- Estimate the program cost to the Medicare program of forgoing the implementation of systematic ordering and referring edits on an annual basis;

- Estimate the impact on the CMS error rate of forgoing implementation of systematic ordering and referring edits on an annual basis;

- Explain why CMS has not implemented a provisional period of enhanced oversight for providers and suppliers considered a "moderate" or "high" provider enrollment screening risk and provide a timeline of when CMS will implement these edits;

- Estimate the amount of payments by provider type made to newly enrolling providers and suppliers considered a "moderate" or "high" provider enrollment screening risk in FY 2011;

- Explain why CMS suspended the practice of deactivation for twelve consecutive months of non-billing for Part B suppliers; whether CMS consulted with HHS-OIG prior to making this program change; the impact of this change CMS' efforts to protect physicians and non-physician practitioners from identity theft, and whether CMS physicians or non-physician practitioners have complained to CMS about this change in policy;

- Explain whether CMS implemented a practice of deactivating Medicare billing privileges for Part A providers and whether CMS suspended this process for Part A providers; and,

- Explain whether CMS implemented a practice of deactivating Medicare billing privileges for DMEPOS suppliers and whether CMS suspended this process for DMEPOS suppliers.

6) Application Fees for Updating Enrollment Information in Medicare Program

CMS has recently announced that pursuant to requirements in PPACA, the agency will require all health care organizations, except medical groups and clinics, to update their enrollment information on file with Medicare program and pay a $505 application fee. While we understand CMS' need to comply with the PPACA requirement, it is public record that many hospitals, skilled nursing facilities, suppliers of durable medical equipment, prosthetics, and orthotics supplies, and other health care organizations have updated enrollment information with Medicare within the last two years and are legitimate health care organizations. Therefore, we are interested in understanding why CMS felt that a whole scale revalidation effort was necessary rather than a more targeted or phased in approach which would result in less provider cost and burden.

It appears that by adopting a one-size fits all revalidation approach, CMS is not reducing fraud, waste and abuse or improving payment accuracy, but instead imposing an excessive amount of government burden on small businesses. Therefore, we request that CMS explain why the recent updating of enrollment information was not limited at those organizations that have not updated their enrollment in more than three years and those health care providers that pose the greatest risk to the Medicare program and to Medicare beneficiaries.

We understand that we are requesting a substantial amount of information, but appreciate your understanding Congress' role in overseeing that taxpayer dollars are carefully stewarded. Thank you for your timely attention to this request. We would appreciate your responding to this request within 45 days.

Sincerely,

Orrin G. Hatch
United States Senator

Tom Coburn, M.D.
United States Senator