United States Senate

May 9, 2013

The Honorable Kathleen Sebelius
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Secretary Sebelius:

As Members of key Senate Committees that oversee Medicare, we have a fiduciary responsibility to ensure that all steps are being taken to safeguard the program. The Government Accountability Office (GAO) issued a report last fall titled "Types of Providers Involved in Medicare Cases and CMS Efforts to Reduce Fraud,[1]" in which durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) were included as one of the provider/supplier types most vulnerable to Medicare fraud and abuse. Congress has enacted various measures to help the Department of Health and Human Services (HHS) and the Centers for Medicare & Medicare Services (CMS) prevent and recover improper payments made to DMEPOS suppliers, including the authority to require DMEPOS suppliers to obtain surety bonds. These bonds prevent fraudulent suppliers from enrolling in Medicare and also aid CMS in recovering overpayments. In spite of their utility, we are concerned that CMS is not making full and effective use of surety bonds to the full extent permitted by the law and as a result has unnecessarily placed taxpayer dollars in jeopardy.

The Office of Inspector General (OIG) for HHS first alerted CMS that DMEPOS are highly susceptible to fraud and abuse in 1997.[2] Since then, both OIG and the GAO have repeatedly identified problems in the monitoring of DMEPOS suppliers and in the suppliers' compliance with Medicare enrollment standards.[3]

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[1] GAO, *Types of Providers Involved in Medicare Cases, and CMS Efforts to Reduce Fraud*, GAO-13-213T, Nov 28, 2012.
[2] OIG, *Medical Equipment Suppliers: Assuring Legitimacy*, OEI-04-96-00240.
[3] GAO, *More Effective Screening and Stronger Enrollment Standards Needed for Medical Equipment Suppliers*, GAO-05-656, September 2005; OIG, *South Florida Suppliers' Compliance with Medicare Standards: Results from Unannounced Visits*, OEI-03-07-00150, March 2007; OIG, *Los Angeles County Suppliers' Compliance With Medicare Standards: Results From Unannounced Site Visits*, OEI-09-07-00550, February 2008.

The Balanced Budget Act of 1997 required DMEPOS suppliers to maintain a surety bond of at least $50,000 as a condition of enrollment in Medicare.[4] In 2009, CMS published a final rule requiring certain DMEPOS suppliers to "furnish CMS with a surety bond."[5] As noted in the rule, the surety bond limits Medicare's exposure to fraud by strengthening the enrollment process, and also aids CMS's ability to recover erroneous and fraudulent payments made to suppliers. The Patient Protection and Affordable Care Act of 2010 (PPACA) also authorized the Secretary of HHS to increase surety bond requirements for suppliers based on billing volume.[6]

Although CMS's final rule has been in place for more than three years, the OIG recently found that CMS has still not implemented a surety bond program that would allow for the full recovery of erroneous and fraudulent payments permitted under the law.[7] Specifically, OIG found that CMS: (1) did not have complete or accurate surety bond information from all required suppliers; (2) did not recover millions of dollars in supplier debt owed by suppliers that should be bonded; and (3) was owed more than $20 million from suppliers without surety bonds.

These findings demonstrate opportunities for improvement by CMS to use an important tool that is available to fight fraud and abuse in the Medicare program, and also raises the question of whether the scope of the surety bond program should be expanded to aid recovery of overpayments. To better understand why CMS has not made better use of the surety bond tool, please provide us with the following information:

1) Given the importance of preventing and recovering overpayments, why did it take CMS nearly three years to finalize its surety bond procedures?
2) Considering the large number of suppliers that OIG identified who owe more than $50,000 in overpayments, is there a better threshold for bond amounts than $50,000?
3) Do you plan to exercise your authority under PPACA to increase surety bond requirements for suppliers with a high billing volume? If so, what is your timeframe for implementing this?
4) What role do contractors serve in the collection of bonded debt? How does CMS staff oversee the collection process?
5) In the CMS Program Integrity Manual, it states that suppliers must obtain an elevated surety bond if any final adverse actions have been taken against them.[8]
   a) Does CMS's Provider Enrollment, Chain, and Ownership System (PECOS) database track which suppliers have had adverse actions taken against them?

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[4] Section 4312(a) of the Balanced Budget Act of 1997, P.L. 105-33 (amending Social Security Act § 1834(a)).
[5] 74 Fed. Reg. 166-67 (Jan. 2, 2009).
[6] PPACA, P.L. 111-148 § 6402(g) (amending Social Security Act, § 1834(a)(16)(B)).
[7] OIG, *Surety Bonds Remain an Underutilized Tool to Protect Medicare From Supplier Overpayments*, OEI-03-11-00350, March 2013.
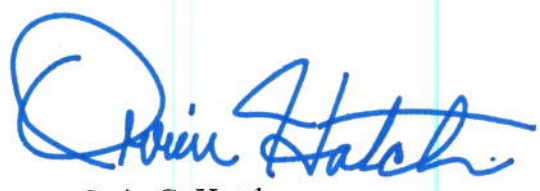[8] 42 C.F.R. §§ 424.57(a) and (d)(3); CMS, *Medicare Program Integrity Manual*, Pub. No. 100-08, ch. 10, § 21.7(A)(3).

      i) If not, how does CMS determine whether a particular supplier should post a bond higher than $50,000?

   b) Has CMS required any suppliers to obtain a bond higher than $50,000 because adverse actions have been taken against them? If so, how many suppliers have been required to obtain an elevated bond and what are their bond amounts?

      i) If not, what steps will CMS take in the future to ensure that these suppliers obtain the appropriate amount of bond?

6) Does the PECOS database allow CMS to determine which bonded suppliers have received overpayments without doing the type of manual calculation that OIG described in their report?

7) CMS used surety bonds to recover just $263,000 of the millions of dollars in debt from bonded suppliers.

   a) Does this $263,000 reflect that total amount of bonds that were posted by bonded suppliers?

   b) If not, what steps has CMS taken to collect the remaining surety bonds from these suppliers?

   c) When does CMS expect that it will collect the full amount of surety bonds for the suppliers identified in the OIG report, or the amount that CMS believes is recoverable?

8) Please update us on the amount of surety bonds that have been collected since July 2012. In your response to the audit dated March 4, you note that "CMS shall immediately begin utilizing surety bonds to recover debts from bonded suppliers." Since that date, what changes has CMS made in its use of surety bonds?

9) The report notes that CMS is considering the use of surety bonds in other areas, such as home health. Please identify these areas and explain why you believe that surety bonds will be helpful.

   a) Please indicate CMS's timeframe for implementing surety bond requirements in this and other areas.

   b) Given that it took CMS nearly three years to finalize its surety bond procedures for suppliers, how will CMS ensure that these significant delays will not occur in other areas where surety bond requirements are implemented?

HHS and CMS have a duty to ensure that taxpayer dollars are being carefully stewarded and that all available tools are being utilized to combat health care fraud nationwide. Therefore, we appreciate your assistance in helping us better understand what HHS and CMS are doing to address these issues.

If you have questions about this request please feel free to contact Kim Brandt at (202) 224-4515. Thank you for your timely attention to this request and we look forward to receiving your response by May 31, 2013.

Sincerely,

Orrin G. Hatch
Ranking Member
Senate Finance Committee

Thomas R. Carper
Chairman
Homeland Security and
Governmental Affairs Committee

Tom A. Coburn
Ranking Member
Homeland Security and
Governmental Affairs Committee

Claire McCaskill
Chairman
Subcommittee on Financial and
Contracting Oversight

Ron Johnson
Ranking Member
Subcommittee on Financial and
Contracting Oversight

cc: Acting Administrator Marilyn Tavenner, Centers for Medicare & Medicaid Services