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United States Senate

COMMITTEE ON FINANCE

WASHINGTON, DC 20510-6200

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December 13, 2011

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 the U.S. Senate Finance Committee with jurisdiction of the Medicare program, we have a responsibility to conduct oversight and ensure that the Centers for Medicare & Medicaid Services (CMS) implements policies to protect the Medicare program from fraud, waste, and abuse. It is in this role that we are writing to request that Department of Health and Human Services (HHS) explain CMS' apparent lack of transparency in the Medicare contractor oversight and program integrity areas.

On November 15, 2011, HHS issued its 2011 Agency Financial Report that contains five strategic goals, with goal 4 (Increase Efficiency, Transparency, and Accountability of HHS Program) emphasizing HHS commitment to responsible stewardship of resources by fighting fraud and working to eliminate improper payments. Also earlier this year, you testified before the Senate Finance Committee regarding HHS' 2012 Budget and stated in your written testimony that, "it means attacking fraud and waste throughout the department to increase efficiency, transparency, and accountability." However, we are concerned that HHS' operative definition of transparency is deficient in several instances.

With more than \$500 billion in Medicare program expenditures annually and more than 1.4 million providers participating in the fee-for-service Medicare program, we are concerned that CMS is implementing policies that affect the health care industry with little or no public notification. CMS actions call into question how these practices are efficient or transparent. Specifically, we believe that there are two areas where CMS has been less than transparent with the public: 1) technical direction letters and 2) effective billing date for physicians and non-physician practitioners, and physician and non-physician practitioner organizations (physicians).

Technical Direction Letters

As you know, CMS issues Technical Direction Letters (TDLs) to a Medicare contractor (after an award) to provide supplementary guidance to the contractor regarding tasks contained in the performance work statement. CMS generally does not disseminate this information to the public, since a TDL is intended to provide further detail or instruction for a contractor. Since TDLs are issued after a contract has been awarded, they cannot conflict with the conditions, terms, or requirements in the task order.

We are concerned that CMS' rather extensive use of TDLs to its Medicare fee-for-service contractors lacks transparency, requires contractor implementation with little or no time for training or the development of compliance requirements, and in some circumstances, may reverse existing program safeguard policies with little or no public notice. It is simply not fair to Medicare providers that they are subject to a type of "black box" decision-making on Medicare contractor changes that leaves them with little notice or warning. Accordingly, we request that HHS explain the rationale for issuing substantive policy direction using TDLs, instead of program manuals or other more transparent and stakeholder-responsive processes. Additionally, we request HHS explain CMS' rationale for issuing instructions via a TDL that instructed its Medicare contractors to:

- Discontinue the practice of verifying whether a foreign born physician or non-physician practitioner is: (1) a United States citizen; (2) a permanent resident of the United States, or (3) otherwise legally authorized to work in the United States given that these requirements are consistent with the requirements for obtaining a Social Security Number. Please explain how this change in policy will improve payment accuracy and reduce fraud, waste, and abuse in the Medicare program; and
- Require Medicare contractors to incur millions of dollars in new provider enrollment processing costs to revalidate more than 100,000 Medicare providers in Phase I of CMS' revalidation effort – rather than issuing a formal contract modification.

Furthermore, so that we can more fully understand the use of TDLs to issue important Medicare policy, we request that HHS provide a:

- Copy of all TDLs issued by CMS to its Medicare contractors (i.e., carriers, fiscal intermediaries, Part A/Part B Medicare Administrative Contractors (A/B MACs), Durable Medical Equipment Medicare Administrative Contractors (DME MACs), and the National Supplier Clearinghouse Medicare Administrative Contractor (NSC MAC) for the period of March 23, 2010 through December 13, 2011; and,
- Copy of any CMS-imposed or Federal Acquisition Regulation contracting limitations associated with issuing a TDL without adequate funding to support the contract action.

Effective Billing Date

As you know, CMS uses an “effective billing date” to establish the earliest date that Medicare will make a payment for services furnished to Medicare beneficiaries. The establishment of this date helps to ensure that Medicare beneficiaries receive quality care from qualified practitioners and reduces the Medicare program exposure to fraud.

We are concerned by reports we have received that CMS is changing the effective billing date for some physicians. There are two problems with these CMS actions.

First, by its decision to set-aside existing Federal enrollment requirements, CMS is effectively picking winners and losers in the Medicare enrollment process. Second, because CMS’ provider enrollment “set-aside” process lacks transparency and increases Medicare expenditures, we are concerned that some physicians may be receiving a different Medicare effective billing date, other than the one established by the Medicare contractor using CMS regulations and published program instructions. Moreover, it is unclear why CMS would decide intervene on behalf of some providers or suppliers, rather than simply allowing these individuals and entities to use the administrative appeals process. Or, if CMS believes there is a more systemic problem, the logical response would be for CMS to clarify its existing regulations or program instructions for all practitioners. Again, it appears that CMS is not acting in a transparent manner.

Accordingly, we request HHS instruct CMS to discontinue its non-transparent review of certain physician effective billing date(s) used in its “set-aside” project and issue clarifying public program instructions to its Medicare contractors regarding the establishment of effective billing dates for physicians. Furthermore, we request that CMS provide us with copies of all documents, including standard operating procedures, used by CMS or its Regional Offices to review and establish an effective date of billing for physicians.

Thank you for your prompt attention to this request. We request your staff provide all items within this request by January 18, 2012.

Sincerely,



Orrin G. Hatch
Ranking Member



Tom Coburn, M.D.
U.S. Senator

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