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United States Senate

COMMITTEE ON FINANCE

WASHINGTON, DC 20510-6200

RUSSELL SULLIVAN, STAFF DIRECTOR
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November 29, 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 United States Senate Committee on Finance (Committee) with jurisdiction over the Medicare program and the Patient Protection and Affordable Care Act (PPACA), 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 our concerns regarding the lack of program enforcement by the Centers for Medicare & Medicaid Services (CMS) and the risk that this inaction poses to Medicare beneficiaries and the Medicare Trust Funds.

In reviewing Dr. Berwick's response to our September 27, 2011 letter, we find it unacceptable that CMS failed to identify that convicted felons were furnishing services to Medicare beneficiaries, and when informed, made the decision not to take immediate action to protect Medicare beneficiaries. We are also concerned about CMS' failure to detect physicians and non-physicians that do not hold a valid medical license, and CMS' inability to implement system edits that would protect the Medicare program from inappropriate payments and its refusal to act in a transparent manner. We are writing to follow-up on the original concerns identified and again underscore that action must be taken to protect seniors and taxpayers.

The September letter we sent included an attachment containing a list of 34 individuals (physician and non-physician practitioners) convicted of a felony or who pled guilty to a felony generally considered detrimental to the Medicare program, but who retained their Medicare billing privileges and/or the ability to order and refer in the Medicare program. The attachment also contained a list of 48 physicians and non-physician practitioners and owners of health care facilities with felony convictions or guilty pleas who may be enrolled and billing the Medicare program. In response to our findings, CMS confirmed that 37 individuals who were participating

in the Medicare program were convicted of a felony. However, CMS did not confirm that they would revoke any single physician or non-physician practitioner identified for such crimes as tax evasion, health care fraud, and lewd and lascivious behavior. It is important to note that CMS has clear regulatory authority (42 CFR 424.535) to revoke the Medicare billing privileges for individuals convicted for felony crimes, such as tax evasion, and felonies that place the Medicare program or its beneficiaries at immediate risk.

In addition, CMS confirmed our understanding that it does not have basic data sharing agreements or performance metrics to share felony indictment or conviction data with the Department of Justice, the Internal Revenue Service, Office of the Inspector General within the U.S. Department of Health and Human Services (HHS OIG), or State Officials. In a time of increased technological capability and need to share information for program integrity efforts, it appears CMS is disconnected. Without data sharing agreements with its law enforcement partners, we fear CMS will remain in the dark and Medicare beneficiaries will be placed at risk. Moreover, it does not appear that CMS has a clear plan of action to utilize the information obtained during the prosecutorial process to strengthen program requirements and prevent future fraud.

Based on CMS' response, it appears that CMS is relying on the HHS OIG to make revocation decisions based on the HHS OIG exclusion authority found in Sections 1128 and 1156 of the Social Security Act. However, it is not apparent that the HHS OIG has the authority to establish an exclusion for non-health care related felonies. Moreover, even within the statutory limitations imposed on the HHS OIG, we are concerned that an individual or owner of health care facility can remain enrolled in the Medicare program for up to 180 days after the date of conviction or plea agreement. We believe that pending HHS OIG action, it is imperative for CMS to take administrative action to reduce Medicare's exposure to overpayments and fraud, especially for organizational entities that can transfer the ownership and Medicare billing privileges during the period between conviction and the date of the actual HHS OIG exclusion. As such, we request that HHS explain CMS' apparent refusal to take immediate administrative action in these instances.

Finally, we noted with interest CMS' statement that, "It is important to note that under existing statutory and regulatory authority, not all felonies are excludable offenses, such as a felony DUI or hunting violation." While it is true that not all felonies are excludable offenses, CMS' non-responsiveness to the core question we raised is troubling. Accordingly, does CMS' statement mean that tax evasion, conspiracy to commit health care fraud, conspiracy to distribute controlled substances and acts of lewd and lascivious behavior are minor violations that can be overlooked by Federal officials? We hope CMS does not view such behaviors as acceptable for participation in federal health care programs.

Accordingly, we request that HHS:

- Review CMS' decision to allow 37 physicians and non-physician practitioners who have been convicted or pled guilty to a felony to continue to participate in the Medicare program and furnish services to Medicare beneficiaries;
- Determine if each individual convicted of a felony reported their felony conviction within 30 days, as required by Federal regulations; and,
- Determine if Medicare should revoke billing privileges and assess overpayments for practitioners convicted of a felony.

Based on our previous review of State licensure actions, we informed CMS of our concerns that its Medicare 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 no longer retain a valid State license for their medical specialty. In response, CMS stated that Medicare Administrative Contractors (MACs) review State-licensing information monthly to determine if practitioners, within the past 60 days, have had their license revoked, suspended, or otherwise inactive.

Unfortunately, for seniors and taxpayers, it seems that CMS continues to rely too heavily on its contractors while not conducting rigorous oversight to ensure contractor compliance. A case that illustrates Medicare's failure to act in the best interest of the seniors is the continued enrollment of Dr. Conrad Robert Murray. Dr. Murray, the personal physician of Michael Jackson, remains enrolled in the Medicare program after the State of California suspended his medical license on January 11, 2011, and a California court convicted Dr. Murray of involuntary manslaughter on November 7, 2011. Despite the national media coverage of Dr. Murray's conviction, he remains a legitimate Medicare provider according to CMS' provider database.

We request that you review and determine if a Medicare revocation or other action is appropriate for individual practitioners who have had their medical license revoked or suspended, and have not been detected by CMS' contractors. An example of this that we identified is an Ohio physician who continues to have a valid Medicare provider number despite a conviction of conspiracy to commit murder. This seems like a clear cut example of where administrative action is warranted by CMS. Given this, please explain the actions HHS will take to ensure that unlicensed or suspended individuals cannot furnish or refer services to Medicare beneficiaries. Moreover, we request that HHS take the necessary steps to inform physicians of their reporting responsibilities and that HHS take the appropriate administrative action when physicians fail to report changes such as medical license revocation or suspension.

To date, CMS has not implemented Section 6401(a) of the Patient Protection and Affordable Care Act even though CMS can implement this provision without accompanying regulations. Section 6401(a) would establish a provisional period of enhanced oversight for new providers and suppliers, and permits CMS to establish payment caps and enhanced pre-payment review.

We question why CMS is not moving forward with implementation of this provision when doing so would provide additional safeguards to help protect the Medicare program. In response to our letter of September 27, 2011, CMS stated that it suspended its deactivation process for Part A and Part B suppliers (other than suppliers of durable medical equipment prosthetic and orthotic supplies) in early 2011. However, in a proposed regulation published on October 25, 2011, (CMS-9070-P), CMS stated that “Currently, Medicare provider and supplier billing privileges are deactivated (made ineligible for Medicare billing purposes) for providers and suppliers that have not submitted a Medicare claim for 12 consecutive months.” If the deactivation process was actually suspended in early 2011 then it appears CMS made an error in describing the deactivation process in this proposed regulation.

We are also perplexed regarding CMS’ statements in their 2011 and 2012 Justification of Estimates for Appropriation Committees that highlighted its deactivation efforts as a program achievement by saying that “Some of the other activities CMS has conducted to prevent fraud and abuse in the Medicare program include...Aggressively and successfully deactivated inactive provider identification numbers.” Since CMS stated that deactivating inactive provider identification numbers was part of its success in preventing fraud and abuse in the Medicare program in February 2010 and February 2011, it seems odd that CMS is now proposing to eliminate that same process. Please explain CMS’ actions and rationale in this regard.

It also appears that the regulatory impact analysis for the proposed changes to the Medicare deactivation provision is seriously flawed. Based on historical information, CMS systematically deactivated approximately 20,000 Part B billing numbers per month during the period of 2007 – 2010. Using CMS’ estimate of increased payments (e.g., \$2,000) to suppliers whose billing privileges would no longer be deactivated due to 12 consecutive months of non-billing, Medicare expenditures would increase by more than \$400 million annually if this proposed change is adopted or if CMS makes the decision to continue to suspend the Part B deactivation process. We ask that you review CMS’ decision to discontinue the systematic deactivation process and its ancillary impact on Medicare expenditures to determine whether this decision was in the best interests of the Medicare program.

Another example of this apparent lack of oversight is CMS’ reluctance to furnish the information we requested with identifying information on approximately 1,000 undefined providers and suppliers participating in the Medicare program. Given the risk for improper payments posed by them, we again request that CMS furnish basic enrollment information about those providers and suppliers enrolled in Medicare as an undefined provider or supplier.

We believe that the lack of systematic editing, the refusal to implement enhanced oversight of high-risk providers and suppliers, and malleable policy positions are the wrong direction for the Medicare program, and that a change is needed to protect the public trust.

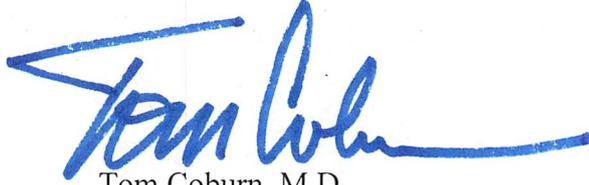
Thank you for your timely attention to this request and we would appreciate receiving your response by January 10, 2012. Once we receive the requested information, we would like to schedule a follow up meeting to discuss HHS' response in more detail.

Sincerely,



Orrin G. Hatch

U.S. Senator



Tom Coburn, M.D.

U.S. Senator

cc: Administrator Donald Berwick, MD, Centers for Medicare & Medicaid Services

Principal Deputy Administrator and Chief Operating Officer Marilyn Tavenner, Centers for Medicare & Medicaid Services