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

October 6, 2010

Via Electronic Transmission

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

Donald M. Berwick, M.D.
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Secretary Sebelius and Administrator Berwick:

The United States Senate Committee on Finance (Committee) has jurisdiction over, among other things, the Medicare and Medicaid programs. As Ranking Member of the Committee, I have a responsibility to conduct oversight to make certain that appropriate steps are being taken to protect Medicare and Medicaid dollars from fraud, waste, and abuse.

I am writing today to reiterate my concerns about the lack of or inadequate management and oversight of contractors by the Centers for Medicare and Medicaid Services (CMS). These contractors include Medicare Administrative Contractors (MACs),[1] Program Safeguard Contractors (PSCs), which are being transitioned to Zone Program Integrity Contractors (ZPICs), and Quality Improvement Organizations (QIOs).

In 2004, the United States government filed a complaint against All-Med Billing Corp. (All-Med), its owners, Abner and Mabel Diaz, and others for Medicare fraud.[2] According to the complaint, between January 2004 and June 2004, 49 durable medical equipment (DME) companies submitted $250 million in Medicare claims through All-Med to the MAC, Palmetto Governmental Benefits Administrator, LLC (Palmetto GBA).[3] The claims were for medical equipment that had not been ordered by a physician or had not been delivered to the beneficiaries as claimed. More than five years later, on February 25, 2010, the United States District Court for the Southern District of Florida entered a final judgment against All-Med and Abner and Mabel Diaz, requiring the defendants to pay more than $445 million to the United States government.

[1] Medicare Administrative Contractors (MACs) are tasked with receiving, adjudicating, processing and paying claims submitted by providers and suppliers to the Medicare program.
[2] United States v. All-Med Billing Corp., et al., No. 04-22075-CIV-Altonaga/Bandstra (S.D. Fla. Aug. 19, 2004).
[3] CMS contracts with Palmetto GBA to serve as a MAC and the National Supplier Clearinghouse (NSC). The NSC processes enrollment of DMEPOS suppliers in the Medicare program.

The MAC's responsibilities include adjudicating and processing claims, yet it appears from this case that Palmetto GBA allowed millions to be paid to the DME companies for fraudulent claims. The federal government's complaint stated that the investigation began "after a related, ongoing FBI investigation revealed a group of 104 DME companies involved in the fraudulent billing of Medicare," not because the MAC detected suspicious billing activity.

While some may argue that MACs are not responsible for deterring or detecting fraud, waste and abuse, it is apparent that at least one court disagreed. In September 2004 when the United States District Court Judge Cecilia M. Altonaga granted the federal government's motion for preliminary injunction in the case against All-Med Billing Corp., she made the following observations:

> **This Court observes that the wealth and effect of the overwhelming evidence of the fraudulent submission of claims to Medicare should have been equally apparent to Palmetto GBA as it was to this Court, if not more so, given Palmetto GBA's obligations as fiscal agent in authorizing millions of dollars in payment. It is unclear why Palmetto GBA is not a subject of the Government's investigation into criminal wrongdoing, in light of the overwhelming evidence covering months of losses in the millions.[4] (Emphasis added)**

Like Judge Altonaga, I have been concerned and puzzled that CMS does not seem to examine its contractors' role in enabling taxpayer dollars to be misused or wasted and to hold contractors accountable if they fail to carry out their responsibilities as expected.

Earlier this year the OIG released its audit findings, which are also related to the MAC, Palmetto GBA. Specifically, OIG examined whether or not the KX modifier was effective in ensuring that suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) had the required supporting documentation when they submitted claims to Palmetto GBA. According to the OIG, "while suppliers must have a written physician's order and proof of delivery for all DMEPOS, suppliers must have additional documentation on file for items that require the KX modifier."[5] The OIG estimated that Palmetto GBA improperly paid about $127 million for the calendar year 2006 dates of service because Palmetto GBA's electronic edits were not effective for determining whether suppliers had the required documentation on file. The edits could only determine whether the required KX modifier was on the claim.

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[4] United States v. All-Med Billing Corp., et al., No. 04-22075-CIV-Altonaga/Bandstra (S.D. Fla. Sept. 14, 2004).

[5] Department of Health and Human Services, Office of Inspector General, *Review of Medicare Payments for Selected Durable Medical Equipment Claims With the KX Modifier for Calendar Year 2006*, A-04-08-04020, January 2010.

However, CMS's contractors made improper payments not only to DMEPOS suppliers for claims with KX modifiers, but also to inpatient hospitals and others in fiscal year 2009. A short time ago the OIG issued its report, *Analysis of Errors Identified in the Fiscal Year 2009 Comprehensive Error Rate Testing Program*, showing the percentage of improper payments made to different types of health care providers. According to the OIG, 40 percent of the improper payments were made to inpatient hospitals. *See Table 1*.

Table 1. Improper Payments by Type of Provider

Type of Provider	Improper Payments	Percentage of Improper Payments
Inpatient hospitals	$1,912,323	40%
Durable medical equipment suppliers	1,184,505	25%
Hospital outpatient departments	584,840	12%
Physicians	313,469	7%
Skilled nursing facilities	260,381	6%
Home health agencies	185,498	4%
Subtotal	**$4,441,016**	**94%**
All other types of providers	279,416	6%
Total	**$4,720,432**	**100%**

Source: Office of Inspector General, Department of Health and Human Services, *Analysis of Errors Identified in the Fiscal Year 2009 Comprehensive Error Rate Testing Program*, A-01-10-01000, July 2010.

With respect to PSCs, Chairman Baucus and I recently wrote concerning CMS's response to my November 5, 2009 letter regarding a Department of Health and Human Services Office of Inspector General (OIG) finding that many PSCs failed to adequately open new investigations or refer cases to law enforcement. PSCs are hired by CMS to provide Medicare benefit integrity functions, such as conducting fraud investigations and referring suspected fraud cases to law enforcement. However, CMS's response suggests that the PSCs are not adequately performing their tasks.

More than four years ago, I also expressed concerns about the apparent lack of accountability by the Medicare contractors known as Quality Improvement Organizations (QIO). QIOs are charged with helping to improve the quality of health care provided to Medicare beneficiaries. I questioned CMS's decision to continue to fund QIOs that did not fulfill the terms of their "Statement of Work." I proposed that CMS change the basis for funding to focus on results relative to improved quality of care and institute competition in the QIO contracting process.

In light of the aforementioned deficiencies in CMS's management of its contractors, I am requesting your responses to the following questions. Please restate the question and follow with the responsive information and documentation.

1) Based on my Committee staff's review of the public record, there was no publicly documented review of Palmetto GBA following Judge Altonaga's comments in September 2004. Did CMS examine the MAC's role in enabling fraud, waste and abuse to be committed by All-Med Billing Corp. and the DME companies? If not, please explain why not. If so, please describe in detail CMS's or HHS's findings and any actions that were taken to improve the operation of the MACs and their ability to detect fraud in cases like the one described above.

2) Has CMS taken any actions this year to ensure that contractors are held accountable when they do not fulfill their tasks as set forth in their contracts, agreements or other legal arrangements with CMS? If so, please describe each incident in detail. If not, please explain why not.

3) Please specify whether or not CMS believes it requires additional authority in order to hold its contractors accountable for inadequate work or substandard performance.

4) What is HHS doing to ensure that CMS effectively oversees and manages its contractors to prevent fraud, waste and abuse in the Medicare and Medicaid programs?

Thank you for your attention to this important matter. I request that you provide a response by no later than October 20, 2010. Should you have any questions regarding this letter, please contact Angela Choy at (202) 224-4515. All formal correspondence should be sent electronically in PDF format to Brian_Downey@finance-rep.senate.gov or via facsimile to (202) 228-2131.

Sincerely,

Charles E. Grassley
Ranking Member