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

April 5, 2010

**Via Electronic Transmission**

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

Dear Secretary Sebelius:

As the senior Senator from Iowa and Ranking Member of the Senate Committee on Finance (Committee), it is my duty to conduct oversight of the Department of Health and Human Services (HHS or Department) and federal healthcare programs. This duty includes the responsibility to monitor the oversight conducted by both the Department and private insurers providing Medicare Part D coverage.

I write today concerning Medicare fraud by what appear to be phantom pharmacies. Furthermore, I am concerned by the Department's apparent lack of response to information that a private insurer attempted to provide your Department. In recent months, one private insurer approached my office with concerns over the lack of responsiveness by HHS when presented with credible evidence that fraudulent pharmacies were defrauding Medicare. These pharmacies included empty store fronts, apparently without customers, that nonetheless billed millions of dollars to private insurers.

As you know, many private insurers have aggressive systems in place to: 1) identify potential fraudsters; 2) stop their ability to commit further fraud; and 3) refer the fraudulent activity to the federal government. However, recent allegations call into question what happens once concerns are brought to the Department. Unfortunately, in the particular cases that were brought to my attention, for about a year, one private insurer attempted without success to have its credible warnings considered by the Department. Repeated calls to the Department to inform them of severe instances of health care fraud went unreturned. This insurer initially approached the Medicare Drug Integrity Contractors (MEDICs) to report some of the phantom pharmacies that it had identified independently. However the insurer remained concerned, noting that the MEDICs were unsophisticated on the issue. Thereafter the insurer contacted Kim Brandt of the Centers for Medicare and Medicaid Services' (CMS) Program Integrity Group with an offer to provide training to the MEDIC employees to improve their effectiveness and to coordinate its fraud, waste and abuse efforts with CMS for maximum impact.

Allow me to provide you with a few of the cases that the insurer would have brought to the Department's attention, along with some photographs of the pharmacies in question.

- A Los Angeles area pharmacy billed $1.3 million under the Part D program in a period of 18 months, more than double the Rite Aid pharmacy blocks away.

- A Miami area pharmacy billed the insurer $26,000 for antipsychotics and inhalers during a three day period. The owners soon disappeared, their lease in default and store empty of inventory.

- A second Miami pharmacy billed the insurer $245,000 in false claims in less than three months. The owner subsequently abandoned the facility and bought a one-way ticket to Europe, where he is at large.

- Another Los Angeles area pharmacy had no inventory and no customers during a three hour audit, despite billing the insurer over $5 million during an 18 month period. Despite such high billing, the owner expedited bankruptcy filings, hampering the insurer's efforts to access documents or recoup funds.

- Another Miami pharmacy increased billing the insurer from $100 to $22,000 per week within a two month period. By acting quickly, the insurer stopped $143,000 in payments after confirming the pharmacy's false claims.

- In less than two months, a Miami pharmacy billed the insurer $18,000 in HIV medication and antipsychotic medications despite the fact its location was completely abandoned. The private insurer terminated the pharmacy from its network.

- Yet another Miami pharmacy billed $106,000 in HIV medication in *two* days. After neighbors stated no pharmacy was present at their location, the private insurer suspended payments and later terminated the pharmacy from its network. The pharmacy continued to bill the insurer an additional $147,000.

- Finally, another Miami area pharmacy began billing for $75,000 in HIV medication until notified of payment suspension, at which time the store was abandoned. The insurer terminated the pharmacy from its network.

This situation is troubling on so many levels. I am disturbed by the cavalier attitude of the Department. Why would the Department fail to respond to these red flags? Phone calls to the Director of CMS's Program Integrity Group, Kim Brandt, went unreturned. The company requested meetings and attempted to report these phantom pharmacies, but it was reported to us that the Program Integrity Group and others at CMS were unwilling to make the time to address these very serious allegations. Simply acting as a good corporate citizen and wanting to alert the executive branch to the fact that it had identified phantom pharmacies, this company was utterly rebuffed.

This situation is also concerning because it comes on the heels of my recent letter outlining the Department's repeated failures to respond to management implication reports by the Office of Inspector General (OIG), which outlined programmatic flaws leading to increased fraud, waste, and abuse. In addition, an OIG report issued late last year found that the MEDICs are not being given sufficient authority to detect pharmacy fraud on their own and that CMS was failing to allow MEDICs to conduct certain audits.

In a day and age when American taxpayers are under incredible economic stress, it is infuriating to learn that HHS may not be doing everything it can to investigate serious allegations of fraud.

While it is CMS's responsibility to safeguard taxpayer dollars by detecting and preventing fraud, waste, and abuse in the Medicare program, the American people look to HHS to make sure CMS is responsive and that the Agency is carrying out its duty to address potential Medicare fraud by pharmacies as well as other healthcare entities. During your confirmation hearing, you stated that you would make it a "top priority… to pursue fraud, waste, and abuse aggressively." While I do not doubt your dedication to this pledge, it surely appears that not everyone at the Department shares your commitment.

In light of the situation set forth above, please provide your responses to the following inquiries:

1) Please describe in detail how HHS interacts with private insurers who report cases of possible health care fraud.

2) Does the Department have a formal system in place to deal with private insurer reported allegations of fraud? If so, please describe that process, including the role of the Program Integrity Group.

3) Please explain what led to the lack of responsiveness from CMS as described above, and what changes are being made to ensure that CMS is taking allegations of fraud from insurers seriously.

Thank you for your attention to this important matter. Please respond to the questions set forth in this letter by April 19, 2010. I look forward to your cooperation in this matter and if you have any questions or concerns, please feel free to contact Christopher Armstrong or Angela Choy of my Committee Staff 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