United States Senate
PERMANENT SUBCOMMITTEE ON INVESTIGATIONS
Committee on Governmental Affairs

Carl Levin, Chairman
Norm Coleman, Ranking Minority Member

FOR IMMEDIATE RELEASE **Contact: Leroy Coleman, 202/224-5641**
September 3, 2008

COLEMAN EXPRESSES ALARM OVER CMS INACCURATE AUDITING OF MEDICARE MEDICAL EQUIPMENT PAYMENTS

Washington, D.C. – Senator Norm Coleman, Ranking Member of the Permanent Subcommittee on Investigations (PSI), recently sent a letter to Mr. Kerry N. Weems, Acting Administrator of the Centers for Medicare & Medicaid Services (CMS), expressing his alarm and serious concerns over purported inaccurate auditing of Medicare medical equipment payments. Coleman, who initiated an investigation into fraud and abuse in Medicare two years ago as Subcommittee Chairman and continued to lead the investigation as the Subcommittee's Ranking Member, demanded CMS's explanation for auditing irregularities and raised numerous questions about a recent contract awarded to a Medicare service provider.

In his letter, Coleman made clear that the irregularities identified in a recent report from the Department of Health & Human Services Office of Inspector General (IG) regarding the auditing of Durable Medical Equipment (DME) payments raised serious questions about the legitimacy of CMS's reported error rates and must be addressed immediately. Coleman expressed concern that CMS officials have on numerous occasions – including sworn testimony by senior CMS administrators at Subcommittee hearings cited low error rate as evidence of CMS's success in battling fraud and waste in the DME benefit. A recently issued IG report, however, reveals that the volume of improper payments on DME payments in 2006 is likely substantially larger than CMS had previously stated. Coleman, who is concerned that CMS may have altered its auditing practices in order to artificially improve the appearance of its performance, directed CMS to answer the following questions immediately:

- Provide the Acting Administrator's assurance that CMS's previous statements and testimony were in fact accurate;
- Provide clear verification of the accuracy of previous error rates as reported;
- Provide an explanation regarding the problems found in the recent IG report, and address the issue of previous error rates; and
- Provide a detailed briefing from CMS for Subcommittee staff regarding the Comprehensive Error Rate Testing (CERT) Program as well as the findings in the IG report that CMS changed the manner in which such reviews were conducted.

"If auditing practices were altered to create false impressions of satisfactory performance, CMS will have to provide immediate explanations," said Coleman. "We must preserve the integrity of Medicare – a vital service to the nation's elderly and disabled – which is why it is disturbing to hear allegations that CMS may have altered its auditing practices in order to inflate their performance results. It is imperative for CMS to produce reliable and accurate error reports. In light of these

findings, my insistence that Acting Administrator Weems provide a detailed briefing with my Subcommittee staff to review the accuracy of CMS testimony regarding error rates, as well as the estimated error rates for previous years, is something that I expect will happen without delay."

Coleman's investigation into fraud, waste and abuse in Medicare found that from 2000 through 2007, Medicare payments for medical equipment claims containing the identification numbers of dead doctors ranged from an estimated $60.3 million to $92.8 million. Notably, this estimate included only claims that occurred at least one year after the doctors' deaths; if claims within 12 months of the physicians' deaths were included, the estimate of claims paid over that timeframe would likely reach over $100 million. Coleman's investigation uncovered that Medicare claims contained the identification numbers of an estimated 16,500 to 18,200 deceased physicians and involved approximately 385,000 to 572,000 claims for medical equipment.

Coleman also raised concerns over CMS's renewal of Palmetto GBA's contract to serve as the National Supplier Clearinghouse (NSC) for DME suppliers after a GAO report requested by PSI revealed that GAO investigators were able to set up two fictitious medical equipment suppliers and received Medicare billing numbers from CMS and Palmetto GBA. According to Palmetto GBA's press release, this contract has the potential to last up to five years and be worth $76 million. In his letter, Coleman inquired whether the renewed contract contained any provisions, terms or penalties relating to poor performance. In addition, he asked the Administrator whether bidders were required during the bidding process to submit documentation on how they plan to address fraud and abuse.

"In light of the serious concerns raised at the Subcommittee's hearing in July and the vulnerabilities uncovered by the Subcommittee's recent GAO sting operation, it is critical for CMS to do its due diligence and take the time to properly assess current and potential suppliers," said Coleman. "Considering the time it takes to thoroughly evaluate contractors, I was surprised to learn that one of the most important Medicare contractors was awarded a new contract merely two weeks after the Subcommittee's hearing. I look forward to a prompt response from the Administrator to ensure that Medicare is able to accomplish its noble goals, while still protecting Americans' hard-earned tax dollars. As long as any of these concerns remain unanswered, my confidence in CMS on this matter is not complete."

A copy of the letter has been attached.

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COMMITTEE ON
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WASHINGTON, DC 20510–6250

August 28, 2008

VIA U.S. MAIL & EMAIL (donald.johnson@cms.hhs.gov)

Mr. Kerry N. Weems
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health & Human Services
Room 314-G Humphrey Bldg.
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Mr. Weems:

I am writing to express my serious concerns about two developments involving Medicare and request your prompt assistance in addressing those concerns. As you know, as the former Chairman of the Senate Permanent Subcommittee on Investigations, I initiated the Subcommittee's bipartisan investigation into the Medicare program roughly two years ago, and I have worked with current Chairman Carl Levin to continue that inquiry. The Subcommittee has largely focused its examination on fraud, waste, and abuse in the durable medical equipment (DME) benefit and on CMS's oversight of Medicare contractors.

With this in mind, I am deeply troubled by two recent developments. First, a report issued last week by the Department of Health & Human Services Office of Inspector General concerning irregularities in the Comprehensive Error Rate Testing (CERT) Program raises serious concerns. According to the IG report, CMS officials instructed auditors "to deviate from written policies" in conducting their review. The IG report ultimately concluded that the estimated rate of improper payments in FY 2006 is 28.9% – almost 400% higher than CMS's previous estimate of 7.5%. CMS, according to an article discussing the IG investigation, has conceded that the error rate is in fact higher than it represented previously.

As you know, senior CMS officials have testified under oath before the Subcommittee at three recent hearings and other CMS officials have briefed Subcommittee staff on numerous other occasions. In many of those interactions, CMS officials have cited to the purportedly low error rate as evidence of CMS's success in combating fraud and abuse in Medicare. For example, last month, the CMS Deputy Administrator testified under oath before the Subcommittee about Medicare's successes in reducing improper payments and specifically cited the FY 2006 error rate:

> CMS has made great strides in significantly reducing the Medicare fee-for-service (FFS) error rate in recent years by educating providers about appropriate medical record documentation and methods to improve their accuracy and completeness. For example, in FY 2005, we strove for a Medicare FFS error rate of 7.9 percent and the actual error rate was 5.2 percent. For FY 2006, the goal was 5.1 percent and the actual error rate was 4.4 percent. The goal for FY 2007

was 4.3 percent and the actual error rate released in November 2007 was 3.9 percent, again improving upon the target.

Just last week, CMS provided detailed responses to questions posed at a Subcommittee hearing on July 9th, and in those responses, CMS emphasized the "reduction [in the fee-for-service error rate] of greater than 50 percent from … the rate reported in FY 2004." CMS further asserted, as a result of the reduced error rate, "a cumulative savings to Medicare and the taxpayers of over $10 billion."

In light of CMS's repeated representations to this Subcommittee concerning its error rates, it is deeply disturbing to hear allegations that CMS may have changed the auditing processes to improve the appearance of its performance. I therefore request your assurance that CMS's statements and testimony to this Subcommittee concerning Medicare error rates and improper payments were in fact correct. In addition, while the IG's examination covered the error rate process only for FY 2006, the report's findings suggest that such failures could have affected the estimated error rates for previous years; as a result, I request that you verify the accuracy of previous error rates as reported and confirm that the problems found in the recent IG report did not occur in the determination of those error rates. Moreover, I request a detailed briefing from CMS for Subcommittee staff concerning CERT Program, as well as the findings in the IG report that CMS changed the manner in which such reviews were conducted and what CMS is doing to address those problems.

As you stated in your response to the IG report, the CERT Program is "central[] to CMS' financial oversight mission." With that in mind, it is imperative that the Program determine the amount of improper payments in the Medicare program accurately. Moreover, this process – particularly because it involves taxpayers' dollars – must be sacrosanct, without any appearance of impropriety. Only after we properly ascertain the size and nature of improper payments in Medicare will we be able to attack the problems of fraud, waste, and abuse head-on.

The second development that raises serious questions involves the National Supplier Clearinghouse (NSC). In particular, I write to express concern and request additional details about CMS's renewal of Palmetto GBA's contract to serve as the NSC for medical equipment suppliers.

As you may know, a Government Accountability Office (GAO) report that was requested by the Subcommittee revealed that GAO investigators were able to set up two fictitious medical equipment suppliers using undercover names and bank accounts and received Medicare billing numbers from CMS and Palmetto GBA. This investigation, along with the Subcommittee's previous efforts concerning DME suppliers, raise serious concerns about the ability of the current NSC, Palmetto GBA, to properly evaluate current and potential suppliers and ensure the overall integrity of the Medicare program.

At the Subcommittee hearing in July, I, along with several other Subcommittee Members, expressed concerns about CMS's contracts related to the Medicare DME benefit and the adequacy of CMS's oversight over those contractors. In particular, the Subcommittee posed numerous questions about whether the contracts contained provisions to withhold payment and/or bonuses from these carriers for poor performance, such as improper payments.

Given these concerns, I was taken aback by the fact that on July 21, 2008, less than two weeks after the Subcommittee's hearing, it was announced that Palmetto GBA would continue to be the National Supplier Clearinghouse for DME suppliers. According to Palmetto GBA's press

release, this contract has the potential to last up to five years and be worth $76 million. In light of the many issues that have been raised by the Subcommittee's investigations, I hope you can answer the following questions regarding Palmetto GBA's new contract:

1. Does the NSC contract include any provisions, terms, conditions, or penalties relating to poor performance? In particular, does the agreement include any terms relating to poor performance regarding supplier registration and certification? If so, what are they? If not, what were the reasons for not including such provisions?

2. During the bidding process, were bidders required to submit any documentation on how they plan to address fraud and abuse? If so, what was included in Palmetto GBA's proposal? How did the proposal from Palmetto GBA differ in that regard from other potential contractors?

Thank you for your attention to these requests. In addition, I appreciate your leadership at CMS and the constructive relationship that CMS has developed with the Subcommittee in your tenure. I look forward to continuing to work with you to improve the integrity of our federal health care programs. If you have any questions or concerns about this request, please feel free to contact me directly or have your staff contact Mark L. Greenblatt, Chief Counsel and Staff Director to the Minority, at 202/224-3721.

Sincerely,

Norm Coleman
Ranking Member
Permanent Subcommittee on Investigations