United States Senate
Committee on Finance

Sen. Chuck Grassley · Iowa
Ranking Member

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M E M O R A N D U M

To: Reporters and Editors
Re: Draft report on Medicare fraud numbers
Da: Thursday, Aug. 21, 2008

Sen. Chuck Grassley, ranking member of the Committee on Finance, with jurisdiction over Medicare, made the following comment on findings in a draft report suggesting that the federal agency responsible for Medicare might have worked to manipulate improper payment rate estimates involving durable medical equipment to make them appear lower than they really were. The New York Times reported on the draft report prepared by the inspector general's office of the Department of Health and Human Services. Grassley has long scrutinized Medicare's improper payment rates for their unacceptably high levels and their methods of calculation. When appropriate, he also has praised the Centers for Medicare and Medicaid services for reducing the rates. He made the following comment on the draft report.

"I'm willing to give CMS some leeway, but this is more than just leeway. It's a more than 300 percent change in the error rate. When you find such a big discrepancy, you can't help but be mad and feel you've been misled. I gave CMS credit for doing a good job in 2006, and now we find out the numbers are bogus. I want to know what happened, who's responsible, who will be held accountable, and what the Secretary will do about it. If people cooked the books, manipulated the methodology, or told the contractor to ignore the rules, those individuals need to take the heat."

Following are: (1) a news release and letter describing Grassley's effort in 2003 to ensure valid statistics about Medicare's improper payment rate and (2) the text of today's New York Times story. Three additional Grassley letters on the topic will be posted at finance.senate.gov.

For Immediate Release
Friday, November 14, 2003

Grassley Seeks Valid Statistics About Improper Medicare Payments

WASHINGTON – Sen. Chuck Grassley today said that the Centers for Medicare and Medicaid Services must work to secure a more reliable Medicare improper payment rate, following the agency's annual announcement of the improper payment rate.

Grassley, who serves as chairman of the Senate Committee on Finance, questioned the government's decision to change the method used to determine the improper payment rate. That rate was determined by an outside contractor used by CMS for the first time this year.

A copy of Grassley's letter to the inspector general for the Department of Health and Human Services follows here.

November 14, 2003

Ms. Dara Corrigan
Acting Principal Deputy Inspector General
Department of Health & Human Services
330 Independence Avenue, SW
Washington, D.C. 20201

Dear Ms. Corrigan:

Today, the Centers for Medicare & Medicaid Services (CMS) advised the Congress and the American people that the Medicare Error Rate for 2003 was 5.8%. Although a small percentage figure, it represents a $12 billion loss to America's taxpayers and is a touch lower than the error rates reported by the Office of the Inspector General for both 2002 and 2001. But the story on the CMS Medicare error rate does not end there because CMS added an important caveat to the 5.8% figure. Specifically, the 5.8% error rate is NOT statistically valid, as it had been in the previous six years; instead it is just a guesstimate. In actuality, the only statistically valid error rate that CMS reports is 9.8%, or roughly $20 billion dollars.

To get to the 5.8% figure, CMS adjusted the audit methodology to reach what CMS believes is a lower, "more accurate" error rate, thereby avoiding the higher, and allegedly "less accurate" error rate. But, even putting that aside, any way you slice and dice it, either $12 billion or $20 billion, the American taxpayer is being ripped off over and over and over again. This must stop.

From 1996 to 2002, the OIG independently provided Congress with a credible and statistically valid Medicare error rate. We relied on that number, and we developed strategies to lower that number. However, last year, over my objections, responsibility for performing the Medicare error rate audit was shifted to CMS. CMS developed a two-pronged approach to address its new responsibility. Specifically, CMS created the Comprehensive Error Rate Testing (CERT) Program and the Hospital Payment Monitoring Program. In turn, CMS contracted with AdvanceMed Corporation (AMC) to conduct the CERT portion of this important audit.

Today, CMS and AMC provided Congress with two Medicare error rates; one that is "adjusted" and the other, which is not. CMS paid AMC over $5 million taxpayer dollars to obtain these results. It appears that the "unadjusted" error rate of close to 10% was too high for CMS-almost 4 percentage points higher than the previous two years. So CMS reports that it adjusted that figure downward to the 5.8% figure.

It is of little value at this juncture to argue the merits of the change in methodology that CMS

engaged upon realizing that the error rate went up as compared to the last two years. And, dwelling upon the fact that CMS reduced the error rate by more than 40% by modifying its methodology serves little purpose, since CMS is already beginning efforts to determine the Medicare error rate for next year. But, I do want to insist, and I request your assistance in this regard, that next year this Congress and the American people who foot the bill for Medicare, get a solid number that is reliable and credible; not two numbers.

In addition, I request that the Office of the Inspector General monitor CMS' implementation of its corrective action plan to avoid the pitfalls of this past year. Lastly, I ask that the OIG carefully examine the information obtained by AMC to continue targeting it resources to rid the Medicare program of the swindlers, hoodlums and scam artists that are bleeding the Medicare trust fund dry.

Thank you in advance for your assistance.

Sincerely,

Charles E.Grassley
Chairman

cc: Secretary Tommy Thompson
Administrator Tom Scully

The New York Times, August 21, 2008
Report Rejects Medicare Boast of Paring Fraud

By CHARLES DUHIGG

Medicare's top officials said in 2006 that they had reduced the number of fraudulent and improper claims paid by the agency, keeping billions of dollars out of the hands of people trying to game the system.

But according to a confidential draft of a federal inspector general's report, those claims of success, which earned Medicare wide praise from lawmakers, were misleading.

In calculating the agency's rate of improper payments, Medicare officials told outside auditors to ignore government policies that would have accurately measured fraud, according to the report. For example, auditors were told not to compare invoices from salespeople against doctors' records, as required by law, to make sure that medical equipment went to actual patients.

As a result, Medicare did not detect that more than one-third of spending for wheelchairs, oxygen supplies and other medical equipment in its 2006 fiscal year was improper, according to the report. Based on data in other Medicare reports, that would be about $2.8 billion in improper spending.

That same year, Medicare officials told Congress that they had succeeded in driving down the cost of fraud in medical equipment to $700 million.

Some lawmakers and Congressional staff members say the irregularities that the inspector general

found were tantamount to corruption and raise broader questions about the credibility of other Medicare figures.

“This is outrageous,” said Senator Charles E. Grassley of Iowa, the top-ranking Republican on the Senate Finance Committee, who has repeatedly credited the Centers for Medicare and Medicaid Services with reducing improper expenditures. “If heads don’t roll, you can’t change the culture of this organization,” he added.

Senator Grassley had not yet received the full report from the inspector general but had been briefed on its contents.

The report — a draft of which was obtained by The New York Times — will probably be made public within the next week, according to federal officials. The inspector general may change or edit the findings of the report before it is officially released. Congressional staff said the Centers for Medicare and Medicaid Services — the agency overseeing Medicare — was lobbying the inspector to play down the report’s conclusions.

A spokesman for Medicare said that the agency agreed with the inspector general that the agency’s reported level of improper billing for durable medical equipment, or D.M.E., should have been higher. But Medicare says the $2.8 billion figure is unsupported.

“Allegations of manipulation of this error rate are preposterous,” said the spokesman, Jeff Nelligan. “The agency has aggressively targeted fraud and improper payments in the D.M.E. program. We have a history of working closely with the inspector general and will continue to do so.”

A representative of the Office of Inspector General that created the report — part of Medicare’s parent, the Department of Health and Human Services — said it did not comment on draft reports.

Fraudulent and improper payments have long bedeviled Medicare, a $466 billion program. In particular, payments for durable medical equipment, like power wheelchairs and diabetic test kits, are ripe for fraud.

Equipment sellers have submitted counterfeit documents, forged doctors’ signatures and filed claims on behalf of patients who were dead or had never been seen by the prescribing physician, according to many reports by government oversight agencies.

For example, a Florida businessman was sentenced last year to 37 months in prison for submitting more than $5.5 million of fake claims to Medicare. The businessman operated for months, despite giving the agency an address that was actually a utility closet.

On July 1, Medicare instituted a new competitive bidding system that officials said would reduce both fraud and costs for medical equipment.

On July 15, however, Congress suspended the program, after equipment manufacturers and sellers began an aggressive lobbying campaign.

Senator Grassley said Congress might push for an investigation into the private company that was hired to fulfill Medicare’s auditing program, the AdvanceMed Corporation, a division of the Computer Sciences Corporation. The report mentions AdvanceMed by name.

Representatives of AdvanceMed did not return calls. The company has received contracts worth more than $34 million from the Centers for Medicare and Medicaid Services since 2005.

“This report doesn’t surprise me,” said Representative Pete Stark, Democrat of California and a

senior member of the Ways and Means Committee. He has pushed to cut improper Medicare spending. “To look better to the public, you cook the books,” he said. “This agency is incompetent.”

The Office of Inspector General’s report details scrutiny of a program known as Comprehensive Error Rate Testing, or CERT, that audits a sample of Medicare claims submitted by sellers of durable medical equipment. That program is supposed to randomly choose claims and review the medical records and other documents supporting submitted claims to determine whether payment is justified.

According to the inspector general’s report, officials at Medicare instructed AdvanceMed to disregard those policies. Instead, AdvanceMed was told to examine only the documents submitted by the companies selling the medical equipment, rather than verify those documents against physicians’ records.

Medicare reported to Congress that, for the fiscal year of 2006, AdvanceMed’s investigations had found that only 7.5 percent of claims paid by Medicare were not supported by appropriate documentation. But the inspector general’s review indicated that the actual error rate was closer to 31.5 percent.

For instance, according to the report, the Office of Inspector General examined a claim for an electric wheelchair that AdvanceMed had said was appropriate. The inspector general’s investigation revealed that the physician who was listed as having prescribed the wheelchair had no knowledge of the prescription.

The person who received the wheelchair said that he had never met with the physician, that he did not need a wheelchair and that he had never used it, according to the report. His wife had also received a wheelchair that she had not asked for and never used.

Equipment sellers can pocket more than $2,500 every time they send a powered wheelchair to a patient and bill Medicare.

“This is like letting the fox guard the henhouse,” said Malcolm Sparrow, a Harvard University professor who focuses on health care fraud. “The supplier has an incentive to supply fabricated documents or to imply that medical records support a purchase when they don’t. If you don’t ask the physician or ask for medical records, you can’t really verify anything.”

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