U.S. SENATE COMMITTEE ON
Finance
SENATOR CHUCK GRASSLEY, OF IOWA - CHAIRMAN
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For Immediate Release
Wednesday, October 12, 2005

Grassley works to stop fraudulent and abusive spending of Medicare dollars

Washington — Sen. Chuck Grassley said today that the federal government agency responsible for Medicare has failed to keep tabs on the contractor it hired to look out for certain problems and, as a result, the Medicare program continues to be vulnerable to fraudulent and abusive billing for medical equipment including prosthetics, orthotics and other supplies.

"Complacency by the watchdogs hurts both taxpayers and beneficiaries. Money is wasted or lost to fraud, and quality of care can be jeopardized when products and services come from con artists rather than qualified suppliers," Grassley said.

In response to a request made by Grassley, the Government Accountability Office reviewed the performance of the Centers for Medicare and Medicaid Services and the National Supplier Clearinghouse in deterring the billing practices that resulted in Medicare improperly paying $900 million in fiscal year 2004 for durable medical equipment, prosthetics, orthotics and supplies.

This independent audit found that the National Supplier Clearinghouse, the contractor hired by Medicare officials to verify that suppliers meet 21 standards before they can bill Medicare, relies too heavily on self-reported information from suppliers rather than on-site inspections and fails to effectively check state licensure of suppliers.

"Medicare dollars have gone to pay bills from suppliers that aren't properly licensed and who may be under investigation for fraud," Grassley said. "There are cases where Medicare has re-enrolled suppliers in its system even when those same suppliers had their billing privileges revoked by Medicare just three months previously."

In its report to Grassley, the Government Accountability Office suggested that Congress consider whether suppliers found to be noncompliant should wait a specified period of time before having their billing numbers reissued. The Government Accountability Office also made recommendations to the Medicare administrator to improve the National Supplier Clearinghouse's licensure verification and on-site inspections, the supplier standards, and oversight of the National Supplier Clearinghouse.

Based on the new findings of the Government Accountability Office and following up on the oversight hearing he conducted in April 2004 on durable medical equipment and the Medicare program, Grassley today asked both the Secretary of Health and Human Services and

the Administrator of the Centers for Medicare and Medicaid Services to report to him on exactly what is being done to address problems with the contractor and the resulting improper payments.

Grassley is Chairman of the Senate Committee on Finance, which has oversight and legislative jurisdiction over the Medicare program. The text of his letter follows below. The Government Accountability Office report is attached in a pdf file.

October 12, 2005

The Honorable Michael O. Leavitt
Secretary
Department of Health & Human Services
200 Independence Avenue, SW
Washington, DC 20201

Mr. Mark McClellan
Administrator
Centers for Medicare & Medicaid Services
Department of Health & Human Services
200 Independence Avenue, SW Room 339G
Washington, DC 20201

Dear Secretary Leavitt and Administrator McClellan:

The Committee on Finance (Committee) has a duty to investigate, review, and evaluate the effectiveness of the Medicare Program to ensure we are responsible stewards of the Medicare trust funds. It is alarming that in FY 2004, the Centers for Medicare and Medicaid Services (CMS) erroneously paid ten percent, or $900 million, for durable medical equipment (DME). Most DME suppliers are honest businesspersons, but this statistic proves there is a problem with respect to DME payments that causes CMS to waste precious tax dollars. As Chairman of the Committee on Finance, I asked the Government Accountability Office (GAO) to look into this important matter and to evaluate the screening and enrollment standards for DME suppliers by CMS. The GAO report released today determined that CMS provides insufficient oversight of the National Supplier Clearinghouse (NSC). The GAO report also determined that suppliers do not comply with the 21 national standards established by CMS federal regulations and notices. As a result, CMS jeopardized quality of care by permitting fraudulent suppliers - scam artists - to provide services to beneficiaries. This is completely unacceptable.

More than a year after the April 2004 Committee on Finance hearing on power wheelchairs (POV hearing), it is disconcerting that CMS has not enforced supplier standards and has only now begun to edit the NSC contract. In fact, many of these changes will not take place until 2006. During the April 2004 hearing, CMS stated they would, “revise the supplier’s standards for enrolling in Medicare to include quality measures.” However, the GAO report found that CMS allowed suppliers convicted of fraud or in violation of multiple standards to re-enroll in the Medicare program within an average of three months. Clearly, CMS should only allow qualified suppliers with sound business practices to participate in the Medicare Program.

At the POV hearing in 2004, the Committee also heard accounts of how suppliers

frequently billed for items never delivered. The GAO report released today still found that suppliers are not meeting the standard to maintain proof of delivery and NSC is not checking to see if suppliers have a real source of inventory. In fact, CMS was unaware that NSC did not conduct all the required inspections and had suspended on-site inspections for 605 suppliers. The GAO report also determined that NSC is not sufficiently reviewing state licensure requirements for DME suppliers. For example, in FY 2004 CMS improperly paid Florida suppliers more than $56.3 million for custom-fabricated orthotics and prosthetics. At least 46 of these fraudulent suppliers were already under investigation for fraud. Nevertheless, CMS continued to pay these claims and allowed fraudulent suppliers – scam artists - to provide services to beneficiaries.

At the same time, the Committee appreciates CMS' efforts in California to focus on Medicare supplier fraud. However, to be diligent stewards of the Medicare trust funds we must prospectively identify fraudulent and abusive behavior and implement the appropriate safeguards in real time. In response to GAO comments, CMS stated they would "explore the idea of requiring the NSC where appropriate, to routinely compare the items for which a supplier bills that require licensure against the items the supplier indicates on the enrollment application it will supply to Medicare beneficiaries." What I conclude from this response is that CMS will wait to require a stronger licensure verification process, as opposed to smothering a flame before it turns into a bonfire.

In addition to the questions raised in this letter, I would appreciate the following information:

1. Provide a detailed explanation of the process for removing fraudulent suppliers from the Medicare program.

2. Establish a timeline for implementing quality standards required by Section 302 of MMA.

3. Detail how CMS will:
a. enforce quality standards required under the competitive bidding program, and
b. ensure uniformity across suppliers that are not in the competitive bidding program.

4. Provide a list that identifies suppliers under investigation in FL, CA, NJ, NY, IL, PA, WA, OH, and NC from FY 2003-FY 2005. Include the corresponding dates of the investigation and enrollment of the supplier in the Medicare program.

5. Describe how CMS and NSC review financial standards for DME.

6. Describe the pros and cons associated with requiring suppliers to provide a delivery/confirmation slip for payment.

7. In 2004, CMS reviewed less than .08 percent of supplier's enrollment and re-enrollment applications. Describe CMS' plans to strengthen the review process.

8. Provide copies of NSC performance evaluations from 2003 – 2005.

9. Provide copies of the NSC scope of work from 2003 – 2006.

10. Describe how the new accreditation program and NSC will coordinate and identify possible areas of overlap.

Last but not least, it appears that NSC may not have met the terms and conditions of its contract with CMS in light of the major deficiencies identified by the GAO. Accordingly, please determine whether it is CMS' position that NSC is in compliance with the terms and conditions of its CMS contract. If a determination is made that NSC is in full compliance, please advise me of that fact and the basis of that determination. In the event CMS determines that NSC is not in compliance with the terms and conditions of its contract, please describe what actions CMS will take to recoup tax payer dollars and ensure compliance.

Thank you in advance for your assistance on this matter. I would appreciate a response to the enumerated request and concerns raised in this letter no later than October 31, 2005.

Sincerely,
Charles E. Grassley
Chairman