



U.S. SENATE COMMITTEE ON

Finance

SENATOR CHUCK GRASSLEY, OF IOWA - CHAIRMAN

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For Immediate Release

Wednesday, May 16, 2001

Grassley Works to Fight Fraud, Reduce Medicare Paperwork

WASHINGTON – Sen. Chuck Grassley, chairman of the Committee on Finance, today sought guidance from government agencies about their efforts to fight Medicare fraud and reduce the regulatory burden on Medicare providers.

“It’s important to strike a balance between easing the regulatory burden on Medicare contractors and preserving the government’s ability to fight Medicare fraud,” Grassley said. “If we tip the scales too much toward easing regulations, we could unwittingly invite fraud. On the other hand, if we’re too heavy-handed in enforcing fraud, we create headaches for a lot of well-meaning providers. I think we can achieve a solution that meets both goals.”

Grassley and Sen. Max Baucus, lead committee Democrat, today sent letters to the General Accounting Office and the Inspector General of the Department of Health and Human Services seeking guidance on how to ease the regulatory burden on Medicare providers without weakening anti-fraud tools. Grassley and Baucus plan to work with the Committee on Finance to develop a proposal that would be included in a larger Medicare bill scheduled for mark-up in July.

Grassley is the Senate author of the 1986 whistleblower amendments to strengthen the False Claims Act, [which is](#) one of the government’s most effective weapons [against](#) fraud. In recent years, the False Claims Act has been especially useful in fighting health care fraud.

Copies of the Grassley-Baucus letters follow.

May 16, 2001

Michael Mangano
Acting Inspector General
Department of Health and Human Services
Office of the Inspector General
330 Independence Avenue, SW
Cohen Building, Room 5246
Washington, DC 20201

Dear Mr. Mangano:

The success of the Medicare program is dependent in large part upon the ability of health care providers to offer quality, efficient services to beneficiaries. As Medicare has evolved since its inception in 1965, and as the number of people being served has continued to rise, communication between the Health Care Financing Administration, program

contractors, and providers has become an increasingly complex task. The Senate Finance Committee is committed to making common-sense adjustments to the program in order to facilitate better communication among the elements of the Medicare delivery system and to reduce the regulatory burden facing Medicare providers. The end goal is to free providers to practice medicine and enhance and maintain the health of Medicare beneficiaries.

On March 5, 2001, Senators Murkowski and Kerry introduced S. 452, the "Medicare Education and Regulatory Fairness Act." The following day, companion legislation was introduced in the House of Representatives. We appreciate the efforts of our colleagues and the contributions being made to the Medicare modernization efforts. We believe all involved share a common goal of improving the program for beneficiaries and providers.

We have concerns, however, about the manner in which S. 452 and H.R. 868 have been drafted. As consistent and staunch advocates against Medicare fraud and abuse, we are concerned these bills will effectively block the ability of the federal government to maintain the integrity of the Medicare trust funds and even place at risk the health and well-being of Medicare beneficiaries.

In light of your office's involvement in maintaining the integrity of the Medicare trust funds, we would appreciate receiving your responses to the following questions. Furthermore, we would ask you to offer any possible solutions to achieve the goal of decreasing the regulatory burden on Medicare providers while still ensuring the integrity of the Medicare trust funds and the sustainability of the program. We feel strongly that acting in any other manner would be a disservice to the millions of current and future beneficiaries who are counting on the program to meet their health care needs. A similar letter is being sent to Mr. David Walker at the General Accounting Office.

1. What percentage of Medicare claims are being billed correctly in any given year? To what degree has the percentage changed in the years following the establishment of fee-for-service audits?
2. How many physicians are currently being prosecuted for fraud? How many physicians are currently under investigation? How does this compare with prior years?
3. The Medicare appeals process was amended for certain categories of providers, i.e. nursing homes and home health agencies. Could you comment on provisions in Section 521 of BIPA and indicate how you think this process will operate? In addition, can you also comment on how you think the process outlined in Section 102(b) in S. 452 will also operate? Would all categories of Medicare providers be eligible for the new appeal process? Are the specified time frames for hearings workable?
4. Section 103 includes an exception using a "clear and convincing evidence" standard of proof. How does the legal standard of "clear and convincing evidence" differ from current law? What impact could this standard be expected to have on the ability of the federal government to collect overpayments through administrative offset?
5. Does S. 452 in any way directly impact the ability of the federal government to carry out the requirements of the False Claims Act?
6. Are there other anti-fraud enforcement implications in S. 452?

We look forward to your response as soon as possible. We greatly appreciate your cooperation and timely response to this very important matter.

Sincerely,

Charles E. Grassley
Chairman

Max Baucus
Ranking Member

May 16, 2001

The Honorable David M. Walker
Comptroller General of the United States
U. S. General Accounting Office
441 G Street, NW
Washington, D.C. 20548

Dear Mr. Walker:

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Provider Education and Participation

7. What educational services are currently offered to Medicare providers and how can providers access these services?
8. How much is currently spent on Medicare provider education programs by HCFA and its fiscal intermediaries and carriers? Would S. 452, sec. 301(b), designate education funding for all Medicare providers or only a selected group?
9. What proportion of Medicare claims were billed correctly in FY 2000 and how does this compare with previous years?
10. What are the implications for program integrity of having Medicare contractors disclose claims processing screens as part of provider education?
11. Is there evidence that physicians are cutting back their participation in the Medicare program?

Medical Reviews, Audits, and Appeals

12. What proportion of Medicare providers were subject to medical review in FY 2000 and how has this percentage changed over the past 3 years?
13. Under current procedures, are there limits on the length of time a provider may be subject to prepayment review?
14. What are the implications of offering extended provider repayment periods on the federal government's ability to fully recover overpayments?

15. What are the respective roles and activity levels of Medicare contractors, DOJ, and HHS/OIG in conducting Medicare audits and investigations?
16. What is the status of cases currently in the fee-for-service appeals process? How would S. 452 affect the appeals process and Medicare providers eligible for appeals?
17. How many providers were prosecuted for fraud in FY 2000 and how has this number changed over the past 3 years?

Recovery of Overpayments

18. In auditing samples of claims from which to extrapolate overpayment amounts, do Medicare contractors always draw statistically valid random samples? Are there ways to improve the sampling techniques used by Medicare contractors?
19. How does the standard of “clear and convincing evidence of fraud” in S. 452, sec. 103, differ from the standard of proof currently required to determine provider fraud? What impact would this standard have on the ability of the federal government to collect overpayments?
20. What procedures are currently in place for providers to voluntarily return overpayments? Could S. 452, sec. 103, allow providers to return only a portion of the overpayment and be held harmless for the remainder?
21. What are the implications of offering extended provider repayment periods on the federal government’s ability to fully recover overpayments?
22. What rate of interest does HHS charge providers on outstanding payments and how does this compare with interest rates charged by the IRS and other federal agencies? Under S. 452, sec. 104, would HHS be allowed to assess an interest penalty while an appeal is in process?

Other Legal Issues in S. 452

23. How does S. 452, sec 3, define a “provider of services”? Are there provisions in the bill that provide differential treatment for some Medicare providers?
24. Is it more difficult to challenge a Medicare regulation in court compared to other federal regulations? How would S. 452, sec. 102, affect an entity’s ability to challenge Medicare regulations?
25. How might S. 452 affect the federal government’s ability to use the False Claims Act in regard to Medicare payments?

We look forward to your response as soon as possible. We greatly appreciate your cooperation and timely response to this very important matter.

Sincerely,

Charles E. Grassley
Chairman

Max Baucus
Ranking Member