Statement for the Hearing Record:

Office of Inspector General
U.S. Department of Health and Human Services

Hearing Title:
"Medicare Mismanagement Part II: Exploring Medicare Appeals Reform"

House Committee on Oversight and Government Reform
Subcommittee on Energy Policy, Health Care and Entitlements

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Chairman Lankford, Ranking Member Speier, and other distinguished Members of the Subcommittee, thank you for inviting the U.S. Department of Health and Human Services (the Department) Office of Inspector General (OIG) to submit a statement for the hearing record about OIG's recommendations to prevent Medicare improper payments and improve the Medicare appeals system.

OIG's mission is to protect the integrity of Department programs and operations and the health and welfare of the people they serve. OIG has recommended numerous actions to advance this goal. The Department has implemented many of OIG's recommendations, resulting in cost savings, improved program operations, and enhanced protections for beneficiaries. In fiscal year (FY) 2013, OIG reported estimated savings of more than $19 billion resulting from legislative and regulatory actions supported by OIG recommendations. However, more remains to be done. In March 2014, OIG issued its *Compendium of Priority Recommendations* (*Compendium*),[1] which highlights additional opportunities for cost savings and program and quality improvements. Implementing these recommendations could result in billions of taxpayer dollars saved and more efficient and effective programs to better serve beneficiaries.

As you requested, this statement provides select recommendations to prevent and reduce improper payments and summarizes OIG's work addressing the Administrative Law Judge (ALJ) level of the Medicare appeals system.

CMS Needs To Better Ensure That Medicare Makes Accurate and Appropriate Payments

Overall, improper Medicare payments cost taxpayers and beneficiaries about $50 billion a year.[2] Medicare fee for service, the largest program, reported an error rate of 10.1 percent ($36 billion) in FY 2013. OIG's audits and evaluations have identified opportunities to reduce Medicare improper payments for specific program areas and services. From our recently issued *Compendium*, priority recommendations to prevent and reduce improper payments include:

- Address wasteful Medicare policies and payment rates for clinical laboratories, hospitals, and hospices.

[1] Office of Inspector General's *Compendium of Priority Recommendations;* available at http://oig.hhs.gov/reports-and-publications/compendium/index.asp.
[2] *Department of Health and Human Services FY 2013 Agency Financial Report*, available at http://www.hhs.gov/afr/2013-hhs-agency-financial-report.pdf.

- Improve controls to address improper Medicare billings by community mental health centers, home health agencies (HHAs), and skilled nursing facilities.
- Detect and recover improper Medicare payments for services to incarcerated, unlawfully present, or deceased individuals.
- Improve monitoring and reconciliation of Medicare hospital outlier payments.
- Ensure that Medicare Advantage Organizations are implementing programs to prevent and detect waste, fraud, and abuse.
- Improve controls to address questionable billing and prescribing practices for prescription drugs.

CMS Should Maximize Recovery of Improper Payments and Better Address Payment Vulnerabilities To Prevent Improper Payments

The ultimate goal is preventing improper payments entirely. However, the reality is that Medicare pays billions of dollars improperly each year. CMS must maximize the recovery of overpayments identified by its contractors and others. It is also paramount to prevent the recurrence of improper payments by identifying why they occurred and improving program safeguards accordingly.

Maximize Recovery of Overpayments

OIG has uncovered numerous impediments to maximizing the recovery of overpayments. For example, as of February 29, 2012, 2,004 HHAs still owed CMS a total of approximately $408 million for $590 million in overpayments that the agency identified for these HHAs between 2007 and 2011. CMS could have recovered at least $39 million between 2007 and 2011 if it had required each HHA to obtain a $50,000 surety bond.[3]

CMS's challenges in recovering overpayments are not limited to home health agencies. OIG examined overpayments in "currently not collectible" status – a classification that CMS uses for overpayments in which the provider has not made a repayment for at least 6 months.[4] In FY 2010, CMS reported that $543 million in overpayments had been newly designated as "currently not collectible." However, CMS had limited information to track most of these overpayments in its accounting system. For those it did track, virtually all went uncollected. According to contractors, inaccurate provider contact information delays or prevents some overpayment demand letters from reaching providers. Expanding the types of provider identifiers used to offset overpayment could improve debt recovery efforts, particularly for providers with multiple Medicare national provider identifiers.

[3] *Surety Bonds Remain an Unused Tool To Protect Medicare From Home Health Overpayments;* available at http://oig.hhs.gov/oei/reports/oei-03-12-00070.asp.
[4] *Medicare's Currently Not Collectible Overpayments*, OEI-03-11-00670, June 2013; available at http://oig.hhs.gov/oei/reports/oei-03-11-00670.pdf.

These challenges echo earlier OIG findings that the vast majority of overpayments identified by CMS's program integrity contractors went uncollected. Further, CMS did not adequately track information on these overpayments and their collection status.[5]

CMS contracts with Recovery Auditors (RACs) to identify Medicare improper payments for recovery (in cases of Medicare overpayments) or return (in cases of Medicare underpayments). OIG reviewed the RAC program for the Medicare fee-for-service program in 2010 and 2011.[6] RACs audits identified improper payments totaling $1.3 billion in FYs 2010 and 2011. These audits resulted in about $768 million recovered from providers and about $135 million in payments returned to providers.

Better Address Vulnerabilities To Prevent Improper Payments

In addition to using RAC audits to recover overpayments, CMS uses them to identify vulnerabilities and develop corrective action plans to prevent future improper payments. Vulnerabilities have included, for example, billing for services or supplies on behalf of deceased beneficiaries. By June 2012, CMS reported that it had taken corrective actions to address most of the vulnerabilities it had identified from the 2010 and 2011 RAC audits. These corrective actions were not considered closed, however, because CMS had not yet evaluated their effectiveness, a key step in its process. Thus, it is not clear to what extent these corrective actions have prevented improper payments from recurring.

CMS has missed opportunities to address improper payment vulnerabilities identified by its program integrity contractors. In 2011, OIG found that CMS had resolved or taken significant action on only about a quarter of the vulnerabilities that its program integrity contractors had reported in 2009.[7]

Key OIG recommendations to CMS to maximize recovery of improper payments and address payment vulnerabilities include:

- Implement the surety bond requirement for HHAs.[8]
- Improve tracking and monitor the status of overpayment collections
- Expand the types of provider identifiers used to recover overpayments.
- Address program vulnerabilities identified by contractors in a timely manner.
- Evaluate the effectiveness of corrective actions.

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[5] *Collection Status of Medicare Overpayments Identified by Program Safeguard Contractors*, OEI-03-08-00030, May 2010; available at http://oig.hhs.gov/oei/reports/oei-03-08-00030.pdf.

[6] *Medicare Recovery Audit Contractors and CMS's Actions To Address Improper Payments, Referrals of Potential Fraud, and Performance*, OEI-04-11-00680, September 2013; available at http://oig.hhs.gov/oei/reports/oei-04-11-00680.pdf.

[7] *Addressing Vulnerabilities Reported by Medicare Benefit Integrity Contractors*, OEI-03-10-00500, December 2011; available at http://oig.hhs.gov/oei/reports/oei-03-10-00500.asp.

[8] In January 1998, CMS promulgated a final rule requiring each HHA to obtain a surety bond in the amount of $50,000 or 15 percent of the annual amount paid to the HHA by Medicare, whichever is greater. However, this regulation remains unimplemented.

The Medicare Appeals System Faces Many Challenges

The administrative appeals system is an essential component of the Medicare program. Appeals decisions affect providers, beneficiaries, and the Medicare program as a whole. It is imperative that the appeals system be efficient, effective, and fair.

The system has experienced an unprecedented surge of appeals over the past several years. According to the Office of Medicare Hearings and Appeals (OMHA), the number of appeals reaching ALJs—the third level of appeals—doubled from FY 2012 to 2013.[9] Further, OMHA estimates that its backlog will reach a million claims by the end of this fiscal year. A concerted effort by all key players—including OIG, the Centers for Medicare & Medicaid Services (CMS), OMHA, and Congress—is needed to address this issue and to maintain the integrity of the appeals system.

A small percentage of providers account for a large number of appeals

Our work in examining appeals in FY 2010 showed that Medicare providers make up the vast majority—85 percent—of appellants at the ALJ level of appeal.[10] State Medicaid agencies filed 3 percent of appeals and beneficiaries filed the remaining 11 percent. Four State Medicaid agencies filed at least 50 appeals each; 2 of these filed more than 500 appeals each.

Moreover, 2 percent of providers that appealed accounted for nearly one-third of all ALJ appeals. Specifically, 96 providers were frequent filers that filed at least 50 appeals each; 1 provider filed over 1,000 appeals. These providers were twice as likely as others to file appeals regarding medical supplies, such as wheelchairs. During interviews, ALJ staff raised concerns that some providers appeal every payment denial and may have incentives to appeal because a favorable decision is likely.

Of the 40,682 appeals that ALJs decided in FY 2010, 39 percent were Part A; 31 percent were Part B; 22 percent were related to durable medical equipment, prosthetics, orthotics, and supplies; and the remaining were primarily Parts C and D.

For over half of appeals, ALJs decided fully in favor of appellants

In FY 2010, ALJs reversed prior-level decisions and decided fully in favor of appellants for 56 percent of appeals.[11] In comparison, Qualified Independent Contractors (QICs)—the second level of appeals—decided fully in favor of appellants for only 20 percent of appeals. At the ALJ level, appellants were most likely to receive favorable decisions for Part A hospital appeals (72 percent) and least likely for Parts C and D appeals (18 percent and 19 percent, respectively).

[9] Department, *Justification of Estimates for Appropriations Committees, Fiscal Year 2015, OMHA.*
[10] OIG, *Improvements Are Needed at the Administrative Law Judge Level of Medicare Appeals*, OEI-02-10-00340, November 2012. Our work was completed before the recent surge in appeals, but remains relevant to understanding and addressing the current challenges. https://oig.hhs.gov/oei/reports/oei-02-10-00340.pdf
[11] We did not examine the appropriateness of these decisions.

Differences between ALJ and prior-level decisions were due to different interpretations of Medicare policies and other factors

Several factors led to ALJs' reaching decisions that were different from those in the prior level of appeals. We found that ALJs tended to interpret Medicare policies less strictly than did QICs. In addition, ALJ and QIC staff commonly noted that some Medicare policies are unclear. Many ALJs noted that unclear policies lead to more fully favorable decisions for appellants and to more variation among adjudicators.

ALJs and QICs also differed in the degree to which they specialized in Medicare program areas and in their use of clinical experts. In contrast to QICs, ALJs do not have medical directors and clinicians on staff. Several ALJ staff said ALJs tended to rely on testimony and other evidence from treating physicians.

The favorable rate varied widely by ALJ

In addition to finding variation between the two levels of appeals, we found variation among ALJs. In particular, the fully favorable rate for appellants ranged from 18 to 85 percent among the 66 ALJs.

Frequent filers received fully favorable rates at different rates from different ALJs. For example, a supplier with close to 600 appeals received fully favorable decisions from 1 ALJ 7 percent of the time and from another ALJ 100 percent of the time.

According to many ALJ staff, different philosophies among ALJs contribute to the variation in fully favorable rates. They said that given the same facts and the same applicable Medicare policy, some ALJs would make decisions that are favorable to appellants, while others would not.

CMS participation in ALJ appeals is limited

CMS may choose to participate in ALJ appeals. In FY2010, CMS participated in 10 percent of ALJ appeals. This participation involved providing testimony or submitting position papers. CMS rarely chose to be a party. When CMS participated, the ALJs were less likely to decide fully in favor of the appellant. Overall, 44 percent of ALJ decisions were fully favorable to appellants when CMS participated. In contrast, 60 percent of ALJ decisions were fully favorable when CMS did not participate. The role of CMS participation was most striking with appeals involving medical supplies; the appellant was about half as likely to receive a fully favorable decision when CMS participated.

CMS and ALJ staff noted several benefits of CMS participation. Most CMS staff cited an improved relationship between the two agencies, and many ALJ staff noted that CMS often provided needed information.

Current practices regarding appeals documents are highly inefficient

Most CMS and ALJ staff noted that the requirements for accepting new evidence at the ALJ level are open to wide interpretation. ALJs may accept new evidence only if the appellant had good cause for waiting until the ALJ level of appeals to submit it. Most ALJ staff said that they usually accept new evidence when it is submitted. Nearly all CMS staff reported that the ALJs' acceptance of new evidence reduced the efficiency of the appeals system.

In addition, both CMS and ALJ staff identified problems with case files. They reported that a case file at the ALJ level often differed in content, organization, and format compared to the same appeal's case file at the QIC level; these problems created inefficiencies in the appeals system. Because the QICs' case files are almost entirely electronic and ALJs primarily accept only paper case files, the QICs must convert the files to paper format before sending to the ALJs. Most staff noted that this process is resource intensive and prone to error.

Further Action Is Needed To Ensure That the Medicare Appeals System Works Efficiently and Effectively

ALJs decide tens of thousands of appeals each year. These decisions are critical to providers and beneficiaries and affect the Medicare program as a whole. Our findings highlight a number of inconsistencies and inefficiencies in the appeals process. Together, they demonstrate that OMHA and CMS must take action to improve the appeals system, while maintaining ALJs' independence.

<u>Key recommendations to OMHA and CMS include:</u>

- Identify and clarify Medicare policies that are unclear and are interpreted differently.
  Unclear policies can lead to inconsistencies between ALJs and QICs and among ALJs. At least annually, CMS and OMHA should identify policies that are unclear and are interpreted differently by soliciting input from CMS contractors and ALJ staff and by analyzing appeals data.
- Develop and coordinate training on Medicare policies.
  OMHA and CMS should work together to develop and provide training on Medicare policies to ALJ and QIC staff. Coordinated training will help ensure that knowledge of Medicare policies is consistent at the second and third levels of appeal.
- Provide more guidance to ALJs regarding the acceptance of new evidence.
  Current regulations regarding the acceptance of new evidence provide little guidance and only one example of good cause. OMHA and CMS should revise these regulations to include additional examples as well as factors for ALJs to consider when determining whether there is good cause.
- Standardize case files and make them electronic.
  To improve the efficiency of the appeals process, OMHA and CMS should make case files more consistent across the various levels of appeal. Finalizing and enforcing a Memorandum of Understanding should be a first step toward

standardization of the content and the organization of case files. In addition, OMHA should accelerate its Electronic Records Initiative to transition from paper to electronic files.

- Continue to increase CMS participation in ALJ appeals.
  Given the benefits cited by both agencies, CMS should continue to increase its participation in ALJ appeals. CMS should establish participation guidelines and incentives for each type of contractor and should track the results of its participation.
- Implement a quality assurance process to review ALJ decisions.
  The range of fully favorable rates among ALJs raises concerns about whether all ALJs are applying Medicare policies in accordance with regulations. OMHA should implement a quality assurance process that includes, for example, reviewing a sample of ALJ decisions and, when needed, providing ALJs with additional training.

Ensuring that the Medicare program works well for beneficiaries, taxpayers, and providers is of paramount importance. An appeals system that is effective, efficient, and fair is critical to accomplishing this goal. This requires a concerted effort by a number of key players, including OMHA, CMS, providers, OIG, and Congress. It also requires a commitment to implementing innovative solutions to improve the appeals process and to evaluating and refining these reforms over time. Such actions are essential for protecting Medicare beneficiaries and the Medicare Trust Funds.

Conclusion

OIG is responsible for oversight of about 25 cents of every Federal dollar. Unfortunately OIG's mission is challenged by declining resources for Medicare and Medicaid oversight at a time when these programs and our responsibilities are growing. Since 2012, we have closed over 2,200 investigative complaints because of lack of resources. We expect to reduce our Medicare and Medicaid oversight by about 20 percent by the end of this FY. Yet the Department estimated that Medicare and Medicaid outlays would grow by about 20 percent from 2012 to 2014. Full funding of our 2015 budget request would enable us to provide more robust oversight and advance solutions to protect the Medicare and Medicaid programs, beneficiaries, and taxpayers.

Thank you for your interest and support and for the opportunity to discuss some of our work.