



U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

Testimony of:
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Office of Evaluation and Inspections
Office of Inspector General
U.S. Department of Health and Human Services

Hearing:
“Current Hospital Issues in the Medicare Program”

House Committee on Ways and Means
Subcommittee on Health

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Good morning, Chairman Brady, Ranking Member McDermott, and other distinguished Members of the Subcommittee. Thank you for the opportunity to testify about the U.S. Department of Health and Human Services (the Department) Office of Inspector General's (OIG) work to improve Medicare oversight and reduce waste, fraud, and abuse. Fighting waste, fraud, and abuse in Medicare is a top goal for OIG.

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*,¹ which highlights additional opportunities for cost savings and program and quality improvements. Implementing these recommendations could result in billions of dollars saved and more efficient and effective programs.

As you requested, my testimony today summarizes OIG's work in three areas that are key to improving the Medicare program for taxpayers and beneficiaries. They are: hospital observation and short inpatient stays; Recovery Audit Contractors (RACs); and the Medicare appeals process. In each of these areas, we identified significant issues and made recommendations to address them. The key takeaways from my testimony today are: 1) the two-midnight hospital policy must be carefully evaluated, 2) the Centers for Medicare & Medicaid Services (CMS) should enhance its oversight of RACs and follow through on program vulnerabilities that lead to improper payments, and 3) fundamental changes are needed in the Medicare appeals system.

The Two-Midnight Hospital Policy Must Be Carefully Evaluated

Last October, CMS implemented a new hospital policy. The new policy provides guidelines for when hospitals should bill for inpatient stays and when hospitals should bill for outpatient services, such as observation. These inpatient-versus-outpatient decisions significantly affect

¹ Office of Inspector General's *Compendium of Priority Recommendations*, available online at <http://oig.hhs.gov/reports-and-publications/compendium/index.asp>.

how much Medicare pays the hospital, how much the beneficiary must pay, and the beneficiary's eligibility for skilled nursing facility (SNF) services when he or she leaves the hospital.

We evaluated hospitals' use of observation stays and short inpatient stays before the implementation of the new hospital policy.² Our findings highlight important issues that require continued attention. They are summarized below.

Short inpatient stays were often for the same reason as observation stays, but Medicare paid nearly three times more for a short inpatient stay than an observation stay, on average

We found that beneficiaries in both short inpatient and observation stays were most commonly treated for chest pain. Additionally, 6 of the 10 most common reasons for short inpatient stays were also among the 10 most common reasons for observation stays. However, short inpatient stays were far more costly to Medicare than observation stays. Medicare paid an average of \$5,142 per short inpatient stay, but it paid an average of \$1,741 per observation stay. For each of the most common reasons the beneficiary was in the hospital, the average Medicare payment was always higher for short inpatient stays than for observation stays.

Beneficiaries also paid far more for short inpatient stays than for observation stays, on average

Beneficiaries paid almost two times more for a short inpatient stay than an observation stay on average—that is, \$725 per short inpatient stay compared to \$401 per observation stay. For all but two of the most common reasons for treatment, beneficiaries paid more, on average, for short inpatient stays than for observation stays. The two exceptions were stays for circulatory disorders and for coronary stent insertions. Only 6 percent of beneficiaries in observation stays paid more than they would have paid had they been in an inpatient stay.

Hospitals varied widely in their use of short inpatient and observation stays

Some hospitals were far more likely to use short inpatient stays while others were far more likely to use observation stays.³ Nationally, just over one-quarter of these stays were short inpatient stays. However, some hospitals used short inpatient stays for less than 10 percent of their stays, while others used them for over 70 percent of their stays.

Some beneficiaries had hospital stays that lasted three nights or more but did not qualify for SNF services under Medicare

Beneficiaries had almost 618,000 hospital stays that lasted 3 nights or more but did not include 3 inpatient nights. Because their stays did not include three inpatient nights, these beneficiaries

² OIG, *Hospitals' Use of Observation Stays and Short Inpatient Stays for Medicare Beneficiaries*, OEI-02-12-00040, July 2013. Short inpatient stays are inpatient stays that lasted one night or less.

³ This analysis includes outpatient stays that lasted at least one night, but were not coded as observation stays. For some of these stays, hospitals may have provided observation services without coding the claims as observation stays. Hospitals are not always paid a separate amount for coding claims as observation stays.

did not qualify for SNF services under Medicare. For about 25,000 of the 618,000 hospital stays, beneficiaries received SNF services following their discharge from the hospital. Medicare nearly always paid (inappropriately) for these SNF services. However, for about 2,000 of the hospital stays, Medicare did not pay for the SNF services, and the beneficiary was charged an average of about \$11,000.

The new hospital policy must be evaluated

The issues that we highlighted in the July 2013 report continue to be relevant. CMS's new policy will affect hospitals' use of observation stays and short inpatient stays, which in turn will affect Medicare and beneficiary payments to hospitals. The new policy may also affect beneficiaries' access to SNF services. Information about the impact of the new policy is needed to ensure that policymakers take these issues into account as they move forward.

CMS Should Strengthen its Oversight of RACs and Follow through on Vulnerabilities That Lead to Improper Payments

Recovery Audit Contractors (RACs) play a critical role in identifying improper payments and protecting the fiscal integrity of Medicare. An OIG review found that RACs identified improper payments totaling \$1.3 billion in FYs 2010 and 2011.⁴ While most of these improper payments were overpayments and resulted in dollars returned to the Medicare Trust Funds, some were underpayments and resulted in dollars returned to providers. Approximately 88 percent of the recovered and returned improper payments came from inpatient hospital claims. Medical services delivered in inappropriate facilities accounted for about a third of the improper payments. This includes claims in which the RAC found that services provided to a beneficiary in an inpatient setting could have been provided in an outpatient setting.

Providers did not appeal RAC decisions for about 94 percent of claims identified as overpayments. Of the 6 percent that were appealed, almost half were decided in favor of the appellant.

CMS should enhance its follow-through on improper payment vulnerabilities identified through RAC audits

CMS uses RAC audits to identify vulnerabilities and develop corrective action plans to prevent future improper payments. CMS identified 46 program vulnerabilities in FYs 2010 and 2011. These included vulnerabilities such as indicating the incorrect place of service on claims or billing for services or supplies for deceased beneficiaries. By June 2012, CMS had taken corrective actions to address the majority of these vulnerabilities. These corrective actions were not considered closed, however, because CMS had not yet evaluated their effectiveness, an

⁴ OIG, *Medicare Recovery Audit Contractors and CMS's Actions To Address Improper Payments, Referrals of Potential Fraud, and Performance*, OEI-04-11-00680, August 2013.

important step in its process. Thus, it is not clear to what extent these corrective actions have prevented improper payments from recurring.

CMS performance evaluations of RACs lacked some key metrics

Although CMS completed performance evaluations for all of its RACs in 2010 and 2011, these evaluations lacked metrics related to some key contract requirements. Most notably, CMS did not evaluate RACs on the extent to which they identified improper payments. In addition, four of eight performance evaluations did not include information on the RAC's ability, accuracy, or effectiveness in identifying overpayments. In response to our report, CMS noted that it has revised its RAC evaluations to incorporate metrics on identification of improper payments and accuracy rates.

Key recommendations to CMS include:

- Evaluate the effectiveness of corrective actions to prevent Medicare overpayments.
- Strengthen performance evaluation metrics and better ensure that contractors meet performance standards.

The Medicare Appeals System Needs Fundamental Changes

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 two years. According to the Office of Medicare Hearings and Appeals (OMHA), the number of appeals reaching Administrative Law Judges (ALJ)—the third level of appeals—doubled from FY 2012 to 2013.⁵ 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, CMS, OMHA, and Congress—is needed to address this issue and to maintain the integrity of the appeals system.

Before the recent surge, OIG completed work that focused on the ALJ level of appeals.⁶ Although the work covered FY 2010, many of the findings and recommendations are relevant to understanding and addressing the current challenges.

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

Medicare providers make up the vast majority—85 percent—of appellants at the ALJ level of appeal. Beneficiaries filed 11 percent and State Medicaid agencies filed 3 percent of appeals. Moreover, only 2 percent of these providers accounted for nearly one-third of all ALJ appeals.

⁵ Department, *Justification of Estimates for Appropriations Committees, Fiscal Year 2015, OMHA*.

⁶ OIG, *Improvements Are Needed at the Administrative Law Judge Level of Medicare Appeals*, OEI-02-10-00340, November 2012.

Specifically, 96 providers filed at least 50 appeals each with 1 provider filing 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.

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. 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).

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

Several factors led to ALJs reaching different decisions than 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 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.

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

CMS participated in 10 percent of ALJ appeals in FY 2010. When CMS participated, the ALJs were less likely to decide fully in favor of the appellant. 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.

Current practices regarding appeals documents are highly inefficient

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, creating 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.

Key recommendations to OMHA and CMS include:

- Identify and clarify Medicare policies that are unclear and interpreted differently.
- Develop and coordinate training on Medicare policies.
- Standardize case files and make them electronic.
- Continue to increase CMS participation in ALJ appeals.
- Implement a quality assurance process to review ALJ decisions.

Further Action Is Needed To Ensure that Hospital Payment Policies, RACs, and the Medicare Appeals Process Work Efficiently and Effectively

Ensuring that the Medicare program works effectively and efficiently for beneficiaries, taxpayers, and providers is of paramount importance. Clear policies, strong oversight of contractors, and an appeals system that is effective, efficient, and fair are critical to accomplishing this goal. This requires a concerted effort by a number of key players, including CMS, CMS contractors, providers, OIG, and Congress. It also requires a commitment to evaluating and implementing smart policy, exercising vigilant oversight of contractors, and implementing innovative solutions to improve the appeals process. Such actions are essential for fighting fraud, waste, and abuse and for protecting Medicare beneficiaries and the Medicare Trust Funds.

OIG is committed to continuing its strong oversight. At stake are billions of dollars, the solvency of the program, and the health and well-being of beneficiaries. We will continue to audit and evaluate these critical program areas and recommend solutions to improve efficiency and effectiveness. We are challenged in meeting this mission by declining resources for Medicare and Medicaid oversight at a time when these programs and our responsibilities are growing. By the end of this fiscal year, we expect to reduce Medicare and Medicaid oversight by about 20 percent. Full funding of our 2015 budget request would enable us to provide more robust oversight and advance solutions to protect programs, beneficiaries, and taxpayers.

Thank you for your interest and support and for the opportunity to discuss some of our work. I am happy to answer any questions you may have.