



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

Testimony of:
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U.S. Department of Health and Human Services

Hearing:
"Medicare Mismanagement: Oversight of the Federal
Government Efforts to Recapture Misspent Funds"

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

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Good morning, Chairman Lankford, Ranking Member Speier, 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) recommendations to prevent Medicare improper payments, increase recoveries of overpayments, ensure effective performance by contractors, and improve the Medicare appeals process that resolves disputes over improper payments. Fighting waste, fraud, and abuse in Medicare is a top goal, and improper payments cost Medicare billions of dollars each year. Reducing this amount is paramount.

In short, more action is needed from the Centers for Medicare & Medicaid Services (CMS), its contractors, and the Department to achieve this goal. CMS needs to better ensure that Medicare makes accurate and appropriate payments. When improper payments do occur, CMS needs to identify and recover them. It must also implement safeguards, as needed, to prevent recurrence. CMS relies on contractors for most of these crucial functions; therefore, ensuring effective contractor performance is essential. Finally, the Medicare appeals system needs fundamental changes to resolve issues about improper payments efficiently, effectively, and fairly. OIG has recommended numerous actions to advance these outcomes.

Overall, 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 audits and investigations resulted in expected recoveries of \$5.8 billion in stolen or misspent funds across Department programs. In addition, OIG reported estimated savings of more than \$19 billion resulting from legislative and regulatory actions supported by OIG recommendations.¹ The Health Care Fraud and Abuse Control Program (a joint program of the Department, OIG, and the Department of Justice to fight waste, fraud, and abuse in Medicare and Medicaid) returned more than \$8 for every \$1 invested.²

¹ Office of Inspector General’s *Semiannual Report to Congress*, Fall 2013, available online at <http://oig.hhs.gov/reports-and-publications/archives/semiannual/2013/SAR-F13-OS.pdf>.

² The \$8 to \$1 return on investment is a three-year rolling average from FY 2010-2013. For more details on this and other HCFAC accomplishments, see the FY 2013 *Health Care Fraud and Abuse Control Program Report*, available online at <http://oig.hhs.gov/reports-and-publications/hcfac/index.asp>.

Despite these successes, further actions are needed to protect Medicare and Medicaid from waste, fraud, and abuse. In March 2014, OIG issued its *Compendium of Priority Recommendations*, which highlights additional opportunities for cost savings and program and quality improvements.³ Implementing these recommendations could result in billions of additional dollars saved. My testimony today focuses on a selection of those key recommendations.

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.⁴ 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. Examples of two critical areas include payments for prescription drugs and payments to home health agencies.

Better Protect Medicare and Beneficiaries from Inappropriate Prescribing, Use, and Billing for Prescription Drugs

OIG has extensively examined CMS's monitoring and oversight of the Part D program and the effectiveness of controls to ensure appropriate payment and patient safety. Our work has found limitations in program safeguards that leave Part D vulnerable to improper payments and Medicare patients vulnerable to potentially harmful prescribing. For example, we found that Medicare inappropriately paid millions of dollars for prescriptions from unauthorized prescribers, such as massage therapists and athletic trainers.⁵

Further, thousands of retail pharmacies demonstrated extremely high billing for at least one of the eight measures of questionable billing we developed (e.g., billing for very high numbers of prescriptions per Medicare patient).⁶ For example, one pharmacy billed an average of 116 prescriptions per Medicare patient – almost 5 times the national average of 24 prescriptions per Medicare patient. Pharmacies with questionable billing could have billed for drugs that were not medically necessary or that were not provided to beneficiaries. We have also uncovered extreme prescribing patterns by hundreds of physicians (e.g., prescribing extremely high numbers of prescriptions per Medicare patient, relative to their peers).⁷ For example, over 100 general-care

³ Office of Inspector General's *Compendium of Priority Recommendations*, March 2014, available online at <http://oig.hhs.gov/reports-and-publications/compendium/index.asp>.

⁴ *Department of Health and Human Services FY 2013 Agency Financial Report*, available online at <http://www.hhs.gov/afr/2013-hhs-agency-financial-report.pdf>.

⁵ *Medicare Inappropriately Paid for Drugs Ordered by Individuals Without Prescribing Authority*, OEI-02-09-00608, June 2013, available at <http://oig.hhs.gov/oei/reports/oei-02-09-00608.asp>.

⁶ *Retail Pharmacies With Questionable Part D Billing*, OEI-02-09-00600, May 2012, available at <http://oig.hhs.gov/oei/reports/oei-02-09-00600.asp>.

⁷ *Prescribers With Questionable Patterns In Medicare Part D*, OEI-02-09-00603, June 2013, available at <http://oig.hhs.gov/oei/reports/oei-02-09-00603.asp>.

physicians prescribed at a rate of more than 70 prescriptions per Medicare patient. Nationally, general-care physicians average 13 prescriptions per Medicare patient. While questionable billing is not necessarily improper or fraudulent, it may be an indication of such and warrants further scrutiny.

These vulnerabilities are even more concerning in light of the increasing number of OIG investigations into prescription drug fraud. For example, a physician in Kansas and his wife ran a pill mill and wrote thousands of medically unnecessary prescriptions for narcotics. The physician was directly linked to the deaths of four patients, and he billed the drugs to Federal health care programs and private insurers for over \$4 million dollars. Both the physician and his wife were sentenced to more than 30 years in prison.⁸ The serious and growing problem of prescription drug abuse lends a greater urgency to efforts to address fraud and improve monitoring and oversight of Part D.⁹

Key OIG recommendations to CMS related to the issues described above include:

- require Part D plans to verify that prescribers have the authority to prescribe,
- instruct the Medicare program integrity contractor to expand its analysis of prescribers, and
- provide Part D plans with additional guidance on monitoring prescribing patterns.

CMS issued a proposed rule that would require all prescribers of Part D drugs to be enrolled in the Medicare fee-for-service program (or officially opt out).¹⁰ If implemented, this requirement could help CMS, Part D plans, and the Medicare program integrity contractor enhance their monitoring and better prevent and detect Part D improper payments and potential fraud.

CMS Should Better Prevent, Identify, and Recover Improper Payments to Home Health Agencies

For decades, OIG has raised concerns about improper Medicare payments to and fraud committed by home health agencies. CMS has taken steps to protect against improper Medicare billing for home health services, but these actions have not fully addressed the problem.

For example, CMS implemented a requirement of the Affordable Care Act that practitioners who certify Medicare patients as eligible for home health services must document their face-to-face encounters with those patients. However, OIG found that almost one-third of home health services claims in 2011 and 2012 did not meet these requirements, resulting in \$2 billion in

⁸ U.S. Department of Justice Press Release, Jury: Haysville Doctor and Wife Guilty in Deadly Prescription Drug Overdoses, June 24, 2010, available online at <http://www.justice.gov/usao/ks/PressReleases/2010/jun/June24a.html>.

⁹ See *Spotlight on Drug Diversion*, available at <http://oig.hhs.gov/newsroom/spotlight/2013/diversion.asp>.

¹⁰ Federal Register, Volume 79, Number 7, pages 1982-1987, published January 10, 2014, available online at <http://www.gpo.gov/fdsys/pkg/FR-2014-01-10/pdf/2013-31497.pdf>.

improper payments.¹¹ Furthermore, CMS has struggled to collect all of the overpayments to home health agencies that it has identified and has not implemented a requirement promulgated in 1998 that home health agencies obtain surety bonds, which could aid in recouping some of these funds.¹²

In addition, OIG found that in 2010, one-quarter of home health agencies met the threshold of at least one of six questionable billing measures that we created (e.g., billing for unusually high numbers of visits per patient or average payment amounts per patient, relative to other home health agencies).¹³ For example, 13 home health agencies billed for more than 300 visits per Medicare patient in 2010. In comparison, the median number of visits per Medicare patient across all Medicare home health agencies was only 32. Further, OIG investigations have uncovered significant home health fraud, including a case in Texas involving more than \$300 million in alleged fraudulent Medicare billing.¹⁴

Key OIG recommendations to CMS related to improper payments for home health services include:

- create a standardized form to ensure better compliance with the face-to-face encounter documentation requirements,
- implement the surety bond requirement for home health agencies, and
- increase monitoring of Medicare claims for home health services.

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.

¹¹ *Limited Compliance with Medicare's Home Health Face to Face Documentation Requirements*, OEI-01-12-00390, April 2014, available online at <http://oig.hhs.gov/oei/reports/oei-01-12-00390.asp>.

¹² *Surety Bonds Remain an Unused Tool to Protect Medicare from Home Health Overpayments*, OEI-03-12-00070, September 2012, available online at <http://oig.hhs.gov/oei/reports/oei-03-12-00070.asp>.

¹³ *Inappropriate and Questionable Billing by Medicare Home Health Agencies*, OEI-04-11-00240, August 2012, available online at <http://oig.hhs.gov/oei/reports/oei-04-11-00240.asp>.

¹⁴ U.S. Department of Justice Press Release, *Dallas Doctor Arrested for Alleged Role in Nearly \$375 Million Health Care Fraud Scheme*, February 28, 2012, available online at <http://www.justice.gov/opa/pr/2012/February/12-crm-260.html>.

Maximize Recovery of Overpayments

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 six months.¹⁵ 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.

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.¹⁶

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 2011.¹⁷

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 recovering overpayments, CMS uses RAC audits 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.

¹⁵ *Medicare's Currently Not Collectible Overpayments*, OEI-03-11-00670, June 2013, available online at <http://oig.hhs.gov/oei/reports/oei-03-11-00670.pdf>.

¹⁶ *Collection Status of Medicare Overpayments Identified by Program Safeguard Contractors*, OEI-03-08-00030, May 2010, available online at <http://oig.hhs.gov/oei/reports/oei-03-08-00030.pdf>.

¹⁷ *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 online at <http://oig.hhs.gov/oei/reports/oei-04-11-00680.pdf>.

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 2009.¹⁸

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

- 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, and
- evaluate the effectiveness of corrective actions.

CMS Needs to Ensure Effective Performance by Its Contractors

CMS relies on contractors to operate vital functions of the Medicare program, including paying claims, running program integrity activities, identifying overpayments, and recouping overpayments. CMS contracts with Medicare Administrative Contractors (MACs) to process claims and implement payment safeguards; program integrity contractors, including the Medicare Drug Integrity Contractor (MEDIC), Zone Program Integrity Contractors (ZPICs), and Program Safeguard Contractors (PSCs), to protect Medicare from fraud and abuse; and RACs to identify and collect overpayments. OIG reviews of these contractors over the past decade have consistently identified problems, including failure to use data to assess contractor performance and inadequate response when contractors do not meet performance standards.¹⁹

Use Data More Effectively to Oversee Contractor Performance and Include Key Metrics in Performance Evaluations

Program integrity contractors are required to periodically report to CMS data describing their activities. However, OIG found that the data used by CMS to oversee ZPICs were not accurate or uniform, preventing a conclusive assessment of contractor activities. Further, OIG found significant differences in fraud detection efforts across ZPICs (and in earlier work, across PSCs) that could not be explained by differences in budget or oversight responsibility. Yet, CMS had not assessed the wide variation across contractors' activity data, and CMS contractor

¹⁸ *Addressing Vulnerabilities Reported by Medicare Benefit Integrity Contractors*, OEI-03-10-00500, December 2011, available online at <http://oig.hhs.gov/oei/reports/oei-03-10-00500.asp>.

¹⁹ Findings and recommendations from a series of OIG evaluations of contractor oversight and performance are summarized and referenced in OIG's *Compendium of Priority Recommendations*, March 2014, available online at <http://oig.hhs.gov/reports-and-publications/compendium/index.asp>.

performance evaluations provide few quantitative details about the contractors' achievements in detecting and deterring fraud and abuse.²⁰

Additionally, CMS's performance evaluations for RACs lacked metrics related to key contract requirements, such as identification of improper payments. 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 and is considering additional performance measures. We encourage CMS to continue to increase its use of performance metrics and data to oversee contractor performance.²¹

Evaluate Contractor Performance in a Timely Manner and Respond More Effectively When Performance Requirements Go Unmet

OIG found that CMS conducts extensive activities to review MACs' performance. However, the reviews are not always conducted in time to inform future contract award decisions. Further, CMS did not ensure that its MACs resolved or developed action plans to address unmet quality assurance standards.²²

Key OIG recommendations to CMS related to contractor performance include:

- improve and more effectively use data to assess contractor performance, including to analyze performance across contractors and assess the causes of variation;
- strengthen performance evaluations and include key metrics to assess how well contractors are performing core functions; and
- conduct performance evaluations in a timely manner and address unmet performance standards more effectively.

The Medicare Appeals System Needs Fundamental Changes

Medicare appeals decisions affect providers, beneficiaries, and the program as a whole. It is imperative that the appeals system be efficient, effective, and fair.

²⁰ *Zone Program Integrity Contractors' Data Issues Hinder Effective Oversight*, OEI-03-09-00520, November 2011, available online at <http://oig.hhs.gov/oei/reports/oei-03-09-00520.asp>.

²¹ *Medicare Recovery Audit Contractors and CMS's Actions To Address Improper Payments, Referrals of Potential Fraud, and Performance*, OEI-04-11-00680, August 2013, available online at <http://oig.hhs.gov/oei/reports/oei-04-11-00680.asp>.

²² *Medicare Administrative Contractors' Performance*, OEI-03-11-00740, January 2014, available online at <http://oig.hhs.gov/oei/reports/oei-03-11-00740.asp>.

In recent years, the system has experienced an unprecedented surge of appeals.²³ According to the Office of Medicare Hearings and Appeals (OMHA), from FY 2012 to 2013, the number of appeals reaching the Administrative Law Judges (ALJ, the third level of appeals) doubled.²⁴ 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 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.²⁵ 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. Moreover, only 2 percent of providers accounted for nearly one-third of all ALJ appeals. Specifically, 96 providers filed at least 50 appeals each with 1 provider filing over 1,000 appeals. ALJ staff has raised concerns that some providers appeal every payment denial and may have incentives to appeal because the cost is minimal and a favorable decision for the appellant is likely.

For more than half of appeals, ALJs decided fully in favor of appellants

In 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. Appellants were most likely to receive favorable ALJ 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. QICs also tend to be more specialized in Medicare program areas than ALJs and have clinicians on staff; ALJs tend to rely on evidence and testimony from the treating physicians. Both QIC and ALJ staff noted that lack of clarity in some Medicare policies is also a factor in the differing decisions.

²³ OIG found that Medicare redeterminations – the first level in the Medicare appeals process – increased by 33 percent from 2008 to 2012. Increases in appeals by Part A providers related to RAC audits was one driver of the increase. See *The First Level of the Medicare Appeals Process, 2008-2012: Volume, Outcomes, and Timeliness*, OEI-01-12-00150, October 2013, available online at <http://oig.hhs.gov/oei/reports/oei-01-12-00150.asp>.

²⁴ Department of Health and Human Services, *Justification of Estimates for Appropriations Committees, Fiscal Year 2015*, available online at <http://www.hhs.gov/budget/fy2015/fy-2015-hhs-congressional-budget-justification.pdf>.

²⁵ *Improvements Are Needed at the Administrative Law Judge Level of Medicare Appeals*, OEI-02-10-00340, November 2012, available online at <https://oig.hhs.gov/oei/reports/oei-02-10-00340.asp>.

Further, ALJs vary amongst themselves in decision-making. The fully favorable rate for appellants ranged from 18 to 85 percent among the 66 ALJs.

CMS participation affects the outcome of appeals

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

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 related to improving the appeals process include:

- identify and clarify Medicare policies that are being interpreted differently and develop and coordinate training on those policies;
- standardize case files and make them electronic;
- continue to increase CMS participation in ALJ appeals; and
- implement a quality assurance process to review ALJ decisions.

OIG Will Continue Working to Prevent and Recover Medicare Improper Payments

Reducing Medicare improper payments and ensuring effective program administration requires a concerted effort by a number of key players, including the Department, CMS, CMS contractors, providers, Congress, and OIG.

More action is needed to ensure that payments are made accurately. Any improper payments that do occur must be identified and recovered, and solutions must be identified and implemented to prevent recurrence. As CMS relies on contractors for most of these crucial functions, oversight of and accountability for contractor performance is paramount. Finally, the Medicare appeals system to resolve issues about improper payments must operate efficiently, effectively, and fairly.

While CMS has taken some important steps to identify and recover improper payments and implement safeguards to prevent them, our work demonstrates that further improvements are

needed. A comprehensive list of OIG's priority recommendations can be found in our *Compendium of Priority Recommendations* on our Web site.²⁶

OIG will continue to audit and evaluate Medicare payments and vulnerabilities and recommend solutions to reduce the billions of dollars wasted each year. 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 our Medicare and Medicaid oversight by about 20 percent. 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.

We are committed to strong oversight of Medicare to reduce waste, fraud and abuse as comprehensively and effectively as possible with the tools and resources we have available. At stake are billions of dollars, the solvency of the program, and the health and well-being of beneficiaries.

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

²⁶ Available at <http://oig.hhs.gov/reports-and-publications/compendium/index.asp>.

Biographical Information

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Brian Ritchie is the Acting Deputy Inspector General for Evaluation and Inspections with the Department of Health and Human Services, Office of Inspector General (OIG). Brian has held several critical leadership positions within OIG. He served as Assistant Inspector General for Evaluations and Inspections from 2006 to 2011, overseeing quality and production of evaluation reports. In 2011, he joined OIG's Office of Audit Services as Assistant Inspector General for Centers for Medicare and Medicaid Audits. In February of 2014, he assumed his current role, where he directs and oversees OIG's evaluation activities for all Departmental programs, including Medicare and Medicaid.

Brian began his Federal career in 1987 with OIG's Office of Evaluation and Inspections, where he served first as an analyst and later as the Director of Technical Support Services. In these roles, he developed extensive experience in data systems and the innovative use of data to conduct program oversight. This background has served him well as data analytics has become an increasingly powerful and widely utilized tool for fighting health care fraud, waste, and abuse.

Through Brian's long history with OIG and participation in a variety of joint initiatives between OIG and the Centers for Medicare & Medicaid Services, he has developed significant expertise and unique insights into the challenges of operating the Medicare and Medicaid programs.