Senate Committee on Finance
U.S. Senator Orrin Hatch (R-UT), Chairman
http://finance.senate.gov

FOR IMMEDIATE RELEASE
April 28, 2015

CONTACT: Aaron Fobes , Julia Lawless
(202) 224-4515

Hatch Statement at Finance Hearing on Medicare Audit and Appeals

WASHINGTON – Senate Finance Committee Chairman Orrin Hatch (R-Utah) today delivered the following opening statement at a committee hearing on Medicare audit and appeals:

Our hearing today will consider audit and appeals issues in Medicare. As some of you may recall, in July 2013, the Finance Committee held a hearing focused on audits of Medicare providers. At that time, Chairman Baucus and I were concerned by some of the stories we were hearing from hospitals, doctors, and others in the medical community. That hearing gave us insight into some of the problems audits pose for providers.

Now we turn to an issue that is directly tied to those audits: Medicare appeals.

I just returned from my home state of Utah, where Medicare issues remain a serious concern for my constituents. For the past two years, like many members here, I have heard about the terrible backlog of Medicare appeals.

Before I move on to the appeals process in detail, I want to mention that improper Medicare payments continue to be a serious issue – and a big part of the reason that we're seeing such a backlog in appeals.

Last month the GAO released a report on Government Efficiency and Effectiveness. The report found that, in Fiscal Year 2014, Medicare covered health services for approximately 54 million elderly and disabled beneficiaries at a cost of $603 billion. Of that figure, an estimated $60 billion, or approximately ten percent, were improperly paid, totaling over $1,000 in improper payments for every single Medicare beneficiary.

These numbers are unacceptable. This error rate must be lowered to ensure the viability of the Medicare Trust Fund so that Medicare can continue serving beneficiaries for years to come.

CMS has, of course, taken steps to identify and recover improper payments, including hiring contractors to conduct audits of the more than one billion claims submitted to the Medicare program every year. These auditors have recovered billions for the Medicare program

– over $3 billion in 2013 alone. However, the increase in audits has led to a seemingly insurmountable increase in appeals, with a current backlog of over 500,000 cases, evidenced by this chart

This increase in appeals has resulted in long delays for beneficiaries and providers alike. There are so many appeals that the Office of Medicare Hearings and Appeals can't even docket them for 20 to 24 weeks. In FY 2009, most appeals were processed within 94 days. In FY 2015, it will take, on average, 547 days to process an appeal – far too long for beneficiaries to find out whether their medical services will be covered or for providers to find out if they will be paid.

Additionally, large portions of the initial payment determinations are reversed on appeal. The HHS Office of Inspector General reported that, of the 41,000 appeals that providers made to Administrative Law Judges in FY 2010, over 60 percent were partially or fully favorable to the defendant.

Such a high rate of reversals raises questions about how the initial decisions are being made and whether providers and beneficiaries are facing undue burdens on the front end. On the other hand, we need to recognize that ALJs have more flexibility in their decision-making than Medicare contractors do.

During the July 2013 hearing, we expressed our hope that CMS would consider the balance between program integrity with administrative burden on providers. CMS has taken steps to show it is considering that balance. These steps include decreasing the burdens on providers, increased oversight of auditors, and more transparency in the programs.

When any Medicare contractor – either an auditor or a contractor that processes claims – decides that a claim should not be paid, it has a real effect on beneficiaries and providers, which is why it is so important that the appeals process allow these appeals to be heard in a timely and consistent fashion.

The Office of Medicare Hearings and Appeals has also taken steps to address its backlog, but there is only so much the agency can do with their current authorities and staffing.

Senator Wyden and I, and the other members of this committee, are committed to finding ways to make the appeals process work more efficiently and effectively in order to ease the burden on beneficiaries and providers and to protect the Medicare Trust Fund.

Today we have the opportunity to hear from those that are closest to the Medicare appeals process. I want to thank our witnesses for appearing today to help us understand the issues that they face in dealing with the large number of Medicare appeals. I look forward to hearing their perspectives on how that process might be changed to create a more efficient and level playing field.

###