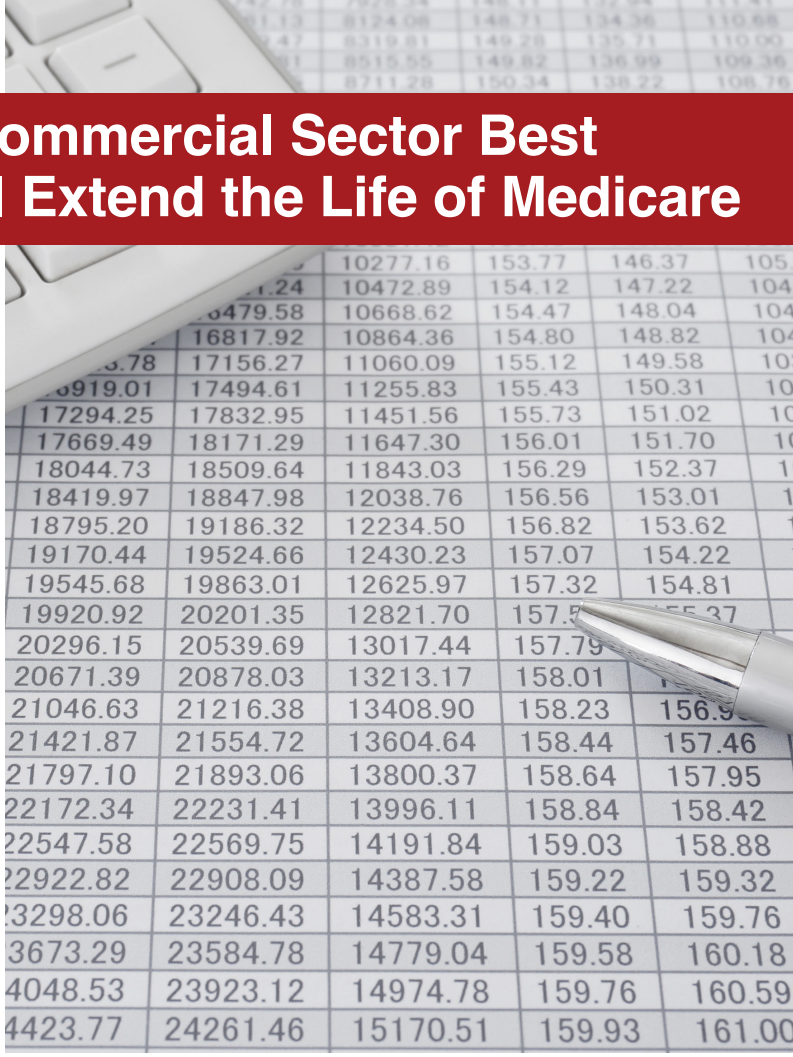
COUNCIL FOR MEDICARE INTEGRITY

Leveraging Commercial Sector Best Practices Will Extend the Life of Medicare



Medicare has the most wasteful spending of all government programs, with $43 billion lost from it's Fee For Service program in FY2015 alone. That waste is caused by extensive provider misbilling and providers not adhering to Medicare policy – at an enormous 12.1% billing error rate. As a result of high billing errors and the influx of new Medicare beneficiaries, the Congressional Budget Office and the Medicare Trustees now warn that **Medicare will be insolvent within the next 10 to 15 years.**

Given such high rates of wasteful spending and serious concerns about the bankruptcy of the program, the federal government may want to turn to the private sector for more guidance on best practices to help identify and return more improper payments back to the Medicare Trust Funds and keep the program intact. For years, commercial payers – private insurance companies – have employed recovery audit contractors to reduce improper payments as well the turn-around time for provider payments, and have had lower error rates than Medicare.

Recovery auditing is a best commercial practice used by the nation's largest private insurance companies, the Centers for Medicare and Medicaid Services (CMS) and the world's leading retailers for years.

More Oversight Needed for Our Nation's Marquee Health Program

When the federal government began building a robust program to audit post-payment Medicare claims – the Recovery Audit Contractor (RAC) program – the intent was to reduce improper payments within Medicare and ensure providers billed correctly and according to Medicare policy. They leveraged best practices from the private sector and in some cases added additional oversight. Specifically:

- Paying for top auditing performance with no out-of-pocket costs, by leveraging the contingency fee pay model.
- Ensuring high audit accuracy rates by monitoring contractors through a 3rd party validator and reports the accuracy rates to Congress.
- Building a robust approval process to identify new billing issues for review and areas where errors trend the highest.
- Providing full transparency for providers with online posting of issues and determination status.
- Identifying and returns underpayments to providers.
- Paying providers for medical records.
- Offering several levels of appeal to help ensure fairness for all stakeholders.

Unfortunately, the Medicare program has gone in the opposite direction of private sector best practices with regard to the rate of auditing of post-payment claims. Historically, Medicare has only allowed auditors to review less than 2 percent of all claims for billing accuracy. Recently, due to provider complaints about the burden of 2 percent review, document request limits were dropped to approximately 96% of in-patient reviews which means that 99.5% of Medicare medical records are not reviewed for accuracy. In stark contrast, commercial payers allow 100% of their payments to be reviewed for billing accuracy. In-patient claims account for approximately 80% of the Medicare spend. For example, a provider that has an annual spend of $206B, previously was subject to 600 reviews every 45 days. Under the new rules, they will be subject to 20 reviews every 45 days.

Additionally, when the program was operating at full scale, recovery auditors reviewed more than 800 CMS approved billing issue areas. Today, just slightly more than 300 billing issues are reviewed, leaving billions of taxpayer dollars unrecovered.

Comparing Auditing in Medicare to that of Private Insurance Payers

Commercial Payers	Medicare FFS
Perform some level of review for 100% of healthcare claims submitted by payers for accuracy, adherence to contract terms, and medical necessity.	Reviews limited to just 0.5% of claims submitted.
Virtually no type of claim is restricted from review.	Recovery auditors are restricted on what can be reviewed. For example, short inpatient hospital stays are off limits unless referred by QIOs.
Provider reimbursement is complex with individual contracts in place for each provider.	Provider reimbursement is relatively simple with the same rules in place for all providers.

Auditing Practices of Private Payers

Today, there's no limit to the number of records that a private health insurer may request from a provider to audit for coding errors and ensure the services performed are billed according to the health plans policy. In fact, private payers are very clear – providers who want to participate within the network of a particular health plan must comply with that company's policies or be kicked out of the network. Providers sign contracts with private payers and comply with an unlimited review of their claims and billing issue areas.

If providers can be subject to audit of up to 100 percent of their private payer claims and with the Medicare program in such dire straits, how does it make sense to be reducing oversight rather than increasing it?

In an effort to get Medicare back on the right track, the federal government should again look to the private sector for best practices that can help improve Medicare solvency. Enhancements to the program should include the following additional private sector practices:

- Auditing a higher percentage of claims and billing issue areas to return more improper payments where history shows a high volume of improper payments
- A less complicated appeals process and one that supports Medicare policy
- More timely auditing, closer to the actual time of the patient encounter.
- More pre-payment auditing for billing accuracy.

Recovery Auditing Works, But Needs Expansion

Despite the constraints placed on the RAC Program, CMS data shows that not only does this Program work, but it's been very successful, having returned more than $10 billion in improper payments back to the Trust Funds while reviewing less than 2 percent of claims. Independent validation contractors have also found that the RAC program is highly accurate – with an average accuracy rate of more than 95 percent.

If the RAC Program was expanded to review more claims and billing issue areas, imagine how much waste could be recovered. Those savings would help extend the life of the Trust Funds, upon which our nation's seniors and future generations rely, by several years.

With Medicare bankruptcy looming, it's time for the federal government to turn again to the private sector to identify the best ways to improve the program so recovery auditors can do much more to protect the financial future of Medicare and save taxpayer dollars while lowering systemic healthcare costs.

To learn more visit: medicareintegrity.org

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