Introduction

BACKGROUND

In 2009, Congress mandated creation of the Recovery Audit Contractor (RAC) Program to review post-payment Medicare Fee-For-Service (Part A and Part B) claims and return misbilled funds back to the Medicare program.

Managed by the Centers for Medicare and Medicaid Services (CMS), the RAC Program’s primary task is to review Medicare claims data and determine if a claim was paid appropriately, according to Medicare guidelines. If a RAC determines a claim was billed and paid incorrectly, the improper payment is returned to the Medicare Trust Funds or to the Medicare provider, depending on if the claim was overbilled or underbilled.

Analyzing government or third-party reports and data, the Council for Medicare Integrity, a nonprofit organization advocating for proper Medicare billing, created this report to detail the current state of the RAC Program as of January 2016.

HISTORY OF THE RAC PROGRAM

Recognizing the success of recovery auditing as a best practice in private sector health insurance, the Medicare Prescription Drug Improvement and Modernization Act of 2003 contained language creating a pilot program to determine if RACs could efficiently and effectively identify and recover improper payments for the Medicare Fee-For-Service (FFS) program.

From March 2005 to 2008, the RAC Program operated in six states as a demonstration project. Based on the success of the pilot in 2006 Congress called for the expansion of the program; and in 2009, the national RAC Program was created with the mandate to expand to all states by January 2010.

Four contracts were awarded for four regions of the country, with each contractor responsible for identifying overpayments and underpayments in roughly one-quarter of the United States.
In addition to identifying misbillings, RACs point out common billing errors, trends and other payment issues to CMS in order to strengthen the Medicare program.

Since the program began in 2010, RACs have recovered more than $10 billion for the Medicare Trust Funds. In fact, Senator Claire McCaskill (D-MO), the Chairman and Ranking Member on the U.S. Senate Special Committee on Aging, credited the Recovery Audit Contractor (RAC) Program with extending the life of the Medicare program by two years.

Improper Medicare payment recoveries grew strongly in those first few years of the program, however due to intense pressure from provider groups, who oppose the auditing of their Medicare billing, in 2014, RAC audit capabilities were first significantly limited and then paused completely.

Although the RAC program restarted on a limited basis in August 2014, the number of issues auditors were able to review drastically decreased. The RAC Program has continued to be severely limited in its auditing capabilities since this time. As a result, annual Medicare improper payment recoveries have dropped significantly, from $3.75 billion recovered in 2013; to just $2.39 billion recovered in 2014.

**ISSUES FOR REVIEW**

**What Can RACs Review?**

After the program pause, recovery auditing was restarted in August 2014 on a very limited basis. As a result, RACs currently review little more than 350 Medicare billing issues, down from the more than 800 when the program was working at full capacity.

In addition, beginning in fall of 2013, RACs were prohibited from reviewing short-stay hospital claims, an area historically causing the highest rates of improper billing within Medicare. This short stay auditing moratorium lasted a full two years – until October 2015. During this time, it’s estimated that the Medicare program lost more than $8 billion due to not reviewing short stay claims during this time.

In late 2015, to address provider concerns, CMS determined that RACs would no longer be the primary auditors of short stay claims. Now, Quality Improvement Organizations (QIOs) have been tasked with conducting reviews of short-stay hospital claims, with the intention to refer only claims from providers with high rates of improper payments over to the RACs for further review.

The chart below highlights just a few of the differences in the types of claim review conducted between the time period when RACs were operating at full scope (“Then”) and how many
issues they currently audit (“Now”).

<table>
<thead>
<tr>
<th>Issue</th>
<th>Then</th>
<th>Now</th>
</tr>
</thead>
<tbody>
<tr>
<td>Automated Overpayments</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Complex Reviews of Diagnosis Related Group (DRG) validation</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Complex Reviews of Pharmacy</td>
<td>Yes</td>
<td>Limited</td>
</tr>
<tr>
<td>Complex Reviews of Therapy</td>
<td>Yes</td>
<td>Limited</td>
</tr>
<tr>
<td>Automated underpayments</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Complex Reviews of Inpatient Rehab Facilities</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Complex Reviews of Skilled Nursing Facilities</td>
<td>Yes</td>
<td>Limited</td>
</tr>
<tr>
<td>Complex Reviews of Durable Medical Equipment, Home Health, and Hospice</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Complex Reviews of inpatient claims from a clinical coding perspective</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Limited Review of Prepayments</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

Specific Billing Problem Areas Exist
The Council for Medicare Integrity has identified the top five CMS-approved billing issues that contribute most to wasted Medicare dollars. These issues include:

• Durable Medical Equipment (DME)
• Home Health Claims
• Medicare Part A and B Pharmacy Claims
• Diagnosis Related Group (DRG) Validation
• Therapy Cap Reviews

In addition, in an effort to draw attention to how Medicare dollars can often be misbilled, RACs have identified examples of egregious errors in Medicare billing, including:

• Home health episodes that started after beneficiaries’ deaths
• Oncology radiation calculations that were billed by a provider and a physician one week before the patient was seen in the office
• Drugs paid for ten times the amount administered
• Hospital claims coded with illnesses the patient didn’t possess
• Excessive units of medication, where the billed dose would be harmful or lethal (to the beneficiary)
• Duplicate provider billing for a medication
• Separate billing for services that should have been bundled and paid for as a single service
• Provider billed for services in one area of the body where procedures are reimbursed at a higher level, when medical records reveal that patient actually received injections in an area where procedures are reimbursed at a lower level

Additional Documentation Request (ADR) limits
There are limits to the volume of claims that RACs can review. ADR limits refer to the specific number of claims any RAC can review from a Medicare provider in a 45-day period.

Historically, this limit was just 2%, meaning that 98% of a provider’s Medicare claims were not reviewed for accurate billing after the provider received payment. RACs identified recoveries or returned underpayments to providers by reviewing this small sample of claims.

Recently, in November 2015, CMS modified current RAC contracts to reduce the ADR limit on the review of inpatient claims to just 0.5% percent, a 75% percent reduction from previous limits. This now means that 99.5% of Medicare inpatient hospital claims will not be reviewed for accurate billing – despite documented high rates of improper billing in this sector.

As a part of this new ADR limit policy, CMS has also stated it will implement a “good” actor/“bad” actor program in which providers who consistently bill properly will have reduced document request limits and providers who consistently bill improperly will be subject to higher ADR limits.

The new ADR policy and the corresponding good/bad actor policy has not yet been operationalized, but is expected to begin in early 2016.

IMPROPER PAYMENTS AND RAC RECOVERIES

Overview of Improper Payments
According to the Office of Management and Budget, the Medicare Fee-For-Service (FFS) program has the highest amount of improper payments across the entire government for each of the past six years.

In 2014 alone, the Government Accountability Office (GAO) found that Medicare FFS overpaid providers by $46 billion – or 12.7% of payments. Of these improper payments, over 84 percent of overpayments collected (more than $2 billion) came from inpatient hospital claims. For 2015, CMS reported similar results with the Medicare FFS program incorrectly paying $43.3 billion – or 12.1% of payments – improperly to Medicare providers.

Improper payments occur for a number of reasons, including:
• Billing for services inconsistent with Medicare policy
• Lack of or insufficient documentation
• Incorrect coding
• Duplicate billing

RAC Program Recoveries

Overpayments

Overpayments occur when a Medicare provider is improperly overpaid for Medicare services. In this case, RACs recover the overpaid funds and return the money back to the Medicare Trust Funds.

According to a 2015 CMS report to Congress, RACs recovered $2,394,846,151 in overpayments in FY2014.

Since the program began, it has returned more than $10 billion to the Medicare Trust Fund.

Underpayments

The RAC Program also identifies improper payments that resulted in a provider not receiving enough payment for a Medicare claim. In these cases, RACs adjust the claim to ensure the provider receives additional payment.

According to a 2015 CMS report, RACs ensured that providers were paid $173,096,904 due to initially being underpaid for their services.

Medicare FFS Improper Payment Rates

CMS calculates the Medicare FFS improper payment rate through the Comprehensive Error Rate Testing (CERT) program. Each year, the CERT evaluates a statistically valid random sample of claims to determine if they were paid properly under Medicare coverage, coding, and billing rules.

The FY2015 CERT error rate is 12.1%, which represents $43.3 billion in wasted Medicare funds. The improper payment rate as reported by CERT has increased dramatically over the past several years, from 3.6% in 2008 to 12.1% in 2015.
In addition to an overall error rate, the CERT report breaks down the error rate by service type as follows:

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Improper Payment Rate</th>
<th>Improper Payment Rate (2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Hospitals</td>
<td>6.2%</td>
<td>$7.0 Billion</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>39.9%</td>
<td>$3.2 Billion</td>
</tr>
<tr>
<td>Physician/ Lab/ Ambulance</td>
<td>12.7%</td>
<td>$11.5 Billion</td>
</tr>
<tr>
<td>Non-Inpatient Hospital Facilities</td>
<td>14.7%</td>
<td>$21.7 Billion</td>
</tr>
<tr>
<td>Overall</td>
<td>12.1%</td>
<td>$43.3 Billion</td>
</tr>
</tbody>
</table>

The CERT report also looks at error rates by claim type for Part A, Part B, and DME:

<table>
<thead>
<tr>
<th>Claim Type</th>
<th>Claim Sampled</th>
<th>Claim Reviewed</th>
<th>Total Payment</th>
<th>Projected Improper Payment</th>
<th>Improper Payment Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Part A (Total)</td>
<td>26,217</td>
<td>20,279</td>
<td>$260.00</td>
<td>$28.70</td>
<td>11.0%</td>
</tr>
<tr>
<td>Part A (Excluding Hospital IPPS)</td>
<td>8,314</td>
<td>7,415</td>
<td>$147.40</td>
<td>$21.70</td>
<td>14.7%</td>
</tr>
<tr>
<td>Part A (Hospital IPPS)</td>
<td>17,903</td>
<td>12,864</td>
<td>$112.60</td>
<td>$7.00</td>
<td>6.2%</td>
</tr>
<tr>
<td>Part B</td>
<td>19,071</td>
<td>18,317</td>
<td>$90.40</td>
<td>$11.50</td>
<td>12.7%</td>
</tr>
<tr>
<td>DMEPOS</td>
<td>11,552</td>
<td>11,007</td>
<td>$8.00</td>
<td>$3.20</td>
<td>39.9%</td>
</tr>
<tr>
<td>Overall</td>
<td>56,840</td>
<td>49,603</td>
<td>$358.30</td>
<td>$43.30</td>
<td>12.1%</td>
</tr>
</tbody>
</table>

According to the CERT report, insufficient documentation was the largest source of improper payments, accounting for 67.3% of all errors.
In addition to national error rates, the CERT report included projected state-by-state improper payments rates.

<table>
<thead>
<tr>
<th>State</th>
<th>Projected Dollars in Error</th>
<th>Overall Error Rate</th>
<th>Projected Overpayments</th>
<th>Projected Overpayment Rate</th>
<th>Projected Underpayments</th>
<th>Projected Underpayment Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>CA</td>
<td>$4,659.80</td>
<td>14.1%</td>
<td>$4,505.60</td>
<td>13.6%</td>
<td>$154.20</td>
<td>0.5%</td>
</tr>
<tr>
<td>TX</td>
<td>$4,393.80</td>
<td>17.6%</td>
<td>$4,310.70</td>
<td>17.3%</td>
<td>$83.10</td>
<td>0.3%</td>
</tr>
<tr>
<td>FL</td>
<td>$3,369.90</td>
<td>13.1%</td>
<td>$3,449.00</td>
<td>12.7%</td>
<td>$120.90</td>
<td>0.4%</td>
</tr>
<tr>
<td>NY</td>
<td>$2,411.40</td>
<td>11.1%</td>
<td>$2,268.20</td>
<td>10.5%</td>
<td>$143.20</td>
<td>0.7%</td>
</tr>
<tr>
<td>IL</td>
<td>$2,392.80</td>
<td>15.0%</td>
<td>$2,353.60</td>
<td>14.7%</td>
<td>$39.20</td>
<td>0.2%</td>
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<tr>
<td>PA</td>
<td>$1,995.60</td>
<td>14.0%</td>
<td>$1,936.00</td>
<td>13.6%</td>
<td>$59.60</td>
<td>0.4%</td>
</tr>
<tr>
<td>NJ</td>
<td>$1,823.40</td>
<td>14.0%</td>
<td>$1,782.90</td>
<td>13.7%</td>
<td>$40.50</td>
<td>0.3%</td>
</tr>
<tr>
<td>OH</td>
<td>$1,802.90</td>
<td>13.7%</td>
<td>$1,791.70</td>
<td>13.7%</td>
<td>$11.20</td>
<td>0.1%</td>
</tr>
<tr>
<td>GA</td>
<td>$1,627.30</td>
<td>16.7%</td>
<td>$1,609.50</td>
<td>16.5%</td>
<td>$17.80</td>
<td>0.2%</td>
</tr>
<tr>
<td>MI</td>
<td>$1,523.80</td>
<td>11.3%</td>
<td>$1,491.00</td>
<td>11.1%</td>
<td>$32.80</td>
<td>0.2%</td>
</tr>
<tr>
<td>LA</td>
<td>$1,267.10</td>
<td>19.7%</td>
<td>$1,250.40</td>
<td>19.4%</td>
<td>$16.80</td>
<td>0.3%</td>
</tr>
<tr>
<td>NC</td>
<td>$1,206.70</td>
<td>10.9%</td>
<td>$1,181.20</td>
<td>10.7%</td>
<td>$25.40</td>
<td>0.2%</td>
</tr>
<tr>
<td>VA</td>
<td>$1,011.20</td>
<td>12.6%</td>
<td>$992.00</td>
<td>12.3%</td>
<td>$19.30</td>
<td>0.2%</td>
</tr>
<tr>
<td>KY</td>
<td>$930.70</td>
<td>15.9%</td>
<td>$907.70</td>
<td>15.4%</td>
<td>$32.90</td>
<td>0.6%</td>
</tr>
<tr>
<td>AL</td>
<td>$912.60</td>
<td>14.7%</td>
<td>$885.60</td>
<td>14.3%</td>
<td>$27.00</td>
<td>0.4%</td>
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<tr>
<td>MA</td>
<td>$905.00</td>
<td>6.0%</td>
<td>$807.40</td>
<td>5.3%</td>
<td>$97.60</td>
<td>0.6%</td>
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<tr>
<td>IN</td>
<td>$896.60</td>
<td>11.2%</td>
<td>$889.60</td>
<td>11.1%</td>
<td>$7.00</td>
<td>0.1%</td>
</tr>
<tr>
<td>SC</td>
<td>$823.00</td>
<td>13.2%</td>
<td>$797.30</td>
<td>12.8%</td>
<td>$25.80</td>
<td>0.4%</td>
</tr>
<tr>
<td>TN</td>
<td>$793.00</td>
<td>7.0%</td>
<td>$765.00</td>
<td>6.7%</td>
<td>$28.00</td>
<td>0.2%</td>
</tr>
<tr>
<td>MO</td>
<td>$774.60</td>
<td>10.8%</td>
<td>$741.30</td>
<td>10.3%</td>
<td>$33.30</td>
<td>0.5%</td>
</tr>
<tr>
<td>MD</td>
<td>$773.20</td>
<td>8.1%</td>
<td>$764.40</td>
<td>8.0%</td>
<td>$8.80</td>
<td>0.1%</td>
</tr>
<tr>
<td>AZ</td>
<td>$714.90</td>
<td>12.1%</td>
<td>$703.50</td>
<td>11.9%</td>
<td>$11.40</td>
<td>0.2%</td>
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<tr>
<td>OK</td>
<td>$705.60</td>
<td>16.5%</td>
<td>$658.10</td>
<td>15.4%</td>
<td>$47.05</td>
<td>1.1%</td>
</tr>
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<td>WA</td>
<td>$624.50</td>
<td>10.6%</td>
<td>$613.50</td>
<td>10.4%</td>
<td>$11.00</td>
<td>0.2%</td>
</tr>
<tr>
<td>MS</td>
<td>$552.60</td>
<td>14.3%</td>
<td>$528.60</td>
<td>13.7%</td>
<td>$24.20</td>
<td>0.6%</td>
</tr>
<tr>
<td>MN</td>
<td>$541.90</td>
<td>9.2%</td>
<td>$529.30</td>
<td>9.0%</td>
<td>$12.70</td>
<td>0.2%</td>
</tr>
<tr>
<td>AR</td>
<td>$431.70</td>
<td>11.4%</td>
<td>$431.10</td>
<td>11.4%</td>
<td>$0.60</td>
<td>0.0%</td>
</tr>
<tr>
<td>CO</td>
<td>$401.60</td>
<td>12.0%</td>
<td>$396.80</td>
<td>11.8%</td>
<td>$4.80</td>
<td>0.1%</td>
</tr>
<tr>
<td>WI</td>
<td>$389.70</td>
<td>7.5%</td>
<td>$371.30</td>
<td>7.2%</td>
<td>$18.40</td>
<td>0.4%</td>
</tr>
<tr>
<td>KS</td>
<td>$370.10</td>
<td>11.0%</td>
<td>$359.70</td>
<td>10.7%</td>
<td>$10.40</td>
<td>0.3%</td>
</tr>
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<td>IA</td>
<td>$363.30</td>
<td>10.2%</td>
<td>$358.70</td>
<td>10.0%</td>
<td>$4.60</td>
<td>0.1%</td>
</tr>
<tr>
<td>UT</td>
<td>$295.90</td>
<td>11.6%</td>
<td>$289.70</td>
<td>11.3%</td>
<td>$6.20</td>
<td>0.2%</td>
</tr>
<tr>
<td>CT</td>
<td>$294.10</td>
<td>5.8%</td>
<td>$271.00</td>
<td>5.4%</td>
<td>$23.10</td>
<td>0.5%</td>
</tr>
</tbody>
</table>
Despite CMS’ settlement offer to providers regarding Medicare appeals, new estimates show that providers are still filing appeals at rapid rates. The Office of Medicare Hearings and Appeals (OMHA) now reports that appeals cases in the pipeline for review will surpass 1 million cases by the end of this month.

While testifying before Congress in April of 2015, Chief Administrative Law Judge (ALJ) Nancy Griswold stated that "51% of the incoming appeals have been filed by five appellants," lending credence to findings by the HHS Office of the Inspector General (OIG) that a few "frequent filer"
hospital systems are appealing every claim in an effort to game the system and get a different result on their claim denial.

The OIG claims that “wide interpretation” of Medicare policy at the ALJ level has incentivized providers to actively seek to appeal to this level in the hope that they will get a different answer on the validity of their claim. In addition, the CMS appeals settlement may have inadvertently added an extra incentive for providers to continue high levels of appeal in the hope of award of another future appeals backlog settlement. Previously, in an effort to reduce the appeals backlog, OMHA offered appellants the opportunity to settle their claim for 68% payment – regardless of the merit of their case.

Both the President’s FY2016 Budget and OMHA have made several recommendations seeking to address the vulnerabilities in the Medicare appeals process. The Council for Medicare Integrity supports the following:

- Sample and consolidate similar claims for administrative efficiency.
- Expedite procedures for claims with no material fact in dispute.
- Require payment of a refundable filing fee when an appeal is filed to reduce the frivolous claims.

The Council also recommends:

- Reforms that would require ALJs to rule according to Medicare policy, which would foster greater consistency, allowing both providers and Recovery Auditors to improve their performance by understanding which management decisions were correct or incorrect according to the law.
- Supporting targeted program adjustments from CMS to include in the next round of RA Contracts. Specifically, CMI supports guidelines for additional document request (ADR) limits, which would adjust the number of additional document requests based on a provider’s past error rates. This new provision seeks to improve provider behavior and encourage correct Medicare billing while reducing improper payments overall.

One reason that has been sited for limiting RAC reviews has been the backlog of appeals at OMHA and the high overturn rates of the ALJs who decide these appeals. However, RAC denials have traditionally had very low rates of appeals overturned. The overall share of RAC overpayment determinations overturned on appeal at any level was 9.3% in FY 2013, the most recent year data is available from CMS.

**FUTURE IMPLICATIONS FOR MEDICARE**

Due to the current level of Medicare spending and the influx of new beneficiaries, several organizations have raised grave concerns about the future of the program.
Medicare Trustees Projection
In July 2015, the Medicare Trustees projected the Medicare Hospital Insurance Trust Fund would be bankrupt by 2030. The report states that in order to sustain the obligations of the Trust Fund for the next 75 years, the Fund needs an additional $3 trillion, beginning in 2015.

Congressional Budget Office Projection
In a more recent report, in January 2016, the Congressional Budget Office projected that the Medicare Hospital Insurance Trust Fund would be insolvent in 2026, four years before the Medicare Trustees projection. This means that in 10 years expenditures for the Trust Fund would exceed its income.

According to the CBO, Medicare spending rose at 7% in 2015, the fastest rate of growth for the program since 2009. Medicare spending is projected to rise by another 5.2% in 2016, reaching 3.7% of GDP. On average, Medicare spending is projected to increase 6% year over year for the next 10 years.

Avalere Health Prediction
Avalere Health is an organization that frequently conducts budget scores for various legislative proposals in a manner intentionally similar to CBO. Recently, Avalere estimated that if CMS continues to pause the RAC program over the next decade (as it has done for the past 18 months), federal spending will be $47 billion higher from 2016 to 2025.

Dramatic Increase in Beneficiaries
According to the CBO, the projected growth in spending is due in part to the increasing number of beneficiaries, with an average increase in Medicare caseloads of 3% per year. The number of Medicare beneficiaries is projected to increase by 36% by 2026.

In June 2015, Brookings hosted a forum to discuss Medicare in 2030 and the challenges the program will face in the coming years.
The University of Southern California Leonard D. Schaeffer Center for Health Policy & Economics and the Center for Health Policy at Brookings produced a white paper on the issue, stating:

“In 2011, the first of 75-million-plus baby boomers became eligible for Medicare. And by 2029, when all of the baby boomers will be 65 or older, the U.S. Census Bureau predicts 20 percent of the U.S. population will be older than 65. Just by virtue of the sheer size of the aging population, Medicare spending growth will accelerate sharply in the coming years.

“The influx of the baby-boom generation, which began turning 65 and aging into Medicare in 2011, will drive Medicare demographic changes between 2010 and 2030. During that time, the total estimated U.S. population aged 65 or older will increase from 39.7 million to 67.0 million.

Because of rising life expectancy, higher prevalence of chronic conditions and medical cost growth, total lifetime Medicare spending for a typical 65-year-old beneficiary will increase 72 percent by 2030, reaching an estimated $223,000. Overall, the combination of 27.2 million more elderly Medicare beneficiaries, higher medical costs and rising rates of chronic conditions will more than double Medicare spending in constant dollars, including disabled beneficiaries aged 64 and younger — from $507 billion in 2010 to more than $1.2 trillion in 2030.”
CONCLUSION

MEDICARE TURNS 50

In July 2015, the Medicare program celebrated its 50th anniversary.

When the program began in 1965, approximately 19.1 million Americans were covered by Medicare. In 2015, more than 55 million Americans were enrolled in the program, with estimates reflecting that enrollment will continue to grow. Unfortunately, little has been done to ensure that the program can handle such expansion. Therefore, as baby boomers become eligible for Medicare benefits, and healthcare costs continue to rise, the future of the Medicare program is now quite uncertain.

Each year, more than $40 billion Medicare dollars are lost to wasteful spending. This cannot continue. Recovery auditors were put in place by Congress to play an important role in safeguarding the Medicare Trust Funds, preserving them for current and future generations by recovering improper payments so the money is spent properly and efficiently. Doing so extends the life of our nation’s marquee healthcare program.

It is critical for the RAC program to be supported and strengthened if it is to continue to play an effective role in safeguarding Medicare resources for both today’s seniors and the future generations enrolling in the program.

About the Council for Medicare Integrity:
The Council for Medicare Integrity is a 501(c)(6) non-profit organization. The Council’s mission is to educate policymakers and other stakeholders regarding the importance of healthcare integrity programs that help Medicare identify and correct improper payments. Learn more at www.medicareintegrity.org