



June 15, 2017

The Honorable Dr. Tom Price
Secretary
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.,
Room 445-G
Washington, DC 20201

Dear Secretary Price:

On behalf of the Council for Medicare Integrity, I am writing to express our sincere interest in working with you to champion the efficient and effective use of Medicare tax dollars. Last week, you testified before the Senate Finance Committee saying, "we are absolutely committed to program integrity." More than 55 million current Medicare beneficiaries and countless future beneficiaries are counting on this commitment to ensure a fiscally healthy Medicare program for all.

According to the Medicare Trustees, [actuaries](#) estimate that at current spending levels Medicare will only be able to cover hospital insurance benefits for seniors until 2028. After that, the program will be forced to reduce coverage to 87 percent of what is covered today – relying solely on dwindling payroll deductions to fund the program.

Medicare's looming insolvency is due to a combination of factors – rising healthcare costs, expanding beneficiary populations, fraud within the program and an improper payment rate that has [exceeded the legal threshold of 10 percent](#) for the past four years in a row.

While you have previously expressed a strong interest in focusing your efforts on Medicare fraud, we urge you to make a concerted effort to identify, recover and prevent more billing errors in the system, which represent 70% of all improper payments.

Over the past four years, **Medicare has lost more than \$166 billion to very preventable billing mistakes.** Those tax dollars, if infused back into the program, would go a long way to solving many of the overarching financial problems plaguing Medicare's future.

In your new leadership role at CMS, we ask for your sincere focus on the reduction of the billions lost each year to improper payments. **Private health insurance companies do not tolerate rampant billing errors and neither should Medicare.**

In fact, if Medicare would consider leveraging two successful private sector best practices, the program could go a long way toward improved solvency and the more efficient use of our nation's tax dollars.

1. **The Volume and Type of Claims Reviewed** - Private health insurance payers generally have all claims reviewed for billing accuracy by an outside contractor before and after they are paid. With Medicare however, the Centers for Medicare and Medicaid Services (CMS) determines which billing issue areas/scenarios can be reviewed for accuracy and then sets the additional document request (ADR) limit, which determines the percentage of those claims that can be reviewed. The contrast between Medicare review practices and private payers is startling. Despite the dire need to safeguard Medicare dollars, CMS currently allows Recovery Audit Contractors (RACs) to **review fewer than 20 Medicare claim types** (down from 800 claim types initially) and now only allows auditors to review a mere 0.5 percent of Medicare provider claims after they have been paid. Considered a basic cost of doing business, the same providers billing Medicare comply, without issue, with the more extensive claim review requirements of private health insurance companies.

In the short term, we recommend that ADR limits be increased to allow RACs to review up to 5 percent of claims. In the longer term, we welcome a discussion about implementing risk-based ADR limits that balance responsible stewardship with provider concerns.

Similar to the state Medicaid waiver discussions, we also ask that the audit scenario review process be revisited to create efficiencies and expedited processes for audits that were previously approved and successful – to be defined by low appeals and/or even high success in the appeals process. Lastly, it is our desire to expand the types of claims that can be reviewed for billing errors. For example, DRG reviews, which are very clearly correctly billed or not, should no longer be artificially limited.

2. **Prepayment Reviews** – Like private payers, CMS can leverage prepayment audits to catch billing mistakes before claims are paid. In 2012, a Recovery Audit Contractor (RAC) Prepayment Review Demonstration Project was implemented to audit a limited number of certain error-prone claims, in eleven states, before they were paid. The short demonstration was greatly successful, saving Medicare \$192 million. Despite this success, the demonstration was paused in 2014 and never restarted. For the past two years, the GAO has urged CMS to ask for the legislative authority to implement a permanent Medicare prepayment review program to prevent improper payments from leaving the program in the first place. The GAO said that “*CMS may be missing an opportunity to better protect Medicare funds and agency resources.*” Despite this, CMS has thus far declined to implement prepayment reviews.

We recommend that CMS move forward with a request to Congress for authorization of a permanent RAC prepayment review program to allow claims to be reviewed for accuracy before they are paid to better protect our taxpayer dollars.

Recovery auditing, a tool proven to be very successful for Medicare, is budget neutral. The practice of recovery auditing is a vehicle you have at your disposal right now to provide additional program funding, improve the quality of the healthcare provided and further educate providers about appropriate Medicare billing habits.

Recovery auditing is not an impediment to the delivery of healthcare services nor is it an intrusion in the physician-patient relationship. The truth is that recovery auditing provides a sentinel effect that greatly benefits Medicare patients, which is why it’s the industry standard used by private insurers and Medicare alike. RACs are your active partners working to determine where Medicare billing problems

exist and helping CMS drive discussions regarding which billing areas need to be a focus of concern and which do not. RACs ensure that when billing errors are made, providers are educated to help reduce likelihood that those errors will be repeated. RAC reviews help prevent patients from being billed for unnecessary services and also help to ensure that patients receive the right care in the right setting. **Recovery audits have absolutely no direct impact on the Medicare providers working hard to deliver much needed healthcare services to beneficiaries.**

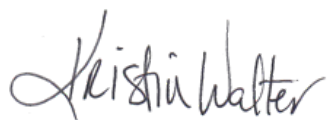
We greatly appreciate the Administration's hard work to address the backlog of appeals cases within Medicare. **We support your efforts to continue to move the Audit & Appeals Fairness, Integrity and Reforms in Medicare (AFIRM) Act forward.** This legislation, when paired with the programmatic changes put in place within the new Recovery Audit contracts, will go far to help complete the reforms necessary to get the Medicare appeals process back on track. We ask that the agency also consider adding a Medicare appeals filing fee – refundable if the provider wins their appeal – a reform, strongly recommended by both Chief Administrative Law Judge, Nancy Griswold, and your predecessor, HHS Secretary Sylvia Burwell, to help even the playing field and prevent future appeals backlogs.

In addition, **we applaud the Department of Health & Human Services' (HHS) effort to dispel the misperceptions** perpetuated by the American Hospital Association regarding the role of RACs within the Medicare appeals backlog. The agency's recent [brief](#) to the Federal DC District Court clarified yet again that the RAC *"program simply was not, and is not, the primary source of the backlog"* and shared that RAC claim determinations made up only 9.5% of all appeals filed with the Office of Medicare Hearings and Appeals (OMHA) in FY2016 and only 14.1% in FY2015.

Since Congress mandated the RAC Program, more than \$10 billion in improper payments have been returned to the Medicare Trust Fund and more than \$800 million in underpayments have been paid out to providers – balancing Medicare's checkbook and ultimately, extending the life of the program by two full years. While a focus on fraud is very important, **we urge you again to consider how a parallel focus on reducing improper payments is the low-hanging fruit that could infuse more than \$40 billion back into the budget each year and save our nation's health safety net programs.**

On behalf of the nation's Medicare program integrity contractors, thank you again for your consideration and your efforts to improve oversight of this vital healthcare program. We look forward to working closely with you to ensure that Medicare has a strong financial future for the millions of Americans who rely on the program.

Sincerely,



Kristin Walter
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. For more information, go to www.medicareintegrity.org