



March 6, 2018

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

Dear Secretary Azar:

On behalf of the Council for Medicare Integrity, I am writing to express our sincere interest in working together to ensure Medicare tax dollars are spent most effectively and efficiently in an effort to reduce budget shortfalls and allow program beneficiaries to continue to benefit from full healthcare coverage.

Medicare faces a number of factors impacting future program solvency – rising healthcare costs, expanding beneficiary populations, fraud within the program and wasteful spending due to provider overbilling. Interestingly, one of those factors is well within the control of the program and if prioritized, could actually be prevented – Medicare waste.

Over the past 5 years alone, **Medicare has lost more than \$200 billion taxpayer dollars to very preventable billing errors made by providers**. Those tax dollars, if recovered and infused back into the program, would go a long way to solving many of the overarching financial problems plaguing Medicare's future.

Currently, [only 0.5 percent of Medicare claims are reviewed](#), on a post-payment basis, for billing accuracy and adherence to program billing rules. This leaves 99.5 percent of claims immune from any checks and balances that would ensure Medicare payments are correct. This absence of Medicare billing oversight essentially “green lights” the loss of billions in improper payments each year and actively prevents those funds from being recovered and returned to the Trust Funds.

As you know, the Medicare Trustees forecast that at current spending levels and while facing budget shortfalls, the program will only be able to cover hospital insurance benefits for seniors until 2029. After that, the program will be forced to reduce coverage to 88 percent of what is covered today – relying solely on dwindling payroll deductions to fund the program.

Your strong background in effective compliance efforts and your commitment to standards of excellence in government management suggest that this issue will be important to you in your new leadership role at the Department of Health & Human Services (HHS). We therefore ask for your support of the Medicare integrity programs put in place by Congress to prevent Medicare waste and request those

efforts be increased to dramatically reduce 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 the Medicare program 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** – To ensure a healthy bottom line, private health insurance payers generally have all claims reviewed for billing accuracy by an outside contractor both 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 30 Medicare claim types** (down from 800 claim types initially) and has scaled back to allow a **review of 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. With Medicare however, provider groups have lobbied aggressively to keep their overpayments, putting intense pressure on CMS to block Medicare billing oversight.

In the short term, we'd like to 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 consistently 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 ask that you allow CMS to move forward with a request to Congress for authorization of a permanent RAC prepayment review program to allow Medicare claims to be reviewed for accuracy before they are paid to better protect and retain program funds.

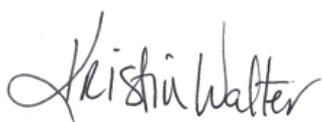
Recovery auditing, a tool proven to be very successful for Medicare, is budget neutral. The practice of recovery auditing is a vehicle you have at your disposal right now to provide additional program funding, improve the quality of the healthcare provided and further educate providers about appropriate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

Recovery auditing has never been an impediment to the delivery of healthcare services nor is it an intrusion in the physician-patient relationship. In fact, 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.**

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. **We urge you to consider how a focused effort to reduce Medicare waste could be the low-hanging fruit that could infuse nearly \$40 billion back into your budget each year and ensure consistent future coverage for beneficiaries.**

On behalf of the nation's Medicare program integrity contractors, we thank you 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,

A handwritten signature in blue ink that reads "Kristin Walter". The signature is written in a cursive, flowing style.

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