Written Testimony

Statement by
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on
Preventing and Recovering Government Payment Errors

before
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Subcommittee on Federal Financial Management, Government Information, Federal Services, and International Security
U.S. Senate

Chairman Carper, Ranking Member McCain and distinguished Subcommittee members, thank you for inviting me to testify at this important hearing and for your efforts to prevent and recover government payment errors.

My name is Andrea Benko, and I am the President and CEO of HealthDataInsights or HDI. Headquartered in Las Vegas, Nevada with additional facilities in both California and Florida, HealthDataInsights is a technology-driven healthcare services company that specializes in claims integrity: the identification and recoupment of improper payments to providers including hospitals, physicians, Durable Medical Equipment and other specialty providers. Our customers include the public sector, specifically the Centers for Medicare & Medicaid Services (CMS), and the private sector, including a number of the largest commercial payors in the United States.

The company employs sophisticated, proprietary software tools and database queries to retrospectively analyze 100% of a payor's claims data. We have an experienced robust, physician-led Clinical Team and Quality Management Team who review the more than $300 billion in annual paid claims. The company's technology—which is deployed retrospectively (post-adjudication, post-payment) — empowers a full review of all claims paid. We focus our efforts on the "honest" end of the spectrum of improper payments— that is, overpayments and underpayments due to improper billing and other sources of errors.

HDI is the national Medicare Recovery Audit Contractor (RAC) for Region D which consists of 17 States and 3 U.S. territories. This includes Alaska, Arizona, California, Hawaii, Iowa, Idaho, Kansas, Missouri, Montana, North Dakota, Nebraska, Nevada, Oregon, South Dakota, Utah, Washington, Wyoming, Guam, American Samoa and Northern Marianas. The permanent RAC program is the next step by CMS in their comprehensive effort to identify improper Medicare payments and fight fraud, waste and abuse in the Medicare Trust Fund.

In the Tax Relief and Health Care Act of 2006, Congress required a permanent and national RAC program to be in place by January 1, 2010. The national RAC program is the outgrowth of a successful demonstration program launched in 2005 and completed in 2008 to identify Medicare overpayments and underpayments to health care providers and suppliers in California, Florida, New York, Massachusetts, South Carolina and Arizona. During the demonstration

program HDI collected over $416 million in improper payments that were recovered in our assigned states of Florida and South Carolina. This represented 41% of the total findings working with only 31% of the total claims data.

HealthDataInsights also serves as the Payment Error Rate Measurement (PERM) Review Contractor for the Federal Medicaid Program. As a health care Claims Payment Integrity contractor with a long track record in the private sector as well as national-level experience in both the Medicare and Medicaid programs, HDI brings a unique perspective to this discussion.

The Problem: Improper Healthcare Payments

Improper medical claim payments carry an enormous economic impact in the government sector. A window into the magnitude of the problem is provided by CMS's Comprehensive Error Rate Testing (CERT) Program or CERT report, formally known as the Medicare FFS Improper Payments Report, which provides an annual assessment of Medicare's payment error rate. According to the CERT report, 7.8% of fee-for-service Medicare claims were paid improperly in Fiscal Year 2009.[1] This equates to $24.1 billion in improper payments in the Medicare FFS program. As you know, this claim payment error dollar amount does not include billions of dollars spent on other federally funded health care programs such as Tricare and the Federal Employee Health Benefits Program or the Federal and State spending on the Medicaid Program.

The Centers for Medicare and Medicaid Services (CMS) developed the Medicaid Payment Error Rate Measurement (PERM) program which is a comprehensive, ongoing federal audit intended to measure how frequently errors occur in the Medicaid program when providers submit claims to states and when states pay those claims. The PERM Medicaid error rate in fiscal year 2008 was 8.7%. The total dollar amount of claims estimated to be paid in error was $28.7B, the federal share of which was approximately $16.4B.[2] The ten (10) year estimated dollar amount of claim payment errors amounts to approximately $700B for the combined Medicare and Medicaid programs.

With mid to high single-digit healthcare inflation for the foreseeable future, I believe that claim payment integrity and accuracy is the first place that Congress should look to maintain the fiscal integrity of the Medicare Trust fund. Recovered funds help preserve the integrity of the trust fund and ensure this vital social safety net is preserved both now and for the future.

The Medicare RAC Project

In section 306 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), Congress directed the Department of Health and Human Services (DHHS) to conduct a 3-year demonstration program using Recovery Audit Contractors (RACs) to detect and correct improper payments in the Medicare FFS program. The Recovery Audit Contractor (RAC) demonstration program was designed to determine whether the use of RACs would be a cost-effective means of adding resources to ensure correct payments are being made to providers and suppliers and, therefore, protect the Medicare Trust Fund. The demonstration operated in New York, Massachusetts, Florida, South Carolina, California and Arizona and ended on March 27, 2008.

This innovative program approached the challenge of recovering erroneously paid claims, not by pursuing the historical Medicare cost center approach, but rather by pursuing a revenue-sharing "pay for performance" approach that could recover significant Medicare Trust funds at minimal cost to the government. The result was an entirely successful proof of concept for Claims Payment Integrity in the Medicare program. Over the 3 year period, the RAC program was able to correct over $1 billion in improperly paid claims. In addition, the government retained approximately $0.80 for every $1 collected to the Medicare Trust fund.[3]

Section 302 of the Tax Relief and Health Care Act of 2006 made the RAC Program permanent and required the Secretary to expand the program to all 50 states by no later than 2010.

HealthDataInsights along with 3 other companies were awarded RAC contracts to provide retrospective review of Medicare claims in all 50 states. Two additional firms act as subcontractors to the 4 RACs. The success of the Demonstration project is currently being replicated on a national scale. When the project is fully up to speed, we believe a significant amount of the error rate can ultimately be recouped through retrospective review.

Recommendations From Lessons Learned

First, I would like to thank CMS for the progress made to date on the implementation of the national RAC program and acknowledge the challenges of implementing a program that requires cooperation among a vast number of contractors while managing potential provider impact and the quality of audit programs. While the national RAC project's performance to date has been encouraging, there are a number of ways to achieve greater success of the RAC project as CMS builds upon the progress made over the past year and half.

Tie Each Agency's Recovery Goals to Identified Errors Rates

We strongly encourage Congress to establish each agency's recovery goal based on the identified error rate. Congress, for agencies that implement recovery programs, should establish a recovery target of at least 50% of the identified payment errors as estimated by the annual reports. For example, based on the 2009 Medicare FFS Error Rate, the 2010 Medicare claim payment integrity recovery goal would be half of the projected error of $24.1 billion, or an estimated $12 billion; or based on the 2008 PERM report, the Medicaid goal would be half of the projected error of $28.7 billion, or an additional $14.3 billion (Federal portion $8.2 billion).

Claims Adjustment Processing

Efforts to retrospectively adjust applicable Medicare claims after improper payments have been identified by the RACs must be expedited and expanded to materially benefit the Trust Fund. Medicare Administrative Contractors, or "MACs," who adjust and pay Medicare FFS claims using CMS systems, on behalf of CMS, must establish efficient back-end processes with system maintainers and data centers to adjust claims on a massive scale after errors are identified by the RACs. Currently, automated mass adjustment processes to adjudicate incorrectly paid claims are in development.

In the Demonstration project, over $1 billion in claims adjustment were handled manually by the few involved MACs at a cost of less than 1% of collections.[4] Over the short term until scalable, mass claim adjustment processes are in place and functioning, we all need to work together to ensure that all incorrectly paid claims are processed in a timely manner. Anything Medicare

claims payment contractors can do collectively to speed throughput in the MACs' adjustment of claims upon completion of the RACs' work will ultimately accelerate returns to the Medicare Trust Funds.

Expansion of Quality and the Scope of Reviews

Medicare's provider network is a key component to the delivery of quality health care, as such, the RAC efforts need to be sensitive to providers. All constituents in the health care delivery system desire claim payment integrity and accuracy: claims should be paid according to the policies and fee schedules; no more – no less. Claims integrity ensures the ultimate proper payment of claims and, at the same time, creates a sentinel effect of ensuring that providers continue to maintain solid billing and treatment practices. Medicare policies are evidence-based, proven protocols for delivering patient care that ensures quality. Achieving claims integrity through sound healthcare claim auditing ultimately improves the quality of health care. For example, in preparation of the national RAC program, many hospitals already have invested in process improvements that enhance their own compliance with Medicare policies, rules and regulations.

CMS should expand complex reviews to encompass a broader cross-section of medical claims which will have a direct impact upon returns to the Medicare Trust Fund. To date, RACs' complex review efforts have been focused on Coding Validation for inpatient hospital stays, and soon, a Durable Medical Equipment ("DME") medical necessity complex review. In the Demonstration project, 62% of the savings from inpatient hospitals, or approximately $513M, were generated from retrospective medical necessity complex reviews of hospitals' inpatient claims. To the extent that RACs are allowed to review inpatient claims and other "new issues" more quickly, we believe returns to the Medicare Trust Fund and government will rapidly increase.

With the RAC opportunity comes the ability to facilitate, through claim payment integrity, compliance with the statues, coverage requirements and guidelines Congress, HHS, CMS and its contractors have so carefully developed over decades of the provision of Medicare healthcare. This program presents a wonderful opportunity to improve the likelihood that beneficiaries will receive the healthcare that the evidence supports in every case because Medicare intends to pay only for the best care that is provided and documented. In addition, this will benefit healthcare reform as the discussion can then shift from improper payment to the provision of connected and complete care of the best sort.

Medical Record Review Limits

Another issue to consider is the current limitation on the ability to request medical record within the RAC program. "Complex" reviews—or reviews in which the RAC requests a medical record from a provider—generated the vast majority of dollar recoveries in the RAC Demonstration project. Under current guidelines, the RACs are limited in their ability to request medical records.

RACs Promote Continuous Process Improvements and Claims Integrity

During the Demonstration and in the National program, CMS has conducted major findings discussions with CMS contractors related to claims payments and review to determine strategies to discuss methods to reduce the improper payment types from continuing to occur, such as,

claim system edits, MedLearn articles, policy clarification and even policy revisions. This best-demonstrated practice should be implemented in all agencies as a recovery program is implemented.

Contracting Strategy

A careful review of the contracting strategy and contingent fee structure is needed for the RAC program, and, more broadly, for other improper payment detection programs in the US Government. As I mentioned previously, the Medicare RAC program is an innovative step into revenue-sharing "pay-for-performance". This approach effectively transforms the review contractor from a cost center to a pure "revenue recovery entity" for the Medicare Trust Fund and eventually for other federal healthcare payment programs. The RACs are paid only on the basis of results.

What is important to recognize and consider is the impact on contracting considerations this contingent payment structure requires for successful maximization of desired outcomes. The federal government must establish contracting considerations that maximize potential returns to the government payor rather than focusing on minimizing contingent fees paid by the government payor. The attention must turn to effectiveness of contractor skill in realizing best recognition and correction of improper payments because it is the actual identification and correction of improper payments that returns "lost" dollars to the Trust Fund.

Appeals to Administrative Law Judges

A separate opportunity for improvement is related to appeals handled by Administrative Law Judges within the Medicare regulatory system. There are 5 levels of appeal in the Medicare claims process. In one of the more advanced levels of the appeal process Administrative Law Judges hold hearings and issue decisions related to Medicare payment determinations. We believe that it is critical that there be more visibility into the process, that there be more consistency in rulings and most importantly, that ALJ rulings be consistent with and grounded in Medicare laws, rules and regulations. ALJ decisions which are inconsistent with Medicare rules result in an unnecessary depletion of the Trust fund.

Expansion of RAC to other Government Healthcare Payors

Our final recommendation is to leverage the success of the Medicare RAC program by extending it to other government healthcare payors. While the Patient Protection and Affordable Care Act mandates that a RAC-like project must be implemented in the Medicaid program as well as Medicare Part C and Part D in 2010, we believe that there is a benefit to the government when data is aggregated. If the data can be audited and analyzed for an entire region for Medicare FFS, Medicaid, and Part D, we can identify more improper payments through better data clarity, more significant statistical analysis, as well as treatment patterns and trends. In addition, the impact on the provider can be effectively managed via one, coordinated program that maximizes the return to the Trust Fund and minimizes the impact on the provider networks.

We also believe that Part C Plans should be required to perform RAC-like audits which will ultimately lower the amount of future premium increases. In addition, we believe that Part C audits should include auditing the severity-adjustment of the patients, a basis on which CMS pays the Part C plans.

The government would benefit by expanding the RAC and claims payment integrity practices to the Federal Employees Health Benefit program, the Veterans Administration, and Tricare. Ultimately, if roughly 50% of the healthcare dollar is expended by public payors, the opportunity for additional Trust Fund savings is compelling, to say the least.

Conclusion

In summary, we at HDI believe that there is a tremendous opportunity to ensure claim payment integrity and to realize literally tens of billions of dollars in recoveries for the Medicare Trust fund. It is the foundation of healthcare cost containment. We believe that pay-for-performance Recovery Audit services are a best practice in both the public and private sector. To the extent that we can accelerate the national RAC program in the ways I have discussed today, speedy returns to the Medicare Trust Fund will be achieved. We also believe that the RAC program helps strengthen quality care and encourages providers to review and update their processes and procedures which ultimately support Medicare evidence-based policies.

The next step is to rapidly extend the benefits of the program to additional government programs. We firmly believe that Medicaid, Medicare Parts C&D, the FEHP, the VA, and Tricare can benefit from this program as has the Medicare Fee-For-Service program.

We applaud Chairman Carper's leadership along with Ranking Member McCain and the other distinguished Subcommittee members of the committee's support of S. 1508, The Improper Payments Elimination and Recovery Act. This groundbreaking bill will require agency heads to conduct recovery audits for agency programs that expend $1 million or more annually. Given the results of the RAC Demonstration project and the current RAC program, such an initiative will clearly be cost-effective and beneficial to the Government. These are all clearly best practices and critically important undertakings.

It is a great honor to be invited to speak before this austere body. Thank you for your time and attention today.

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[1] Improper Medicare FFS Payments Report, November 2009 – Executive Summary
[2] U.S. Department of Health and Human Services, Medicaid Payment Error Rate Final Report, Fiscal Year 2008
[3] The Medicare Recovery Audit (RAC) Contractor Program: An Evaluation of the 3-Year Demonstration Project
[4] The Medicare Recovery Audit (RAC) Contractor Program: An Evaluation of the 3-Year Demonstration Project