Written Testimony of

Spencer Young

Senior Vice President of Clinical Operations

HDI

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Chairman Collins, Ranking Member McCaskill, and Members of the Committee, thank you for the opportunity to testify today about the work of our company, HDI, and our ongoing mission to safeguard the public resources dedicated for the care of American seniors.

My name is Spencer Young and I serve as the Senior Vice President of Clinical Operations for HealthDataInsights (HDI), a technology-driven healthcare services company that specializes in claims integrity and the correction of improper payments for the Medicare Trust Fund, and other government agencies and private payors. HDI currently serves as the CMS Recovery Auditor for Region D, which is comprised of 17 western states and 3 U.S. territories.

I am very pleased to have this opportunity to provide a perspective for the Committee on the value of recovery audits for taxpayers and the Medicare program.

Evolution of the Recovery Audit Program

As you know, the Recovery Audit program is an innovative approach to recovering improperly paid Medicare claims. Unlike other contractors in the Medicare program integrity field, our work is not focused on fraudulent payments, but instead we review paid claims to ensure that providers who participate in the Medicare program are complying with Medicare billing policies and guidelines. These are the most prevalent types of Medicare improper payments: payments made for services that do not meet Medicare's coverage and medical necessity criteria; payments made for services that are incorrectly coded; and payments made for services where the submitted documentation does not support the services as billed. The funds we recoup from improperly paid Medicare claims are returned directly back to the Medicare Trust Fund. In addition to identifying claims that were improperly overpaid, Recovery Auditors also identify underpayments – where a provider is due more for the service they provided – so providers can be fully compensated.

Unlike many other Federal healthcare program integrity contracts, the Recovery Audit program was first piloted in three states —New York, Florida and California, with a few additional states added mid pilot – through the Medicare Recovery Audit Demonstration Program. During this three-year period, more than $1 billion in improper payments were corrected and returned to the Medicare Trust Fund. As a result of the success of the program, in 2006, Congress mandated that the Department of Health and Human Services institute a permanent and national Recovery Audit program.

The Recovery Audit demonstration served as an important tool to help CMS prepare and shape the permanent Recovery Audit Program that is in place today. As a result of lessons learned and feedback from Medicare providers and suppliers during and after the demonstration period, CMS adopted numerous changes to improve the permanent Recovery Audit program. These changes included:

- Limiting the number of medical records that are requested for review to no more than 2% of a provider's claims;

- Requiring each Recovery Auditor to employ a full-time medical director who is a licensed physician, as well as licensed RNs and certified coders to ensure reviews are completed accurately;
- Requiring Recovery Auditors to return their contingency fee if a provider contests an audit and the Recovery Auditor loses at any level of the appeal;
- Requiring new issues targeted by the audits to be posted on the Recovery Auditor's Provider Portal website to provide more transparency;
- Changing the look back period from four years to three years; and
- Accepting imaged medical records from providers on CD/DVDs in lieu of paper records.

In addition to general contract oversight, CMS also has specific requirements of RAC auditors that include:

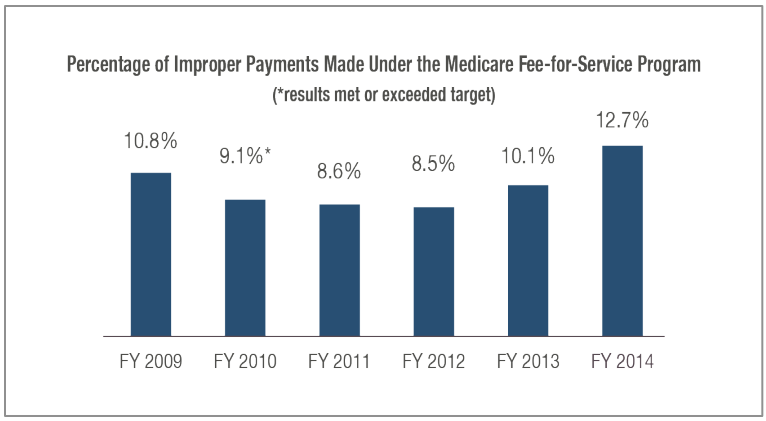
1. Complying with an established CMS approval process for all new review issues,
2. Requiring all CMS approved new issues to be posted to the Recovery Auditor's Provider Portal website,
3. Requiring that each specific audit issue is detailed in every request for medical records,
4. Following CMS established medical record request limits,
5. Reimbursing providers for the medical records they provide,
6. Applying restrictions on findings of improper payments for minor omissions that other CMS review contractors deny,
7. Providing written notification to providers on all determinations –whether there is a finding of an improper payment or not,
8. Affording providers the opportunity to have a discussion with a Recovery Auditor's physician about their claim,
9. Affording providers a discussion period with the Recovery Auditor to correct a claim prior to initiating a formal appeal with the Medicare Administrative Contractors (MAC), and
10. Complying with monthly accuracy sampling conducted by an independent CMS contractor to review the accuracy rates of Recovery Audit findings.

These CMS requirements are unique to Recovery Auditors when compared to other Medicare Program Integrity contractors. In fact, according to the Government Accountability Office (GAO), Recovery Auditors are subject to greater oversight than all other Medicare contractors to ensure the enviable accuracy and precision of their work.

CMS Requirements on Post-payment Reviews Unique to Recovery Auditors, Compared to Other Contractor Types, as of May 7, 2013

Requirement	Contractor Type			
	Medicare Administrators (MAC)	Zone Programs Integrity Contractors (ZPIC)	Comprehensive Error Rate Testing (CERT) Contractor	Recovery Auditors (RA)
Selection of claims for post-payment review CMS approval of criteria for selecting billing issues prior to widespread use	No	No	n/a	Yes
Provider notice of issues targeted for review Provider notice (on website) of billing issues targeted post-payment review	No	No	n/a	Yes
Additional documentation requests (ADR)				
Providers reimbursement for copies of medical records	No	No	No	In some cases
Limits on number of ADRs contractor can request from provider	No	No	No	Yes
Reviews				
Authority to deny claim for minor omissions	Yes	Yes	Yes	No
Provider communications				
Provider notification regardless of review outcome	No	No	No	Yes
Reviewer's credentials available upon provider request	No	No	No	Yes
Access to contractor's medical director to discuss claim denials upon request	No	No	No	Yes
40 days to discuss any revision to initial determination informally prior to having to file an appeal	No	No	No	Yes
Quality assurance External validation of randomly selected claims by independent contractor	No	No	No	Yes

Source: GAO: Medicare Program Integrity: Increasing Consistency of Contractor Requirements May Improve Administrative Efficiency, July 2013

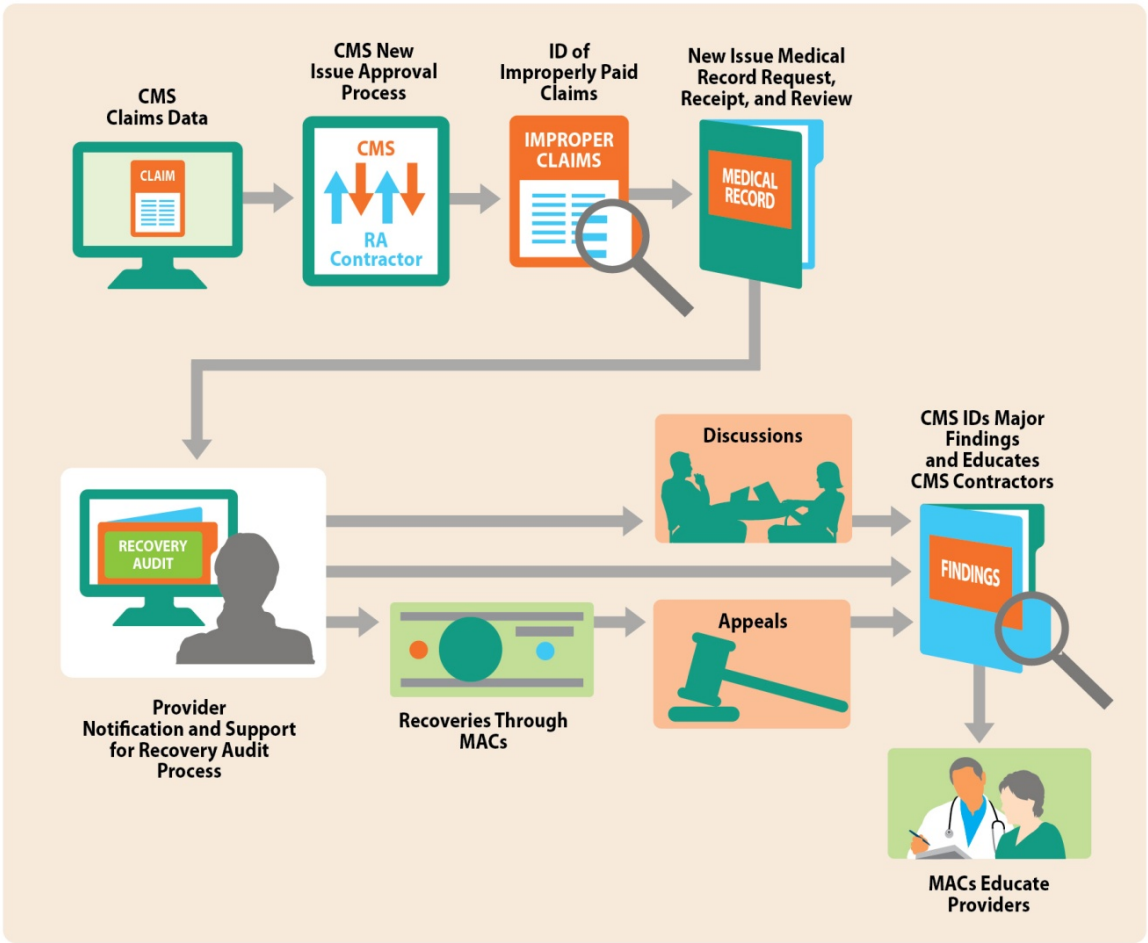


The Recovery Audit Program Today

Billions of taxpayer dollars are paid out improperly each year by the Medicare program. The improper payment rate for Medicare recently increased from 8.5% in FY2012 to 10.1% in FY2013 and reached an all time high of 12.7% in FY2014. The Medicare Fee-For-Service program pays more than $300 billion in claims each year, which means of that, more than $46 billion in taxpayer dollars is lost to waste and billing errors each year.

Recovery Auditors serve an important role in correcting improper Medicare payments. Nearly $10 billion in improperly paid Medicare dollars have been recovered under the Recovery Audit program since 2006.

How Recovery Auditors Identify Improper Payments



CMS specifically designed the Recovery Audit program to identify improper payments and return funds to the Medicare Trust Fund. Recovery Auditors identify the types of claims that are most at risk for improper payment by employing vast auditor experience, data mining, and the use of Federal publications such as HHS OIG, GAO and CERT reports. In order to ensure Recovery Auditors are making accurate claim determinations, every issue that a Recovery Auditor seeks to review must be submitted first to CMS for a rigorous evaluation and approval process. In submitting new issues, the Recovery Auditor must describe the CMS rationale for identification of the improper payment including federal reports, statutory references and CMS rules and regulations. Furthermore, new issue submissions must provide methodology for claim selection and identification of medical record review guidelines based on identified medical record elements in support of a submitted claim. Issues that are approved are then posted to the Recovery Auditor's Provider Portal website in advance of any audit activity.

Recovery Auditors use three methods to review claims:

- Automated – improper payments identified based on claims payment data
- Semi-Automated – Improper payments based on claims payment data and provider has opportunity to submit record prior to improper payment determination
- Complex – review of medical records with higher probability of improper payment

Medical records are only requested for complex review claims and CMS has limited the amount of medical records (ADRs) a Recovery Auditor can request to less than 2% of Medicare claims for any given provider.

Licensed and experienced clinicians who undergo extensive screening, comprehensive training and meet specific education requirements conduct all medical reviews of claims. HDI's team includes licensed physicians, licensed RNs, certified coders and registered pharmacists with oversight of all provided by the Medical Director. In addition, HDI has established Quality Review and Assessment programs that drive audit review accuracy and precision in real time to generate the most accurate and precise provider audit results possible.

HDI's goal is to generate quality determinations that are accurate, precise and well documented. These determinations are clearly and concisely communicated to the provider. Within the provider communication, Recovery Auditors cite the specific sections of CMS manuals, guidelines, rules and regulations that are associated with the audit finding. CMS appeal instructions are also included in the provider communication, should the provider disagree with the review determination.

How the Appeals Process Works for Audited Claims

In cases in which a provider disagrees with a finding by the Recovery Auditor, the provider has an opportunity to initiate a "discussion period" before formally appealing the denial. This offers the provider an opportunity to submit supporting documentation for their original billing. It is also an additional opportunity for the Recovery Auditor to explain the rationale behind an overpayment decision. Upon review of all provider information, the Recovery Auditor notifies the provider of its final determination.

The provider also can utilize the normal CMS appeals process, the five-level Medicare claims appeal process through which fee-for-service providers appeal reimbursement decisions.

There are five levels of appeal –note that appeals rarely reach the last two levels. The levels are as follows:

1. Redetermination by the Medicare Administrative Contractor (MAC)
2. Reconsideration by a Qualified Independent Contractor;
3. Administrative Law Judge Hearing;
4. Medicare Appeals Council Review; and
5. Judicial Review in U.S. District Court.

In November 2012, HHS OIG reported that certain improvements should be made at the Administrative Law Judge (ALJ) level of Medicare Appeals. Since then, an enormous backlog of cases at the Administrative Law Judge level has grown, causing concern for all Medicare stakeholders. It has been documented that a number of factors have created the ALJ backlog. In April 2015 testimony before the U.S. Senate Finance Committee, Chief Administrative Law Judge for the Office of Medicare Hearings & Appeals, Nancy Griswold, shared the following reasons for the ALJ backlog:

> *"Although it is impossible to assign any single cause to the rapid growth in Medicare appeals, it is possible to identify a number of probable contributing factors. In 2010, OMHA began to take on new workloads, including appeals that result from the Recovery Audit program, which Congress established in 2006 and expanded nationwide beginning in 2010. While the program has led to more appeals as providers exercised their right to a hearing, the program has also reduced improper payments and returned significant dollars to the Medicare Trust Funds. During these same years, OMHA also experienced a concurrent growth in its traditional workload. Between FY 2009 and FY 2014 OMHA's traditional workload increased 543%. In FY 2011 and FY 2012, OMHA also noted an increase in the number of appeals filed by Medicaid State Agencies (MSAs) related to treatment for beneficiaries dually enrolled in both Medicare and Medicaid. Finally, Medicare enrollment has grown as the Baby Boom generation becomes Medicare-eligible. Recent increases in SSA disability adjudications have also resulted in the influx of larger numbers of younger disabled individuals becoming eligible for Medicare benefits. This increase in the number of beneficiaries utilizing Medicare services may be resulting in a higher universe of potential disputes."*

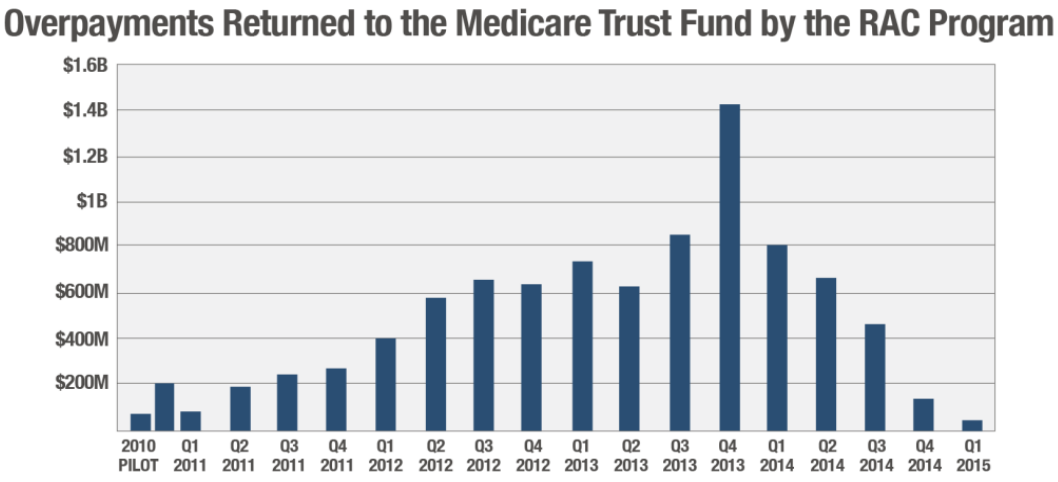
All stakeholders agree that this stage of the Recovery Audit process needs much closer attention. We look forward to collaborating with all stakeholders to focus on long-term reforms to the Recovery Audit appeals process, which will allow the ALJ's to effectively manage all incoming appeals.

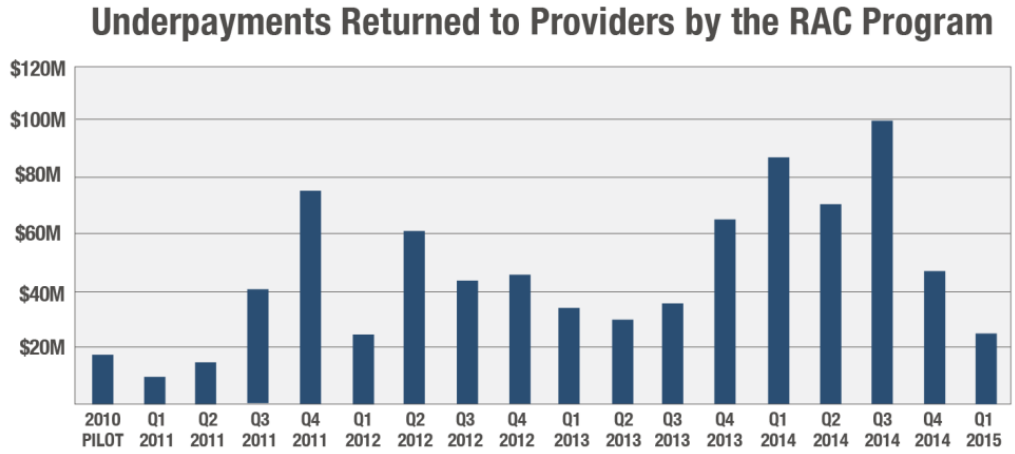
Beyond the correction of improper Medicare payments, Recovery Auditors also work together with CMS to evaluate recovery audit results and identify major findings and possible corrective action steps. CMS corrective actions include installing national claims edits, generating provider education materials, refining billing and medical necessity requirements to improve improper

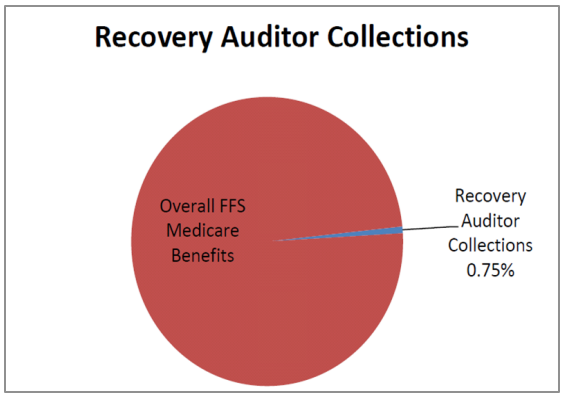
payment rates, and clarifying or changing policy. Regular Major Finding discussions among CMS and its contractors are held to understand Recovery Audit findings and identify corrective interventions with MACs and CMS, including the identification of provider outreach, education opportunities and instruction.

Success of the Recovery Audit Program

From FY 2012 to FY 2014, Recovery Auditors returned more money to the Medicare Trust Fund than any other healthcare integrity initiative, earning the distinction by the HHS OIG as the "most improved" program. Since 2006, the Recovery Auditors have recovered nearly $10 billion in improper payments to the Medicare Trust Fund as well as returned more than $800 million in underpayments to providers. Based on the return on investment that the Recovery Audit program yields, the program is a cost-effective means of identifying underpayments and overpayments in the Medicare fee-for-service program. Because of the program's success, the projected life of the Medicare Trust Fund has been extended by two additional years.







This high level of recovery has occurred notwithstanding the fact that Recovery Auditors are limited to reviewing less than 2% of providers' Medicare claims volume. In fact, in the 2013 RAC Report to Congress, a graph (left) was shared demonstrating that Recovery Auditor reviews account for less than 1% of the over one billion fee-for-service benefits paid annually. Controls such as those in place for the RAC program have been put into place to ensure there is beyond fair balance between oversight of Medicare spending and provider burden. These safeguards, along with efforts to maximize transparency and provide vital data to the Medicare Administrative Contractors for provider education, are very unique to the Recovery Audit program and have played a key part in the overall success of the program.

New Changes to the Recovery Audit Program

CMS has played an integral role in the Recovery Audit program since the demo began in 2006. The agency has made continual advancements to enhance the program and ensure minimal provider burden, high levels of accuracy, and transparency. The Medicare provider community and Recovery Auditors played a distinct role in developing and encouraging the numerous changes made to the Recovery Audit program after the demonstration. Additionally, in February 2014, CMS announced it would be making a number of new changes to the Recovery Audit program, which would be effective with the new contractor awards. These changes will be made not only to enhance the program, but also to address provider concerns. A number of the new program changes are listed below.

Recovery Audit Program Improvements

Provider Concern	Benefit to Provider Community
ADR limits are the same for all providers of similar size and are not adjusted based on a provider's compliance with Medicare rules.	CMS will establish ADR limits based on a provider's compliance with Medicare rules. Providers with low denial rates will have lower ADR limits while provider with high denial rates will have higher ADR limits. The ADR limits will be adjusted as a provider's denial rate decreases, ensuring the provider that complies with Medicare rules has less Recovery Audit reviews.
To comply with timely filing rules, hospitals must submit a claim within 1 year from the date of service, but the Recovery Auditors have a 3-year look – back period, which results in acute inpatient hospitals being unable to rebill denials from patient status reviews.	CMS will limit the Recovery Auditor look – back period to 6 months from the date of service for patient status reviews, in cases where the hospital submits the claim within 3 months of the date of service.
Additional documentation request (ADR) limits are based on the entire facility, without regard to the differences in departments within the facility.	CMS established ADR limits will be diversified across all claim types of a facility (e.g., inpatient, outpatient). This ensures that a provider with multiple claim types is not disproportionately impacted by Recovery Audit review in one claim type (e.g. all of a provider's inpatient rehabilitation claims reviewed or all inpatient).
Providers who are not familiar with the Recovery Audit Pro gram immediately receive requests for the maximum number of medical records allowed.	CMS established ADR limits will include instructions to incrementally apply the limits to new providers under review. This will ensure that a new provider is able to respond to the request timely and with current staffing levels.
Providers must wait 60 days before being notified of the outcome of their complex reviews.	Recovery Auditors will have 30 days to complete complex reviews and notify providers of their findings. This provides more immediate feedback to the provider on the outcome of their reviews.
Upon notification of an appeal by a provider, the Recovery Auditor is required to stop the discussion period.	Recovery Auditors must wait 30 days to allow for a discussion request before sending the claim to the MAC for adjustment. Providers will not have to choose between initiating a discussion and an appeal and can be assured that modifications to the improper payment determination will be made prior to the claim being sent for adjustment.
Providers do not receive confirmation that their discussion request or other written correspondence has been received.	Recovery Auditors must confirm receipt of a provider's discussion request or other written correspondence within three business days.
Recovery Auditors are not penalized for high appeal overturn rates.	Recovery Auditors will be required to maintain an overturn rate of less than 10% at the first level of appeal, excluding claims that were denied due to no or insufficient documentation or claims that were corrected during the appeal process. Failure to do so will result in CMS placing the Recovery Auditor on a corrective action plan, that could include decreasing the ADR limits, or ceasing certain reviews until the problem is corrected. This will help to assure the providers that the Recovery Auditors are making valid determinations by holding the Recovery Auditors accountable for their decisions.

Source: CMS

Current Status

The Recovery Audit program has proven to be a great success, however external constraints have resulted in a significant decrease in recovery audit reviews and recoveries.

First, as part of the implementation of the "Two Midnight" rule, a moratorium was placed on Recovery Auditors, preventing auditing of short, inpatient hospital stay claims from October 2013- March 2015. Recently, this moratorium was extended again until October 2015 – making it a full two-year period where the area with the very highest level of Medicare improper payments will not be audited. CERT reports have documented that short-stay inpatient claims historically have a high probability of improper payment. As such, Members of Congress and taxpayers should be concerned that Medicare providers will be shielded from Recovery Audit review of these types of claims for two years. Based on years of historical Recovery Audit data, it is estimated that the short stay audit moratorium will result in the Medicare Trust Fund losing more than $8 billion in taxpayer dollars.

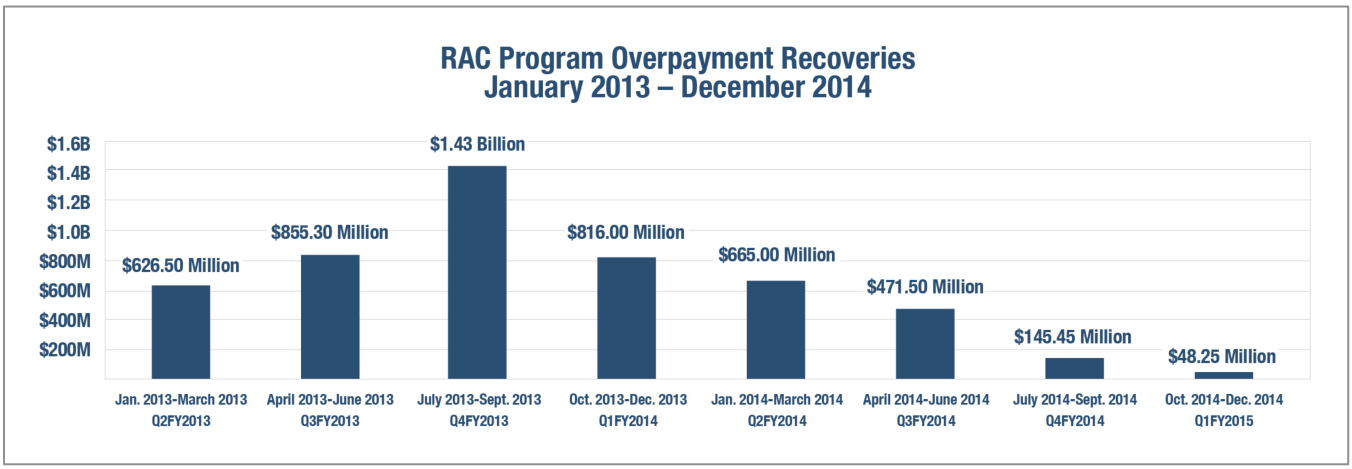
The second significant change to the program is the current program "pause" until the new Recovery Auditor contracts are finalized. In February 2013, CMS began the procurement process for the next round of Recovery Audit contracts. At that time, CMS announced the Recovery Audit program would continue during the transition, with some decline in the number of audits allowed. As of today, the new Recovery Audit contracts have still not been awarded.

The following year, in February 2014, CMS announced that beginning June 2, 2014 there would be a pause in the Recovery Audit Program. The last improper payment files would be submitted to the MACs on June 1, 2014. A contract modification occurred in late August, 2014 allowing a "limited restart" of the Recovery Audit program to perform automated reviews and very limited complex reviews.

When the program was fully intact, Recovery Auditors reviewed more than 800 claim issues. Today, under the limited restart, auditors are only reviewing slightly more than 350 claim issues, and are currently unable to do automated review of underpayments, which is how we find the majority of underpayments.

The audit moratorium, in tandem with the program "pause" and current limited review of claims, has significantly scaled back the effectiveness of the Recovery Audit program. The result is billions of dollars of improper payments that are not being recovered and restored to the Medicare Trust Fund, contributing to grave concerns regarding Medicare's long-term solvency.

Recent Recovery Audit corrections quarterly reports clearly demonstrate that recoveries have declined significantly over the past year.



Myths and Facts about the Recovery Audit Program: Setting the Record Straight

Despite the success of the Recovery Audit program, misconceptions about how the program works and how Recovery Auditors carry out their audits remain. The Recovery Audit program administered by CMS is relatively simple and very similar in its scope and structure to audit programs carried out in other government programs, such as Medicaid and TRICARE, and in the commercial sector by insurers and other payors. Unfortunately, confusion about the program remains. I would like to take this opportunity to dispel some common myths about the program:

Myth #1: Recovery Auditors operate under a payment structure that encourages overly-aggressive auditing.

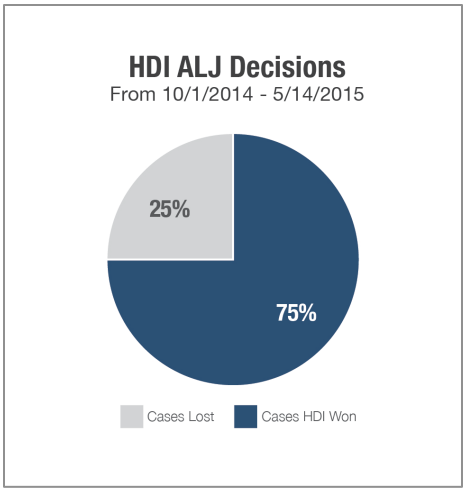
A Recovery Auditor is required to return all of its fees when a finding is reversed at any level of provider appeal. This means Recovery Auditors are only incentivized to work accurately and precisely.

Recovery Auditors are paid through performance-based contracts in which they are only paid for overpayments and underpayments that are accurately identified and corrected. This type of fee structure requires Recovery Auditors to absorb all of the front-end costs of auditing. Unlike cost-plus contractors, the federal government does not provide any funding for hiring and training of experienced clinicians, claims analysts, and other experts to run the program. Recovery Audit Contractors only pursue claims that are improperly paid according to CMS policy. Contingency-based contracting protects taxpayer dollars by only paying for results.

Myths #2: 70% of RAC appeals before an ALJ are overturned in favor of the hospital.

According to CMS' most recent Recovery Audit program Report to Congress, in FY 2013, only 9% of all Recovery Auditors' determinations have been challenged and later overturned on appeal. Several different contractors review Medicare claims, Recovery Audit claims are only a small portion of those that make it to the ALJ level of appeals.

Provider groups have frequently cited this misleading 70% statistic. This number comes from a 2010 OIG report. That year, only 3 total RAC claims made it to the ALJ level of appeals.

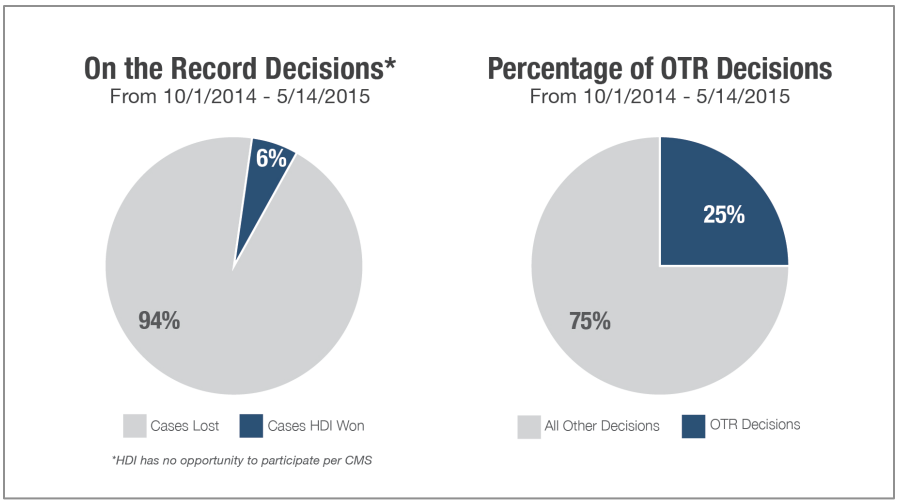


In fact, in FY2013 Medicare providers appealed 162,344 RAC determinations and of those only 10.6% were appealed to the ALJ level.

For HDI, we can report that in FY 2014 when we attend a hearing, 75% of our improper payment denials are upheld at the ALJ level.

In its March 2014 Recovery Audit report to Congress, CMS notes "the receipt of an appeal and the reversal of a Recovery Auditor decision does not necessarily mean the Recovery Auditor was wrong in its determination." For example, providers are often given the opportunity to reopen their claims to correct their billing during the appeals process. Additionally, the report notes that inconsistencies also occur between the Recovery Auditor decision and ALJ decision due to the fact that Recovery Auditors are required to base their findings on CMS policies, including manuals and Local Coverage Determinations (LCDS). In their rulings, ALJs often loosely interpret Medicare regulations and are afforded broad discretion regarding adherence to Medicare policy.

There has also been an increasing number of ALJ appeal decisions occurring "on the record," which are decisions based solely on the review of relevant documents without a hearing. Decisions made "on the record" do not afford Medicare Recovery Audit Contractors an opportunity to participate, provide legal arguments or clinical testimony that addresses the merits of the review and the regulatory foundation for the claim denial. Our data support the fact that when decisions are made by ALJs on the record, and HDI does not participate in a hearing, the overturn rate increases significantly. Additionally, we have found that Recovery Auditors are only receiving a notice of ALJ hearings 11% of the time, which is a major concern, and calls into question the transparency with regard to ALJ processes and proceedings.



Myth #3: Recovery Auditors Generate Inaccurate Findings and are an Administrative Burden on Hospitals. Another program safeguard that is unique to the Recovery Audit program is the use of an independent validation contractor to review random samples of

Recovery Auditor claims. These samples are collected on a monthly basis and scored on an annual basis to produce an accuracy score for each Recovery Auditor. This score represents Recovery Auditors' accuracy in terms of overpayment and underpayment determinations. CMS' most recent report to Congress cites that in FY 2013 all Recovery Auditors had a cumulative accuracy score of 96%. I am also proud to report that in the March 2014 report, HDI's cumulative accuracy rate was reported at 97%.

Cumulative Accuracy Score by Recovery Auditor

Region	% of Accuracy
Region A	99.1%
Region B	96.8%
Region C	92.8%
Region D	97.0%
Average Accuracy Score	**96.4%**

Source: CMS Recovery Auditing in Medicare and Medicare for FY 2012 Report to Congress, March 2014

Myth #4: Recovery Auditors Lack Clinical Expertise. CMS regulations, instructions and statements of work for Recovery Auditors are very clear – a licensed clinician is required to perform every medical review. Those include medical doctors, licensed RNs, certified coders, and registered pharmacists. CMS requires a licensed physician to serve as a full-time Medical Director for every Recovery Audit contractor. I am pleased to tell you HDI meets or exceeds these requirements. A qualified clinician, in accordance with CMS requirements, performs every medical record review completed by HDI.

HDI employs a full-time Corporate Medical Director, a full-time Senior Medical Director, and a team of Physician Reviewers, while our parent company maintains a staff of physicians and other clinicians across every specialty, who are available for consultation as needed. It is also important to note that HDI's clinicians are recruited based their credentials, experience in the practice of their field, and level of expertise vis-à-vis utilization management and/or medical review expertise. The result is that HDI is able to recruit high-quality clinicians to our team. The HDI training and mentoring process also ensures complete familiarity with CMS Medicare manuals, guidelines, rules, regulations, and coverage, resulting in demonstrated clinical expertise before any audit determinations are released.

Myth #5: Recovery Auditors Impact Care. It is important to understand that Recovery Audits occur after care is provided. Therefore, in no way do auditors impact clinical decisions made by providers or affect the quality of service to beneficiaries. Recovery Audit Contractors review claims after care has been completely provided to patients. In addition, Recovery Auditor reviews take place on a post-payment basis, long after hospitals have received Medicare payments.

The CMS statement of work also precludes the recovery of claims where a beneficiary would be liable for an improperly paid claim. This means that Medicare beneficiaries are never affected financially by any recovery audit work.

Myth #6: Recovery Auditors Target Short Inpatient Stays. There is a very compelling reason why Recovery Auditors focus on short Inpatient hospital stays. Medicare data, such as CERT measurements, HHS OIG and PEPPER/Fathom reports have consistently noted costly error rates for these types of hospital claims. With persistent billing error rates for hospital care driven by costly hospital short stays, an HHS OIG study in 2013 reported both Medicare and its

beneficiaries pay more for hospital care that is billed as inpatient care than they pay for hospital care billed as outpatient care. Based on this data, CMS directed Recovery Auditors to focus on this type of billing, and it is imperative to the longevity of the Medicare Trust Fund that Recovery Auditors review short inpatient stays.

That being said, we understand the hospital industry's desire for clarity regarding the "Two Midnight" rule and we will continue to work with CMS and the provider community toward that goal. Clarity, combined with effective education, outreach and transparency, will help all Medicare system stakeholders move forward in a way that balances the the concerns of providers with the importance of program integrity and the interests of the taxpayers.

Recovery Audit Program Recommendations

As the Committee continues to examine the Recovery Audits, I would like to reiterate our industry's recommendations for future improvements to the program.

1. Appeals Reform as documented in the 2012 HHS OIG Report

The ALJ process, under the executive branch, is the third level of appeal for providers and has presented CMS contractors with significant difficulties leading to results that are inconsistent with the goals of the Medicare program. For example, the HHS OIG documented serious issues with the ALJ process contained in their 2012 report, including:

- Medicare Regulations, Policies and Manuals that are not being followed by the ALJs
- ALJ decisions that are inconsistent with MAC and QIC rulings that uphold the audit approximately 90% of the time
- That many ALJ judges rule against CMS audit findings regardless of the issue presented
- That many ALJs do not have clinical expertise for reviewing clinical cases and require additional training
- An overwhelming number of ALJ decisions that are favorable to providers, creating an incentive for providers to continue appealing
- That certain providers are "serial appellants," committed to appealing 100% of audits, thereby clogging the system and creating a financial burden on the program. In fact, on May 6th, Chief Judge Nancy Griswold testified to the Senate Finance Committee that 5 appellants submitted 51% of appeals to the ALJ level. We agree with Judge Griswold that an appeals filing fee, which has also been supported in the President's budget and by Secretary Burwell, would help to deter providers from clogging the ALJ process.

Effective appeals reform would include:

- Increasing the number of ALJ judges to allow for effective management of the work load
- Implementation of ALJ training on Medicare policy for consistent application of CMS policy and rulings
- Review of the increased use of "on the record" decisions by ALJs
- Review of the ALJ policy of "complete individual independence"
- Implementation of an appeals filing fee

2. Continue to empower MACs to offer provider education that increases provider knowledge of Medicare policies

Consistent reinforcement of CMS policies, rules and regulations by effective educational outreach would be an effective means of addressing many of the issues discussed in this testimony. When providers fully understand Medicare rules and how to abide by them, the entire system benefits. We believe this should be an important priority for CMS and for this Committee.

3. Collaboration among stakeholders

Increase the dialogue between Recovery Auditors, providers, policymakers and other stakeholders to strengthen the Recovery Audit program – with the common goal of protecting the Medicare program and safeguarding tax dollars from improper payments.

4. Consistent program integrity oversight by CMS

Recovery Auditors recommend that in order to reduce the billing error rate, which stands at more than $46 billion in claims improperly paid each year, CMS should continue to provide oversight of claim payments through continuous, consistent program integrity efforts to ensure accurate payment of claims, clear payment policies and recoupment of improper payments. We recommend that more reviews be shifted to pre-payment review for more immediate feedback to the providers.

Conclusion

In summary, HDI is pleased to be a part of this important discussion. The Recovery Audit program is constantly improving, and we are constantly striving to balance all stakeholder priorities in our ongoing evolution from a demonstration program to a permanent program. Quality measures have shown that Recovery Auditors have a 96% accuracy rate and perform with a high level of effectiveness and efficiency. This accuracy rate is achieved through the use of experienced clinical experts and licensed professionals, with physician oversight and medical direction. Recovery Auditors maintain low appeals overturn rates and steady recoveries of resources back to both providers and to the federal government.

We believe the Recovery Audit program must continue to play an integral role in the Medicare program—especially in light of the consistent and dramatic increase in improper payments. The program has proven successful in fulfilling its mission to identify and correct Medicare improper payments and return those overpayments back to the Medicare Trust Fund.

The ongoing work of recovery auditors is vital if we are to effectively safeguard public resources for the care of American seniors who continue to count on the current and future viability of the Medicare Program.

I appreciate the opportunity to appear before you today and would be pleased to answer your questions. Thank you.