January 16, 2018

Seema Verma, MPH
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

RE: CMS-4182-P

Dear Ms. Verma:

HMS welcomes the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) notice of proposed rulemaking entitled, "Medicare Program; Contract Year 2019 Policy and Technical Changes to the Medicare Advantage, Medicare Cost Plan, Medicare Fee-for-Service, the Medicare Prescription Drug Benefit Programs, and the PACE Program". We appreciate CMS's continued commitment to Medicare and its members, promotion of program integrity, and protection of taxpayer dollars.

To those ends, HMS applauds the CMS solicitation for proposed changes to the calculation of the medical loss ratio (MLR) particularly as it relates to the treatment of fraud reduction activities. Under today's MLR methodology, the calculation and accounting for the cost of fraud reduction activities is problematic. Currently Medicare Advantage Plans (MAs) may include in the numerator of the MLR fraud recoveries only up to the total costs incurred to achieve those fraud recoveries. However, the detection, prevention and recovery of fraud can be a lengthy and costly process. Recoveries may occur months or even years after detection, and it is not uncommon for costs incurred to identify and recover those fraudulent overpayments to actually exceed the total value of the fraudulent overpayments.

We commend CMS for proposing to allow fraud reduction activities to be included in the numerator as a quality improvement activity (QIA). Indeed, this will go far in ensuring proper incentives for the rigorous pursuit of fraud, waste and abuse (FWA).

CMS requests feedback on whether fraud reduction costs should be included as a QIA or have a separate MLR numerator. Without question, improper payments due to fraud, waste and abuse directly relates to quality and often and can significantly impact the patient. Calculating the costs associated with the prevention, detection and recovery of fraud waste and abuse is therefore appropriately accounted for as a QIA.

CMS also solicits input on the types of activities that should be included or excluded from fraud reduction activities. HMS recommends that all costs associated with prevention, identification and recovery of fraud be an allowable expense. Such activities may include, but not limited to development and maintenance of fraud detection systems, data collection, matching, and mining; investigations; education and enforcement activities.

HMS highly recommends that "fraud reduction activities" include the identification, prevention and recovery of non-fraudulent overpayments. In HMS's experience the vast majority of overpayments are in fact errors verses intentional fraud. As a Medicare and Medicaid Recovery Audit Contractor we identify and recovery upon hundreds of millions of dollars annually due to waste. Examples of non-fraudulent overpayments can include improper coding, duplicate billing or even overpayments for care that is not medically necessary or does not follow well established best practices or care guidelines.

Fraud is often identified through the application of a broader set of overpayment tools over a long period of time. For example, a provider billing error in of itself would constitute waste, but if patterned may indicate abuse and fraud. Without rigorous program integrity efforts, fraud reduction activities are minimal. Additionally, the same concerns CMS noted regarding fraud incentives and disincentives exist today as it relates to broader program integrity efforts. Specifically, there are few incentives to pursue non-fraudulent activities given the fact that recoveries must be deducted from incurred claims. This financial disincentive coupled with strict provider network adequacy requirements, dramatically impairs program integrity activities. For these reasons we request that all program integrity activities be included as a QIA.

In order to ensure proper fraud reduction and program integrity incentives, HMS also supports CMS' proposal to eliminate the exclusion that applies to activities that are designed primarily to control or contain costs from §§ 422.2430(b)(1) and 423.2430(b)(1).

Ultimately, when MA and Part D sponsors prevent FWA, and recover on inappropriately paid claims, overall costs of providing coverage to MA and Part D enrollees is lowered. Fewer improper payments are reflected in their subsequent cost projections, resulting in lower payments to MA organizations and Part D sponsors out of the Medicare trust funds. These savings can then improve beneficiary experiences by way of lower premiums or even enhanced benefits.

We appreciate your consideration of our comments on this important proposed rule and look forward to ongoing collaboration on these issues. If you have any questions concerning these comments, please contact me directly at kballantine@hms.com or (202) 448-2024.

Sincerely,

Kristen Ballantine
Vice President, Government Relations