

RAC COALITION
STATEMENT FOR THE RECORD
HEARING ON CURRENT HOSPITAL ISSUES
IN THE MEDICARE PROGRAM
MAY 20, 2014

The RAC Coalition commends the Ways & Means Health Subcommittee for holding a hearing on Current Hospital Issues in the Medicare Program on May 20, 2014. The RAC Coalition is encouraged by the Members' determination to evaluate possible changes to the Medicare Recovery Audit Contractor (RAC) program in order to eliminate the program's unintended consequences that are placing unnecessary burdens on the nation's hospitals and taking necessary resources away from patient care. We stand ready to be of assistance in formulating workable solutions to this vexing issue.

The RAC Coalition

The RAC Coalition lobbies on behalf of 14 hospital systems or hospitals which operate more than 70 hospitals across the country. The members of the RAC Coalition lobby are: Adventist Health System/Sunbelt, Inc.; Bon Secours Health System, Inc.; Erlanger Health System; The University of Kansas Hospital; Mercy Health; Memorial Hermann Healthcare; Mount Sinai Medical Center, NY; Oakwood Healthcare, Inc.; Ochsner Health System; OSF HealthCare System; Piedmont Healthcare; Presbyterian Healthcare Services New Mexico; SSM HealthCare of Oklahoma -- St. Anthony Hospital; and Tampa General Hospital.

The mission of the RAC Coalition is to urge Congress to enact reasonable, targeted reforms to the RAC program that will eliminate the program's unintended consequences and increase transparency, improve provider-RAC auditor relations, and promote an efficient Medicare appeals process. All of our member hospitals have had significant experience with Medicare and Medicaid audits, including RAC audits. While the details for each of our hospitals varies, our RAC audit experience has been similar to that of the hospitals whose representatives testified at the May 20th hearing:

- Each of our organizations has diverted significant amounts of manpower and resources away from patient care in order to respond to large volumes of RAC audits of Medicare inpatient claims. Many of our members have formed teams of employees whose new job duties are to receive, respond to and track appeals of RAC audits.
- When we appeal RAC audit results, we have a very high success rate. Our success rate varies from hospital to hospital, but on average we have above a 60 percent success rate.
- Because the current volume of inpatient claim denials on appeal is so large, we are waiting years to obtain a hearing even though the Medicare statute requires a decision within 90 days.
- The financial impact is significant. Many of our members have millions of dollars per hospital of recouped Medicare reimbursement tied up in the appeals process. One of our members, for example, has appealed inpatient claims worth \$24 million dollars, yet has been told that no hearing on these claims will be scheduled for an indefinite amount of time.

RAC Audits of Inpatient Hospital Stays

We believe our experience with the RAC program is representative of hospitals around the country. Until CMS temporarily paused RAC activity to award new contracts, RACs were requesting medical records on hundreds of cases every 45 days. This will begin anew once the new RAC contracts are awarded. According to a July 2013 Government Accountability Office report on Medicare contractors, RACs "conducted almost five times as many reviews as the other three contractors [MACs, ZPICs and CERTs] combined." An overwhelming amount of

these reviews focus on whether physicians made the correct decision to admit their patients as inpatients, a decision which until this past year Medicare rules reserved to the complex medical judgment of physicians.

CMS's attempt to bring clarity to the inpatient admission decision with the so-called two midnight rule was well-intended but misdirected. When CMS proposed the two-midnight rule in 2013, the RAC Coalition filed comments with CMS that pointed out that the variation in interpretation of these admission standards was caused by CMS's failure to ensure that the RACs, whose audit review guidelines are not made public and not specifically approved by CMS, were applying consistent guidelines that reflected accepted medical practice. The two midnight rule is not more clear, and it raises just as many audit traps as existed before. We appreciate the Members' questions regarding the need for CMS to explore an alternative Medicare payment methodology that would fairly reimburse hospitals for short inpatient stays. We strongly believe any attempt at payment reform should also include reasonable modifications to the RAC program, as we outline below.

The Medicare Appeals System Is Broken and Providers Need Immediate Relief

A substantial amount of the dialogue at the May 20th hearing focused on the question of the success rate of hospitals in appealing RAC overpayment decisions. The RAC Coalition supports the Members' request for more detailed and current information from CMS and the Office of the Inspector General regarding the appeals success rate. The critical question in our view is not what percentage of the hundreds of thousands of RAC decisions are overturned, the statistic that CMS and the RACs frequently cite. The entire universe of RAC reviews includes numerous, non-controversial decisions such as coding errors that are simply corrected and never appealed. Further, this universe may also include decisions made at the first and second levels of the appeals process, before a matter reaches the ALJ level. The more instructive data will focus on RAC audits of hospital inpatient short stays which, as the Committee understands, is at the heart of the audit-burden problem. The important questions are:

- At what rate are hospitals appealing RAC denials of inpatient claims?
- At what rate are hospitals successful in those appeals? and
- What percentage of the dollars recovered by RACs have been, or can expected to be, returned to hospitals?

In its most recent report on the RAC program, CMS informed Congress that hospital inpatient claims accounted for 91 percent of the \$2.3 billion the RAC program claimed to have recovered for the Medicare program in 2012. What CMS did not report was what percent of this \$2.1 billion was the subject of appeal and what amount was returned to hospitals because the RACs' audit results were overturned on appeal. If the RAC Coalition experience is representative of the rest of the country, and we believe it is, then the vast amount of overpayment recoveries for which CMS and the RACs are taking credit will ultimately be returned to hospitals, or at least would be if the appeals process were working as it should.

There is no question that the RAC program has had an unintended and negative impact on the Medicare appeals system. RAC denials have flooded the appeals process and overwhelmed the Administrative Law Judges, who are directed by statute to adhere to a 90-day time limit for making a decision. As the Committee knows, in December 2013, the Office of Medicare Hearings & Appeals (OMHA) confirmed that the appeals system has ground to a halt. OMHA temporarily suspended the assignment of ALJs for most new appeals effective July 15, 2013, and it does not expect general assignments to resume for at least 24 months. In a Federal Register notice, OMHA explains that "in 2013, appealed claims related to the RA (Recovery Audit) program grew to over 136,000, further exacerbating the backlog of cases and resulting in a substantial increase in the adjudication time frame."

What does the OMHA shutdown mean for hospitals? For most it is a financial crisis. Hospitals have experienced wide-spread success in appealing RAC denials of inpatient stays that second-guess physician judgment. But a condition of appealing a RAC denial is that the hospital must refund its Medicare payment. Many of the RAC Coalition members have refunded millions of dollars to the Medicare program in order to challenge the results of RAC audits. We have a reasonable expectation of winning most of these challenges and, therefore, expect to see the return of these funds. But due to the OMHA shutdown, these funds are kept out of our reach for an indefinite amount of time. Meanwhile, the RACs who denied the claims have already received their contingency fee, and will hold that contingency fee for what is now an indefinite period of time even though, in the majority of cases, they will ultimately be required to return the fee. The Medicare appeals system should not be used to give hospital-funded interest free loans to RACs, and without some action to immediately remove many of these cases from the appeals system, the financial problems for hospitals will compound daily, imposing greater and greater costs to our health care system. We outline additional proposals below, but we strongly believe that CMS should be authorized to offer providers the option to have a smaller statistical sample of appeals reviewed and decided, and be bound by the results of the decision, as a means to clear the backlog in appeals.

The Need to Realign Incentives and Improve Audit Guideline Transparency

A question was raised at the May 20th hearing as to whether the RAC contingency fee affects the quality of the review of Medicare payments. In our experience, the answer is yes. Each of the members of the RAC Coalition can cite numerous examples of claims for inpatient services that were denied by RAC contractors relying upon an overly technical application of the rules that are easily overturned on appeal (missing physician signatures that can easily be located in the medical record). There are just as many examples in which RAC auditors have reached inconsistent decisions on two similar inpatient claims or have overruled physician judgment or clearly misapplied established medical guidelines. The fact that hospitals are willing to incur the expense of pursuing appeals, and the fact that they win the vast majority of these appeals, demonstrate that the quality of RAC contractor review is low, at least when it comes to inpatient stays.

This poor quality is directly related to how RACs are paid. As was stated at the May 20th hearing, RACs are like fisherman; they “cast a wide net.” The hope of a contingency fee incentivizes them to review and deny as many high dollar claims as possible. The fact that they have to return the contingency fee if they are overturned on appeal does not give them incentive to conduct high quality reviews. If anything, it produces the opposite effect. Contractors that work on success fees are incentivized to keep volume high and overhead low (*i.e.*, deny as many claims as quickly and cheaply as possible) in order to maximize the chances of success and minimize the cost of losses.

We believe there are two easy answers as to how to improve the quality of RAC reviews: Realigning financial incentives and improving transparency.

Realigning Financial Incentives: Under the current RAC system, hospitals must refund Medicare payments and wait until they have exhausted their appeals in order to receive proper payment for their services. RACs, on the other hand, receive payment up front, immediately after the funds are recouped, and only return wrongfully collected contingency fees at the end of the appeal. If RACs were made to wait for their fees until after the result of any appeals, then they would have more “skin in the game” and a higher incentive to make overpayment determinations that would survive the test of an appeal (and hospitals would be far less inclined to appeal higher quality decisions) and not clog the appeals system with questionable decisions. The RAC Coalition supports proposals that would realign the RACs financial incentives, such as moving the contingency fee award until after ALJ review or adjusting contingency fees downward for high overturn rates. We appreciate that CMS has moved part-way toward such a reform in the next round of RAC contracting by moving the receipt of RAC contingency fees until after the second or “QIC” level of appeal. This is an important step because it acknowledges that the contingency fee may have unintended consequences. But in the RAC Coalition’s

experience, the QICs almost universally and uniformly affirm RAC decisions in complex medical reviews of inpatient claims. To be truly effective, CMS must move RAC payments to follow the first truly independent review of their audit work, at the ALJ level.

Improving Transparency: Greater transparency of the RACs' audit review guidelines would also improve the quality of their claim reviews. Under the current RAC contracts, RACs are required to generate audit guidelines, which CMS also refers to as "review methodologies," for the claims they intend to review. These review guidelines are, in effect, the RACs' interpretation as to how Medicare payment and coverage policy should be applied on a claim-by-claim basis. For example, Medicare's standards for when it will pay an inpatient claim are not diagnosis or case-specific. They call for physicians to use their best medical judgment after considering several factors such as patient history and symptoms. The RACs must translate this standard into audit guidelines in order to give direction to their non-physician reviewers whether to approve or deny an inpatient admission for someone who, for example, has presented with chest pain or received a cardiac procedure.

CMS itself does not approve these specific audit guidelines in advance. In fact, CMS informed Congress in the 2012 RAC report that it recently instituted a policy to require MACs to validate these proposed "review methodologies" in order to minimize incorrect findings. Hospitals do not see and have no opportunity to comment on or provide other input into these review guidelines. According to testimony at the May 20th hearing, medical specialists societies do not have direct input into these guidelines either.

Under the current RAC program, disagreements as to whether RACs are applying review guidelines to inpatient stays that are consistent with Medicare policy are hashed out in the appeals system. These controversies can largely be avoided by opening the review guideline process to public review and input so that consensus is achieved as to whether the review guideline is a correct interpretation of Medicare policy before RACs use the guidelines to request and review hundreds of records from each hospital. Consensus can be achieved in a number of ways, including as having the guidelines reviewed by an independent panel of technical experts or requiring guidelines to be subject to public comment. The immediate priority should be on review guidelines used to review certain types of short-term inpatient stays, such as those associated with cardiac procedures, which, according to CMS's 2012 RAC report to Congress, have received the most audit focus from RACs and which, according to the RAC Coalition members, are most often the subject of an appeal.

Our Reform Proposals

In summary, we urge Congress to enact reasonable reforms to the RAC program to increase transparency, improve provider education, and promote an efficient appeals process:

In response to the OMHA suspension of appeals assignments, we encourage Congress to consider:

- Empowering CMS to offer providers the option to have a smaller statistical sample of appeals reviewed and decided, and be bound by the results of the decision
- A moratorium on recoupment of any overpayments from providers until the appeals system is functioning
- Moving provider recoupment to the end of the process, upon a final and binding overpayment determination

Reasonable, Targeted Reforms of the RAC Process:

- Create a CMS Ombudsman for Provider/Recovery Auditor Relations:
 - Provide an advocate within CMS to work through Recovery Auditor/MAC issues and identify potential areas of improvement in the Recovery Auditor program for CMS and congressional consideration.

- Re-align Recovery Auditor Financial Incentives – Improve Quality of Claims Denials and Align Economic Interests for a Functioning Appeals System:
 - Pay contingency fee only upon final and binding overpayment determination
 - Structure contingency fees to reflect appeals success rate
- Eliminate Controversy Over Medical Necessity Reviews By Adopting Policies and Measures to Achieve Consensus on Recovery Auditor Review Guidelines In Advance of Audits:
 - Technical Expert Panel
 - Ensure review guidelines include relevant medical societies’ guidelines and policies
 - Require public comment/participation in developing review guidelines
 - Use “roll out” Probe & Agreement period to confirm that review guidelines include evidence-based standards in advance of audits

We support the reforms in the Medicare Audit Improvement Act (S. 1012/H.R. 1250) and support in particular provisions which would:

- Realign incentives by requiring RACs to pay penalties to hospitals for high error rates
- Limit RAC audits to claim types that meet a minimum error rate
- Lower the current limits on the number of medical records a RAC can request in a 45 day period
- Require RACs to hire physicians to review each claim before denial (a requirement that the HHS imposed when such reviews were performed by Peer Review Organizations)