

# Reforming Program Integrity Efforts to Improve Accuracy, Fairness and Transparency

## AHA View

The Centers for Medicare & Medicaid Services (CMS) and Congress must undertake comprehensive reform of the audit processes to be more accurate, fair and transparent.

## Background

Hospitals take seriously their obligation to bill properly for the services they provide to Medicare and Medicaid beneficiaries and are committed to working with CMS to ensure the accuracy of Medicare and Medicaid payments. However, hospitals are drowning in a deluge of unmanageable medical record requests and inappropriate payment denials made by redundant government auditors. This wastes hospitals' resources by diverting money from patient care and contributes to growing health care costs.

In recent years, the number of program integrity auditors that review hospital claims to identify improper payments has increased dramatically. These audit contractors include Medicare recovery audit contractors (RACs) and Medicare administrative contractors (MACs). RACs are charged with identifying improper Medicare fee-for-service payments – both overpayments and underpayments. They are paid on a contingency fee basis, receiving a percentage of the improper payments they identify and collect. MACs conduct pre-payment and post-payment audits and also serve as providers' primary point-of-contact for enrollment and training on Medicare coverage, billing and claims processing. Additional entities that may audit hospitals' Medicare claims for payment accuracy include Medicaid RACs, the Supplemental Medicare Review Contractor, the Comprehensive Error Rate Testing contractor, and the Department of Health and Human Services (HHS) Office of Inspector General (OIG).

## Key Priorities

The AHA recommends the following actions to reform the audit process to be more accurate, fair and transparent:

- Providing audit relief through legislation;
- Fixing the overburdened appeals process;
- Ensuring payment for all medically necessary services; and
- Preventing improper payments.

### Providing Audit Relief through Legislation

The AHA urges Congress to reform the RAC program by realigning the financial incentives that drive RACs to deny claims inappropriately. Specifically, Congress should:

- Change the RACs' current payment structure from a contingency fee that is paid on every claim to a fixed-price contract that does not incentivize them to deny claims;

# Reforming Program Integrity Efforts to Improve Accuracy, Fairness and Transparency

- Assess RACs' financial penalties for poor performance;
- Eliminate CMS's application of the regulatory requirement that a claim must be filed within one year of the date the services were provided (the one-year filing limit) to rebilled outpatient (Part B) claims, which would allow hospitals to request outpatient payment for certain denied inpatient claims, no matter when the denial is made; and
- Limit RACs to considering only the medical information available when a patient was seen by his or her physician when determining whether an inpatient stay was necessary, or whether the care should have been provided in an outpatient setting.

In December 2014, CMS announced changes to the RAC program that will take effect upon commencement of new multi-year RAC contracts, which CMS is in the process of awarding. The future changes include providing more time for hospitals to contest appeals directly with RACs through a pre-appeal discussion period; requiring RACs to complete audits and provide results to hospitals within 30 days; reducing the number of records RACs can pull from hospitals with lower error rates (while potentially increasing the number from hospitals with higher error rates); and limiting the RAC lookback period to six months when reviewing the medical necessity of an inpatient admission. In addition, in April, the Medicare Payment Advisory Commission (MedPAC) put forth a package of recommendations designed to address its concerns about the RAC program, including tying a RAC's contingency fee to its denial overturn rate. While these are steps in the right direction, they fall far short of necessary fundamental RAC reform.

## Fixing the Overburdened Appeals Process

The HHS Office of Medicare Hearings & Appeals (OMHA) in December 2013 announced that it had suspended assignment of appealed Medicare claim denials to an administrative law judge (ALJ) until it clears the significant backlog in its workload. Inappropriate RAC denials are a significant contributor to the dramatic increase in the ALJs' workload because their inaccurate denials leave hospitals with no other option but to appeal in order to receive payment for medically necessary services they delivered to Medicare beneficiaries. As a result, hospitals must wait an estimated two years before their appeals are heard by an ALJ, during which time the disputed funds are recouped by CMS. It is at an ALJ hearing – the third level of appeal – that hospitals have the first opportunity to receive an objective, independent review of denied claims and where they have experienced a high level of success in overturning denials. Specifically, the HHS OIG has shown that hospitals win an overturn of appealed Part A claim denials 72 percent of the time at the ALJ level. Appeals at the first two levels of appeal are heard by Medicare contractors that too often simply affirm the original decision to deny the claim. The significant delays in obtaining an ALJ hearing and decision mean that hospital resources that could be used for other priorities, such as patient care, are held captive for years.

# **Reforming Program Integrity Efforts to Improve Accuracy, Fairness and Transparency**

In May 2014, the AHA and three hospitals filed suit in federal court to compel HHS to meet statutory deadlines for timely review of Medicare claims denials. In fall 2014, in an apparent attempt to alleviate the appeals backlog, CMS offered acute care and critical access hospitals the opportunity to settle certain denied Medicare claims for 68 percent of the claims' value. Whether that initiative will reduce the appeals backlog significantly is not yet clear, and the AHA's lawsuit is ongoing. In addition, the AHA continues to urge CMS to address the underlying cause of the appeals backlog by focusing on fundamental RAC reforms that would curb the significant volume of inappropriate denials. CMS could take additional steps immediately to mitigate the impact of the ALJ backlog on hospitals, including enforcing statutory timeframes within which appeals determinations must be made; permitting hospitals to wait to repay claims denied by RACs until after an ALJ hearing; and addressing other systemic issues within the RAC program that lead to avoidable claim denials and appeals.

## **Ensuring Payment for All Medically Necessary Services**

Medical necessity is the top reason why RACs deny claims. However, roughly half of medical necessity denials are because the RAC claimed treatment should have been provided on an outpatient rather than inpatient basis, not because the RAC believes the care provided was unnecessary. Historically, in these cases, CMS denied the claim in full and permitted the hospital to rebill only for selected ancillary Part B services (e.g., diagnostic laboratory tests and X-rays), rather than for full Part B payment. After the AHA and five hospital organizations filed a lawsuit in federal court challenging that general nonpayment policy, CMS modified the policy through a March 2013 "Administrator's Ruling" and subsequently in the fiscal year (FY) 2013 inpatient prospective payment system (PPS) final rule. CMS specified that hospitals may rebill under Part B for denials of services provided on or after Oct. 1, 2013, but only if they meet the one-year filing limit.

Since RACs often review claims that are more than a year old and can review claims that are up to three years old, CMS's policy to allow rebilling only for services within the one-year filing limit is insufficient. The practical effect is that many denials are ineligible for rebilling at the time they are denied. This artificial barrier to payment violates CMS's statutory requirement to pay hospitals for all reasonable and necessary outpatient services provided to Medicare beneficiaries.

In the FY 2014 inpatient PPS rule, CMS also finalized its "two-midnight" policy whereby the agency will generally consider hospital admissions spanning two midnights as appropriate for payment under the inpatient PPS. In contrast, hospital stays of less than two midnights will generally be considered outpatient cases, regardless of clinical severity. The policy took effect Oct. 1, 2013, but CMS and Congress have acted to delay enforcement of the policy a number of times. Most recently, the Medicare Access and CHIP Reauthorization Act of 2015 (H.R. 2) extended the partial enforcement delay of the two-midnight policy through Sept. 30, 2015. MedPAC, as part of its recent work designed to improve the RAC

program, recommended that CMS withdraw the two-midnight rule. The AHA, several hospital associations and four hospital organizations have challenged the two-midnight criteria, along with a related physician order/certification requirement and the one-year filing limit for rebilled claims, in a lawsuit filed in April 2014. The suit is currently pending in federal court.

## **Preventing Improper Payments**

CMS must take proactive steps to prevent improper payments and thereby alleviate the need for audits and denials in the first place. Doing so would reduce hospital burden and mitigate the current appeals backlog. The AHA continues to urge CMS to offer more substantive provider education to assist hospitals in proactively identifying the most common payment errors and the remedies needed to eliminate errors and related payment denials.

In addition, the AHA provides members with educational resources to help hospitals better understand the RAC and Medicare appeals processes. A series of Advisories and Audit Education webinars can be accessed through AHA's RAC policy portal under "Education and Tools" at [www.aha.org/rac](http://www.aha.org/rac).