



**American Hospital
Association**

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Kerry Weems
Acting Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

RE: *Recovery Audit Contractor (RAC) Request for Proposal (RFP) RFP-CMS-2007-0022*

Dear Mr. Weems:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 37,000 individual members, the American Hospital Association (AHA) appreciates your consideration of our comments on the Centers for Medicare & Medicaid Services' (CMS) proposed Statement of Work in the Request for Proposal on CMS' national implementation of recovery audit contractor (RAC) program.

While CMS has chosen not to implement the program through a notice and comment process, we are using the "Questions" time period of the Request for Proposal to share our concerns about plans for expansion of the RAC program.

The Medicare Modernization Act of 2003 (MMA) established the RAC program as a demonstration program to identify improper Medicare payments – both overpayments and underpayments. *The Tax Relief and Health Care Act of 2006* made the RAC program permanent and authorized CMS to expand the program to all 50 states by 2010. RAC review has already expanded to Massachusetts and South Carolina. As delineated in the Statement of Work, CMS plans to expand RAC review to all states by March 2008.

Hospitals strive for payment accuracy and are committed to continuing to work with CMS and its contractors to ensure the validity of hospital payments. However, we have serious concerns about the RAC program, and we believe the proposed expansion is not the right approach. CMS already employs fiscal intermediaries (FIs), carriers, Medicare administrative contractors (MACs), the CERT program, and quality improvement organizations (QIOs) to administer Medicare payments. Additional oversight is provided by Office of the Inspector General reviews. Rather than add another Medicare contractor



to the system, performance problems that may exist with these contractors should be corrected and improved.

In addition, the funding mechanism for RACs must be changed. These contractors are paid on a contingency fee basis, receiving a percentage of the improper overpayments they collect from providers. This “bounty hunter-like” payment mechanism gives RACs incentives to aggressively deny any claims that appear at all questionable. It is an “act now, ask questions later” approach that creates significant burden and requires unnecessary administrative costs for hospitals to resolve. At the very least, RACs should be paid a contractual amount unrelated to collections. Any collections should be used to support health care services to America’s seniors and disabled, not the bottom line of RAC companies.

We, along with the hospital associations in California, Florida and New York, have raised many concerns with the demonstration program. These issues must be resolved prior to any nationwide rollout of the RAC program. CMS’ push to quickly ramp up the RAC program across the country without first addressing major program flaws is irresponsible. The implementation time frames CMS has laid out are overly aggressive and will likely lead to major confusion and processing problems for hospitals. We urge CMS to adopt a more rational implementation timeline and approach that allows RACs and providers to adequately prepare for RAC implementation.

SPECIFIC CONCERNS

Medical Necessity

CMS should remove medical necessity determinations from the RAC Statement of Work. We believe that medical necessity determination reviews are not appropriate for the RAC program and are beyond the scope of the authority granted to RACs by Congress both in the demonstration program enacted by Section 306 of the MMA and in the national expansion enacted in Section 302 of the *Tax Relief and Health Care Act of 2006*, which requires contracts with RACs “for the purpose of identifying underpayments and overpayments and recouping overpayments” under Medicare.

Medical necessity determinations are fundamentally distinct from other RAC reviews. They are highly subjective cases that require extensive clinical review and are not “mistakes” more suitable for RAC identification. RACs identify procedural billing errors using automated, software-based, simultaneous searches of numerous Medicare claims. By contrast, medical necessity reviews are individualized clinical assessments of compliance with Medicare coverage policy. Each medical necessity review should involve a comprehensive assessment of a medical record by a clinician with relevant experience who reviews physicians’ orders, patient history, execution of the patient’s plan of care and other details to determine whether the care provided satisfies Medicare coverage criteria. We believe that RACs have not used qualified clinical staff to review claims and medical records for medical necessity. Further, the “bounty fee” RAC

payments provide an incentive to deny claims that ultimately are deemed to be medically necessary upon appeal once each case is comprehensively examined and physician experts weigh in. Medical necessity reviews must be based on clinical review and are entirely inappropriate for RAC review.

In the past, when Congress empowered private contractors to conduct medical necessity review, it granted that authority in a very explicit manner. For example, the provisions addressing Peer Review Organizations, now known as QIOs, expressly provide that one of the functions of such an organization is to review the activities of practitioners and providers for the purpose of determining whether the services they render under Medicare “are or were reasonable and medically necessary...” Further, the provisions concerning QIOs contain various safeguards to ensure reviews are fair and equitable, such as requiring the QIOs to engage specialists in the areas they are reviewing “to the maximum extent possible.”

In contrast, Congress did not explicitly direct the RACs to conduct medical necessity reviews, nor establish any safeguards to ensure that any such reviews would be fair. Consequently, we believe that CMS has exceeded its authority in granting RACs the ability to conduct medical necessity audits, because had Congress intended to authorize these reviews, it would have provided clear language to that effect, as it has in the past.

Given the lack of congressional intent and the stark difference between medical necessity reviews and other RAC reviews, the AHA urges CMS to exclude all medical necessity determinations from the RAC Statement of Work. At a minimum, CMS must require that RAC contractors utilize personnel with relevant clinical qualifications and experience to conduct medical necessity determinations, including physicians with experience in the specialty involved in the disputed case.

Furthermore, the rollout of the RAC expansion and sequenced reviews should be uniformly applied to all states in a region. The rollout chart provided in the Statement of Work allows for only coding reviews in the “expansion states” as of March 2008, but does not similarly restrict that type of review in the demonstration states. There is no rationale for continuing to permit medical necessity and other coverage reviews in the demonstration states if the other states in the RAC region are not subject to such reviews.

Time Period Available for RAC Review

The AHA requests that CMS clarify the claims review time frame for RACs. The Statement of Work no longer includes a provision from the demonstration Statement of Work (section *B.4. Claims Paid in the Prior 12 Month Period*¹) that would have precluded the RAC from reviewing claims during the current fiscal year.

¹ “The RAC shall not attempt to identify any overpayment or underpayment if the claim has a claim processed/claim paid date in the preceding 12 months. This equates to a rolling 12-month period of time. The RAC shall limit its work to claims paid in the time before the preceding 12 months. For example, on June 1, 2007 the RAC may not review claims with a claim processed/claim paid date between June 1, 2006 and May 31, 2007.”

In contrast, on page 8, the current Statement of Work makes the following declaration:

The RAC shall not attempt to identify any overpayment or underpayment more than 3 years past the date of the initial determination made on the claim.

While shortening the time frame from four years in the demonstration to three years is a step in the right direction, we are concerned that there will be overlap between the RAC review of claims and review that is currently the responsibility of other contractors, such as the FIs, carriers, MACs and QIOs. It is not appropriate for the RACs to be reviewing claims that are less than 12 months from their original payment determination. This provision would require providers to respond to concurrent claims review, including reviews for medical necessity, which would create confusion and substantial burden. Excluding the claims with determination dates less than 12 months old does not prevent RACs from reviewing these claims. It merely delays their review beyond the first year. RACs should not be paid to review claims that are still being processed and reviewed by FIs, carriers, MACs and QIOs. Introducing RACs into this initial 12-month period is a waste of tax dollars and creates inappropriate incentives for these other contractors. There is no compelling additional benefit to the Medicare program by including these claims in the RAC review process. However, the burden, confusion and cost it would create for hospitals and other providers would be overwhelming.

Furthermore, the look-back period for RAC reviews should be limited to a 12-month window, rather than the proposed three-year window. Specifically, the AHA recommends that CMS limit the time frame for RAC review of all claims to a period of 12 to 24 months from the date of the initial determination made on the claim. This will give RACs 12 months' worth of provider claims to review, and prevents the overlap with FIs, MACs, QIOs and carriers that would occur if RACs reviewed claims within 12 months of initial claim payment determination. Twelve months of claims provides more than enough claims for RAC review and ensures that every year is given a serious consideration. Limiting claims to 12 months of data also provides an incentive for RACs to evaluate all Part A and B services, rather than focusing primarily on higher paying hospital services.

Electronic Tracking Platform for Providers

Currently, all communication from RACs to providers is paper correspondence sent through the mail. Paper correspondence, which easily can be lost, is an inefficient way of communicating in a timely manner. It is our understanding that, under the current demonstration project, if a provider's appeal is successfully settled at the FI level, there is no formal communication from the FI to the provider – the provider only becomes aware of the outcome when it receives a remittance check.

It is important that there be clear communication closing the loop for each claim being appealed so that providers may track the status of the claims in dispute. Because both the

RAC and FI are involved in the appeals process, there must be a mechanism for communication between them and the hospital regarding the status of any claim in the appeals process.

We recommend that CMS establish an electronic platform, similar to ones used by the FIs, that would allow providers to actively track the status of claims being processed for review, as well as medical record requests. This would allow for quick, efficient and timely communication between the RAC and the institution. Electronic mail correspondence alerting the hospital to updates within that platform would effectively ensure that all parties are kept informed of the status of claims under review. The absence of an electronic tracking tool for providers has been a hurdle for hospitals that has created tremendous inefficiencies and additional costs. Any expansion of the RAC program to additional states should be delayed until a system is in place.

Reducing Incentives for Abusive RAC Behavior

The AHA supports the change in contingency fee policy that is reflected in the most recent RAC Statement of Work. The new Statement of Work requires contractors to repay their contingency fees if a provider files an appeal and that appeal is adjudicated in the provider's favor at any appeal level. Under the demonstration project, the contractor has been able to retain their contingency fee if their determination was not overturned at the first level of FI appeal, even if it is decided in the provider's favor at a later level of appeal. This created an inappropriate incentive for the contractors to deny services without adequate consideration. The ability to retain their contingency fee if their decision "passes" the first level of FI appeal provides a disincentive to consider the validity of their decision and its ability to withstand the comprehensive review that is characteristic of higher levels of appeal. Although we strongly support the change reflected in the current Statement of Work, this change does will not fully eliminate the perverse incentives mentioned above.

We also support the change that requires that all RAC recovery efforts be ceased once the RAC is notified of the appeal request. This would allow the due process measures to first be completed and would target recoupment to only those cases that are ultimately found to have errors upon the conclusion of the appeals process. This has been a significant problem in the demonstration program, and CMS must take action to ensure that RACs are returning any recouped payments if hospitals appeal.

As a further disincentive for RACS to seek recoupment without appropriate cause, we also recommend that they be required to repay these amounts *with interest*. Both providers and FIs incur considerable costs in appealing cases that were inappropriately targeted for take-back. CMS also should consider creating penalties against RACs for poor performance if they have a high percentage of their determinations overturned upon provider appeal (at any level). This will provide a disincentive for abusive behavior in which the RAC makes many requests for medical records in circumstances in which there is inadequate evidence to support an overpayment.

CMS should clarify that RACs, FIs, QIOs, PSCs, carriers and MACs must only use the rules, policies and practices that were in place at the time the original service was rendered to the beneficiary. We have learned of multiple situations in which RACs denied claims, and the other Medicare contractors upheld these decisions, based upon policy interpretations and regulations that were put into place after the claim was originally filed. In a related concern, the new MACs may have very limited knowledge of local medical review policy that was in place prior to their tenure.

Transparency in Oversight

The Statement of Work includes increased reporting requirements for RACs. The AHA supports this increased oversight and recommends that these reports be available to the provider community. We also recommend that CMS make the new validation contractor reports available to providers. We also support the creation and publication of a RAC “report card” that comes out on a regular basis (e.g., monthly, quarterly). It also is important for CMS and RACs to notify providers of the target/vulnerability areas that RACs will be pursuing for reviews.

Re-billing of Claims Beyond the “Timely Billing” Period

In the RAC demonstration program, CMS has allowed hospitals to re-bill denied inpatient claims as outpatient services beyond the “timely billing” time frame under certain circumstances. The AHA recommends that CMS waive “timely billing” rules and allow providers to re-bill claims which are denied by a RAC as an inpatient service but could meet requirements as an outpatient service. For reviews that are re-coded and resubmitted under Part B, it is expected that only certain elements of the claim would be eligible for Part B coverage, such as laboratory and X-ray costs. Allowing inpatient claims to be reprocessed at a different coverage level is critically important and must be addressed before implementation of RACs nationally.

RAC Pursuit of Underpayments

Though statutory language and the demonstration Statement of Work that govern the RAC program provide the RAC with authority to pursue *underpayments* as well as *overpayments*, we observe that underpayments have been pursued with much less vigor. Indeed, in several cases providers or provider associations have identified specific areas of expected underpayments for the RAC and, even after such areas have been identified, contractor pursuit of underpaid claims has been considerably less zealous than their pursuit of overpaid claims. CMS must provide the oversight necessary to assure that inaccurate payments are pursued by RAC contractors with equal zeal, irrespective of whether they represent overpayments or underpayments to providers.

Provider Education

While CMS has consistently said that the RACs are not to be involved in proactive provider education, the agency has committed to ensuring provider education for those areas identified as vulnerable to errors. It is important that CMS follow through on this commitment to furnish provider education through meetings, conference calls and written guidance. Further, CMS should better clarify which of its contractors is responsible to

proactively conduct provider education and ensure that such education and FI, carrier, MAC, QIO and RAC practices are consistent with the interpretations of Medicare regulations that are contained in contractor educational materials. CMS also should evaluate with each issue that is identified/reviewed whether it is appropriate to make systems changes to improve payment accuracy upfront and to reduce the need for retrospective reviews.

CONCLUSION

We urge CMS to re-evaluate its RAC implementation plan and pursue a more reasoned approach. We have raised many concerns with the demonstration program, and these issues need resolution prior to any nationwide rollout of the RAC program. CMS has not yet performed a complete evaluation of the demonstration program or an overall assessment of the three RAC firms. It is critical that problems with the demonstration be addressed and that contractor performance and provider experience with the RACs be considered in shaping the final Statement of Work, rollout timelines and selected firms for RAC contracts.

The AHA and the state, metropolitan and regional hospital associations are committed to working with CMS to ensure the best possible process for the RAC program. We urge you to ensure that RACs work with us to help smooth this implementation and the overall operation of the program.

Thank you for considering these comments. If you have any questions, please contact me or Don May, vice president for policy, at (202) 626-2356 or dmay@aha.org.

Sincerely,

Rick Pollack
Executive Vice President

cc:
Timothy Hill
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