



**American Hospital  
Association**

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January 14, 2014

Dear Member of Congress:

America's hospitals treat millions of Medicare beneficiaries each year, upholding our end of the Medicare promise to care for America's seniors. The federal government also has a promise – to provide payments for services Medicare beneficiaries receive. But that promise has been broken by the Recovery Audit Contractor (RAC) process.

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 43,000 individual members, the American Hospital Association (AHA) thanks you for your leadership in addressing the persistent failures of the Medicare RAC program through your support and co-sponsorship of the *Medicare Audit Improvement Act of 2013* (H.R. 1250/S. 1012). **The need for fundamental RAC relief has become even more apparent and urgent by operational changes described in the attached memo from the Department of Health and Human Services' Office of Medicare Hearings and Appeals (OMHA).**

The memo states that “OMHA temporarily suspended the assignment of most new requests for an Administrative Law Judge hearing to allow OMHA to adjudicate appeals involving almost 357,000 claims for Medicare services and entitlements already assigned to its 65 Administrative Law Judges.” In addition, the OMHA memo states “with the current backlog we do not expect general assignment to resume for at least 24 months and we expect post assignment hearing wait times will continue to exceed 6 months.” **During this 30-month period in the appeals process, hospitals are not paid for the care they provided to Medicare beneficiaries.**

America's hospitals support the important goal of ensuring accurate payments to Medicare providers; however, the national RAC program has incentivized private Medicare contractors to deny as many high-dollar inpatient hospital claims as possible for the contractors' financial gain. **According to AHA's RACTrac data, hospitals win more than 70 percent of appealed inpatient denials, meaning that the majority of appealed inpatient claims that were denied by RACs are accurate, necessary and supported by clinical guidelines.** These overzealous denials by private RACs are causing the appeals process to be backlogged with hundreds of thousands of claims, a majority of which should not have been denied in the first place.

Hospital resources should be spent on patient care, not fighting incorrect RAC denials for years on end. Additionally, Medicare beneficiaries are hurt when their inpatient stay is inaccurately



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denied by a RAC, resulting in higher out-of-pocket expenses and, in some instances, bills that otherwise would have been covered by Medicare. Without fundamental reform, the RAC program will continue to improperly harm Medicare beneficiaries and hospitals.

**We urge you to contact the Centers for Medicare & Medicaid Services (CMS) and encourage the agency to adopt the RAC reforms contained in the *Medicare Audit Improvement Act of 2013*. In addition, we urge you to encourage CMS to adopt a policy change so that when a hospital appeals to the Administrative Law Judge level, CMS should not recoup the disputed funds until after the hospital has received an Administrative Law Judge determination.**

We look forward to working with you to pass this important legislation during this session of Congress. Thank you again for your leadership.

Sincerely,

/s/

Rick Pollack  
Executive Vice President

Attachments



## Memorandum to OMHA Medicare Appellants

Re: Administrative Law Judge Hearings for Medicare Claim and Entitlement Appeals

Based on a number of recent inquiries regarding delays in the processing of Medicare claim and entitlement appeals, I want to apprise you of some recent operational changes that may impact your interaction with the Office of Medicare Hearings and Appeals (OMHA). You have been chosen to receive this letter because you have a significant number of Medicare appeals currently pending before OMHA.

Due to the rapid and overwhelming increase in claim appeals, effective July 15, 2013, OMHA temporarily suspended the assignment of most new requests for an Administrative Law Judge hearing to allow OMHA to adjudicate appeals involving almost 357,000 claims for Medicare services and entitlements already assigned to its 65 Administrative Law Judges. This temporary measure was necessitated by a dramatic increase in the number of decisions being appealed to OMHA, the third level of administrative review in the Medicare claim and entitlement appeals process.

From 2010 to 2013, OMHA's claims and entitlement workload grew by 184% while the resources to adjudicate the appeals remained relatively constant, and more recently were reduced due to budgetary sequestration. Even with increased productivity from our dedicated Administrative Law Judges and their support staff, we have been unable to keep pace with the exponential growth in requests for hearing. Consequently, a substantial backlog in the number of cases pending an ALJ hearing, as well as cases pending assignment has resulted.

In just under two years, the OMHA backlog has grown from pending appeals involving 92,000 claims for services and entitlement to appeals involving over 460,000 claims for services and entitlement, and the receipt level of new appeals is continuing to rise. In January 2012, the number of weekly receipts in our Central Operations Division averaged around 1,250. This past month, the number of receipts was over 15,000 per week. Due to this rapidly increasing workload, OMHA's average wait time for a hearing before an Administrative Law Judge has risen to 16 months and is expected to continue to increase as the backlog grows.

Although assignment of most new requests for hearing will be temporarily suspended, OMHA will continue to assign and process requests filed directly by Medicare beneficiaries, to ensure their health and safety is protected. Assignment of all other new requests for hearing will resume as Administrative Law Judges are able to accommodate additional workload on their dockets. However, with the current backlog we do not expect general assignments to resume for at least 24 months and we expect post-assignment hearing wait times will continue to exceed 6 months.

We remain committed to providing a forum for the fair and timely adjudication of Medicare claim and entitlement appeals; however, we are facing significant challenges which reduce our ability to meet the timeliness component of our mission. To address this challenge, OMHA is working closely with our colleagues within the Centers for Medicare and Medicaid Services (CMS) and the Departmental Appeals Board (DAB). We are committed to finding new ways to work smartly and more efficiently, in order to better utilize resources to address the increased demand for hearings.

In order to keep you apprised concerning our workload and to facilitate your interaction with OMHA, we will host an OMHA Medicare Appellant Forum on February 12, 2013, from 10:00 am to 5:00 pm. The event will take place in the Wilbur J. Cohen building located at 330 Independence Ave. SW, Washington DC 20024. The purpose of this event is to provide further information to OMHA appellants and providers on a number of initiatives underway and to provide information on measures we can take to make the appeals process work more efficiently. You can obtain further information and register for the event by visiting the OMHA website; <http://www.hhs.gov/omha/index.html>. We are pleased to offer this opportunity and hope you will be able to join us.

Although we know that this information will not alleviate your concerns with regard to delays in processing appeals, we hope that we have at least provided a backdrop for the environment in which OMHA currently processes appeals. We ask for your indulgence as we work to address these challenges and thank you in advance for your patience as we continue our efforts to serve the Medicare appellant and beneficiary communities. For additional information and updates on OMHA's adjudication timeframes, or to register for our OMHA Medicare Appellant Forum, please visit the OMHA website at: <http://www.hhs.gov/omha/index.html>.

Sincerely,



Nancy J. Gryswold  
Chief Administrative Law Judge

## H.R. 1250 Does Not Diminish Medicare Fraud Fighting

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- If a hospital engages in fraud, that organization can – and should – be held accountable under the *False Claims Act*.
- Recovery Audit Contractors' (RACs) primary task is assessing payment accuracy – not addressing fraud. If a RAC identifies fraud, it must refer that case to a Medicare fraud-fighting entity.
- H.R. 1250 does not place any limits on the ability of any entity charged with fighting Medicare fraud to do so. Medicare fraud fighters are Zone Program Integrity Contractors, the Department of Health and Human Services (HHS) Office of Inspector General and the Department of Justice.

## Hospitals Work Hard to Accurately Bill Medicare the First Time

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- Hospitals take seriously their obligation to properly bill for the services they provide to Medicare and Medicaid beneficiaries.
- Hospitals make large investments in personnel, software and compliance program checks and balances to avoid costly and time-consuming inaccuracies.
- Hospitals want to bill, and be paid, accurately the first time.

**RAC Fact:**

**Nearly 60% of the hospital medical records reviewed by RACs are found to have no overpayment error.<sup>1</sup>**

## Hospitals Need a Level Playing Field with RAC Bounty Hunters

- RACs are not impartial judges of Medicare payments. Rather, RACs prosper financially from commissions on each rejected claim.
- A single auditor can produce dozens of denials per day, while hospitals must appeal every incorrect denial through a two-or-more year, one-claim-at-a-time appeal.
- RAC auditors much later second guess the medical decisions made by physicians who examined and treated a Medicare beneficiary in a hospital.
- RACs audit services that are up to three years old, but hospitals can only rebill RAC decisions on services from the prior 12 months.

**RAC Fact:**

**RAC auditors are typically nurses and therapists, who are paid to second guess the medical expertise of the physicians who treated Medicare beneficiaries.**

## RAC Appeals Are Adding Costs to an Overloaded System

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- Nearly three-fourths of all appealed claims are still sitting in the appeals process.<sup>1</sup>
- Each appeal typically requires two or more years for a final decision.
- The extreme backlog of appeals has resulted in a suspension of assignment of at least two years for appeals to the Administrative Law Judge (ALJ); wait time of at least an additional six months occur before a judge hears an appeal after assignment.

**RAC Fact:**

**Per RACTrac, 47% of hospital denials are appealed and almost 70% of these appeals are overturned.<sup>2</sup>**

## H.R. 1250 Would Fix Many Problems with the RAC Program

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- H.R. 1250 would correct persistent operational problems by the RACs.
- H.R. 1250 would correct Centers for Medicare & Medicaid Services (CMS) policies that provide hospitals with less than full payment for reasonable and necessary care.
- H.R. 1250 would establish manageable limits on record requests and ease the heavy administrative burden for hospitals.
- H.R. 1250 would require transparent reporting of RAC audit and appeals.

<sup>1</sup>AHA RACTrac survey of 3,400+ hospitals. Quarter 3, 2013 data.

<sup>2</sup>CMS's FY 2011 Report found an overturn rate of 44% for denials that were appealed for Medicare Part A, Part B and DME.

# Facts about Recovery Audit Contractors (RACs)

## RACs are Bounty Hunters

RACs are not impartial judges of payment accuracy because they receive a commission on every claim they deny.

## Fixing the RAC Program Does NOT Reduce Fraud-Fighting Efforts

The primary task of RACs is to assess the accuracy of Medicare payments.

Medicare fraud fighters are Zone Program Integrity Contractors, the Department of Health and Human Services (HHS) Office of Inspector General and the Department of Justice. If a RAC identifies fraud, it must refer that case to a Medicare fraud-fighting agency.

If a hospital engages in fraud, that organization can – and should – be held accountable under the *False Claims Act*.

## RACs are Inaccurate

Despite being charged with ensuring the accuracy of Medicare payments, and despite a supposed expertise in identifying inaccuracies, RACs have a hard time finding legitimate errors in hospital claims.

Only two-fifths of the hospital charts audited by RACs are found to contain a payment error. Even the Centers for Medicare & Medicaid Services (CMS) has recognized that RACs find no error in a majority of the records they audit.

The accuracy of RAC findings also is called into question by their high

overturn rate: Nearly 70 percent of RAC denials that are appealed are overturned in favor of the hospital.<sup>1</sup>

## CMS is Not Paying for All Medically Necessary Care

**CMS is violating its legal requirement to pay hospitals for all care that is reasonable and necessary.** If a

Medicare auditor finds that hospital care should have been provided on an outpatient rather than an inpatient basis, Medicare should provide full outpatient payment for the services provided.

Many inpatient claims denied by RACs are disqualified from full payment through the rebilling process because of the date of service. CMS allows hospitals to rebill only for services from the prior year, even though RACs can audit claims from the prior **three years**. RACs often deny services that are more than one year old, and therefore hospitals are disqualified from full outpatient payment through rebilling. This leaves hospitals with only one remedy to seek full payment for the denial – a Medicare appeal.

In addition, CMS has exempted some services from outpatient payment following a RAC denial of an inpatient claim. This often means that, even if a hospital can meet the timely filing requirement, a portion of full outpatient payment will be withheld by CMS.

## The Medicare Appeals Process is Broken

Hospitals face a highly uneven playing field when they appeal an erroneous RAC denial. To recapture full payment for reasonable and necessary care, hospitals must separately appeal each RAC denial through a **two or more year appeals process**.

Nationwide, hospitals report appealing more than 40 percent of all denials. Nearly 70 percent of denials appealed have been overturned in favor of the hospital. Almost three out of every four appealed claims are still sitting in the appeals process.<sup>1</sup>

The extreme backlog of appeals has resulted in the suspension of assignment of appeals to an Administrative Law Judge (ALJ) for at least two years. Since payment for claims denied by a RAC are recouped before the ALJ level of appeal, a significant amount of hospital funds may be held captive for years while the hospital waits for an appeals hearing.

CMS recently exacerbated appeals delays when it inappropriately allowed RACs to double the volume of audits.

The appeals process is not only lengthy, but extremely costly. Many hospitals do not have the resources to pursue Medicare appeals.

## The RAC Program Needs Better Oversight & Management

After three years, CMS has not corrected chronic operational problems within the RAC program. Problems include overdue audit decisions; very late issuance of key correspondence hospitals need to manage Medicare payments and appeals; and a high overturn rate for appealed RAC denials.

Despite these persistent problems, CMS in spring 2012 doubled the volume of claims that RACs may audit.

The agency also allows RACs to continue to deny claims frequently overturned on appeal.

## RACs are Second Guessing Physicians

Medicare rules grant physicians the authority to decide whether a patient should be admitted to a hospital. In these rules, CMS recognizes that deciding whether to admit a patient to a hospital is a “complex medical judgment” that requires the professional expertise of doctors.

RACs hire auditors – typically nurses and therapists – to subjectively evaluate paper charts up to three years after the patient was treated. RACs are only required to hire one physician, which leaves most second guessing to non-physician auditors.

<sup>1</sup>AHA RACTrac survey of 2,400+ hospitals. Quarter 3, 2013 data.