

### H.R. 1250/S. 1012 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/S. 1012 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:**

**49% of hospital denials are appealed<sup>1</sup> and 72% of appeals brought before an ALJ are overturned in favor of the hospital.<sup>2</sup>**

### H.R. 1250/S. 1012 Would Fix Many Problems with the RAC Program

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- H.R. 1250/S. 1012 would correct persistent operational problems by the RACs.
- H.R. 1250/S. 1012 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/S. 1012 would establish manageable limits on record requests and ease the heavy administrative burden for hospitals.
- H.R. 1250/S. 1012 would require transparent reporting of RAC audit and appeals.

<sup>1</sup>AHA RACTrac survey of 2,400+ hospitals. Quarter 4, 2013 data.

<sup>2</sup>Office of the Inspector General. November 2012.

# 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: 72 percent of

RAC denials that are appealed to an Administrative Law Judge are overturned in favor of the hospital, according to the OIG.

## 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 almost half of all RAC denials. 72 percent of denials appealed to ALJ have been overturned in favor of the hospital. More than two out of every three 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 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 4, 2013 data.

# THE RAC BURDEN

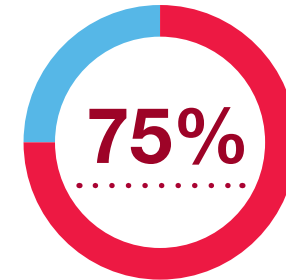
## How a Well-Intentioned Federal Program Has Become a Drain on Hospitals

The national Recovery Audit Contractor (RAC) program began in 2010 with the goal of ensuring accurate payments to Medicare providers. However, 5 years later, the program requires fundamental reform.

### Unlawful policy prevents full payment for needed patient care.

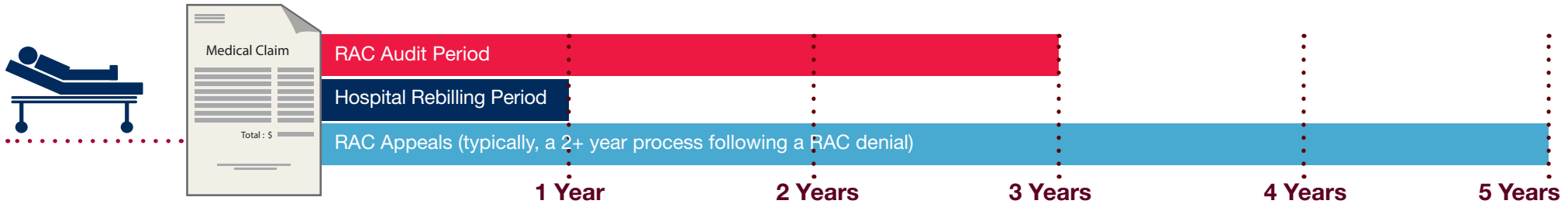
- Many denials are for inpatient care (Part A) that was medically necessary, but RACs contend the care could have been provided in the hospital outpatient (Part B) setting.
- Medicare rules prohibit hospitals from rebilling these services for payment under Part B if they are older than 1 year, while RACs can audit medical records up to 3 years old.

This disparity costs hospitals millions and violates CMS's statutory requirement to pay for all reasonable and necessary care.



of RAC-denied claims fall outside of the 1-year filing window and therefore cannot be rebilled.

Source: Centers for Medicare and Medicaid Services, March 2013



RACs are bounty hunters paid a contingency fee based on the money clawed back from denied claims.

For each Medicare claim they deny, RACs receive a commission of

**9.0 - 12.5%.**

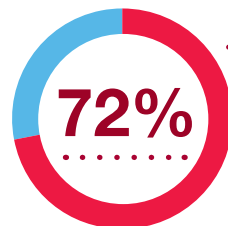
Due to this incentive structure, RACs frequently target high-dollar inpatient claims.

RACs are often inaccurate and inflict avoidable legal and administrative costs on hospitals.

RACs find no overpayment error with 58% of audited claims. RAC-denied claims: 42%



49% of denied claims are appealed.

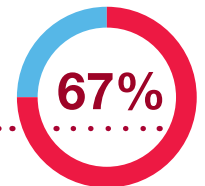
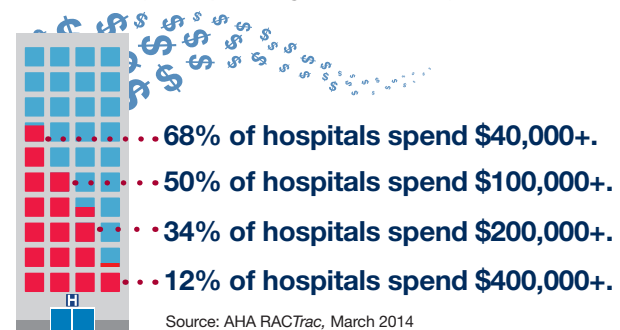


of appealed hospital Medicare Part A denials are fully overturned at the third level of appeal.

Source: Office of the Inspector General, November 2012

RACs' errors and inefficiencies force hospitals to redirect resources that could have otherwise been used for patient care.

Annual hospital spending due to RAC process:



of RAC appeals are stuck in the Medicare appeals process.

Assignment of most new requests for an Administrative Law Judge hearing will be temporarily suspended . . . for at least 24 months. — Office of Medicare Hearings and Appeals, December 2013

Your support of H.R. 1250/S. 1012 will help fix the flawed RAC system.