Editorial

Honoring our volunteers

Are your hospital's volunteers teaming up with others in your community to help the people you serve become healthier? Are they working to enhance the public's trust and confidence in your hospital? Are they taking on a major health problem and helping those who suffer regain their normal lives? Are they involved in getting primary or preventative care to people who would otherwise be left behind?

If your answer to any of these questions is yes or if your volunteers have something similar up and running, we're looking for you. The search is on for nominees for our annual Hospital Awards for Volunteer Excellence (HAVE). A service of the AHA's Association for Healthcare Volunteer Resources Professionals and Committee on Volunteers, the awards honor exceptional volunteer efforts that provide distinguished service to hospitals, patients and communities. The 2015 awards will be presented at the AHA Annual Membership Meeting next May 4 in Washington.

The winners share a key criteria: volunteer programs that, as a result of creativity, innovation and leadership, help improve people's quality of life and bolster the hospital's standing in the community.

Each year, we select HAVE award winners in four categories: community service programs, in-service hospital volunteer programs, fundraising programs and community outreach/collaboration. The awards are our way of saying thanks to the people who give these initiatives their heart and strength.

Through the years, the HAVE awards have created a fund of ideas that hospitals across America can draw on. Dozens of these volunteer efforts have been spotlighted and dozens more have served as role models for successful volunteer programs elsewhere. That is one of the dividends of being part of a national association.

You can nominate your volunteer program or initiative by clicking on: *http://tinyurl.com/o7k76es*.

To qualify, the program needs to demonstrate a significant contribution to the hospital field, accomplished by unpaid volunteers, and be in effect for at least a year. For more information, contact the AHA's Joan Miller at (312) 422-3321; or email *jmiller@aha.org*. The deadline for applying for a 2015 HAVE award is Sept. 26.

Express your appreciation for the men and women who freely give their time to help others. By nominating your volunteers for a HAVE award, you are recognizing the enormous value they bring to your hospital and community, and the pride you have in their efforts.

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Reversing Medicare's downward spiral means reining in the RACs

By Rich Umbdenstock

Hospitals subject to Medicare payment policy know it's a lot like being condemned to an eternity of rolling a boulder uphill. Just when you think you've made some progress, things can start to go downhill. When hospitals became more efficient and adopted proven patient treatment protocols that got patients home sooner, they expected some recognition and reward, at least a pat on the back.

Instead, the Centers for Medicare & Medicaid Services (CMS) instituted duplicative audit programs of short hospital stays in which private contractors are rewarded for second-guessing the medical judgment of hospitals' admitting physicians.

We're all for audits – they are a necessary and important form of oversight. But private contractors – particularly the recovery audit contractors (RAC) – have created a torrent of problems that harm both hospitals and patients.

RACs have no incentive to reward hospital efficiency and every reason to deny it. Why? Because RACs are paid 9 to 12.5% of every dollar they claw back from hospitals. Because short hospital inpatient stays offer the most lucrative target for RACs, that's where they spend most of their energy.

First wave. The first wave in the torrent of RAC denials unearthed a CMS policy that denied hospitals the right to rebill Medicare for care RACs claimed should have been provided in an outpatient setting rather than as an inpatient in the hospital. Since Medicare pays more for hospital inpatient stays, RACs had a considerable financial incentive to second guess the admitting physician. And CMS's non-payment policy left hospitals no choice but to appeal the denial; otherwise they got paid virtually nothing for care they delivered.

As RAC denials mounted, so did the appeals. Even though hospitals won most of their appeals, the RACs were undaunted.

The AHA and four hospitals went to court to challenge the CMS policy. Once the lawsuit hit the courthouse steps, CMS reversed its policy and allowed rebilling. But CMS limited rebilling to care provided in the prior 12 months. They also made it prospective – claims that predated the policy reversal weren't eligible. Both limitations were unfair, particularly the 12-month limitation. RACs can and regularly do review claims that are much older than that. So the AHA updated its lawsuit to force CMS to pay for claims that predated its policy reversal.


Umbdenstock

In a separate lawsuit, we challenged the 12-month limitation. The court has not yet ruled on either matter.

Second wave. The second wave created a problem – growth in observation stays. Predictably, RAC rejection of so many short-stay inpatient claims created confusion for hospitals and physicians that resulted in a disproportionate number of patients being assigned to observation care. Observation care is considered an outpatient service, even though patients may stay as long as several days. It can include short-term treatment and tests to help physicians decide whether the patient should be admitted as an inpatient.

Patients pay a price for being assigned to observation care. Unlike inpatient care, patients have co-payments for physicians' fees and hospital services, and there is no coverage for follow-up care in a skilled nursing facility.

CMS attempted to bring clarity to this confusing situation with its "two-midnight" rule, which took effect in October 2013. The rule requires physicians to certify that a patient's condition is serious enough to warrant at least two overnight stays in order for Medicare to cover the patient's care as an inpatient. Hospitals object to the arbitrary time period and to the crystal ball burden it places on physicians.

Furthermore, under the mistaken assumption that the rule would increase payments to hospital, the agency imposed a 0.2% Medicare payment cut. Fortunately, hospitals got some temporary relief when first CMS and then Congress (at the AHA's behest) agreed to suspend RAC audits through March 31, 2015.

The suspension doesn't upend the rule, so the AHA and several state hospital associations were joined by four hospital systems in a lawsuit challenging the rule and the payment cut. The rule flies in the face of common sense and good medical care and the payment cut is indefensible.

Third wave. Meanwhile, the proliferation of RAC denials created a serious backlog in the appeals system, as hospitals were forced to appeal them over and over again. RACs aren't bound by precedent, so even though denials were overturned on appeal with great regularity, RACs could, and did, deny the very same type of claim again and again.

Predictably, the huge number of inappropriate RAC denials and subsequent appeals created such a massive backlog in cases before administrative law judges (ALJs) that the Department of Health and Human Services (HHS) has imposed a two-year moratorium on assigning new appeals. That meant that hospitals could wait as long as five years to have an appeal decided, delaying billions of dollars in Medicare reimbursements to hospitals, many of which are not in good financial health. Some 800,000 appeals awaited assignment to an ALJ as of July 2014.

In May 2014, the AHA and three hospitals filed a lawsuit in response to the two-year moratorium on assigning new appeals. This suit would compel HHS to meet the statutory deadline of 90 days for timely review of Medicare claims denials.

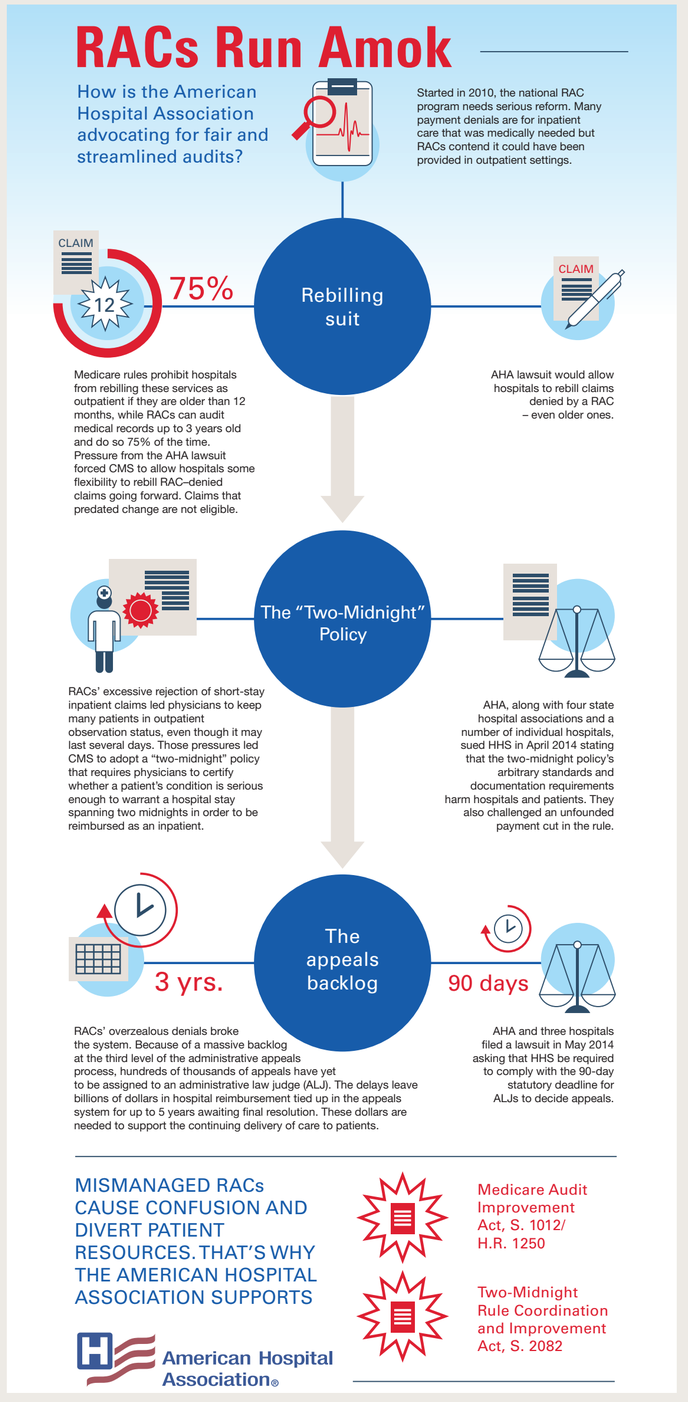
Legislative remedies. We're rolling the boulder uphill again by pressing for changes not just before the courts, but also with HHS and Congress, where we support legislation to address this untenable situation.

The Two-Midnight Rule Coordination and Improvement Act (S. 2082) would require HHS to develop "appropriate criteria" for payment of short inpatient stays – those expected to last less than two midnights – in consultation with hospitals and other stakeholders. Using the criteria that emerge from this consultation, HHS would develop a payment methodology for short inpatient stays.

The Medicare Audit Improvement Act (S. 1012/H.R. 1250) would improve auditor performance, penalize RACs that fail to comply with the program, make performance evaluations of auditors public, and permit hospitals to rebill denied claims without unreasonable restrictions.

Our legal, regulatory and legislative advocacy is focused on making certain that RACs and other Medicare auditing programs are fair and rational and respect the realities hospitals face every day. Let's work together to get CMS to reward efficient high-quality medical care and roll the boulder to the top of the hill and keep it there.

Umbdenstock is the AHA's president and CEO.



Telling the hospital story

RAC*Trac* survey helps tell the hospital story

The AHA's free web-based quarterly RAC*Trac* survey helps the association and hospitals monitor the impact of Medicare Recovery Audit Contractors, or RACs, on the field, provide up-to-date information on the status of hospital appeals both nationally and for specific regions of the country, and help advocate for needed changes to the program.

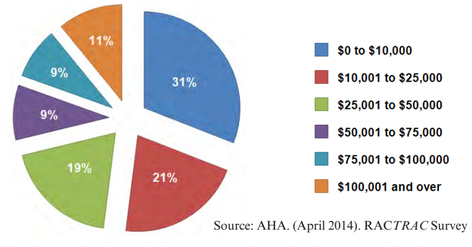
RAC auditing activities are divided among four regions – Region A (Northeast), Region B (Midwest), Region C (South) and Region D (the Plains and West).

The Centers for Medicare & Medicaid Services (CMS) had announced a "pause" in RAC audits in the spring of this year, in preparation for the procurement of the next round of RAC contracts. The agency recently decided to resume limited audits due to delays in the RAC contracting process. CMS says it hopes the new RAC contracts will be in place by the end of the year.

The tables on this page are from the latest RAC*Trac* survey, which tracked audits conducted during the first quarter of this year. For more on the survey, click on: *http://tinyurl.com/p58suzx*.

Percent of Participating Hospitals Reporting Average Cost Dealing with the RAC Program, 1st Quarter 2014

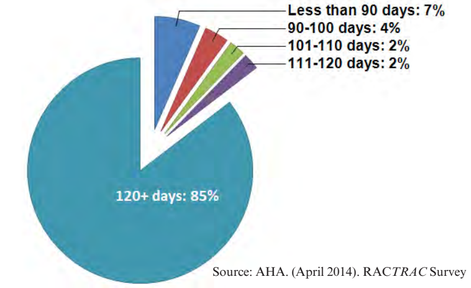
** Includes participating hospitals with and without RAC activity*



Source: AHA. (April 2014). RAC*TRAC* Survey

93% of reporting hospitals have experienced at least one delay longer than the statutory limit of 90 days for an administrative law judge (ALJ) to decide the case.

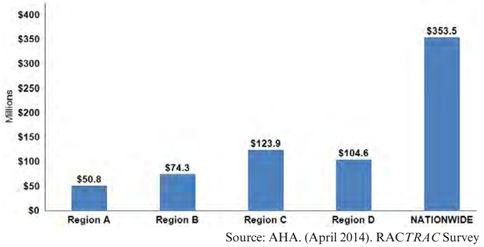
Percentage of Reporting Hospitals by Longest Delay Experienced for ALJ to Issue a Decision on an Appeal, for Participating Hospitals, 1st Quarter 2014



Source: AHA. (April 2014). RAC*TRAC* Survey

Hospitals reported a total of $353 million in overturned denials, with $123.9 million in Region C alone.

Value of Denials Overturned in the Appeals Process, by Region, through 1st Quarter 2014, in Millions



Source: AHA. (April 2014). RAC*TRAC* Survey