



American Hospital
Association®

RAC Auditing Reform is Essential to Fix Urgent, Critical Problems

Recovery Audit Contractors (RACs) audit Medicare claims submitted by hospitals and other health care providers. They are one of many different contractors tasked by the Centers for Medicare & Medicaid Services (CMS) to evaluate payment accuracy. However, RACs differ from other types of audit contractors in that they are paid a commission on each claim that they deny.

This financial structure has created incentives resulting in troubling RAC behavior. For example, RACs largely concentrate their auditing on hospital claims for short inpatient stays, because denying payment for an entire inpatient stay is far more lucrative for the contractors than identifying an incorrect payment amount. This has led CMS to release regulations that establish arbitrary time thresholds for hospitals to admit short-stay patients, without any articulated clinical benefit to Medicare beneficiaries.

The RAC commission structure also incentivizes contractors to deny as many

claims as possible with little regard for the accuracy of their denials. In fact, the volume of inappropriate RAC denials has grown to such a level that the Medicare appeals system is overloaded, causing at least a two-year delay for appeals to be heard at the Administrative Law Judge (ALJ) level.

Without action by Congress and/or CMS to reform RACs and relieve the burden on hospitals, RACs will continue to operate under their current financial incentives and resist changes that would improve the program through enhanced audit accuracy and reduced burden on our communities' hospitals.

Payment incentives cause RACs to focus audits on high-dollar inpatient claims

The law creating the Medicare RAC program specified that RACs must be paid on a "contingency fee" basis. This means that the contractors receive a portion of the funds they recoup by denying claims from Medicare providers. Indeed, RACs are paid a sizeable commission by Medicare – 9.0-12.5 percent of each dollar taken back from providers, depending on the RAC's contract. RACs are the only Medicare contractors that are paid on a contingency fee basis.

If a claim is later overturned on appeal, the RAC must pay back the

contingency fee but does not otherwise face financial penalties for incorrectly denying the claim and imposing unnecessary and preventable burden on hospitals and the Medicare appeals process. Due to the contingency fee structure and the lack of financial repercussions for poor auditing performance, RACs have a financial

RACs receive commissions from Medicare of 9.0-12.5% on each claim they deny.

incentive to deny claims with impunity rather than conduct impartial audits.

Likely driven by these financial incentives, RACs largely have focused on claims for short inpatient hospital stays. RACs review these claims and routinely deny the entire inpatient payment because the auditor claims the care provided – although medically necessary – should instead have been provided in the outpatient setting. RACs historically have been able to deny large numbers of short-stay inpatient claims for this reason due to a lack of clear admissions criteria from CMS.

Data from the most recent AHA RACTrac survey show two-thirds of short-stay medical necessity denials were because the RAC ruled the care should have been provided in a lower-acuity setting, though the RAC agreed the care was medically warranted (AHA RACTrac Q1 2014).

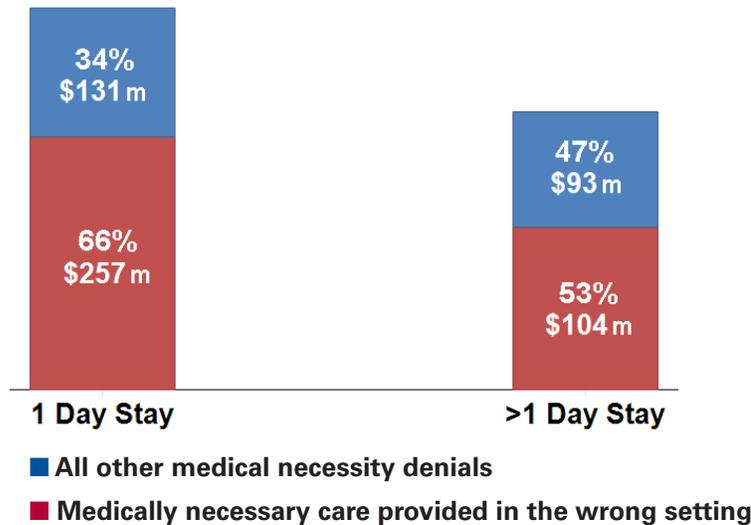
These denials second-guess the

medical judgment of trained physicians who cared for Medicare beneficiaries and made the admission decision based on the conditions the patient presented at the hospital. Many hospitals also invest in external secondary review of Medicare claims to ensure correct billing. In contrast, RACs hire non-physician auditors

– typically nurses and therapists – to subjectively evaluate paper charts up to three years after the patient was treated. These auditors evaluate information in hindsight and have access to data that were unavailable to the physician at the time of admission, such as the patient’s outcome once they have received care.

Sixty-six percent of short-stay denials for medical necessity were because the care was provided in the inpatient setting, not because the care was medically unnecessary.

Reason for Medical Necessity Denials by Length of Stay Among Hospitals Reporting Medical Necessity Denials, through 1st Quarter 2014



Source: AHA RACTrac (April 2014). 1,165 participating hospitals.

Controversial “two-midnight” hospital admission policy created to address ambiguous inpatient admission criteria

CMS implemented a new guideline for inpatient admissions – the two-midnight policy – starting in fiscal year (FY) 2014. The policy states that inpatient admission and payment is generally appropriate if the treating physician reasonably expects that the patient requires care that will span at least two midnights in the hospital. Inpatient stays of less than two midnights

are treated as outpatient for purposes of payment, in most cases, regardless of clinical severity.

The two-midnight timeframe is arbitrary and fails to provide adequate reimbursement for beneficiaries who require an inpatient level of care but who do not meet the two-midnight benchmark for admission. Specifically,

CMS reimburses for this care under the outpatient prospective payment system (PPS), which does not cover the cost of the inpatient level of care that is provided, and it typically results in a higher cost-sharing burden for the beneficiary. As such, the two-midnight policy is an imprecise policy for payment.

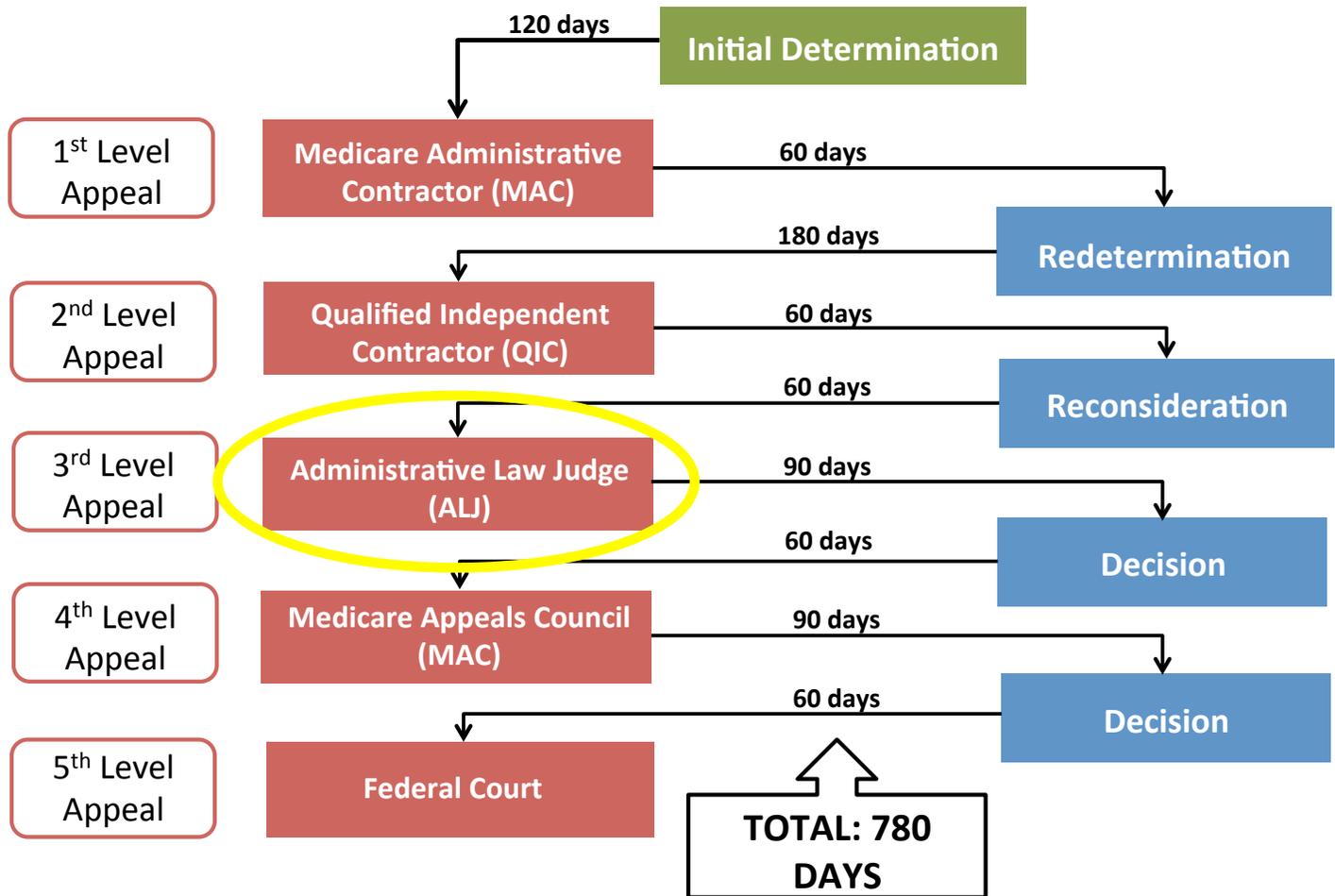
Widespread delays in the Medicare appeals process attributable to RACs

Hospitals may appeal inappropriate RAC denials through the Medicare appeals process. However, the process is extremely burdensome: an appeal

for a single claim often takes more than two years to resolve and requires a significant investment of resources in the form of hospital staffing –

including additional billing, legal and administrative support – and interrupted cash flow for recouped funds.

Medicare Appeals Process Timeline



Excessive inappropriate RAC denials have forced hospitals to navigate the burdensome appeals process, though hospitals have been very successful in overturning RAC denials. The Department of Health and Human Services Office of the Inspector General (OIG) reports that 72 percent of RAC-denied hospital inpatient claims that are appealed are overturned in favor of the hospital by an ALJ, who presides over the third level of the appeals process (OIG Nov. 2012). Yet inappropriate RAC denials persist despite this high overturn rate, causing hospitals to appeal half of all RAC denials (AHA RACTrac Q1 2014). This inaccuracy is perhaps unsurprising given that, as mentioned above, if a claim is later overturned on appeal, the RAC does not face financial penalties.

The influx of appeals of RAC denials has broken the Medicare appeals process.

72% of appealed hospital inpatient claims denied by a RAC are overturned on appeal by an ALJ.

(OIG November 2012)

Hospitals appeal 50% of all RAC denials.

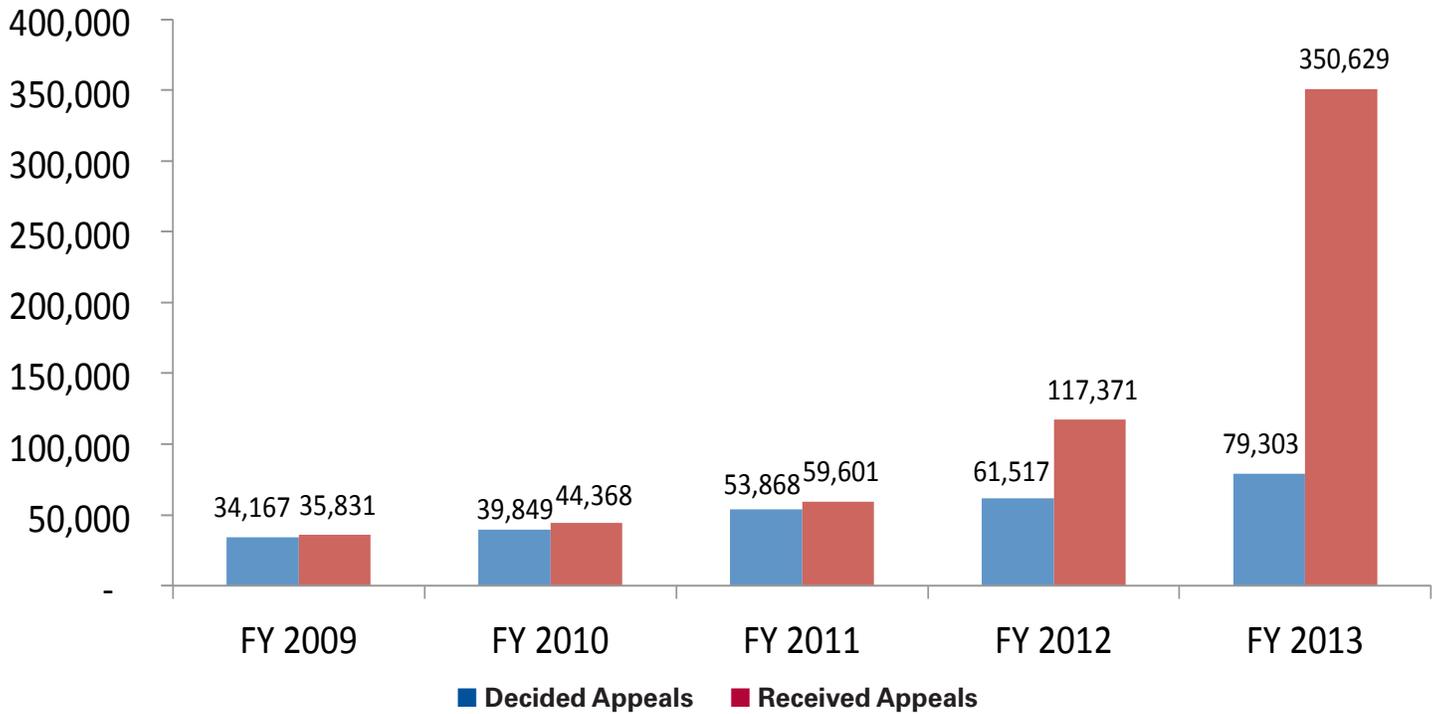
(AHA RACTrac Q1 2014)

Specifically, currently delays exceed statutory deadlines at each level of an already-long appeals process. In fact, 62 percent of all hospital Medicare Part A appeals filed since the start of the national program in 2010 still await a determination (AHA RACTrac Q1 2014).

While all levels of the appeals system are experiencing delays, the ALJ level has experienced the largest impact due to appeal of inappropriate denials. By law, ALJs must issue a decision within 90 days of receipt of the appeal. However, the number of claims appealed to an ALJ has increased exponentially since the launch of the national RAC program in 2010 – there were 10 times more appeals submitted to an ALJ in 2013 (350,629) than there were in 2009 (35,831) (Office of Medicare Hearings and Appeals (OMHA) Forum Feb. 2014). Because of this dramatic increase in volume, claims appealed to an ALJ have waits of up to 28 months just to be placed on a judge’s docket (OMHA Forum Feb. 2014). Claims typically then take at least an additional six months to be heard by an ALJ (OMHA letter, December 2013).

The number of appeals filed annually to an ALJ have increased exponentially since the start of the RAC program in 2010.

Appeals Received and Decided by Fiscal Year, FY 2009-2013



Source: Office of Medicare Hearings and Appeals (OMHA). OMHA Medicare Appellant Forum. February 2014.

In addition, hospitals report other delays in the appeals system. For example, the Qualified Independent Contractor (QIC), which hears the second level of appeal, fails to meet its statutory 60-day time limit for review more than 63 percent of the time. (OMHA Forum, Feb. 2014). Rather, it takes the QIC an average of 98 days to review a Part A claim (OMHA Forum, Feb. 2014).

The backlog of appeals and the excessive burden this has caused is due to the inaccuracy of RAC determinations. However, additional funding and staffing for ALJs are not readily available and must be approved by Congress. Hospitals are harmed by the extensive delays in due process and the adjudication of appeals while substantial sums of money for care already provided to Medicare beneficiaries is withheld. However, due to

their commission-based reimbursement and the lack of penalties for contractors for excessive errors, RACs have little incentive to change their behavior and correctly audit claims.

RACs fail to meet basic operational standards on an ongoing basis, further increasing hospital burden.

Hospitals also face additional burden due to ongoing operational challenges from the RAC audit process:

- More than half of all hospitals have waited for a “demand letter,” which includes repayment instructions and appeals rights, from their Medicare Administrative Contractor (MAC)

for more than 30 days after the RAC notifies the hospital of a RAC denial (AHA RACTrac Q1 2013). The demand letter from the MAC is required in order to begin the appeals process.

- Hospitals are spending large amounts of money on an annual basis to manage the RAC process:
 - 69 percent of hospitals reporting to RACTrac spent more than \$40,000
 - 48 percent spent more than \$100,000
 - 29 percent spent more than \$200,000
 - 11 percent spent more than \$400,000 (AHA RACTrac Q1 2014)
- CMS has not focused on provider education to avoid potential billing errors. However, CMS should prioritize investing in provider education, as proactive instruction can prevent potential payment errors before they occur.

Recommended Reforms

Inappropriate RAC denials are a key problem facing the Medicare program. The contingency fee structure is the biggest driver of RACs' harmful behavior because it incentivizes them to issue inappropriate denials with impunity. If CMS assessed RACs a financial penalty for making inappropriate denials, it would lessen these strong financial incentives and promote more appropriate and accurate behavior by the RACs. The AHA supports the Medicare Audit Improvement Act (H.R. 1250/S. 1012), a bipartisan, bicameral bill that would create a financial penalty for inappropriate RAC denials and make additional, critical reforms to the RAC program.

In addition to the statutory changes proposed in this legislation, the AHA has pressed CMS to make administrative changes that would lessen the burden hospitals bear as a result of the RAC program. Those changes include lowering the number of claims RACs may audit; codifying regulatory language

that would limit RAC review to those factors that were known to the physician at the time of treatment; postponing recoupment of denied hospital payments until the hospital has had the chance to appeal to an ALJ; and increasing CMS oversight of RACs' application of Medicare policy.

**More information on
RACs can be found at:
www.aha.org/RAC.**