

Recovery Audit Contractors

THE ISSUE

Medicare Recovery Audit Contractors (RACs) are tasked with auditing Medicare claims for payment accuracy. However, RACs are not impartial auditors – instead they act like bounty hunters, because they receive a 9-12.5 percent commission on every claim they deny.

The program's misaligned financial incentives incentivize RACs to inappropriately deny claims and force hospitals to pursue a lengthy and costly appeals process in order to receive payment for medically necessary services provided to Medicare beneficiaries.

AHA POSITION

The Medicare Audit Improvement Act of 2015, H.R. 2156, would reform the RAC program by realigning the financial incentives that drive RACs to inappropriately deny claims. We support the bill, which would change the RACs' current payment structure from a 9-12.5 percent commission payment on every denied claim to a flat fee that does not incentivize them to deny claims. To ensure auditing accuracy, RACs should be assessed financial penalties for poor performance. In addition, the bill would level the playing field by eliminating the Centers for Medicare & Medicaid Services' (CMS) one-year timely filing limit to rebill outpatient (Part B) claims, which would allow hospitals to request outpatient payment for certain denied inpatient claims, no matter when the denial is made. The bill also would limit RACs to consider only the medical information available when a patient was seen by his or her physician when determining whether an inpatient stay was necessary, or whether the care should have been provided in an outpatient setting.

WHY?

- **Hospitals take seriously their obligation to properly bill for the services they provide to Medicare beneficiaries.** Hospitals are engaged in a number of efforts to ensure accurate coding and billing, making large investments in personnel, software and compliance programs. They are eager to work with CMS to ensure hospital payments are accurate each and every time.
- **Fixing the RAC program does not reduce fraud-fighting efforts.** RACs assess the accuracy of Medicare payments. If a RAC identifies potential 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 purported expertise in identifying inaccuracies, RACs have a hard time finding legitimate errors in hospital claims. Although they are supposed to target audits to those claims most likely to contain errors, only two-fifths of the hospital charts audited by RACs are found to contain a payment error. The accuracy of RAC findings also is called into question by their high overturn rate: 72 percent of hospital inpatient denials that are appealed to an Administrative Law Judge (ALJ) are overturned in favor of the hospital, according to the Department of Health and Human Services' Office of Inspector General.

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■ **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. However, this is not typically the case – many inpatient claims denied by RACs are disqualified from full outpatient payment through the rebilling process because of CMS’s one-year rebilling filing deadline.

Specifically, 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. 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 may 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 medically necessary care, hospitals must separately appeal each RAC denial through a costly, multi-year appeals process. Nationwide, hospitals report appealing almost half of all RAC denials. Some hospitals are unable to appeal every erroneous RAC denial due to the high costs of an appeal.

Inappropriate RAC denials have contributed significantly to a backlog of appeals at the third level of appeal – the ALJ level. Currently, hospitals must wait at least two years before their appeals are assigned to an ALJ for hearing. Since CMS takes back payment for claims denied by a RAC before the ALJ level of appeal, hospital funds are held captive for years while the hospital waits for an appeals hearing.