

The Real Cost of the Inefficient Medicare RAC Program

The Recovery Audit Contractor (RAC) program was created by Congress to audit providers' Medicare claims to identify overpayments and underpayments. However, the current structure of the RAC program has led to an overwhelming number of inappropriate denials, with contractors often denying claims for necessary medical care. As a result, the implementation of the RAC program has imposed a significant administrative and financial burden on hospitals.

Overzealous denials can be largely attributed to the RACs' contingency-based fee structure. Contractors receive commissions on each Medicare payment they deny. As a result, RACs have focused the majority of their audits on inpatient hospital claims – which typically have the highest associated reimbursement – rather than proportionately across all settings of care. This incentive has led to a large volume of denied claims and associated reimbursement recoupment from hospitals for claims that should not have been denied in the first place. Additionally, RACs are not financially penalized for inappropriate denials that are later overturned in the Medicare appeals system.

The payments taken back from hospitals are only part of the expense that is incurred as a result of RAC audits. Hospitals also incur ongoing administrative and personnel

expenses to manage and respond to RAC audits. This cost is often significant.

Hospitals report spending hundreds of thousands – or even millions – of dollars each year to manage RAC audits, denials and appeals; money that could otherwise be spent on improving patient care. Inefficient – and often incorrect – RAC audit processes and determinations lead to increased costs. Hospitals report that these expenses have negative implications for their finances and ability to reinvest in patient services and infrastructure. In September 2014, the American Hospital Association (AHA) surveyed hospitals nationwide to gain insight into the efforts that hospitals undertake to manage audits.¹ Additional data insights in this paper have been drawn from the AHA's quarterly RACTrac survey² of hospital RAC activity, where noted.

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¹The September 2014 RAC Administrative Burden survey was answered by 402 hospitals. 311 hospitals completed all questions in the survey.

²RACTrac data in this report represents 547 hospitals that submitted data for all four quarters of FY 2013.

A Wide Range of Staff are Involved in RAC Audits and Appeals

The process for responding to a RAC audit is complicated and a wide range of personnel may be involved. Staff involved in responding to the audit range from compliance staff to health information management personnel to physicians. Those staff, as well as hospital executives and legal staff, are often consulted when a RAC denial merits an appeal.

When a RAC requests records for an audit, a hospital must access the records, replicate them, and ensure all relevant documentation is included with the medical record before sending the claim to the contractor. While the size of each patient's record may vary, responding hospitals report that the average size of a record audited by a RAC is 230 pages. Some hospitals copy the medical record and mail the record to the RAC, while other hospitals place the record on digital media to send to the contractor. In addition to mailing the file, compliance staff enter the claim into a tracking system to monitor claims that are being audited.

230 pages
the average size of a
medical record audited
by a RAC

Once the hospital receives a claim denial, compliance and clinical staff first review the denial to determine if the denial was warranted. In the case of an incorrect denial, staff then assess whether the claim warrants

the investment of resources necessary to appeal the RAC's determination. When hospitals accept denials, financial services staff assess the related payment information to determine if there are any changes to the beneficiaries' level of liability.

When hospitals contest denials, staff must replicate and resubmit all documentation as part of their request for an appeal. They also must write an appeal letter to explain the rationale for why the RAC should not have denied the claim. Often, this letter is written by a clinician, or in the case of a denial based on insufficient supporting documentation, by a member of the compliance or health information management (HIM) staff. If a claim reaches the third level of the appeals system – an Administrative Law Judge (ALJ) appeal – clinicians, HIM and/or compliance staff may participate in the appeals hearing.

Background on RACs

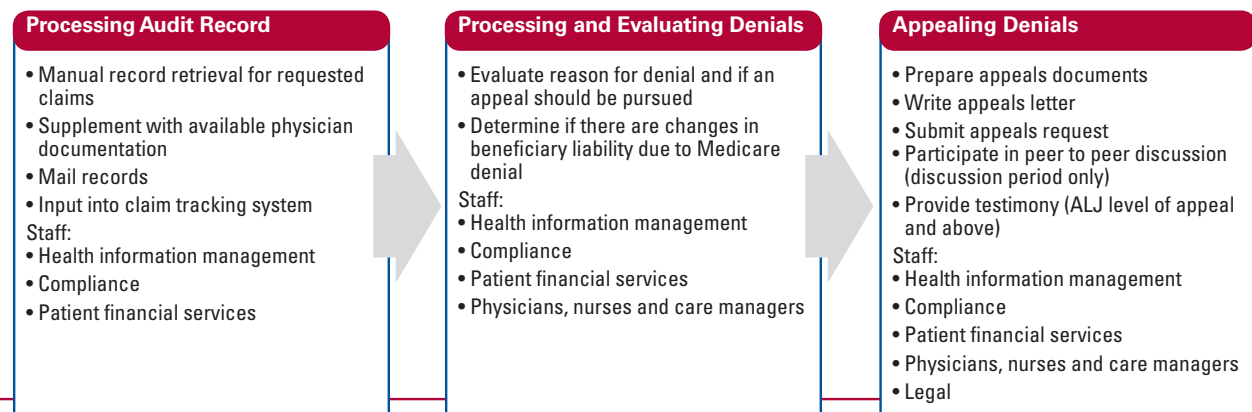
The RAC program was launched nationally in 2010, following a Centers for Medicare & Medicaid Services (CMS) demonstration program from 2006-2008. RACs are able to review claims from a wide range of Medicare-participating providers and can review claims that are up to three years old. RACs are paid by CMS on a "contingency fee" basis, which means they are paid a commission on each claim that they deny. RACs are currently reimbursed 9-12.5 percent of the Medicare payments they deny.

Providers are able to contest claim denials through the Medicare appeals system. The appeals system consists of five sequential levels of appeal. If a provider disagrees with the decision it receives at one level, it may appeal the decision to the next level. Appeals at the first two levels are reviewed by CMS contractors. Third- and fourth-level appeals are reviewed by entities independent of CMS and are considered to be more objective reviews; in particular, hospitals have generally received favorable decisions by ALJs at the third level of appeal. The fifth level of appeal is federal court.

9.2-12.5 percent
commission received for
each RAC denial

The RAC audit and subsequent appeals process is complex and requires input from a wide range of hospital staff.

Chart 1: Simplified Audit Flow Process



While many denials are eventually overturned in the Medicare appeals system, RAC audit requests involve substantial work for a hospital

550 pages

average length of a medical record requested at JCMH

Jackson County Memorial Hospital (JCMH) is a 69-bed inpatient hospital that serves southwestern Oklahoma. JCMH has experienced a large number of audits from its RAC. For the initial audit request, the RAC coordinator has to manually retrieve each record requested to determine who coded the claim, the relevant Medicare severity-diagnosis related group (MS-DRG), and the amount that Medicare reimbursed for the claim.

The medical record is then replicated and assembled by HIM staff. The records that are requested by a RAC are physically large – the average length of a medical record requested at the hospital is 550 pages. The printed record is then mailed to the RAC; however, with an average of 30 to 40 records in each request, it often takes 7-10 days to fulfill a single RAC audit request.

JCMH also reports that it appeals the majority of RAC denials it receives. The hospital has experienced significant success, including an 86 percent overturn rate at the ALJ level of appeal.

The hospital compliance staff noted the impact that the RAC program has had on the hospital's clinicians. Physicians have grown increasingly frustrated with RAC denials because "doctors want patients to get the care they need," and now often are concerned that a RAC will retroactively deny payment for the hospital stay months or years after the patient was treated.

In addition, hospital staff cited lack of timely due process as a major concern due to the five-plus year timeframe it takes for an appeal to complete the process. Even once an appeal is overturned, there are often delays before the hospital is repaid – the final reconciliation of an account may not occur until a year after an appeal is completed. These delays can be detrimental, as some hospitals may have limited access to capital resources to offset the money tied up in the appeals and audit process.



7-10 days

time it takes for a hospital to respond to a single RAC audit request

Inconsistent RAC audit practices create distractions for care coordination efforts

Cedars-Sinai Medical Center (CSMC), a non-profit academic medical center with 865 hospital beds in Los Angeles, receives hundreds of medical record requests every 45 days. Because CSMC internally audits 100 percent of its claims before it submits the claims to CMS, the hospital's experience with the RAC program largely has highlighted inconsistencies in auditor determinations.

Unpredictable determinations by the RAC have created uncertainty for physicians, coders and compliance staff. For example, one patient underwent treatment for cancer and received eight cycles of chemotherapy. All chemotherapy treatments were performed in the inpatient setting, as the patient required additional hydration due to reduced kidney function and the patient's medication regimen. The hospital's RAC audited each of the eight claims for the patient, approving four claims and denying four claims, all for the same service and patient. So far, CSMC has spent more than \$3,000 to defend the four denials; the cases are still in the appeals process.

In addition, CSMC's RAC has disproportionately focused on claims for particular types of services and settings, even though medical record request limits are established on the basis of a hospital's number of claims across all settings. RACs are able to request claims that are within three years from the date of service toward the request limit. Early in 2014, CSMC received a medical record request for 600 claims, 150 for inpatient psychiatric stays and 450 claims for inpatient rehabilitation. The volume of inpatient rehabilitation claims is notable, given that CSMC only has an estimated 400 Medicare inpatient rehabilitation discharges in a single year.

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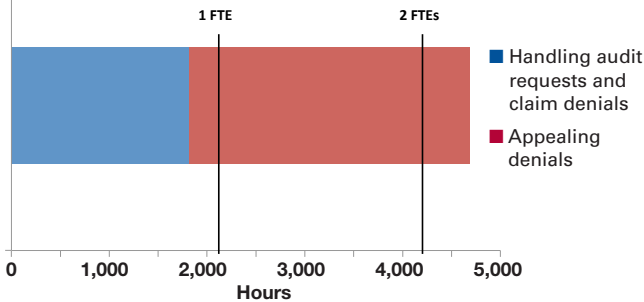
CSMC also noted that the hospital's RAC has denied claims on grounds that they are not eligible for auditing, including claims for "inpatient only" procedures. These are procedures that CMS has determined it will pay for only when provided in an inpatient setting. However, the RAC has denied these services, claiming they should have been provided in an outpatient setting. Even though these denials should never have occurred under Medicare payment

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The time spent on RACs has diverted leadership attention from key priorities. Hospital staff assert that if the RAC process were more efficient and accurate, more leadership time could be devoted to developing care models that offer the opportunity to gain ongoing efficiencies and improvements in patient care.

Hospital staff spend more time appealing RAC denials than they do processing audit requests and denials.

Chart 2: Hospital FTEs spent on RAC audits and denials; appealing RAC denials in CY 2013



Source: AHA RAC Administrative Burden Survey, September 2014.

Impact of RAC Audits on Staffing

Hospitals often need to hire new staff or reassign current staff to handle the ongoing operational aspects of RAC audit requests and the appeals process. On average, hospitals hire or reassign 2.2 full-time equivalents (FTEs) to manage the RAC process; 73 percent of hospitals have reassigned staff to fulfill RAC-related duties.

While responding to audit requests and denials requires a significant amount of time – an average of 1,821 hours annually – the appeals process often involves even greater levels of staff effort. Hospitals report spending an average of 2,868 combined hours per year on the discussion period (a pre-appeal opportunity to discuss a denial with the RAC) and the first three levels of the appeals system.

External Resources also Contribute to the Ongoing Expense of Audit Program Administration

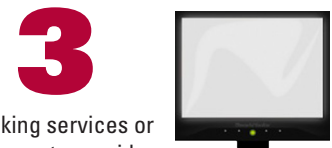
In addition to in-house staff, hospitals often utilize external resources to assist in RAC audit management. These services serve a number of purposes, including:



Secondary medical record and utilization management review, where an external physician reviews a medical record before the related claim is submitted to Medicare in order to proactively ensure correct coding and accuracy. Hospitals spend an average of \$117,000 on these types of services, but some large hospitals reported spending more than \$2 million in CY 2013 for secondary medical review and utilization management.



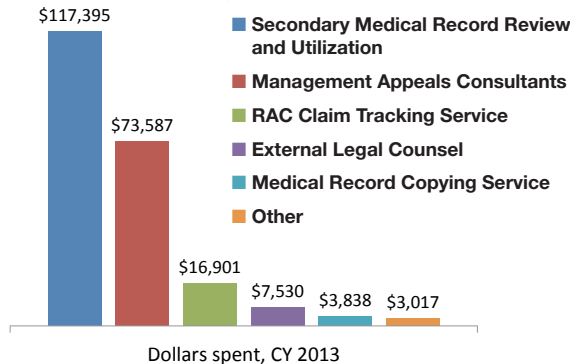
Appeals consultants to assist hospitals with the Medicare appeals process. Hospitals spent an average of \$74,000 on appeals consultants in 2013, while some hospitals spent more than \$1 million on appeals assistance.



Tracking services or software to provide ongoing tracking of the status of RAC reviews, denials and appeals. These services and/or software represented an average expenditure of \$17,000 per hospital in CY 2013, up to a maximum of \$300,000 for one participating hospital.

Hospitals often have to spend significant sums of money on external support to supplement their internal staff management of the RAC program.

Chart 3: Average Spending on External Resources to Manage RAC Audits and Denials, CY 2013



Reimbursement for Audits Does Not Fully Cover Costs

Medicare provides a nominal reimbursement to providers for copying inpatient records. This payment is currently 12 cents per page, plus first class postage. However, the payment is capped at \$25 per medical record, which often means that hospitals are not fully reimbursed for the cost of copying and mailing records, given the large size of medical records and cost of materials. In fact, three out of four hospitals note that the Medicare reimbursement fails to cover the cost of materials for responding to RAC audits. Hospitals are never reimbursed for costs associated with staff time spent fulfilling an audit request.

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Significant Dollars are Tied up in the RAC Appeals Process

Hospitals often report that RACs inappropriately deny payment in cases where patient care was medically necessary or for technical errors in coding for payment. Many times, hospitals choose to contest RAC denials through the Medicare appeals system. However, the process of appealing a RAC denial is a long process. It often requires years to overturn a RAC determination, as the volume of appealed denials due to inappropriate RAC denials has overloaded the system. For example, in January 2014, hospitals faced waits of more than two

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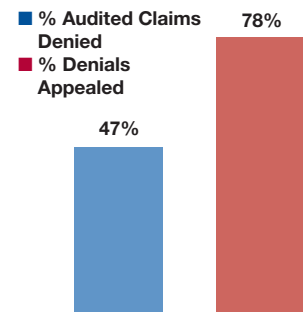
years for a case to be assigned to an ALJ, and another six months or more before a judge hears the appeal.³ These delays have important financial implications for hospitals, as dollars associated with appeals are often withheld from hospitals while appeals are in process. Hospitals report an average of \$1.4 million in claims under appeal, while some larger hospitals report that \$20 million in claims are tied up in the appeals process.⁴

Hospitals are appealing 78 percent of denied RAC determinations according to the September 2014 AHA survey, while data from the Department of Health and Human Services Office of Inspector General (OIG) show that 72 percent of hospital appeals that go to the third level of the Medicare appeals system are overturned in favor of the hospital.⁵ The high percentage of claims that are appealed by hospitals and

later overturned in the appeals process indicates that RACs often deny claims for medical care that is needed and appropriate.

RACs deny nearly half of the claims they audit, while hospitals appeal over three-fourths of the claims that are denied.

Chart 4: Percent of Hospital Claims Audited that are Denied by a RAC and Percent of Claims Denied by a RAC that are Appealed



Cost of RAC Denials and Program Administration Delays Important Investments

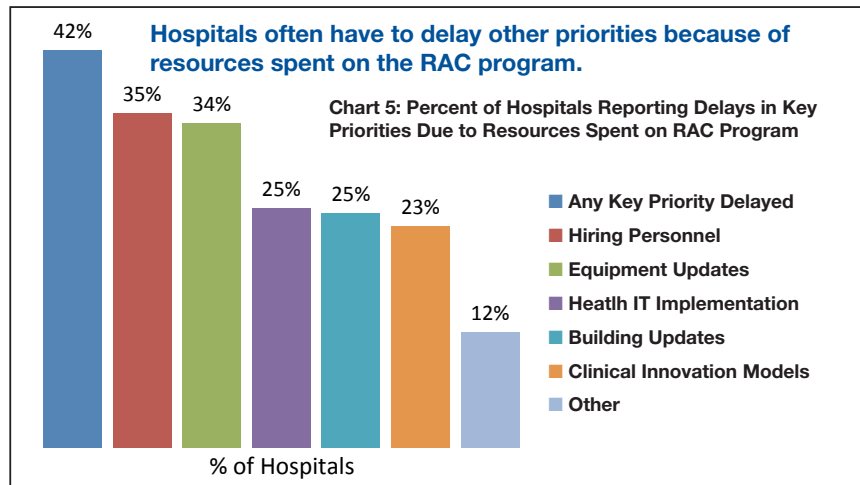
Hospitals, regardless of size and location, often spend a significant amount of time and money on RAC audits; however, the downstream effects of overzealous RAC audits and a bogged-down appeals system have a negative impact on many hospitals' ability to pursue other key priorities, such as patient care transformation efforts and infrastructure improvements.

More than half (55 percent) of hospitals participating in the September 2014 AHA survey report that RAC audits and delays in the Medicare appeals process have created "significant" issues with availability of capital resources. Forty-two percent of hospitals state that RAC-related expenses have delayed

other key priorities for their hospital, including hiring personnel for other hospital activities (35 percent), equipment

updates (34 percent), building updates (25 percent) and investment in clinical or payment innovation models (23 percent).

Hospitals often have to delay other priorities because of resources spent on the RAC program.

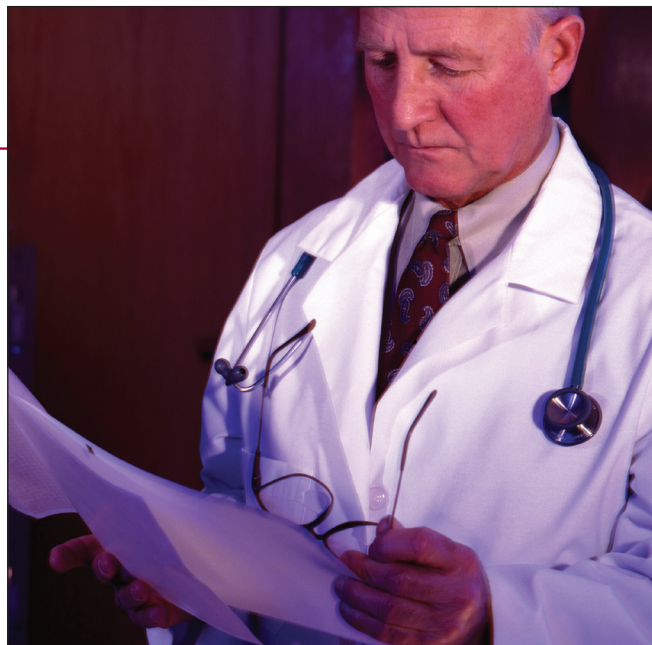


³Office of Medicare Hearings and Appeals. Memorandum to OMHA Appeal Applicants. December 31, 2013.

⁴On Aug. 29, 2014, CMS offered acute inpatient and critical access hospitals the opportunity to settle pending Medicare appeals of inpatient status denials for 68 percent of the Medicare payable amount. The deadline for hospitals to inform CMS that they intended to pursue the settlement was Oct. 31, 2014. Data on the impact of the settlement on hospitals' pending Medicare claims are not yet available.

⁵HHS Office of the Inspector General. Improvements are Needed at the Administrative Law Judge Level of Medicare Appeals. November 2012. <http://oig.hhs.gov/oei/reports/oei-02-10-00340.pdf>

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Financial uncertainty due to RAC audits delays other key priorities

Illinois Valley Community Hospital (IVCH) is a 56-bed hospital located in Peru, Ill. While RAC audits impact day-to-day workflow, hospital leaders also are concerned that strategic initiatives are being delayed due to funds and staff time diverted to managing the audits. The financial impact of audits on the hospital equates to a 1-2 percentage point reduction in the hospital’s margin. This decline in financial performance limits IVCH’s ability to invest in several key areas, such as clinical documentation improvement and voice recognition systems to allow easier data input into electronic health record (EHR) systems. In addition, the staff time spent on RAC audits has interfered with the hospital’s ability to devote sufficient personnel to meet federal meaningful use implementation deadlines.

The hospital’s CEO, Tommy Hobbs, noted that while the rural hospital has only \$62,000 in appeals that are awaiting a determination, it is important to remember the real-world impact of those funds. “It is someone’s potential salary, and it is being held by Medicare for multiple years,” said Hobbs. In addition, the hospital has budgeted \$500,000 per year for Medicare RAC audits. Ultimately, RAC audits can result in lower operating reserves, which can have an adverse impact on debt covenants and can limit the hospital’s ability to access additional capital. These financial pressures were exacerbated in late 2013 and early 2014, when Illinois’ disbursement of Medicaid payments often lagged six to eight months after the care was provided.

IVCH noted a core concern with the RAC program – the lack of clarity and transparency around auditing standards. RACs are not required to share their interpretations of the Medicare payment standards on which they are auditing hospitals, which results in inconsistent determinations and uncertainty for physicians. Hobbs stated, “How can we be accountable to a standard, if we don’t know what criteria the auditors are using?” The lack of information shared by its RAC limits the hospital’s opportunities for educational programs and to proactively avoid errors that may result in a claim denial.

Conclusions and Policy Considerations

The cost of RAC audits, denials, and appeals presents a major operational challenge to hospitals. Hospitals are committed to accurate billing for every patient, every time, and widely support CMS’s right to ensure compliance with payment regulations. Many hospitals spend significant funds on secondary review of claims to ensure accuracy; despite these efforts, RACs continue to deny a large number of claims, many of which are appealed and eventually overturned in favor of the hospital.

The problems in the RAC system should be addressed in order to improve the program and alleviate excessive administrative burden that diverts attention and resources from key mission-related initiatives. The AHA supports the following reforms to improve and strengthen the Medicare RAC audit system:

1

Reform the RAC payment structure by eliminating the contingency fee structure; instead, pay RACs on a retainer-type basis similar to that used for other Medicare contractors in order to reduce the incentive for overzealous auditing practices that lead to additional hospital burden.

2

Reduce the incentive for inappropriate denials by imposing payment penalties for denied claims that are overturned on appeal.

3

Eliminate application of the one-year timely filing limit to the Medicare Part B rebilling policy that allows hospitals to rebill denied inpatient claims as outpatient claims in certain cases. This would allow hospitals to pursue fully their Part A appeals rights before rebilling under Part B, which often results in lower payment for the services delivered. In addition, this would eliminate the inequity whereby hospitals are allowed to rebill claims only within one year of the date of service, while RACs are able to review and deny claims that are up to three years old.

4

Codify in regulation CMS's assertion⁶ that RACs are limited to determining whether an inpatient stay is medically necessary based only on the medical documentation available at the time the physician's admission decision was made.

5

Limit RAC approved auditing issues – such as inpatient short stays for medical necessity – to a defined time period, and designate a senior CMS official accountable for approval of audit issues. Currently, issues can be audited by a RAC for an indefinite period of time, even if a provider illustrates they are correctly billing through record reviews and success in the appeals process.

⁶From the preamble to the FY 2014 Inpatient Prospective Payment System (IPPS) final rule.