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September 2, 2014

The Honorable Kevin Brady
Chairman
U.S. House Committee on Ways and Means, Subcommittee on Health
1135 Longworth House Office Building
Washington, DC 20515

Dear Chairman Brady:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and 43,000 individual members, the American Hospital Association (AHA) is pleased to respond to your request for comments on your discussion draft of "The Protecting the Integrity of Medicare Act" (PIMA), aimed at combating fraud, waste and abuse in the Medicare program. Thank you for seeking our input.

The AHA applauds the work of the Committee to fight fraud, waste and abuse, and your work on this legislation specifically. Hospitals have a strong commitment to billing correctly and appropriately, and dedicate significant resources to their compliance programs and activities. Hospitals are among the most audited and regulated entities in the health care system. While we generally support the efforts of this bill, we appreciate your seeking our input so we can identify some potential unintended consequences or areas where additional reform can be made. Our detailed comments follow.

Section 2 – Prohibition of the inclusion of Social Security account numbers on Medicare cards.

This section authorizes the Department of Health and Human Services (HHS) Secretary to remove $320 million from the Medicare trust funds. Our understanding is that this represents the cost of the administrative change to reissue Medicare cards without Social Security numbers and is not money that will be spent on patient care. This is problematic in the context of the fiscal problems facing Medicare. Removing money from the Hospital Insurance Trust Fund for non-hospital related activities also is concerning. As the Committee is aware from the July 2014 Medicare and Social Security Trustees Report, the Medicare Federal Hospital Insurance Trust Fund will be solvent only through 2030. As you noted upon the report's release, "Given that this year alone Medicare will need a $273 billion transfer from taxpayers to cover its bills, this important program for seniors will simply not survive in the long haul unless Congress acts soon to preserve it."

Section 3 – Preventing wrongful Medicare payments for items and services furnished to incarcerated individuals, unlawfully present individuals and deceased individuals.

The AHA strongly opposes giving Recovery Audit Contractors (RACs) the authority to audit and deny payments for claims based on the eligibility status of a Medicare beneficiary. This would represent a significant expansion of the scope of RAC audits. RACs audit providers – including hospitals – to determine whether they have billed in accordance with Medicare payment rules. RAC audits include issues such as whether a hospital billed the correct diagnosis-related group (DRG) and whether a service was provided in accordance with Medicare rules governing medical necessity. They do not currently audit to determine whether an individual was eligible for the services provided.

We agree with the goal of ensuring that Medicare does not pay for services for individuals who are not entitled to them. However, hospitals rely on information beyond their control – namely, data maintained by the Centers for Medicare & Medicaid Services (CMS) and other federal agencies – to determine whether an individual is, indeed, eligible for Medicare services. We are concerned with the accuracy and reliability of available information to assist hospitals with making that determination. For example, last year CMS took back payments from providers under the premise that the related services were provided to individuals who were incarcerated on the date of service. However, the agency later discovered that there were problems with the Social Security Administration database on which it relied. As a result, many of the payments were taken back in error. Providers were initially forced to appeal the decisions, which required them to track down the beneficiary – often a difficult task, given the transience of those going in and out of the penal system – and obtain documentation that the individual was not, in fact, incarcerated when services were provided. CMS then reversed course and re-reviewed all payment recoveries, and had to put together a process to return correct payments to providers – a process that took several months and tied up significant funds in the meantime. From this experience, it is clear that there are gaps in the eligibility information that CMS maintains and makes available to providers.

Providers that make a good faith effort to determine Medicare eligibility before furnishing services using data provided by CMS should not be penalized later by being exposed to RAC audits of those services. RACs are paid 9-12.5 percent of all Medicare payments they deny. Given their clear financial incentive to deny claims, and their dismal track record in dealing with hospitals, it would be fundamentally unfair to providers to allow them to provide services in reliance on flawed agency data, then set the RACs loose to deny payments on that basis.

Section 6 – Reducing improper Medicare payments.

We appreciate the educational effort contemplated in this section, as the concept of ensuring proper payment for health services on the front end of the process is superior to the burdensome and costly RAC program. We appreciate the recognition by the Committee that the RAC program is in need of reform, and the hearing held earlier this year where members and witnesses discussed the significant problems with the current RAC program and the need for reform.

As you know, in recent years, CMS has drastically increased the number of program integrity auditors that review hospital claims to identify improper payments. These audit contractors include RACs and Medicare administrative contractors (MACs). RACs are charged with identifying improper Medicare and Medicaid fee-for-service payments – both overpayments and underpayments. They are paid on a contingency fee basis, receiving a percentage of the improper payments they identify and collect. MACs conduct pre-payment and post-payment audits and also serve as providers' primary point-of-contact for enrollment and training on Medicare coverage, billing and claims processing.

No one questions the need for auditors to identify billing mistakes; however, responding to the increasing number of audits and challenging inappropriate denials drains hospitals' time, funding and attention that could more effectively be focused on patient care. For example, according to AHA's RACTrac survey of 2,400 participating hospitals, there was a 60 percent increase in the number of records requested for RAC audits during 2013. These Medicare claims now collectively represent almost $10 billion in Medicare payments, a 56 percent increase from the claims requested for RAC audits through 2012. In addition, through 2013, RACTrac data show that hospitals appeal almost half of all Medicare claims denied by a RAC, and in such cases, hospitals are successful at overturning the RAC denial more than 70 percent of the time.

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.

Excessive inappropriate RAC denials have forced hospitals to navigate the burdensome appeals process, though hospitals have been very successful in overturning RAC denials. The HHS Office of 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 administrative law judge (ALJ), who presides over the third level of the appeals process (OIG, Nov. 2012). Yet inappropriate RAC denials persist despite this high overturn rate. This inaccuracy is perhaps unsurprising given that, if a claim is later overturned on appeal, the RAC does not face financial penalties.

The influx of appeals of inappropriate RAC denials has broken the Medicare appeals process. 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 RAC*Trac*, 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, Dec. 2013). Clearly, the RAC program is in need of serious, comprehensive reform, and we continue to urge the committee to enact statutory changes to rein in an out of control RAC program.

Section 20 – Gainsharing study and report.

The AHA appreciates and fully supports the Committee's interest in moving forward in the area of clinical integration by studying how gainsharing could work and what laws would need to be changed to yield more effective and efficient care under Medicare.

In communities across America, hospitals provide the most sophisticated and advanced health care in the world 24 hours a day, seven days a week, 365 days a year. Hospitals are increasingly working more closely with physicians, including a growing trend of employing physicians. A primary factor in this trend is barriers to clinical integration when physicians are not employed by the hospital. Three of these barriers are included in the gainsharing study in the legislation: the "Stark" law, civil monetary penalties (CMP) and the anti-kickback law. We support the study, and see it as a good first step to comprehensively addressing these barriers to clinical integration in the following ways.

The **Stark law** was originally enacted to ban doctors from referring patients to facilities in which the doctor has a financial interest (known as self-referral). However, a tight web of regulations and other prohibitions that have grown up around the law can now ban arrangements designed to encourage hospitals and doctors to team up to improve patient care in a clinical integration program. The Stark law requires that compensation for health care providers be fixed in advance and paid only for hours worked. As a result, payments that are tied to achievements in quality and efficiency (such as gainsharing contemplated in the draft bill) instead of hours worked do not meet the law's strict standards. That means a hospital or clinic that rewards a doctor, and the doctor who earns the reward for following protocols that guide the clinical integration program, can be found in violation. The best solution is to return the Stark law to its original focus of regulating self-referral to physician-owned entities. This could be accomplished by removing compensation arrangements from the definition of "financial relationships" that are subject to the Stark law. These same compensation arrangements would still be regulated, but by other existing federal laws, such as anti-kickback and civil money penalty laws, that are better equipped to do so.

The **Civil Monetary Penalty** (CMP) law prohibits hospitals from rewarding physicians for reducing or withholding services to Medicare or Medicaid patients. HHS OIG, however, has taken the CMP law a step further, claiming that the law prohibits *any* incentive that affects a physician's delivery of care. The result: a clinical integration program that, for example, rewards a doctor for following an evidence-based timetable for the administration of beneficial drugs could be in violation of the law. An illustration of how CMPs, and the OIG's interpretation of them, impede clinical integration comes from a court decision. Finding that CMS lacked the authority to waive the CMP, the court forced CMS to terminate a demonstration project that had been designed specifically to improve the efficiency of surgical services. The CMP law should

be amended to make clear it applies only to the reduction or withholding of *medically necessary* services.

The **anti-kickback law's** main purpose is to protect patients and federal health programs from fraud and abuse. The law states that anyone who knowingly and willfully receives or pays anything of value to influence the referral of federal health program business, including Medicare and Medicaid, can be held accountable for a felony. Today, the law has been stretched to cover any financial relationship between hospitals and doctors. If, as part of a clinical integration program, a hospital rewards a doctor for following evidence-based clinical protocols, the reward could be construed as violating the anti-kickback law. That is because, technically, such a reward could influence a doctor's order for treatment or services. The law carries both civil and criminal penalties and can result in both the hospital and the doctor being barred from Medicare, Medicaid and other federal programs, effectively shutting down the hospital and ending the doctor's career. Congress, recognizing that the anti-kickback statute sometimes thwarts good medical practices, has periodically created "safe harbors" to protect those practices. However, there is no safe harbor for clinical integration programs that reward physicians for improving quality, such as gainsharing. Congress should create a safe harbor for clinical integration programs. The safe harbor should allow all types of hospitals to participate, establish core requirements to ensure the program's protection from anti-kickback charges, and allow flexibility in meeting those requirements so the programs can achieve their health care goals.

Section 13 – Alternative sanctions for technical noncompliance with Stark rule under Medicare.

We appreciate the inclusion of a provision that provides alternative sanctions for technical noncompliance with the Stark law. The AHA supports H.R. 3776, "the Stark Administrative Simplification Act," introduced by Representatives Boustany and Kind on the Committee. Section 13 succeeds in establishing a fixed penalty for technical violations of the Stark law by capping them at $5,000 or $10,000 (depending on when disclosed), and we support this provision. This correction of the disproportionate nature of the penalties that a hospital can incur for minor violations of the Stark law will provide some certainty as to financial exposure. The other component of H.R. 3776 that we supported gave hospitals and physicians predictability for when technical violations would be resolved. We are concerned that the changes in drafting PIMA from H.R. 3776 may not have created the expedited review process that gives providers a sufficient level of predictability as was included in H.R. 3776 as introduced. The language should be revised in a manner that provides more predictability and certainty than currently drafted.

Section 15 – Renewal of MAC Contracts.

The AHA is concerned about the provision that would require CMS to contract with MACs for at least 10 years. Such a change may hinder CMS's ability to change contractors in the event that a contractor exhibits significant performance problems. Further, such a long contracting period may actually discourage MACs from addressing performance issues, since they will be locked into long-term contracts.

Section 25 – National expansion of prior authorization demonstration program for repetitive scheduled non-emergent ambulance transport.

The ambulance provisions requiring prior authorization would be a new program and could have substantial impact on access to care in the outpatient setting for beneficiaries who rely upon ambulance transport. Our understanding of the current demonstration is that CMS has limited it to non-institutional ambulance providers and suppliers. We ask for clarification that this legislation would not expand the demonstration to institutional providers. While we understand the Committee's desire to ensure only proper usage of the ambulance transport benefit, there are potential concerns here that may need to be explored more fully.

Thank you for giving the AHA an opportunity to provide you with ideas on improving fraud, waste and abuse prevention in Medicare. If you have additional questions or would like to discuss policy options at length, please feel free to contact me or Erik Rasmussen, AHA vice president for legislative affairs, at (202) 626-2981 or erasmussen@aha.org.

Sincerely,

/s/

Rick Pollack
Executive Vice President

Cc: Representative Jim McDermott, Ranking Member