American Hospital Association

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Jennifer Main
Chief Financial Officer
Director, Office of Financial Management
Centers for Medicare & Medicaid Services
7500 Security Boulevard
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Dear Ms. Main:

Thank you for meeting last month with the American Hospital Association (AHA) and two of our member hospital systems to discuss the urgent need for the Centers for Medicare & Medicaid Services (CMS) to take a more active role in addressing and preventing the serious problems that flow from the "hospital compliance reviews" conducted by the Office of Inspector General (OIG). We appreciate your engagement with us on this critical issue and we look forward to working with you to improve CMS's process for reviewing and implementing these OIG audits.

As we discussed, we understand the need for robust and effective review of billing and payment practices by all Medicare providers, including hospitals. However, the OIG's hospital audits regularly include fundamental flaws and inaccuracies, both in the OIG's understanding and application of Medicare payment rules and in the procedures the OIG uses to conduct the audits. These flaws result in vastly overstated repayment demands, unwarranted reputational harm, and diversion of hospital and physician leaders' time from their core mission of caring for patients. The OIG's mistaken legal interpretations also result in uneven application of Medicare payment rules, both because only some hospitals are subject to OIG audits, and because there is a lack of consistency in the appeals process. In addition, the audits frequently do not provide a basis for making further improvements to a hospital's practices or procedures because auditors too often review obsolete standards and include large numbers of incorrect claim denials. Moreover, many of the claim denials that are not appealed by hospitals typically involve complex medical judgments that OIG audits are not well equipped to evaluate.

The negative effects of the audits are exacerbated because the OIG regularly extrapolates its findings to all claims in the audit period, even though many hospitals (including those with whom you met) have a documented history of successfully appealing most or almost all of the

virtually identical claim denials in the audit.[1] As a result, it is premature for CMS to issue a repayment demand based on the OIG's extrapolated findings.[2] Extrapolation often inflates the repayment demand from tens of thousands to millions of dollars, which forces hospitals to appeal each claim (even when they otherwise would not have done so) and creates a severe financial and reputational impact on the hospital that continues long after the OIG's errors are corrected on appeal. During our meeting, we were surprised and disappointed to hear that the OIG now plans to extrapolate in every single hospital audit, despite the legal and statistical limitations on extrapolation and the significant concerns about the OIG's sampling and extrapolation methodologies. This decision to extrapolate in every audit is of serious concern, which we intend to convey to Department of Health and Human Service (HHS) officials, as it will only increase the already serious effects of improper extrapolation.[3]

These flawed hospital audits have gone on for years despite previous efforts by the AHA to engage CMS, the OIG and HHS to make improvements. When hospitals object to the numerous errors in the audits, the OIG and CMS tell the hospitals that they can appeal the repayment demand. But appeals consume vast amounts of time and money for both the hospital and the government, which could be better spent by the hospitals on patient care and by the government on rooting out actual cases of fraud, waste and abuse in the Medicare program. Moreover, the appeals process is fundamentally broken, which means that hospitals must wait three to five years and expend even more resources just to recover money that they never should have had to repay in the first place.

CMS action is needed now to address all of these serious concerns. During our meeting, we made several specific suggestions to improve the accuracy and fairness of the OIG audits

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[1] For example, the majority of claim denials in the Mount Sinai audit relate to "short stay" admissions prior to October 2013 (when the Medicare rules changed). The OIG reviewers ignored the physicians' judgment to admit the patients, concluding that the patients should have been treated as outpatients under observation. Mount Sinai appealed numerous identical "short stay" denials from Recovery Audit Contractor (RAC) reviews and prevailed at the Administrative Law Judge (ALJ) stage in approximately 85 percent of these cases. The hospital has every reason to believe that this same category of denials in the OIG audit will be reversed on appeal. Similarly, with respect to the recent OIG audits for the two hospital systems represented at our meeting, at the first level of appeal alone, the Medicare Administrative Contractor (MAC) already has reversed 11 of the 29 denials appealed by Mount Sinai Health System and 10 of 41 denials appealed by Allina Health. The first level of appeal typically results in relatively few reversals, and we expect many more of the claims to be reversed on further appeal.

[2] As a related matter, the OIG also errs by routinely including in its audit reports a recommendation that the hospital "exercise reasonable diligence to identify and return any additional similar overpayments outside of our audit period, in accordance with the 60-day rule, and identify any returned overpayments as having being made in accordance with this recommendation." Among other things, the recommendation is premature for the same reason that extrapolation is premature: The hospital cannot determine whether it may have received "similar overpayments" outside the audit period if the hospital is in the process of appealing whether there was any overpayment in the first place.

[3] Extrapolation in cases involving a low error rate is particularly unjustified. For example, in the most recent audit report, the OIG identified only 12 of 100 claims as incorrectly billed, and the hospital agreed as to only 4 of 100 claims, yet the OIG extrapolated anyway. OIG, Medicare Compliance Review of Parkridge Medical Center, Inc., for 2014 and 2015, available at: https://oig.hhs.gov/oas/reports/region4/41608048.pdf.

through discrete and targeted action by CMS. We reiterate these suggestions below. We believe that taking these actions will have an immediate and positive effect for hospitals, patients and the Medicare program. We look forward to working with CMS to implement them as soon as possible.

1. *Extrapolate only if there is a significant error rate.*

After appeals are exhausted, CMS and its contractors should extrapolate from any remaining claims only if there is a significant error rate. Under the Social Security Act, CMS contractors may extrapolate from overpayment determinations only if there is a "sustained or high level of payment error" or if a documented educational intervention has failed to correct the payment error. This provision makes clear that Congress intended to limit extrapolation to cases where the level of error is extreme or the provider has failed demonstrably to improve despite educational efforts. We recognize that the OIG is not bound by this limitation, and neither we nor CMS can prevent the OIG from extrapolating in every case, even though we believe it is inaccurate and unfair to do so. However, we ask CMS to recognize Congress's clear intent by declining to instruct contractors to issue extrapolated repayment demands unless there is a significant payment error after the hospital's appeals are exhausted.

2. *Delay extrapolation until the appeals process is complete.*

CMS should not accept the OIG's recommendation to extrapolate from audit findings until the hospital has exhausted its appeals of individual claims denied based on the audit. In many cases, hospitals succeed in having many or almost all of the individual claim denials reversed. Delaying extrapolation until the individual claim appeals are exhausted will ensure that CMS is looking at an accurate error rate when it decides whether it is appropriate to extrapolate. It also will avoid the unnecessary reputational harm that hospitals suffer when an extrapolated repayment demand is published in the media and is never corrected, even after the hospital significantly reduces the amount of the demand through its appeals. Finally, delaying extrapolation will save the government the time and resources needed to recalculate the repayment amount after each level of appeal as more claim denials are reversed and refund money that was improperly recouped as a result of the inflated error rate.

We understand that delaying extrapolation until after appeals are exhausted may require CMS and the hospital to agree in advance on how and when CMS would proceed to consider whether extrapolation is appropriate, which may include a limited stipulation by the hospital that it will not object to a later extrapolated repayment based on timeliness. We would be happy to work with CMS to determine a fair and effective process that allows extrapolation to occur based on an accurate error rate that is legally and statistically significant.

3. *Allow rebilling of denied inpatient claims regardless of the usual timely filing period.*

In cases where CMS accepts the OIG's determination that hospital services were improperly billed as Part A inpatient claims, we believe that equity requires CMS to allow hospitals to bill under Part B for all covered care and services that were provided (including observation services), regardless of

the expiration of the one-year claim filing deadline. By revising its policies to allow rebilling of certain services denied as inpatient claims in a Recovery Audit Contractor (RAC) audit,[4] CMS already has recognized that it would be unfair to deny hospitals any payment for covered and legitimately provided services. But, as a matter of basic fairness, rebilling should be allowed for *all* covered services that the hospital provided. If changing this Medicare policy would require involvement of individuals in another CMS office or center, then we would appreciate your raising this issue with those individuals. We would be happy to participate in a discussion with relevant staff about how such rebilling could be accomplished.

4. *Provide feedback to the OIG to facilitate issuance of an amended audit report and improvements in audits.*

The OIG's findings frequently are overturned on appeal to a Medicare Administrative Contractor (MAC) or an Administrative Law Judge (ALJ), often with significant effects on the amount of the MAC's repayment demand. We do not see any reason why errors that have been corrected by a MAC or ALJ should remain uncorrected in the public audit report, and we ask CMS to provide the OIG with information on the disposition of claim appeals that flow from OIG audits and guidance on the underlying Medicare policies. Providing this feedback loop would allow the OIG to develop a process for issuing an amended audit report acknowledging that the reversed claims were correctly billed and prevent the OIG from making the same errors in future audits.

5. *Review and address legal issues raised by hospitals before an audit is performed or before a repayment demand is issued.*

We do not believe hospital or government resources are well spent on appeals of legal mistakes by the OIG that could be avoided or corrected before a repayment demand is issued. We respectfully ask CMS to review and address legal arguments raised by hospitals, rather than simply accepting the OIG's interpretation of the law and issuing a demand letter based on that interpretation. For example, in the hospital audits discussed at our meeting, the OIG misread or misapplied CMS rules on manufacturer credits for replacement devices and the use of modifier 59 to bill for clearly distinct procedures. Each of these errors now has been corrected on appeal, at least in part, but hospitals should not have to expend the time and resources – and the government should not waste the time and resources – to resolve such appeals. By taking a closer look at legal issues before a repayment demand is issued, CMS can avoid wasted resources and ensure uniform and accurate application of its own rules.

We also urge CMS and the OIG to consult on the categories of claims to be audited and the correct interpretation of Medicare rules *before* the OIG conducts an audit. Although we recognize that the OIG has ultimate authority to decide what to audit, we believe that the OIG's meaningful consultation with CMS before performing an audit would significantly reduce unnecessary and costly appeals. Moreover, it would help focus payment review activities on areas more prone to fraud, waste and abuse, rather than gray areas in the law where even the most careful providers are likely to make mistakes. We were encouraged to see that CMS plans to take a more targeted

[4] CMS Ruling 1455-R (Mar. 13, 2013).

approach to audits of physician payment and we hope that CMS will take a similar approach to hospital payment review, including by declining to accept OIG audit findings based on legal interpretations on which CMS has not been adequately consulted.

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Thank you for your attention to this important matter. The AHA believes it is critical that CMS take action to improve implementation of the OIG audits for the benefit of hospitals, patients and the Medicare program, and we stand ready to work with you to carry out the improvements suggested above and any others that you may wish to discuss. If we can provide further information or if you would like to discuss any of these matters further, please contact me at mhatton@aha.org or (202) 626-2336.

Sincerely,

/s/

Melinda Reid Hatton
General Counsel

cc:
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