



**American Hospital
Association®**

800 10th Street, NW
Two CityCenter, Suite 400
Washington, DC 20001-4956
(202) 638-1100 Phone
www.aha.org

**Statement
of the
American Hospital Association
before the
Special Committee on Aging
of the
United States Senate**

**“Improving Audits: How We Can Strengthen the Medicare Program for Future
Generations”**

July 9, 2014

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 43,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to provide input on how the Centers for Medicare & Medicaid Services (CMS) can improve its auditing of health care providers and its oversight of the agency’s many auditing contractors.

Hospitals take seriously their obligation to properly bill for the services they provide to Medicare and Medicaid beneficiaries and are committed to working with CMS to ensure the accuracy of Medicare and Medicaid payments. We recognize the need to identify billing errors; however, redundant government auditors, unmanageable medical record requests, abundant inappropriate payment denials and now an Administrative Law Judge (ALJ) work stoppage are wasting hospital resources and contributing to growing health care costs.



Every time nurses, physicians and other caregivers treat a Medicare or Medicaid patient, many regulations and laws govern their actions. More than 30 agencies oversee some aspect of the health care delivery process at the federal level alone. In recent years, CMS has drastically increased the number of program integrity auditors that review hospital payments to identify improper payments. They include Recovery Audit Contractors (RACs), Medicare Administrative Contractors, the Comprehensive Error Rate Testing Program, the Department of Health and Human Services (HHS) Office of Inspector General (OIG), Zone Program Integrity Contractors and the new Supplemental Medical Review Contractor. OIG has added yet another layer of audit, reviewing the same type of claims that are by reviewed by RACs, and then extrapolating to determine an error rate and demanding that hospitals repay without giving them a meaningful opportunity to appeal what are often flawed results.

Among these numerous auditors, RACs are the *only* Medicare ones paid on a contingency fee basis. RACs receive 9 to 12.5 percent of claims denied, which results in a high percentage of erroneous denials. Despite being charged with ensuring the accuracy of Medicare payments, and despite a purported expertise in identifying inaccuracies, RACs have a dismal track record for properly identifying errors in hospital claims. According to an HHS OIG report, 72 percent of RAC inpatient denials that were appealed were overturned in favor of the hospital at a higher level of appeal. Some hospitals have reported appeal success rates above 95 percent; however, not all hospitals have the resources to appeal denials because it is costly and time consuming. Congress should take immediate action to reform payment to RACs, paying them like all other

CMS audit contractors, to remove the incentive to deny claims to boost their contingency fee collections.

To address this unchecked proliferation of auditors that impact hospitals and the Medicare patients they serve, the AHA strongly urges CMS to:

- Impose a financial penalty on RACs when a denial is overturned on appeal – not just to recoup their contingency fee – to provide a check on the strong financial incentive RACs have to improperly deny claims;
- Eliminate application of the one-year timely filing limit to rebilled Part B claims;
- Enshrine in regulation that RACs are limited to using the medical documentation available *at the time the admission decision was made* when determining whether an inpatient stay was medically necessary; CMS included this precept in the preamble but neglected to add it to the regulation itself;ⁱ
- Limit RAC approval for auditing approved issues (such as short inpatient stays) to a particular defined time period, instead of approving them indefinitely, as is now the practice;
- Enshrine in regulation that the treating physician’s judgment is paramount in making the decision whether to admit patients to a hospital;
- Streamline all auditing into one program and eliminate all other auditing programs; and
- Make more investments in provider education and payment system fixes to prevent mistakes before they occur – this would make tremendous inroads to reducing the current error rate.

In addition, the AHA urges CMS to eliminate the lengthy delays in the Medicare appeals system caused by the ALJ work stoppage and the barrage of appeals flow through the system due to RAC overzealousness and error. To that end, AHA recommends:

- When a hospital appeals to the ALJ level, CMS should not recoup the disputed funds until after the hospital has received an ALJ determination;
- CMS should enforce the statutory timeframes within which appeals' determinations must be made by entering a default judgment in favor of the provider if an appeal has not been heard within the required time period; and
- CMS should provide a mechanism for erroneous denials to be reversed outside of the appeals process.

CMS also must improve oversight of the RAC program to ensure, among other things, that hospitals have an opportunity to avoid appeals by having an adequate and effective discussion period; problems with submitting documentation to RACs in response to additional documentation requests are resolved; and claims for procedures on the "inpatient-only list" are no longer wrongly denied by RACs.

The AHA supports the Medicare Audit Improvement Act (S. 1012), legislation that would improve the RAC program and other Medicare audit programs. Sens. Mark Pryor, D-AR, and Roy Blunt, R-MO, introduced the bill in the Senate. We urge members of the committee to support this legislation.

CONCLUSION

Medicare patients and hospitals are harmed when inpatient stays are inaccurately denied by a RAC. For Medicare patients, such denials result in higher out-of-pocket expenses and, in some instances, bills that otherwise would have been covered by Medicare. Hospital resources should be spent on caring for these patients not fighting incorrect denials for years on end. Without fundamental reform, overzealous and redundant auditors, including RACs, will continue to do harm to Medicare patients and hospitals.

America's hospitals have a longstanding commitment to compliance, establishing programs and committing resources to ensure that they receive only the payment to which they are entitled. The AHA and hospitals across the country stand ready to work with CMS and Congress to reform the burdensome, inaccurate and duplicative auditing programs.

ⁱ 78 Fed. Reg. 50495, 50952 (Aug. 19, 2013)