S. HRG. 113–236

PROGRAM INTEGRITY: OVERSIGHT OF RECOVERY AUDIT CONTRACTORS

HEARING

BEFORE THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDRED THIRTEENTH CONGRESS

FIRST SESSION

JUNE 25, 2013

Printed for the use of the Committee on Finance

U.S. GOVERNMENT PRINTING OFFICE

87–944—PDF WASHINGTON : 2013

For sale by the Superintendent of Documents, U.S. Government Printing Office
Internet: bookstore.gpo.gov Phone: toll free (866) 512–1800; DC area (202) 512–1800
Fax: (202) 512–2104 Mail: Stop IDCC, Washington, DC 20402–0001

COMMITTEE ON FINANCE

MAX BAUCUS, Montana, *Chairman*

JOHN D. ROCKEFELLER IV, West Virginia
RON WYDEN, Oregon
CHARLES E. SCHUMER, New York
DEBBIE STABENOW, Michigan
MARIA CANTWELL, Washington
BILL NELSON, Florida
ROBERT MENENDEZ, New Jersey
THOMAS R. CARPER, Delaware
BENJAMIN L. CARDIN, Maryland
SHERROD BROWN, Ohio
MICHAEL F. BENNET, Colorado
ROBERT P. CASEY, Jr., Pennsylvania

ORRIN G. HATCH, Utah
CHUCK GRASSLEY, Iowa
MIKE CRAPO, Idaho
PAT ROBERTS, Kansas
MICHAEL B. ENZI, Wyoming
JOHN CORNYN, Texas
JOHN THUNE, South Dakota
RICHARD BURR, North Carolina
JOHNNY ISAKSON, Georgia
ROB PORTMAN, Ohio
PATRICK J. TOOMEY, Pennsylvania

AMBER COTTLE, *Staff Director*
CHRIS CAMPBELL, *Republican Staff Director*

CONTENTS

OPENING STATEMENTS

WITNESSES

ALPHABETICAL LISTING AND APPENDIX MATERIAL

COMMUNICATIONS

PROGRAM INTEGRITY: OVERSIGHT OF RECOVERY AUDIT CONTRACTORS

TUESDAY, JUNE 25, 2013

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 10:05 a.m., in room SD–215, Dirksen Senate Office Building, Hon. Max Baucus (chairman of the committee) presiding.

Present: Senators Carper, Casey, Hatch, Grassley, Enzi, Thune, and Isakson.

Also present: Democratic Staff: Amber Cottle, Staff Director; David Schwartz, Chief Health Counsel; Matt Kazan, Professional Staff Member; Tony Clapsis, Professional Staff Member; and Karen Fisher, Professional Staff Member. Republican Staff: Kim Brandt, Chief Health Care Investigative Counsel; and Chris Coughlan, Tax Counsel.

OPENING STATEMENT OF HON. MAX BAUCUS, A U.S. SENATOR FROM MONTANA, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. The committee will come to order.

Benjamin Franklin once said, "Waste neither time nor money, but make the best use of both." This committee has oversight of Medicare. Forty-nine million seniors and disabled Americans depend on the program. Making sure the government spends Medicare dollars wisely is one of our chief responsibilities, and one this committee takes very seriously.

In 2011, $29 billion of Medicare payments were considered improper. Our goal should be to lower this amount to zero. Regular audits save Medicare money by recouping these errant payments. Since 2010, audits have identified $4.8 billion of incorrect Medicare payments, but they also can impose burdens on providers.

Today we will examine the audits performed by private contractors called Recovery Audit Contractors. Their mission is to uncover and collect inappropriate payments made to medical providers, both under- and over-payments.

In 2003, the Medicare prescription drug law created the Recovery Audit Contractor program as a 6-State demonstration. Over a 3-year test period, the program returned $900 million to Medicare. It was so successful that Congress expanded it nationwide.

The Affordable Care Act further expanded the program to cover Medicare managed care and Medicaid. As the baby boom generation ages, Medicare must remain financially strong. The Medicare trustees determined last month that the Medicare trust fund will

last 2 years longer than previously estimated, that is, until 2026. Per-beneficiary spending is at a historical low. We have made real progress ensuring Medicare will be strong for future generations.

Private audits play a key role in strengthening Medicare's finances. In 2011, these audits returned nearly half a billion dollars to the Medicare trust fund. We need to build on this success, but we cannot over-burden legitimate providers who play by the rules. We need balance.

Providers should focus on patient care, not senseless red tape. Recovery Audit Contractors frustrate many Montana providers, and one is Kalispell Regional Medical Center. In the last year, the hospital has had to spend nearly $1 million and hire three new full-time staff just to deal with the audits. In total, eight of their employees respond to audits. For a small hospital in Montana, that is a serious investment.

Charles Pearce serves as the hospital's chief financial information officer. What is it that frustrates Mr. Pearce the most? The randomness of the audit process. He believes the auditors are overzealous and incur no penalties or consequences when an audit is overturned on appeal.

Mr. Pearce provides example after example of audits that were eventually overturned on appeal. One case involved a 65-year-old man who had leg surgery and was fitted with a cast. Several weeks later, he came into the emergency room with severe chest pain. A CT scan showed he had a blood clot on his lung.

The doctor on duty admitted the man and prescribed medication. Almost 3 years later, a private contractor's audit said this admission was unnecessary. The audit claimed the patient's medical history did not support the admission. As a result, Kalispell Regional was forced to pay back Medicare.

The hospital appealed the decision, arguing that the admission was necessary because the original surgery and cast increased the risk for a lethal blood clot. Kalispell Regional won its appeal. Kalispell Regional has won appeals in 90 similar cases. All told, that hospital is successful in 53 percent of its appeals. There must be better ways to spend the government's and hospitals' time and money.

Here are three steps Medicare should take. (1) Incentivize private contractors to focus on the most at-risk services and providers. This way, providers with a long track record of following the rules are rewarded. (2) Bolster provider education by Medicare and its contractors. Providers cannot follow the rules if they do not know the rules. Medicare regulations can often be confusing and require more time than providers have. (3) Make the appeals process more efficient. One of my top rules is to do something that has to be done and do it now. The second rule is, do it right the first time.

As Kalispell Regional's experience shows, appealed cases often face a long and expensive road for both the provider and the government. The Inspector General for the Department of Health and Human Services found rulings in the final stages of the appeals process—a hearing in front of a judge—are highly inconsistent.

The IG report found the same facts and circumstances often lead to two opposite decisions. Recovery Audit Contractors are only one piece of a larger concern with the growing use of contractors. En-

suring Medicare payments are made accurately is difficult, and it is complex. Over the years, different contractors, all with their own acronyms, have been layered over one another.

While some overlap may be necessary, Congress should work to simplify the way the contractors interact with providers. This should increase efficiency and will also reduce some unnecessary burden on doctors and hospitals.

As we work to strengthen our Federal health care system, we must keep Benjamin Franklin's words in mind. We must waste neither time nor money, but make the best use of both. We must do so to improve patient care.

[The prepared statement of Chairman Baucus appears in the appendix.]

The CHAIRMAN. Senator Hatch?

OPENING STATEMENT OF HON. ORRIN G. HATCH, A U.S. SENATOR FROM UTAH

Senator HATCH. Thank you, Mr. Chairman. I welcome this opportunity to discuss one of the key tools used by the Centers for Medicare and Medicaid Services, CMS, to identify and recover improper payments in the Medicare program: the Recovery Audit Contractors, or RACs. Medicare improper payments are a really serious issue.

In 2012, Medicare covered more than 49 million elderly and disabled beneficiaries at an estimated cost of $550 billion. Of that amount, CMS reported that the improper payments from Medicare were estimated to be more than $44 billion.

That means 8 cents out of every dollar spent on Medicare was paid improperly. That rate is unacceptable, especially given the recent Medicare trustees report which said that the Medicare trust fund could be depleted by as early as 2022.

Reducing the amount of improper payments is imperative to extending the financial longevity of the Medicare trust fund and to ensuring that Medicare continues serving patients for years to come.

CMS identifies and recovers improper payments by hiring contractors to conduct audits of the 1 billion-plus claims submitted to the Medicare program each year. Auditing is essential to ensuring Medicare payments are submitted properly and that Federal dollars are being spent wisely.

The RACs are a key part of CMS's oversight strategy, and they audit millions of Medicare claims each year. However, we need to make sure that RACs are going about their work in a smart and productive way.

Over the past 3 years, CMS has made many important changes to the RAC program that have significantly improved their efforts to recover improper payments. RACs have increased the amount of collected over-payments from $75 million in 2010 to $2.3 billion in 2012.

Along with recovering Federal dollars, RACs returned $100 million in over-payments to providers in 2012. Clearly these are positive steps, but we are still a long way from eliminating even half of the estimated $44 billion in improper Medicare payments.

Now RACs must walk a fine line between chasing down every last dollar and putting an unnecessary burden on our Nation's caregivers. Even though RACs have reviewed less than 1 percent of claims nationwide, their efforts can be burdensome to providers caring for sick patients.

No one goes into the health care business to respond to auditors' requests for dozens of documents, yet we have heard from providers across the country that responding to RAC audits can be a long and painful process.

Providers have also stated that, at times, the RAC audits seem arbitrary and that the people conducting these reviews do not fully understand the Medicare requirements or acceptable medical practice. These kinds of reports concern me. I support requirements that minimize burdens on providers by reducing the look-back period to 3 years, limiting the number of medical records requested, and accepting electronic copies of requested documents.

Another issue that concerns me is the high rate at which RAC decisions are overturned on appeal. The HHS Office of Inspector General reported that of the 41,000 appeals that providers made to administrative law judges, over 60 percent were partially or fully favorable to the defendant. Now, such a high rate of reversals raises questions as to whether RACs are being too aggressive or do not understand current medical practice.

Currently, CMS is reviewing RACs' bids for new contracts for the coming years. As they review the bids, I would like to see CMS take into consideration the balance between program integrity and administrative burden. There is a lot of unrecovered money still out there, and RACs are an important component in the effort to get some of that money back where it belongs, but we need to make sure they are going about it in the right way.

Once again, I want to thank our chairman here for calling this hearing, and I look forward to working with him on this important issue.

It is now my pleasure to introduce one of our witnesses today from my wonderful home State of Utah, Ms. Suzie Draper, who is the vice president of ethics and compliance for Intermountain Healthcare, a large regional integrated health care delivery system headquartered in Salt Lake City, and one that is recognized nationwide as one of the leading health care provider groups in the country.

Ms. Draper has a wide range of experience in the health care environment, with 10 years in a variety of clinical areas, including primary care, intensive care, and several surgical specialties. In addition, Ms. Draper has over 13 years in the capacity of a consultant for medical records, physician services, and corporate compliance.

At Intermountain Healthcare, Ms. Draper has carried out a pivotal role in the development and implementation of Intermountain Healthcare's compliance and privacy program. So I am very grateful that you would take time out of what I know is a busy life to come here and testify and help us to understand this better.

We are grateful to the other two witnesses as well, so I do not mean to ignore you, but I just want to make that point while introducing Suzie and also saying that we are very proud of Intermountain Healthcare and the work that they do.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator.

[The prepared statement of Senator Hatch appears in the appendix.]

The CHAIRMAN. Turnabout is fair play, and I have someone I want to introduce from Montana: J.J. Carmody.

Senator HATCH. Let us not go overboard here.

The CHAIRMAN. That is right. [Laughter.]

Also from a beautiful, wonderful State, only this time, Montana. But anyway, thank you very much, Senator, for your statement. We have three witnesses today. First is J.J. Carmody, director of reimbursement at the Billings Clinic, Billings, MT; as well as Ms. Suzie Draper, vice president of business ethics and compliance at Intermountain Healthcare; and Robert Rolf, vice president, CGI Federal.

Thank you all for coming today, and thanks for taking the time to travel here to Washington, DC. Your statements will be automatically included in the record, and I would urge each of you to summarize in about 5 minutes.

Ms. Carmody, you are first.

STATEMENT OF J.J. CARMODY, DIRECTOR OF REIMBURSEMENT, BILLINGS CLINIC, BILLINGS, MT

Ms. CARMODY. Good morning, Mr. Chairman and distinguished members of the committee. I am J.J. Carmody. I am the director of reimbursement services for Billings Clinic in Billings, MT.

Billings Clinic is a physician-led, integrated health care organization with a multi-specialty physician group practice, a 285-bed hospital, and a 90-bed skilled nursing and assisted living facility.

Our system also includes partnerships with 10 critical access hospitals across Montana and Wyoming and is a participant in the Mayo Clinic Care Network. Like health care organizations across the Nation, Billings Clinic is dedicated to ensuring access to the highest-quality care while providing the greatest value for every dollar spent on medical treatment.

As part of this commitment, Billings Clinic has, since the late 1990s, invested significant resources in its compliance program, based on the recommendations of the Office of Inspector General, to make sure that medical services that are provided to Medicare beneficiaries and other patients are appropriate and are billed accurately. A key part of this effort is early detection of claims processing errors, as well as returning over-payments in a timely manner.

In addition, our compliance team monitors data for trends that may cause compliance risk, performs risk assessments, and conducts pro-active audits. Recovery Audit Contractors, or RACs, are a recent entry into the compliance process but in just a few short years they have had an enormous impact, both on the clinical and the administrative side of our operations.

Since our RAC began auditing Billings Clinic in May of 2002, we have been asked to provide roughly 6,000 records, totaling more than $45 million in claims. That is about 14 percent of our overall Medicare payments. We expect to see this volume increase in the

near future as a result of CMS's decision in March of 2012 to increase the maximum number of record requests.

At Billings Clinic, approximately seven out of 10 claims audited by the RAC had no error. From 2010 to 2012, Billings Clinic appealed 62 percent of the claims that were denied by the RAC. Of those appeals that have been resolved to this date, the RAC decision was overturned 84 percent of the time.

However, 65 percent of the appeals, totaling $3.3 million, are still awaiting a decision. Billings Clinic does not take the decision to appeal lightly. It is costly and it diverts our staff and other resources from improving patient care, quality, and safety. If this were not the case, we would appeal more denials.

RACs are just one of the entities currently reviewing our patient billing. We are also being audited by the Medicare RAC, Medicaid, Medicare Advantage, commercial payers, and others. The administrative resources required to respond to this level of scrutiny are a major cost to our organization.

We estimate that we currently spend 8,600 work hours and about $240,000 a year just for internal staff to manage audits and appeals. Our internal resources include patient financial services, coding, and care management staff who spend time tracking requests and processing Medicare and RAC recoveries, as well as checking data integrity. In addition, we spend $45,000 a month on an outside contractor to help with medical necessity reviews. This is in direct response to anticipated RAC activities.

My written testimony includes a number of recommendations for how the RAC process can be improved, but I will just highlight a few of these. First, CMS should do a better job of issuing clear and concise guidance to help prevent misinterpretation of coding and other criteria. The issue of whether a patient stay is inpatient or outpatient is the latest example of the need for improvement in this area.

Second, RACs should not continue to audit claims that are found over time to have a low error rate or for which their denials are consistently overturned. Even when a RAC's denial for a certain procedure is overturned, RACs continue to investigate these procedures in the future.

Third, Congress and CMS need to do a better job of overseeing the activities of the RACs. RACs were created to help make sure Medicare pays the appropriate amount for the services delivered to beneficiaries. In our view, RAC activities have grown well beyond their intended scope.

Without action from Congress, CMS is likely to continue. There is no doubt in our minds that audit and oversight are important components to the Medicare program. However, we cannot lose sight of Medicare's goal to promote access to high-quality care. Significant changes in the RAC program will help us achieve that goal.

Thank you for your attention.

The CHAIRMAN. Thank you, Ms. Carmody, very much.

[The prepared statement of Ms. Carmody appears in the appendix.]

The CHAIRMAN. Ms. Draper, you are next.

STATEMENT OF SUZIE DRAPER, VICE PRESIDENT, BUSINESS ETHICS AND COMPLIANCE, INTERMOUNTAIN HEALTHCARE, SALT LAKE CITY, UT

Ms. DRAPER. Chairman Baucus, Ranking Member Hatch, and distinguished members of the committee, on behalf of Intermountain, I would like to express our appreciation for having this opportunity to describe for you our experience with the RAC program.

Intermountain is a not-for-profit integrated health care system that operates 22 hospitals and more than 185 clinics, with 1,200 employed physicians. We also have an insurance plan, Select Health, which covers over 600,000 lives in both Utah and Idaho.

Our focus at Intermountain is to provide high-value health care, care of the highest quality provided as affordably as possible. We have an equally strong commitment to doing the right thing for the right reasons. The RAC program has been the largest Medicare claims auditing initiative in which we have participated, and I would like to share a brief overview of our experience with the RAC program.

In some ways, Intermountain has benefitted from the program. We have spent significant amounts of time and effort to improve our internal processes. We have improved our infrastructure and processes for responding about medical records, and the level of detail used by the RAC program to identify issues to be audited has helped us to improve our monitoring and auditing processes, as well as improve our internal controls.

Because we have such a small net loss, only $16,000 out of the $120 million of Medicare payments, we feel that our compliance program is effective. Although not perfect, we feel that we are effective in monitoring the accuracy of our claims.

But the RAC program has placed excessive burdens on Intermountain as well. The program diverts precious resources that might be well-applied to quality improvement and other patient care initiatives.

I will now provide five examples of inefficiencies that add little or no benefit. First, multiple government auditors are requesting the same records. There have been multiple cases where other government auditors and the RAC are requesting the same records.

We have also experienced where the RAC has requested the same records for review for the same issue more than once. Of course, this is not supposed to occur, according to the RAC's statement of work.

Second, our appeals unit has been burdened in various ways. We understand the purpose of the program was to identify over- and under-payments. However, in practice the scope of the RAC program seems to have expanded. We now have to justify that the care given to the patient was appropriate without being given clear criteria from CMS. Indeed, the wide variation in criteria used by contractors within the RAC appeals process is highly problematic.

Let me give you one example in a cardiac case. For cardiac stent placement, a patient is given a drug called Integrilin. It is an antiplatelet drug to eliminate the blockage in a stent. At the first level of appeal, regardless of the amount of time that the patient is given the medication, the claim is denied as inpatient.

In contrast, at the second level of appeal, the contractor has criteria that the patient should be considered inpatient if the patient has been given the medication for 6 hours. As a side note, this is a change from last year when the patient was required to have the medication for 18 hours in order to be deemed inpatient.

At the third level of appeal, our experience is that the administrative law judge may well have a differing opinion of Integrilin, and our experience at the fourth level of appeal is still pending.

The third issue is, under the statement of work, the RAC was required to comply with reopening regulations that state that, before a RAC makes a decision to re-open a claim, the RAC must have good cause. We believe that the RAC data mining has not identified errors on our part and, given our favorable overturn rate of over 90 percent, we feel that this has been justified.

In our first level of appeal, we get 5 percent overturned; on the second level of appeal, we get 10–15 percent overturned; on the third level, at the administrative law judge level, we have over an 85-percent overturn of our denials.

The fourth issue, as related to the recent claims, has raised concerns about our patient safety and care. Similar to the example that Chairman Baucus gave of Kalispell, we have received frequent denials of cases involving pulmonary embolism.

Although low-risk pulmonary embolism can be safely treated on an outpatient basis, the majority of Medicare patients are high-risk, and most medical literature recommends hospital admission. Failure to admit and treat a patient with this condition in a hospital puts the beneficiary at risk, with possible complications and possible death.

The fifth issue is, it seems that RAC cannot determine the accounts that we have already self-corrected or adjusted. As part of our compliance program, we have a very active auditing and monitoring process, and when we brought this to the attention of our RAC contractor, they said our only course of action was to continue to appeal those in which we had already made the corrected claims.

In conclusion, the RAC's statement of work clearly states that the RAC program should not be a burden to providers. Yet at Intermountain, we have added 22 FTEs, including nurses and physicians, resolved more than 17,000 claims, and are currently appealing 6,000, with 1,700 pending. To date, as stated before, Intermountain has had a total of over $120 million reviewed, but Medicare has had a net repayment of only $16,000.

At least in Intermountain's experience, the RAC program is not producing significant payment recruitment by the Medicare program. Instead, the RAC program is unjustifiably adding to the burden and cost of health care with little or no benefit. I sincerely hope that the inefficiencies in the RAC program will be addressed.

Thank you for this opportunity to share Intermountain's experience.

The CHAIRMAN. Thank you, Ms. Draper, very, very much.

[The prepared statement of Ms. Draper appears in the appendix.]

The CHAIRMAN. Mr. Rolf, you are next.

STATEMENT OF ROBERT ROLF, VICE PRESIDENT, CGI FEDERAL INC., FAIRFAX, VA

Mr. ROLF. Chairman Baucus, Senator Hatch, members of the committee, thank you very much for the opportunity to appear before you today. My name is Robert Rolf, and I am a vice president at CGI Federal, a global information technology and business process services firm.

In my role, I am responsible for CGI's efforts to implement the Recovery Audit Contractor program in RAC Region B, which is comprised of seven States in the Midwest, as well as similar audit and recovery efforts that CGI performs for its State government and commercial clients.

It is my pleasure to appear before you today to discuss the role of recovery auditors and the lessons learned as CGI looks to improve efforts to identify and recover improper payments as a way to strengthen the Medicare trust funds.

Under our contract with CMS, CGI is tasked with the identification of improper payments using both automated and manual claims review processes intended to identify provider over-payments and under-payments. Although most of this work involves catching improper payments on the back end, CGI fully supports all efforts to prevent such improper payments from happening in the first place.

Since February 2009, CGI, much like our fellow recovery auditors, has worked diligently to implement the program in an open and transparent fashion. CGI's efforts to date involve extensive outreach to the provider community in each State served, through town hall-style meetings as well as regular and ongoing Internet and audio conferences. Today, CGI has conducted over 100 such meetings and received nearly 20,000 contacts at its call center.

Nationally, recovery auditors have identified more than $4.8 billion in improper payments. However, the RAC program also serves as a model in terms of the recovery auditor's transparency of provider interactions and CMS's strong program governance to ensure that providers are treated fairly and do not experience burdensome compliance costs.

Based on CGI's experience with the RAC program, I would like to share a few observations with the committee about this important CMS program and some lessons learned about recovery audit efforts.

Transparency and communication are critical to the success of the program. It is important that recovery auditors provide transparent information to providers regarding issues under investigation, as well as information about the basis for an improper payment determination.

In addition to the communications described above, each recovery auditor hosts a website that provides information on the issues that recovery auditors are auditing in their regions and the ability to check the current status of claims under review.

The contingency payment approach works well in practice. Medicare Administrative Contractors have many significant duties in the Medicare program and simply are not able to catch every error on the front end. Recovery auditors have one primary mission: to catch improper payments and correct them. The contingency pay-

ment approach allows recovery auditors to dedicate the necessary resources to this task.

Contrary to some assertions, the contingency approach does not encourage the pursuit of questionable recoveries or discourage the pursuit of under-payments, for three important reasons. First, recovery auditors do not get paid unless and until a recovery is received by the government; second, fees earned on recoveries that end up reversed on appeal must be returned to the government; and third, recovery auditors receive an equal fee for finding both provider over-payments and under-payments.

To ensure that incentives remain properly aligned, CMS conducts a monthly audit of each recovery auditor to determine how accurate its determinations are. In the last set of cumulative annual data published by CMS, all four recovery auditors received accuracy scores greater than 90 percent. I am proud that CGI's accuracy score was 95.8 percent.

CMS successfully built in provisions to prevent over-auditing. At the outset of the program, CMS developed safeguards to prevent fishing expeditions. First, a recovery audit may only conduct an audit if a CMS policy team approves it and the nature of that audited is communicated to the provider community in advance. Second, CMS has developed a specific formula to limit the number of medical records that a recovery auditor may request. Third, a recovery auditor must pay a provider 12.5 cents per page for most documents requested. Overall, the Medicare RAC program works well; however, CGI remains open to common-sense suggestions to improve the RAC program for all parties involved.

Specifically, CGI recommends that the committee focus on improving the appeals process. The HHS Inspector General has identified several issues in this area, including the flexibility that administrative law judges have to make decisions that are not in line with Medicare policy.

In cases where recovery auditors do have findings that are overturned on appeal, it is most frequently when an ALJ has made such a decision. To increase program effectiveness and consistency, Congress and CMS should look at the Inspector General's findings in this area and see if there are opportunities to implement improvements.

CGI is proud of its ability to deliver successfully on the RAC program and remains passionate about the opportunity to partner with CMS and other public agencies in one of the most critical good government efforts under way today.

I appreciate the opportunity to appear before you today and would be pleased to answer any questions you may have.

The CHAIRMAN. Thank you very much, Mr. Rolf.

[The prepared statement of Mr. Rolf appears in the appendix.]

The CHAIRMAN. First, I would like to ask Ms. Carmody and Ms. Draper about CMS's audit of the auditors. Mr. Rolf said, according to CMS—I have forgotten the figure. It was the high 80s or 90 percent of the audits by the CMS auditor of the RACs turned out favorably. Do either of you have a reaction to that?

Ms. CARMODY. I actually have not seen the audit of the auditors, but I think that you can do a lot with numbers and still be giving an accurate statement. But in our case, it is almost 75 percent of

the claims that actually the RAC agrees there was no issue with. So that is 75 percent accurate out of the gate, where we both agree that we submitted the claim correctly.

The CHAIRMAN. All right.

Ms. Draper, do you have a thought on that point?

Ms. DRAPER. HDI is our contractor, and that has not been our experience. Again, I have not seen CMS's audit of the auditors, but our experience has been that when they have determined that there was an error in the claim, we have been able to win those appeals over 90 percent of the time, so our numbers are not consistent with the findings.

The CHAIRMAN. I was struck with your point, Ms. Carmody, that, as the appeals process goes up the chain, the overturn rate is higher. I think at the ALJ level, you mentioned it is about 80 percent. I have forgotten the figure that you used.

Why is that? Why are more decisions by the RAC overturned at a higher level? The second question is, is it the medical knowledge that the RAC folks have, or more importantly the ALJ has or has not? That sort of assumes the point that some medical knowledge, or significant medical knowledge, is necessary.

But first, the first question: why is the overturn rate much higher at the ALJ level rather than at lower levels?

Ms. CARMODY. I think that is a question we would like to ask. I mean, what we find is, maybe that we have a better opportunity to explain our case in point as the appeal process goes up a level, but we really work hard on submitting our appeals with our part of the story.

In answer to your second question about the knowledge base, it really is a matter of interpretation as to what we think is medically necessary. We are looking at the case when the patient is there, on-site, presenting. We are not looking at it using the hindsight that the RAC auditors are able to use when they review the case.

The CHAIRMAN. Well, my question is, would you feel more comfortable with ALJs who had more medical knowledge? I am not asking whether they should be graduates of medical school, but should they have more medical knowledge? Is that very important as opposed to whether the "i"s are dotted or the "t"s crossed?

Ms. CARMODY. I think medical knowledge is important, but I echo Ms. Draper's point that we need to have the same sets of rules apply to the claims from the submission of the claim all the way through the process, and they are changing the rules as they review them.

The CHAIRMAN. Ms. Draper, what about the competence of the judges, the medical competence of the judges?

Ms. DRAPER. We have hypothesized, as we have mined our data, that at the first level, which is usually not physicians who review those claims, that we are not getting a thorough review of the charts. So, as we go to the second and third level, we get to tell our story.

We have also been concerned that, at the highest level, we have not had similar levels of expertise. I am not saying that it has to be a cardiologist, but oftentimes, even at those third and fourth levels of appeal, we do not have those specialists who have the same level of clinical competency.

The CHAIRMAN. We do not have much time here, but where is there a meeting of the minds here? Providers think the RACs are over-zealous, the RACs think they are doing a good job finding errors. Where is there some agreement? Is there any?

Mr. ROLF. Well, Mr. Chairman, I think there is common agreement on the appeals process. I think we may take different approaches to it, but I think there is agreement that the——

The CHAIRMAN. And what is the agreement?

Mr. ROLF. That the appeals process needs to be reformed.

The CHAIRMAN. In what way?

Mr. ROLF. Well, I think if you look at the ALJs, they are not using clinical judgment in their decision-making process. The first two levels of appeals, which Ms. Draper indicated were 5-percent or 10-percent overturn rate, those are using clinical staff to review the medical records and are in large agreement with our decisions. I think, once you get to the administrative law judge level, the Inspector General has pointed out the inconsistencies.

I would agree with the point that, in any judicial process, decision-making process, predictability in the law is tantamount. If there are arbitrary decisions being made up the line, then that makes it very difficult to know how to practice and very difficult for us to know how to audit.

The CHAIRMAN. My time has expired.

Senator Hatch?

Senator HATCH. Thank you, Mr. Chairman.

Mr. Rolf, in a report last year, the Office of Inspector General for HHS issued a report in which they found that, when CMS or a RAC representative participates in an actual appeal before an administrative law judge, the RAC's decision is reversed much less frequently. Could you tell us why you think this is the case, and what lessons can be learned from these particular findings?

Mr. ROLF. Thank you for your question, Senator. So, in our experience, early on in the program there was a very high level of overturned appeals at the ALJ level, primarily because we were not timely notified that hearings were even taking place, and, when we were, we were not granted the ability to participate in that process.

Once we became more active in the process and were given the ability to provide testimony as part of that ALJ process, our physicians who participated in that process were able to provide information to the administrative law judge as to the rationale for our decisions, and our success rate has been much higher at that level since.

Senator HATCH. All right. Well, let me ask a question that all three of you can take a crack at, and that is this. In my opening statement, I talked about the importance of striking the right balance between conducting appropriate program integrity oversight of the Medicare program and ensuring that there is not an undue administrative burden on health care providers.

Now, given each of your experiences with the RAC program over the past 3 years, how do you think that that balance can be better achieved, and what recommendations would you give to Congress and/or CMS to help improve the program so that there is a better balance between those competing objectives? You have answered

that in part, but I would be interested in hearing all three of you on that: Mr. Rolf, then Ms. Draper, then Ms. Carmody.

Mr. ROLF. Certainly. I think one of the primary areas that there can be continuous improvement on—I talked about transparency, education, and communication. We participate in monthly communication sessions with our provider associations.

We still maintain our distance as an auditor—no one enjoys being audited—but we can reduce the administrative burden through communication, understanding what their pain points are in the process, how we communicate to them, how we provide information to them.

That feedback has encouraged us to make significant changes to our provider web portal, which gives them access to information about their particular claims. That transparency and that communication really helps dispel a lot of the concerns and myths in the program.

Senator HATCH. Thanks.

Ms. Draper?

Ms. DRAPER. My recommendations are two-fold. First is, upstream there needs to be greater clarity from CMS regarding the criteria of the claims that are submitted. The significant number of the claims that we throw through the appeals process are those where there is confusion, particularly on the in- versus out-patient criteria. I think that is demonstrated in recent proposed and interim changes that CMS has published.

If, once we have clarity, providers are committed to doing the right thing, and when we can work directly with our CMS contractor, we have much better communication and transparency and really do not see the need for separate auditing contractors to be out looking at our integrity. So, if we can have improved clarity of CMS regulations and then have the responsibility of the program integrity back with the contractors, we feel that that reduces our administrative burden significantly.

Senator HATCH. All right.

Ms. Carmody?

Ms. CARMODY. Yes. I would like to point out, obviously Mr. Rolf is not our RAC contractor. Our experience with our RAC contractor is not quite as transparent. So it is very difficult for us to even tell why the records are being requested, or under which venue they are looking, when we send the records in, so I think that moving that transparency and making more of a clear effort to tell us what they are looking at when they send the letters in the beginning, in their requests, would be very helpful to us.

On a broader note, obviously, clearer guidelines. "Inpatient" versus "outpatient" is really the majority of what we have seen as far as RAC activity. I think that we need to think on a bigger scale at the CMS level about, what if we did not have observation status anymore?

So I mean, really throwing that out, that is a big one, but it is something that we had actually talked to Senator Baucus's office about before. The observation status is just a killer for us. What if there was an inlier payment on the DRG that eliminated the argument to begin with? So I mean, we have broad ideas of how we

could make this work better at the CMS rulemaking level to alleviate these disputes in the end.

Senator HATCH. Mr. Chairman, my time is about up.

The CHAIRMAN. Thank you very much.

Senator Enzi, you are next.

Senator ENZI. Thank you, Mr. Chairman. I want to thank Ms. Carmody and Ms. Draper for being here. I will have some questions in writing for them that I think will help clarify some things, but I will not have this chance with Mr. Rolf again, probably.

In studying this as an accountant, I was kind of surprised that it was based on contingency. Audits normally are not done on a contingency basis. Lawyers do things on a contingency basis, but not the prosecutor. Somebody thinks they are going to clean up on it. So there is a 9- to 12.5-percent over-payment made. Do you get any kind of compensation when you find an under-payment?

Mr. ROLF. Senator, yes. As I said in my testimony, we get an equal payment whether we find an over-payment or an under-payment. I would like to add to that that, in CMS's 2012 annual financial report, they reported that the percentage of under-payments as a percentage of the total improper payment for the year was about 3.6 percent.

Recovery auditors are returning or identifying an under-payment rate, as a percentage of the total improper payments that we have identified as of CMS's April report, inception to date, of nearly 7 percent. So we are actually identifying improper payments on the under-payment side of nearly twice what CMS reports in their annual financial report.

Senator ENZI. I will have to absorb that a little bit I think, but I am pleased to hear that you do have some incentive for finding under-payments too.

You mentioned in your testimony that you use computer software that kind of does an automated review and helps you to select, I assume, whom you are going to audit. Is that computer software available to the providers?

Mr. ROLF. Senator, to directly answer the question, we do not provide that audit software directly to the providers. We attempt to maintain our distance from them in that respect.

Senator ENZI. All right. It seems like somebody ought to provide them with something like that so they can tell in advance whether they are having a problem or not, and not necessarily the contractor, but somebody ought to be providing them with that. Since the contractors are using that to determine the need for audits, it seems like that might be something that could be contracted for too.

Do you have territories for where you do your auditing? It seems like there is an overlap here.

Mr. ROLF. So, within the RAC program itself, there are four current regions. Those divide up the country into roughly four equal regions. We have a 7-State region in the Midwest. No other recovery auditor has our region.

Senator ENZI. So there would not be two people auditing the same provider, then?

Mr. ROLF. Not within the RAC program itself, Senator.

Senator ENZI. All right. Thank you.

Mr. ROLF. There may, however, be Medicare Administrative Contractors or Zone Program Integrity Contractors who will conduct audits in that same region.

Senator ENZI. All right.

I noticed on the appeals, you mentioned that yours are 95.8 percent, I think it was, that are good. But then I read the information about the administrative law judges—and I know that is a little ways up the process—that they overturn 80 to 85 percent of what comes to them, again, depending on the region I guess, which means in some regions they do worse.

Do you suppose that has anything to do with the administrative law judge knowing that the accounting firm gets a percentage of the amount?

Mr. ROLF. I have——

Senator ENZI. Would that tend to make them think that maybe they could be over-zealous?

Mr. ROLF. Senator, I think the decision-making at the administrative law judge level—I think the Inspector General's report pointed out some specifics about why there is inconsistency at that level, having to do with the need for increased peer review so there is more consistency across the decisions, more consistency in how they allow additional documentation to be introduced at that level. I think we find that, many times we make a decision based on what we have been provided in the medical record, and then, at a later appeal level or in a discussion period that we have with the provider directly, they are able to identify additional information that may not have been provided at the time of the original audit.

Senator ENZI. All right.

I also noticed that the fee for the records is 12.5 cents per record. That sounds pretty cheap if you figure in the amount of time that it takes for them to retrieve the record as well as the copying costs.

Mr. ROLF. It is per page, Senator. So, yes.

Senator ENZI. I realize that, yes.

Mr. ROLF. CGI alone has paid out over $8 million to providers to provide medical records. I will add that we are the only Medicare contractor that is required to do that.

Senator ENZI. I will have to do the math to see how many records $8 million worth is, but that is a lot of effort on somebody's part to get all of that together. One of the things that I will be checking is to see how you would feel about the cost of appeal being charged to the provider. I have run out of time, so I will send that one in writing.

The CHAIRMAN. Thank you, Senator.

Senator Isakson?

Senator ISAKSON. Thank you, Mr. Chairman.

I want to follow up on a question the chairman earlier referred to in his opening remarks, and some of the other members have referred to. There is a fine line between recovering payments that are clearly improper and questioning a judgment call made by a professional at a moment in time. I am very interested, particularly, about the determination between inpatient admission versus outpatient observation status.

Can you tell me what standards you apply to those judgments you make, the questions you ask about those judgments that are made by those professionals?

Mr. ROLF. Certainly, Senator. The criteria that we are required to use by CMS are clinical review judgment and the education, experience, and medical opinion of the auditor who is conducting the review, applying national coverage determinations and local coverage determinations, and CMS policy regarding particular types of services. We apply those and use that information to make our determinations.

We also provide, on the web portal and to the providers, the specific policies that apply to each issue that we are auditing for so that they can link to those policies and be able to identify them and read them for themselves in advance of any audit being conducted.

Senator ISAKSON. So the standard is, the person making the determination or the review is not necessarily a medical professional, but they are somebody who is using medically professional information, is that correct?

Mr. ROLF. By contract, all of our reviewers have to be licensed clinicians, overseen by a chief medical director, which we exceed by—we actually have 5 direct physicians on staff who oversee the audits.

Senator ISAKSON. How arbitrary is the determination of which cases you review and which ones you do not?

Mr. ROLF. The cases that we decide to select are based on specific, narrow policy rules that we present to CMS. CMS reviews those policies, determines whether our scope, whether our audit approach, and whether the good cause language that we use for that review, is appropriate. Only after they determine that and we post that information on our portal for the providers to be able to access it, are we allowed to then select claims in that narrow category to audit.

Senator ISAKSON. So every Medicare claim that is filed is reviewed to determine whether or not it should be reviewed by a RAC or not?

Mr. ROLF. No, Senator. We do not focus on individual providers or individual claims; we focus on specific areas of review. Most of the criteria that are used to identify a particular program vulnerability area come from reports by the Inspector General, or the comprehensive error rate testing contractor that identifies specific areas of high error rate within the Medicare program, and we focus our efforts on those.

Senator ISAKSON. So a computer might kick out a common type of claim that you want CGI to review, and then you have an individual look at it, is that correct?

Mr. ROLF. Correct.

Senator ISAKSON. All right.

Ms. Draper, I think I heard you say that you had $120 million in claims questioned, and they recovered $16 million.

Ms. DRAPER. Sixteen thousand.

Senator ISAKSON. Sixteen thousand?

Ms. DRAPER. Correct. We still have $24 million in claims—the majority of which are in this controversy over inpatient versus out-

patient—that are in appeal. To concur with Mr. Rolf, we have had under-payments that have also been returned, so our net recovery is $16,000. We have returned $1.9 million in over-payments and have recovered $1.8 million and change in under-payments.

Senator ISAKSON. Mr. Rolf, I understand the recovery, payment based on recovery, both from an under-payment as well as an over-payment. But if you had a provider that had $120 million in claims questioned and a net of $16,000 in actual recovery, would that not indicate that maybe you did not need to look so deeply into that provider as you would somebody else where you had a much higher rate?

Mr. ROLF. Actually, Senator, if across the program all providers had the experience that Ms. Draper did, we would not have recovered $4.8 billion, and we would not still be in business.

Senator ISAKSON. Yes, you would be out of business.

Mr. ROLF. Exactly.

Senator ISAKSON. But the question still remains. I mean, bad behavior is what we want to stop. Over-payment is what we want to stop. But it seems like, if you have a consistent record of performance and good behavior, that you ought to focus more on those providers where you do not have that than where you do.

Mr. ROLF. In our experience, in my nearly 20 years of experience in this area, that does drive our behavior.

Senator ISAKSON. Thank you. My time is up.

The CHAIRMAN. Thank you, Senator.

Senator Casey, you are next.

Senator CASEY. Thanks very much, Mr. Chairman. Thanks for calling this hearing. I wanted to really pick up where Senator Isakson left off, and that is to focus—I know there are a lot of parts of the testimony to focus on, but there are two that continually jump out at me.

One is, Ms. Draper, the amount that Senator Isakson mentioned, the $120 million. I am reading from your testimony, the last page. Intermountain had a total Medicare payment review of $120 million. After all of this, Medicare has recovered only a net of $16,000. That is point one.

Point two is, Ms. Carmody, you say on page 2 of your testimony, from 2010 through 2012, 20 percent of all cases were appealed. Then you go on to say, "Billings Clinic had been successful on appeal 84 percent of the time, winning 308 cases while losing 57."

I am going to review the same issue and see whether or not—I just do not know the answer to this, and it is why I am asking this question about the statute and the rules. Is there a provision in law or in practice where, if an entity is reviewed year after year in a certain time frame, if there are no findings, if there are no over-payments, or if they have a high batting average, so to speak, on appeal, is there a risk-based assessment done? Are you aware as to whether or not there is a provision for that in the law?

Mr. ROLF. So, Senator, the entire program is a risk-based assessment because of the nature of how we are reimbursed. As I testified to, only and until dollars are not just simply identified but actually recovered and deposited into the Medicare trust funds are we able to invoice for our services.

If any of our decisions are overturned on appeal, we owe the entirety of our fee back to CMS. So again, Ms. Draper's experience aside, we would not still be in business if we were not focusing on those areas where there were significant errors in recoveries and where there were more black-and-white issues that were less likely to be overturned on appeal.

Senator CASEY. I want to make sure I understand this. So, if you have an entity that has—say we have two entities. One entity has no errors, no finding of over-payment. That is prevailing for, say, 10 years. Then you have another entity B that has continual problems, lots of over-payments, lots of problems. Are those two entities, under the law, treated the same? Are they audited at the same frequency? That is the question I have.

Mr. ROLF. I would say that, under the law, they are both subject to a RAC review if they are a fee-for-service Medicare provider. In practice, we would not continue to request medical records and review in areas where no findings were being found. It is very simple economics for us as a contractor reimbursed on a contingency fee basis.

Senator CASEY. All right. But there is no prohibition on you auditing the good performer at the same rate as the bad performer?

Mr. ROLF. No, Senator.

Senator CASEY. And that is just a point I wanted to establish, and I was not sure if that was accurate.

The other question, which is difficult to answer, but maybe Ms. Carmody or Ms. Draper can answer this, if you have an opinion; maybe you cannot. Is there any instance where you believe this program or the impact of the program has had an impact on care or the quality of care?

Ms. CARMODY. Well, I would say that it has an impact on our physicians and how they want to think about whether or not somebody is an inpatient or an outpatient. From a physician perspective, they want the patient in a hospital bed, and they want to treat them the same way they are going to treat them.

So it is a process that the physician has to think about in a different way than they did prior to the RACs. They kind of feel like their judgment is being second-guessed. So, in that case, they are more likely to default to the outpatient setting than the inpatient setting, and that financially impacts patients.

So I would not say that there is a quality of care issue. We are going to treat the patient the same, we are going to take care of them, but it does have a financial impact on the patient that we have not talked about. It moves them from the inpatient deductible to the outpatient co-insurance, and it brings up the fact that they have to pay for their self-administered drugs.

The patient does not understand why, 2 years later, they were in a bed in a hospital and now they are subject to different co-insurance or different payments, or heaven forbid the patient does not have Part B Medicare. They have to pay for everything. They have no coverage, they do not get that. So there is a financial impact on patients that we did not have a chance to bring up, and that is hurtful.

Senator CASEY. Thanks very much.

Senator HATCH [presiding]. Senator Thune, you are next.

Senator THUNE. Thank you, Mr. Chairman. Thank you, panel, for your answers and for your insights.

Ms. Carmody, if you find that the practices of your RAC auditor are abusive or outside the scope of the RAC statement of work, what is your recourse? I will ask maybe a more specific question. In your case, what do you do if Health Data Insights, the RAC auditor not only for Montana but for my home State of South Dakota and 15 other States, is engaging in abusive or unauthorized auditing practices?

Ms. CARMODY. Right now what we do is we talk to our Senator, and we appeal. In the beginning, we were not as good at appealing. We were not quite as ready as Intermountain Healthcare, and so we did not appeal as much. We are appealing more and more. We have gotten people to come in and help us, and all we can do is appeal and continue to respond and make comments, send letters to CMS about changes that we would like to see in the program, and talk to all of you.

Senator THUNE. All right. And is the appeal to CMS?

Ms. CARMODY. The appeal of the RAC?

Senator THUNE. Of the RAC.

Ms. CARMODY. It goes through the appeals process, so it starts with CMS and goes up the chain.

Senator THUNE. Yes. All right.

Ms. Draper, in your testimony you expressed frustration about the volume of record requests. In your opinion, what is an appropriate amount of record requests for a RAC?

Ms. DRAPER. If we could look at specifics in the different hospitals—when we are looking at one hospital that can be bombarded by 450 requests for records within a 45-day period, that is a significant change for our medical records staff, and we are shifting the care or the work that they need to do on coding and submission of the claims in the day-to-day process in order to respond to that record request.

Again, if we could have a more focused area and, if they found a problematic area, then increase that scope, that would be much more helpful for us.

Senator THUNE. Good.

Mr. Rolf, for claims that involve review of medical necessity, what is the educational level of the auditors?

Mr. ROLF. So the first-level auditors are licensed nurses, the same practice that is being employed by commercial insurers and State Medicaid agencies, most payers throughout the system. They are overseen and supported by physicians in multiple specialty areas that can provide them higher-level clinical opinion on particularly difficult cases.

Senator THUNE. And decisions that are made on medical necessity that are made by a physician, are they reviewed by a peer physician at CGI?

Mr. ROLF. Oftentimes, if there is an area that they require additional information on, they will seek out one of their peers for that information. We also do a QA step with inter-rater reliability that, on a monthly basis, is reviewing the decisions of all of the auditors on staff to ensure consistency within and across the program.

Senator THUNE. Would you support a requirement that RACs have to abide by time lines for review like hospitals have for data requests?

Mr. ROLF. Let me address that in a couple of different ways, if I may, Senator. So currently, under our statement of work with CMS, we are required to follow all timeliness guidelines for the completion of a review. If we do not, we are subject to losing our fee for that individual claim that we did not review on a timely basis, which is the ultimate penalty. With regards to many of the time frames that have been discussed here, those involve appeals contractors that we have no responsibility for. But, as we have said before, reform of the appeal system, I think, is warranted.

Senator THUNE. And what role does peer-reviewed medical literature play in the decision-making?

Mr. ROLF. I think it is critical. Our physicians, our staff, continue their continuing medical education, are kept up and current on current medical process and literature, and are provided with an electronic literature library for the most updated information in order to make their decisions.

Senator THUNE. How about evidence-based approaches?

Mr. ROLF. All factors that are part of current medical practice are involved in the decision-making process on any one case.

Senator THUNE. Now, you mentioned you would be open to a reform of the appeals process. Do you have any suggestions about how to do that? I would pose that question as well to both Ms. Draper and Ms. Carmody.

Mr. ROLF. We should increase the ability of contractors to participate in the third level of appeal, add clinical judgment and review to the third level of appeal, and increase consistency in decision-making so there is predictability in the regulations and the rules so that my fellow panelists know how to practice and we know how to audit.

Ms. DRAPER. I would concur with his last statement, but I would also add that, in the appeals process, we need a greater level of medical experience in the first level of appeal. It is a great deal of wasted time, energy, and resources if we have to get to the third level of appeal before we can recoup our monies, and so, why not put that level of expertise up at the front level?

Ms. CARMODY. Once again, I would agree with that statement. We need the consistency up-front to know in the beginning that it is going to be looked at in the same way and that everybody is applying the same rules to how you bill a claim. And then if we could get that opinion moved up the appeals process, and also speed up the appeals process. Right now our money in those claims is held up for a significant amount of time.

Senator THUNE. My time has expired. Thank you, Mr. Chairman.

Senator HATCH. Thank you, Senator Thune.

Senator Grassley?

Senator GRASSLEY. I just have a couple elementary questions on the overall view of this, since I was involved in 2006 and 2008 in setting this up.

CMS works under the principle that clean claims should be paid quickly, so we created RACs to follow behind and confirm that

claims were properly paid. Do any of you argue against the idea of having some review of claims?

Ms. DRAPER. No, I think we all owe that responsibility to the taxpayer, that we as health care providers are held accountable for the claims that we are submitting.

Senator GRASSLEY. Mr. Rolf? Well, you are involved with it, so that answers that.

Mr. ROLF. Yes. No, Senator.

Senator GRASSLEY. Opponents of RACs being allowed to keep a portion of the insurance claims say that this approach wrongly incentivizes RACs. However, we have seen other audit contractors who fail to ever collect any money that they identify as waste, fraud, and abuse. Mr. Rolf, do you have an opinion on how best to pay contractors for inaccurate claims?

Mr. ROLF. Absolutely, Senator. I think, as I testified, my experience over the past, again, 18 years of doing this work is that the contingency audit approach allows for the greatest flexibility and scaling to the size of the problem, which, as you know, within the Medicare program is a very large issue.

If you only fund, through an administrative budget, 50 auditors, they are only ever going to do 50 auditors' work regardless of whether it is a $1-million issue or it is a $29-billion issue. Allowing a contingency approach gives recovery auditors the flexibility to address the full scope of the improper payment problem.

Senator GRASSLEY. Do any of you have any problems, the other two of you?

Ms. DRAPER. I would disagree with Mr. Rolf, because we see that, by the contingency methodology, this is one reason why we have a lower level of clinicians reviewing at the first level of appeal. It de-incentivizes providers to appeal for claims for services that they have appropriately rendered. Intermountain has taken the position to aggressively appeal those claims because we feel that we have provided quality care and should receive the appropriate payment for that.

Senator GRASSLEY. Ms. Carmody?

Ms. CARMODY. Yes, I would agree. It is costly for us to appeal. I think we have kind of pointed that out. So, even when we win, we have still lost those resources. It has caused us to move the resources to the back end of the claim instead of to the front end of the claim.

So, if we had a process that was more of a review up-front—and Mr. Rolf did refer to that in his testimony—I think that that would be a better incentive and a better payment methodology that got the claim right the first time and educated providers better about what the issues are. Then we would not have the need for this back-end approach with a contingency attached to it.

The feeling is among our staff that a lot of times with these medical necessity reviews, they literally are just looking at length of stay. That is really what that first level of denial is based on—length of stay and hindsight only—and then it is forcing us to spend more resources to get our money back.

Senator GRASSLEY. I yield back my time.

The CHAIRMAN. Thank you, Senator.

Senator Carper?

Senator CARPER. Thank you, Mr. Chairman. Welcome, everyone. Nice to see you all. Thanks for coming by to help us with this.

I want to go back just a little bit in time. You have all heard of GAO, the Government Accountability Office. They are a watchdog for the legislative branch.

One of the things they do for us is, about every other year they come up with something called a high-risk list. The high-risk list is high-risk ways of us wasting money, the taxpayers' money. It is sort of like a to-do list. I chair the Committee on Homeland Security and Governmental Affairs. We sort of use it as our to-do list to go out there and try to figure out how to save some money for the taxpayers.

In 2002, when George W. Bush was President, he signed into law legislation, I think in response in part to the GAO's high-risk list. He said one of the high-risk ways of wasting money is improper payments. A lot of people thought, well, it is fraud. It is not so much fraud as it is just mistakes. It is over-payments, it is under-payments, accounting errors, paying bills that really, really are not owed.

And the 2002 legislation, the bill the President signed into law, said basically, Federal agencies across the board, you have to start keeping track of your improper payments, is what it said. You have to start keeping track of your improper payments.

Well, every 2 years GAO would come up with a new high-risk list, and they still would list improper payments and say, as agencies were starting to report them and identify them, the number would go up and up and up. In 2010, the improper payments disclosed—not by every agency, especially the Department of Defense; they are still not even today doing a very good job of reporting improper payments—but the agencies that are reported in 2010 about $120 billion of improper payments. About $120 billion. Over $40 billion of that was Medicare, about $20 billion was Medicaid-related.

In 2010, Senator Coburn—Dr. Coburn—and I worked with a bunch of our colleagues to pass legislation, signed by President Obama, that said, Federal agencies, you have to start, not just tracking your improper payments, you have to report them. You have to stop making them and then, if the Federal Government is owed money, you have to go out and collect the money. All right.

Also, we are going to start evaluating Federal agency heads, in part, on their performance as to whether or not they take this direction seriously, whether they actually go out and try to recover monies that have been improperly paid. We saw that number drop, improper payments drop, government-wide from about $120 billion in 2010 to about $115, $114 billion in 2011, and it dropped to about $108 billion in 2012.

Part of what happens with this recovery audit contracting is that we actually do recover some money. The other thing that happens is, it is an educational process, and it enables whoever is doing the auditing to hopefully work with the providers to say, here are some things you may want to do differently so we will not have to bug you on this in the future. I say all that in part to say, this is a big problem, and it requires the efforts of a lot of people to fix.

Everything I do, I know I can do better, and I am sure the same is true of recovery audit contracting. One of the good things about you all being here today is you can help us figure out what is working and what makes sense. My dad always used to say, just use some common sense. He said it to my sister and me, his children, a great deal in hopes that we would someday learn to use some common sense.

A lot of times, when I am sitting in a hearing like this, I recall my father, I channel my father, and I say, well, if we were going to use some common sense, what would we do differently? You all have had a chance—I got here too late to hear your testimonies, but you all have had a chance to share some ideas and respond to a bunch of questions.

Just think if we were to use some common sense and try to realize that this is a huge problem, it is a big issue, it is a lot of money, it is tens of billions of dollars, what are a couple of things—let me just start with you, Ms. Carmody. Just use some common sense. What should we do differently?

Ms. CARMODY. Well, being on our compliance team from its inception in the 1990s at Billings Clinic, the first thing we do is a root cause analysis. We find something, we do a root cause analysis. Here is the problem, inpatient versus outpatient. It is unclear, it is confusing, let us do something about it. I think that is the part that is missing in all of this.

So yes, we need the RACs and they are recovering improper payments, but yet we all agree it was a medically necessary service. We are disagreeing about the setting or the method that it was billed, not even the method in which it was delivered. We do not deliver outpatient observation services any differently than we do in inpatient service. So there is a root cause there. What are we doing about that root cause? It does not really feel like we are doing much.

So in my opinion, if there is one thing we should do, it is going back to the rules and regulations guiding us—or not guiding us in some cases—to the decisions we are making and that education and feedback. We have a different RAC, as I said, and we are not really receiving that education and feedback, and we do not really feel like they are motivated to do that in all cases. If they are continuing to make their money by identifying the same issue over and over again, where is the motivation for teaching us——

Senator CARPER. So we may want to think about realigning the incentives just a little bit.

Ms. CARMODY. Yes, a little bit. I mean, I just think a friendly—I started my career as a Medicare auditor, and we actually had great relationships with the places that we audited, because we had aligned incentives. The max incentive was, get the payment structure right, get the cost reports right, teach them how to do a better job next year. I think if we could align those incentives, we could work together in a better way.

Senator CARPER. Good. Thanks. Thank you.

Ms. Draper, same question.

Ms. DRAPER. I would concur. The greatest frustration that we have is lack of clarity of the criteria by which CMS requires us to do billing. Where we have clear rules and regulations, we are com-

mitted to doing that right every time, but I think you see the great deal of frustration on those areas where there is a lack of clarity.

So, using the concept of a root cause analysis, it seems to me that we would all step back and say, where is the greatest amount of money that is being appealed in all of the RAC contractors within our MACs, or in all the other acronyms that I will not go into that are currently auditing us, and say, where are those stumbling blocks to providers to getting the claims right? Similar to what your father was saying, if you tell me how to do it right, I will do it right, but you have to tell me what right is.

Senator CARPER. All right. Same question, Mr. Rolf.

Mr. ROLF. Thank you, Senator. Thank you for your leadership, along with the chairman and Senator Hatch and Senator Coburn, on these issues. I would agree, transparency and communication and openness of dialogue between both the auditor and the auditee are important.

I would also say that, as I testified, we should expand some of the governance programs that CMS has put in place in the RAC program to some of the other audit programs that are out there, such as the limitation on records requests, the notice of the types of audits being performed, and the work that we do to prevent overlap with other audit entities, through tools like the RAC Data Warehouse that prevent us from auditing records that someone else has requested but do not necessarily apply back the other way. I think those things would help overall with the entire comprehensive look at Medicare audit programs, not simply the RAC program.

Senator CARPER. All right.

Lastly, if I could, Mr. Chairman, we oftentimes send follow-up questions in writing to folks who come and testify before us. Sometimes it is helpful, sometimes not. Just a thought: I do not know if anybody else on the panel would be interested in doing this, but what about the idea of convening a teleconference call to just continue this conversation, because, between the three of you, you can help us make some real improvements here. We have plenty of money to recover, and there are smarter ways to do it. Some of them are doing it, others are not.

Some of the concerns I hear are really not about the RACs, the Recovery Audit Contractors, but it is kind of the clear guidelines that we need and we are not getting. So is that something you all would be willing to do?

Ms. DRAPER. Of course.

Mr. ROLF. I would be happy to participate.

Ms. CARMODY. Yes.

Senator CARPER. All right. Thanks. Thank you so much. All right, Mr. Chairman. Thanks so much.

The CHAIRMAN. Thank you very much, Senator.

I am trying to figure out how to ask, where is the beef?

Mr. ROLF. Mostly in Montana. [Laughter.]

The CHAIRMAN. Yes, that is true. There is a lot more beef in our State than in many other States. But where is the beef here? That is, where is most of the waste? I mean, over-payment. You talked about over-payment. With Intermountain, it is kind of almost as much under-payment as over-payment. But you say it is inpatient,

outpatient. Is that where most of the beef is, most of the stuff? I guess, go ahead, Ms. Carmody.

Ms. CARMODY. Yes, that is really where the bulk of the repayments that we have made are, really the two: inpatient versus outpatient.

The CHAIRMAN. All right.

Ms. CARMODY. So there were services provided. It was an argument over the setting.

The CHAIRMAN. Right. Now, if that is the case, let us just focus on that a little bit. What clarity would help with respect to inpatient versus outpatient decisions? Drilling down a little more, where?

Ms. DRAPER. As we look to some of the proposals that have been made by CMS, there is still a great deal of confusion. But relying on the provider—the physician who has that patient in the emergency room—he or she is the best one to determine the level of care and the intensity of care, and helping to give clearer, easy, consistent guidelines to those providers is really what our physician community is crying for.

If I have to call them in for one more mandatory training about what we think is the current criteria, I am going to have a medical staff revolt. So, if we can have just a clear, consistent, and long-lasting criteria, we would all applaud.

The CHAIRMAN. So you are saying what, that there are many changes, there is inconsistency, or the criteria are just too vague and ambiguous? What do you mean?

Ms. DRAPER. All of the above.

The CHAIRMAN. Well, what most?

Ms. DRAPER. Most is, it is very ambiguous about what actually constitutes an inpatient claim. When we look at a patient who requires intense care, whether it is in our ICU, increased acuity of our nursing staff, et cetera, that is one area.

But it can also be a patient, particularly in our Medicare population, who is very frail. So there are standards that have been written by other clinical contractors that, at least as a baseline, would help us. Currently, Medicare does not have that baseline for clinical criteria.

The CHAIRMAN. Mr. Rolf, what do you think of that? What do you think about the basic question, most of it is inpatient/outpatient. Do you agree with that?

Mr. ROLF. I think, when we hear concerns from the provider community in our area, that that is certainly one of the areas that does come up. I know we have a representative here from hospital providers, but we are also auditing durable medical equipment companies, we are auditing anybody who bills fee-for-service. So, depending on the particular provider category, there may be unique circumstances to that.

The CHAIRMAN. But we hear from the providers the constant refrain of "more clarity, more clarity." Would you agree with that?

Mr. ROLF. I think there is opportunity for that. I think where confusion does come in is where we are required to audit strictly against Medicare policy. The first level of appeal is required to judge our decision based on a Medicare policy, which may be crystal clear, and then you get to the final level of appeal, and they

have broad discretion to make a decision based on a looser interpretation of those rules.

So I would say, again, where you get lack of clarity is often when you get to that third level of appeal where they are not being consistent with clear medical policy.

The CHAIRMAN. Why is there less clarity at the third level?

Mr. ROLF. I do not believe there is any less clarity in the policy of the third level. I think there is less clarity in how they are interpreting that policy at the third level.

The CHAIRMAN. And why is that?

Mr. ROLF. Since 2005, they have been granted greater latitude to make decisions on cases without strictly following Medicare policy.

The CHAIRMAN. And why?

Mr. ROLF. I could not tell you that, Senator.

The CHAIRMAN. The greater latitude has caused a deviation from Medicare policy?

Mr. ROLF. It is an identification that was made in the Inspector General's report.

The CHAIRMAN. All right.

Ms. Carmody, do either of the two of you want to address that point?

Ms. CARMODY. Yes. I think one of the things that Mr. Rolf is likely referring to is the administrative law judges' decision to allow claims that have been determined to have been outpatient when we had billed them initially as inpatient claims.

The ALJs in many cases have allowed providers to go back and re-bill those as if they were outpatient, so in some cases we are talking expensive cardiac surgeries that were indeed done, they were medically necessary. We billed them as inpatient. The patient maybe stayed a day and a half in the hospital and was released. CMS's current rules do not allow you to go back and basically rebill that claim. Also, many of them are outside of the timely filing guidelines because RACs have gone back 3 years.

The ALJs have made a lot of decisions to say, you know what, provider? You did provide the service. You did the service. If you agree to go ahead, we will let you bill it as outpatient. So that is the latitude I believe he is referring to, or at least that is the experience we have had, to say you are allowed to recoup some money for the service you did. Current CMS rules allow us to recoup no money.

The CHAIRMAN. All right. Thank you.

I am sorry, Senator Thune, I did not see you come back. Go ahead.

Senator THUNE. I already went.

The CHAIRMAN. I missed that. I was not here when that happened. All right.

Senator Hatch?

Senator HATCH. I think this has been a terrific panel, between you and me. It seems to me, as a former medical liability defense lawyer in my prior life, and realizing that an awful lot of the cases were frivolous just to get the defense costs, it seems to me the incentives are perverse here. The incentives are to find fault, unless

I am missing something. Am I wrong? You make more money if you find more fault. Am I wrong there, Mr. Rolf?

Mr. ROLF. So, Senator, the way I would address that question is that, again, since we only get paid when the government gets paid, and, if we are wrong we owe our fee back, our incentives are to be very clear in our decisions, focus on black-and-white issues, and really only address those areas where——

Senator HATCH. I am not criticizing you. It is the system that I think is a lousy system. It is a subjective system to begin with, in a lot of ways. I am concerned about that. We have to really look this over to see if we can find some better way of making this a quality system that works better than it currently works.

But I think you two women have done a terrific job in presenting your respective medical institutions' feelings in this matter, or in these matters, I guess I should say, and I personally appreciate you very much. I think we need to look at this really carefully, Mr. Chairman, and see what we can do. You have not really spent a lot of time going into all the multiplicity of these things. I would like to hear just a little bit more. How many different groups are auditing you and finding fault?

Ms. DRAPER. We concurrently have our Medicare Administrative Contractor. I was happy that you were helping me with some of the acronyms. They are called CERT auditors or Comprehensive Error Rate——

Mr. ROLF. Testing.

Ms. DRAPER [continuing]. Testing contractors. I mean, really you almost have to have a play sheet.

Senator HATCH. I do not blame you for not remembering all of these.

Ms. DRAPER. I am happy when I can remember all the acronyms. We have our Zone Program Integrity Contractors that can also audit us. Then at multiple levels with our MACs, or our Medicare Administrative Contractors, you can have pre-payment audits, you can have probe audits, a variety of different ways in which they are reviewing our claims.

Senator HATCH. Ms. Carmody?

Ms. CARMODY. Yes. And I would say, that is just Medicare. I mean, obviously all the other government payers can audit claims as well—Medicaid.

Senator HATCH. And people wonder why hospital costs are going up and up and up.

Ms. CARMODY. Correct.

Senator HATCH. Then they blame you for it.

Ms. CARMODY. So it is the same staff and the same personnel who are responsible for the integrity of pre-payment in our compliance program, so we keep going back to those same people or types of people. So, R.N. nurse coders, they are wonderful people. They are hard to come by. We have a need for more and more of them. So it is continual pressure on the same types of people with multiple audits, and the same account could be audited multiple times.

Senator HATCH. Well, I just have to say that I think all three of you have been very helpful to the committee here today. We have to find a way of getting health care to a point that the government can live with it and the people who give health care can live with

it. We do not need to have doctors second-guessed on everything that they do, especially when they have good results.

I am very concerned about it, because I see just billions and billions of unnecessary costs in some of the things that we do here, that we require here in the Congress. I think we are at fault too, because we could do a better job.

I appreciate your testimony, Mr. Rolf. You have been very articulate, representing your industry very, very well as far as I am concerned. But I really have empathy with the two women here and their prospective institutions, because I do not know how they put up with it, to be honest with you. You do not have any choice, I guess, but we have to find some way of making this more reasonable and, like you say, more transparent and more workable.

I have to leave, but I just want to thank all three of you for being here. Thank you, Ms. Draper, for making the trip back here. It means a lot to me.

Mr. ROLF. Thank you, Senator.

Senator HATCH. Thank you.

The CHAIRMAN. Thank you all.

Senator Carper?

Senator CARPER. One of the things I heard from a couple of you today—I think we have heard from a couple of you today—is that there is still a need for CMS to conduct stronger outreach and education.

I understand that a change in law is needed to allow some of the Medicare recovery to be used for this sort of outreach, which would help prevent future over-payments, or maybe under-payments, and reduce the burden, at least a little bit, on providers. Am I correct that additional outreach and education by CMS would prove helpful?

Ms. DRAPER. It would in our situation. Previous to the RACs experience, we had a very beneficial—and I think mutually beneficial—relationship with our Medicare contractor. We would welcome additional outreach from CMS and our Medicare contractor.

Senator CARPER. All right.

Ms. Carmody?

Ms. CARMODY. And I would agree. When we do receive the Medicare audits from the MACs themselves, their motivation is, it is not a contingency; the providers are judged on how accurately they pay from the get-go. So their motivation is to teach us how to do it correctly or tell us what their beef is. So that is not a contingency-based fee, and it leads to more of an incentive for them to teach us.

One other example or item of note I wanted to bring up is that, when we get back to the contingency fee, it used to be a common hospital practice that you would hire an outside contractor or consultant to come in and help you with your billing practice. This has been years ago.

Those might have been paid on a contingency basis. The OIG has expressed huge concerns with hospitals hiring these outside firms to come help you look at under-billing on a contingency basis because of the motivation to potentially over-bill that it created. So if those sorts of contracts are frowned upon in a hospital setting from the one side, why are they encouraged on the other?

Senator CARPER. All right.

Well, Mr. Chairman, I would just note that the vision we are talking about here where CMS would provide some additional outreach and education, there is actually a provision in the legislation that Dr. Coburn and I and a bunch of others—I think 20-some other Senators—recently introduced to address a range of Medicare integrity issues.

There is an acronym for it, but I am going to give you the full name: the Preventing and Reducing Improper Medicare and Medicaid Expenditures Act, PRIME. We think it would help provide some of these additional funds, and maybe they could be put to good use.

None of you have easy jobs; frankly, we do not either. We need to help figure out how we could, each of us, do our jobs a little bit better. At the end of the day, I would like to reduce some of the headaches for our provider community.

At the end of the day, we want to make sure that the improper payments that are being paid continue to be reduced, and we want to make sure that we are still going to have a Medicare program in 10 or 20 years. Right now, the prospects are not really encouraging there, because we are running out of money.

So we are all in this together, and there is a shared responsibility to figure out how to do, here, the important job that we are going to do, and do it better. So we look forward to hooking up with you all on the phone and to continue this conversation.

One of the things I will be asking you, Mr. Rolf, from what you have heard from Ms. Carmody and Ms. Draper, is, what are some things you actually agree with? Or maybe you could modify—not now. No, no, not now. But we will ask, what do you agree with? I always like to put myself in other people's shoes and say, how would I like to be treated if I were in their shoes—Golden Rule.

Mr. ROLF. Certainly.

Senator CARPER. And to do it the other way around. Somebody needs to put on the hat of the taxpayers, because they have a stake in this as well.

Mr. Chairman, good hearing. We thank you all for joining us.

The CHAIRMAN. Thank you very much, Senator.

We thank all three of you for taking the time to come here. There will be more questions in writing. You might also, when you answer the questions—or even not answering the questions—let us know if you have an idea, how to further improve here, something that has not come up at this hearing, or if you want to emphasize something that has come up, again, our goal is to try to resolve this as much as possible. The RAC process exists, it is there, we want to make it work best for patient care and as efficiently as possible.

Thank you very much for your testimony. The hearing is adjourned.

[Whereupon, at 11:36 a.m., the hearing was concluded.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

Hearing Statement of Senator Max Baucus (D-Mont.)
On Saving Medicare Dollars and Preserving High-Quality Care
As prepared for delivery

Benjamin Franklin once said, "Waste neither time nor money, but make the best use of both."

This Committee has oversight of Medicare. Forty-nine million seniors and disabled Americans depend on this program. Making sure the government spends Medicare dollars wisely is one of our chief responsibilities – one I take seriously.

In 2011, $29 billion of Medicare payments were considered improper. Our goal should be to lower this amount to zero. Regular audits save Medicare money by recouping these errant payments. Since 2010, audits have identified $4.8 billion of incorrect Medicare payments, but they also can impose burdens on providers.

Today we will examine the audits performed by private contractors called Recovery Audit Contractors. Their mission is to uncover and collect inappropriate payments made to medical providers – both under- and overpayments.

The 2003 Medicare prescription drug law created the Recovery Audit Contractor program as a six-state demonstration. Over the three-year test period, the program returned $900 million to Medicare. It was so successful that Congress expanded it nationwide. The Affordable Care Act further expanded the program to cover Medicare managed care and Medicaid.

As the "Baby Boom" generation ages, Medicare must remain financially strong. The Medicare Trustees determined last month that the Medicare Trust Fund will last two years longer than previously estimated, until 2026. Per-beneficiary spending is at a historical low. We have made real progress ensuring Medicare will be strong for future generations.

Private audits play a key role in strengthening Medicare's finances. In 2011, these audits returned nearly half a billion dollars to the Medicare Trust Fund. We need to build on this success, but we can't overburden legitimate providers who play by the rules. We need balance.

Providers should focus on patient care, not senseless red tape. Recovery Audit Contractors frustrate many Montana providers.

One is Kalispell Regional Medical Center. In the last year, the hospital has had to spend nearly one million dollars and hire three new full-time staff just to deal with the audits. In total, eight of their employees respond to audits. For a small hospital in Montana, that's a serious investment.

Charles Pearce serves as the hospital's Chief Financial and Information Officer. What is it that frustrates Mr. Pearce the most? The randomness of the audit process.

He believes the auditors are over-zealous and incur no penalties or consequences when an audit is overturned on appeal. Mr. Pearce provides example after example of audits that were eventually overturned on appeal.

One case involved a sixty-five year old man who had leg surgery and was fitted with a cast. Several weeks later he came to the emergency room with severe chest pain. A CT scan showed he had a blood clot in his lung. The doctor on duty admitted the man and prescribed medication.

Almost three years later, a private contractor's audit said this admission was unnecessary. The audit claimed the patient's medical history did not support the admission. As a result, Kalispell Regional was forced to pay back Medicare.

The hospital appealed the decision, arguing that the admission was necessary because the original surgery and cast increased the risk for a lethal blood clot. Kalispell Regional won its appeal. Kalispell Regional has won appeals in 90 similar cases. All told, Kalispell Regional was successful in 53 percent of its appeals.

There must be better ways to spend the government's and hospitals' time and money. Here are three steps Medicare should take.

One, incentivize private contractors to focus on the most at-risk services and providers. This way, providers with a long track record of following the rules are rewarded.

Two, bolster provider education by Medicare and its contractors. Providers can't follow the rules if they don't know the rules. Medicare regulations can often be confusing and require more time than providers have.

Three, make the appeals process more efficient. One of my top rules to live by is, "do it right the first time."

As Kalispell Regional's experience shows, appealed cases often face a long and expensive road for both the provider and the government.

The Inspector General for the Department of Health and Human Services found rulings in the final stage of the appeals process – a hearing in front of a judge – are highly inconsistent. The IG report found the same facts and circumstances often lead to two opposite decisions.

Recovery audit contractors are only one piece of a larger concern with the growing use of contractors. Ensuring Medicare pays accurately is difficult and complex. Over the years, different contractors, all with their own acronyms, have been layered over one another.

While some overlap may be necessary, Congress should work to simplify the way the contractors interact with providers. This should increase efficiency and may also reduce some unnecessary burden on doctors and hospitals.

As we work to strengthen our federal health care system, we must keep Benjamin Franklin's words in mind. We must waste neither time nor money, but make the best use of both. And we must do so to improve patient care.

###

Statement of Jennifer J Carmody, CPA
Billings Clinic

June 25, 2013

Senate Finance Committee Hearing
on

"Program Integrity: Oversight of Medicare Recovery Audit Contractors"

Chairman Baucus, Ranking Member Hatch and members of Senate Finance Committee, my name is JJ Carmody. I am the Director of Reimbursement Services for Billings Clinic, in Billings, Montana.

The Billings Clinic is a physician-led health care organization, consisting of a multi-specialty physician group practice, a 285-bed hospital, and a 90-bed skilled nursing and assisted living facility. We are a member of the Mayo Clinic Care Network, and the only Magnet-designated health care organization in Montana and Wyoming. For the past two years, Billings Clinic has received an "A" rating for the Hospital Safety Score by The Leapfrog Group. Our system includes partnerships with 10 critical access hospitals serving communities in Montana, Wyoming and the western Dakotas.

For the past 15 years, I have worked in the Finance Division at Billings Clinic in a variety of roles. Much of my job is to review the impact of Medicare policy decisions on the cost and delivery of patient care at Billings Clinic. I also actively participate in the compliance program in our organization.

Like health care organizations all across the U.S., we are dedicated to ensuring access to the highest quality health care possible while providing the greatest value for every dollar spent on medical treatment. We strive to deliver the right care at the right time in the right setting.

In pursuit of this goal, we have participated in a number of innovative payment reform models, such as the Physician Group Practice Demonstration, the Medicare Shared Savings Plan and the Bundled Payment Initiative.

I began my career as a Medicare cost report auditor working for the fiscal intermediary in Montana. I started out in a contracted position auditing hospitals for compliance with Medicare cost reporting regulations – it was a role not dissimilar to the role of a Recovery Audit Contractor (RAC).

However, I was not paid based on the Medicare savings I recovered from hospitals. My job was to ensure the integrity of the information reported to Medicare and to make sure the most accurate data was available for the development and refinement of Medicare payment systems.

Since my role was not judged based on recoveries, I found that a good, cooperative and working relationship was easy to develop and useful for all involved.

The Billings Clinic has a vigorous compliance program
Billings Clinic was an early adopter of a formal compliance program in the late 1990s. Our compliance program incorporates the recommended OIG elements, which allow for early detection of claims processing errors, as well as timely return of overpayments.
The compliance structure at Billings Clinic incorporates a multidisciplinary approach that allows the independence and appropriate skill required to detect, prevent and report claims processing concerns.

Compliance staff works with claims processing system design, modification and deployment in an effort to ensure that claims are filed accurately the first time. In addition, the compliance program proactively monitors data for trends that may cause compliance risks, performs risk assessments and conducts various proactive audits.

The impact of RAC audits is increasing
Since the RAC began auditing Billings Clinic in May 2010, we have seen roughly 6,000 records requested for more than $45 million. That amounts to about 14% of our overall Medicare payments.

Because CMS significantly increased the maximum number of record requests in March 2012, we expect to see this volume increase significantly in the near future.

Today, we have about $8 million in claims sitting somewhere in the RAC pipeline. That amount is about 17% of the $45 million tagged for review since 2010. Of that, nearly $3.3 million has been appealed and is awaiting a decision (2010=$100,000; 2011=$900,000; 2012=$2.3 million).

The balance of these claims is awaiting an initial determination by the RAC, or, if they have been denied, they are awaiting a decision by Billings Clinic on whether to file an appeal. Most of these are related to the current year.

Thus far, about 75% of claims requested for complex review have been upheld or verified as acceptable by the RAC with no further review required.

Of the remaining 25%, approximately 1% has been determined to be underpaid, resulting in additional payment to Billings Clinic, whereas 7% (about $2.8 million) has been repaid to Medicare.

From 2010 through 2012, 20% of all cases were appealed. Of these, 65% are still awaiting a decision (676 cases). Billings Clinic has been successful on appeal 84% of the time, winning 308 cases while losing 57.

These results are fairly comparable to data from the American Hospital Association that show only one third of the hospital charts requested by RACs are found to contain a payment error. Additionally, 72% of RAC denials that are appealed are overturned in favor of hospitals.

Billings Clinic does not take the decision to appeal lightly. For us, it is a costly endeavor. On average, an appeal could cost a minimum of $400. Furthermore, it diverts staff time and attention from current tasks, such as improving patient care, quality and safety.

It would appear that the RAC is expanding the number and types of claims it is reviewing, without significantly justifying a history of noncompliance on our part. This seems to contradict

the intent of the program, which was to focus on areas where evidence of widespread errors exists.

Unfavorable findings by the RAC have generally been related to situations where the RAC feels that a procedure or stay should have been considered outpatient, but Billings Clinic considered it to meet inpatient criteria.

When we couple this RAC activity with all of the other entities currently reviewing our patient billing, the combined audit activity becomes overwhelming. In total, we are currently being audited by the Medicare RAC, Medicaid, Medicare Advantage, commercial payers and others.

Substantial resources required to manage RAC audits and appeals
With this level of scrutiny, the administrative resources required to respond to these reviews has become a major cost to our organization.

Billings Clinic currently estimates that it spends roughly 8,600 work hours and approximately $240,000 per year for internal staff to manage audits and appeals. That is in addition to the $45,000 per month (or over $500,000 per year) that Billings pays an outside contractor, EHR, to help with medical necessity reviews.

EHR helps us navigate the sometimes confusing and vague regulations surrounding patient status (i.e. inpatient versus outpatient). This company, led by expert physicians, helps our care managers and physicians determine patient status on difficult Medicare cases from the onset of an admission. If one of the cases determined to qualify as inpatient by EHR is later questioned by the RAC, then EHR assists our appeal. It is important to note that although not all the cases reviewed by EHR are later reviewed by the RAC, implementation of this contract was in direct response to anticipated RAC activities.

The Billings Clinic's internal resources include, patient financial services staff, who spend time tracking requests and processing Medicare/RAC recoveries as well as checking data integrity. Billings Clinic also utilizes Healthcare Information Management clerical staff for copying, printing, collating and validating medical records information to send to the RAC.

The Coding Resource department also plays a role in any unfavorable RAC decisions involving DRG (diagnostic related groups) reviews. Each denial is assessed by two nurse coders who review the denial to determine whether an appeal is defensible. Billings Clinic management monitors RAC denial trends and reviews documentation for follow up training with physicians and staff.

The Care Management department has a dedicated full-time nurse who works solely on RAC issues. Other clerical staff and another nurse provide part-time support as well.

The compliance department plays a key role in coordinating RAC response. They serve as a general liaison to our senior executive team and other key departments. Compliance personnel are responsible for data analytics. These analytics are used for reporting and risk mitigation. They ensure that follow-through and education are being done in a timely manner.

Various other departments throughout Billings Clinic are involved in the RAC process, including legal, finance and payer relations. They all play a role, although they have not been closely tracking the time and expense related to this regulatory burden. In addition, many physicians and clinicians have dedicated time to increase their understanding of the documentation

requirements and RAC interpretations of Medicare requirements in order to avoid disagreements in the future.

How the RAC process can be improved
Billings Clinic has a number of recommendations for Congress and the administration to consider that would improve the RAC process.

First, the RAC process is adversarial and does little to prevent inappropriate billing. If Billings Clinic were able to devote the resources on compliance and physician education that it spends to defend against RAC investigations, we could do a far better job of preventing billing problems.

Second, When RACs deny a Part A claim and determine that care should have been provided on an outpatient basis, hospitals should be paid the outpatient payment amount in full. In addition, when rebilling these Part A denials, no timely filing limit should apply. The timely filing limit prevents providers from filing claims that a RAC has identified as appropriate for outpatient care. We suggest that Congress examine creating an exception for claims audited by RACs that could be processed outside of the timely filing requirements.

Third, CMS should do a better job of issuing clear and concise guidelines so that misinterpretation of coding and other criteria are not used in a "gotcha" mentality. We can't afford to lose sight of the bigger picture of Medicare – and its goal to deliver high quality care to the right beneficiaries at the right time.

One example of this lack of clear guidance is the confusion surrounding inpatient versus observation status. As has been the widely accepted practice, physicians are prescribing inpatient services that they think are necessary based on their professional judgment. However, CMS and RAC reviewers systematically think these cases do not merit the higher level of reimbursement for the Part A DRG.

As a result, the payment system is not rewarding accepted practice and is pushing more patients into observation status. CMS has noted in its most recent proposed rule that there has been a nationwide increase in observation status. Billings Clinic believes that this is a direct result of RAC reviews, which put providers in a situation where they are more likely to choose observation status out of fear of an inpatient denial.

RAC denials eliminate payment for medically necessary services rendered to patients simply because of a disagreement about the admission status. The decision that the accounts should have been billed as outpatient is being made retrospectively by reviewers who have the advantage of hindsight and are using it to second guess the opinion of physicians treating patients in real time, often emergent, situations. We recommend that RAC reviewers be allowed to use only the clinical information that was available to the physician at the time of the admission.

An example of a claim we have pending appeal where this guidance would be helpful is as follows: A 74 year old female presents to the emergency room with difficulty breathing. She had open heart surgery approximately two weeks earlier following a heart attack. Her oxygen levels were well below normal. She was diagnosed with a blood clot in the lung and was started on IV blood thinners. The RAC denied this as not medically necessary as an inpatient because in reviewing the whole record her length of stay was only two days due to appropriate and expeditious treatment. However, the mortality rate for this type of patient is extremely high, and

she met the definition of an inpatient, according to accepted Medicare criteria at the time she was admitted.

Fourth, the number of record requests should be limited.

Fifth, RACs should not continue to audit claims that are found over time to have a low error rate. Congress and CMS should do a better job of evaluating the performance of the RACs. A small percentage of records requested actually have errors plus the rate of denials overturned is high. These are indicators that CMS should do a more effective job of focusing the RACs' efforts.

Sixth, RAC reviews should not harm beneficiaries financially. Out of pocket expenses can change drastically when patient status is changed. An example of this is related to the change from the inpatient deductible to the outpatient coinsurance. These changes are confusing and upsetting to patients who don't understand why they were in a hospital bed but still considered an outpatient.

Seventh, health care providers are required to meet prescribed timelines when submitting data to RACs upon initial request and every step of the process, but RACs are not. This double standard extends beyond the RAC review every step of the appeal process and is a root cause for the high percentage of appeals Billings Clinic has remaining unresolved.

Conclusion
I fully agree that audit and oversight are critical to the Medicare program. I think everyone in the industry would share this view.

But the current structure of the RAC program frustrates our efforts to achieve this goal. Significant changes are needed to ensure that the program protects patient care and to promote administrative efficiencies for providers.

Throughout this process, we can't lose sight of Medicare's goal to deliver high quality care.

Thank you for your attention, and I am happy to take any questions you may have.

Recovery Audit Contractor Program:
The Experience of Intermountain Healthcare

The United States Senate Committee on Finance
Tuesday, June 25, 2013 – 10:00 a.m.

Suzie Draper, Vice President of Business Ethics & Compliance

www.intermountainhealthcare.org

Intermountain Healthcare
Healing for Life®

Recovery Audit Contractor Program: The Experience of Intermountain Healthcare
The United States Senate Committee on Finance, Tuesday, June 25, 2013 – 10:00 a.m.

Written Testimony – Suzie Draper, Vice President of Business Ethics & Compliance, Intermountain Healthcare

Intermountain Healthcare appreciates the opportunity to describe its experience with the Recovery Audit Contractor ("RAC") program. My name is Suzie Draper, and I am the Vice President of Business Ethics & Compliance at Intermountain Healthcare in Salt Lake City, Utah. Intermountain is a not-for-profit 501(c)(3) integrated healthcare system that operates 22 hospitals in Utah and Idaho; more than 185 clinics; and an insurance plan, SelectHealth, which covers more than 600,000 lives in Utah and Idaho. Intermountain's Medical Group employs approximately 1,200 physicians, and about 5,000 other physicians affiliate with Intermountain.

Intermountain has become well-known nationally and internationally for identifying best clinical practices and applying them consistently. Dr. John E. Wennberg of the Dartmouth Institute for Health Policy and Clinical Practice said "Intermountain is the best model in the country of how you can actually change health care for the better." Dartmouth estimated that if healthcare were practiced nationally in the way it is provided at Intermountain, "the nation could reduce healthcare spending for acute and chronic illnesses by more than 40%."

Intermountain's focus is on providing high-value healthcare. To that end, we:

- Have developed physician-led clinical programs so that medicine at Intermountain is practiced by collaborative teams and is based on the best available data.
- Establish specific clinical improvement goals, with accountability for accomplishing these goals reaching all the way to Intermountain's Board of Trustees.
- Have developed information technology that allows us to track, compare, and improve outcomes—and eliminate inappropriate variation.
- View variation as an opportunity to improve, whether we find it in our clinical processes, our business processes, or our supply chain.

Introduction

The RAC Program has been the largest Medicare claims auditing initiative in which Intermountain has participated. The objective of this written testimony is to provide the Committee with an overview of Intermountain's experience with the RAC program.

Benefits of the RAC Program to Intermountain

When the RAC program became permanent, Intermountain began by working with key operational departments to develop an infrastructure to respond to the new regulatory demands. After this

assessment phase, an enforcement response strategy was implemented that has allowed Intermountain to interface successfully with the RAC Program–retaining appropriate payments and returning those that were received in error. A crucial piece of this infrastructure was the development of more efficient systems to track and report claims data. Because of careful planning and preparation, Intermountain has developed mechanisms to benchmark against other healthcare systems and to provide critical data to our internal stakeholders involved in process improvement.

A few of our successes related to the RAC Program include:

(1) Processing more than 16,000 RAC requests for individual patient medical records without a single denial for untimely responses.

(2) For audits requiring a chart review, 60% have been approved with no errors found as compared to 52% for our region.

(3) More than 81% of the denials have been appealed as compared to 48% for the region.

(4) More than 90% of those appeals resulted in the denials being overturned in Intermountain's favor, compared to 62% for the region.

(*Region data used Q4 2012 AHA's RACTrac Report*).

Largely because of the high level of commitment by senior management and staff, as well as the ability to internally share and analyze the data, Intermountain has been able to refine and adapt the enforcement response strategy for continued success.

Another benefit gained from the RAC program comes from the specific manner in which the contractors identify the issues they are going to audit. While some government audit entities will simply state they will be reviewing claims for "excessive units," for example, the RACs will provide more specific information on what type of units they will examine. The RACs have posted more than 600 specific issues they are auditing, which allows us to complete our own internal audits to proactively review claims, correct them, and develop internal processes as needed to avoid future overpayments.

Lastly, because the RACs were given the responsibility to review underpayments and overpayments, Intermountain has received more than $1.8 million in additional Medicare payments as a result of the RAC-identified underpayments.

RAC Audit Activity for Intermountain Healthcare

Figure 1.a shows the number of claims and the Medicare payment amounts reviewed by our region's RAC. Of the 25,473 claims reviewed, more than 16,000 required Intermountain to send the RAC complete patient medical records.

Figure 1.a

Claims Requested/Reviewed	Total Claims	Original Medicare Payment Reviewed
Claims Resolved	17,437	$78,978,764
Unresolved Claims (Intermountain determining to appeal or claims are in the appeal process)	6,245	$24,453,305
Pending Completion of RAC Review	1,791	$16,214,260
Total	**25,473**	**$119,646,329**

Figure 1.b provides detail on the 17,437 claims that have been completely resolved. As indicated below, more than half of all claims resolved were found with no error. The RAC did find almost $1.9 million in underpayments that have been returned to Intermountain and slightly more than $1.9 million in overpayments have been returned from Intermountain to the Medicare fund. Accordingly, of the approximately $120 million dollars in claims examined, Intermountain has realized a net loss of just over $16,000. Put another way, the audit of $120 million dollars in Medicare payments made to Intermountain has thus far resulted in about $16,000 being returned to the Medicare program.

Figure 1.b

Claims Resolved Detail	Total Claims	Actual Medicare Payment Gain or Loss
No Error Found (No Loss or Gain)	8,805	$0
Underpayment Amount (Gain)	678	$1,887,176
Overpayment Amount (Loss)	7,954	-$1,903,620
Total	**17,437**	**-$16,444**

Intermountain's Current RAC Burdens

The RAC Program has placed many burdens on Intermountain, from the release of medical records process through the appeals process. Overall, the information below shows that – at least at Intermountain - the RAC program is not helping reduce healthcare costs and that the program diverts resources that might otherwise be applied to quality improvement and patient care.

Intermountain has increased staffing in order to be able to manage and comply with the RAC program. We estimate that 22 additional full-time employees have been added, with the majority going to the Appeals Unit, the release of information groups, patient account staff, legal representatives, physician advisors, case managers, and a centralized RAC manager.

The processing of more than 16,000 medical records for transmission to the RAC has produced a heavy operational burden on our Health Information Management team. It is not unusual for the same record to be produced multiple times due to RAC operational issues. Software updates and computer programming to manage the release of records process is ongoing. Daily operations are impacted when the RAC requests multiple records at once and the staff must prioritize work to log requests, locate, copy, and package records. We have found it necessary to continuously educate our Health Information Management staff to keep them current on the regulatory changes to RAC processes. The staff is also

involved in the appeal preparation, since they must review records, validate coding decisions, and go to hearings to present justifications for particular coding assignments.

Multiple government auditors are requesting the same records. There have been cases where other government auditors and the RAC are requesting the same records for audit review. We have also experienced the RAC requesting the same records for review for the same issue more than once, even though this is not allowed according to the RAC Statement of Work.

- *Case Study:* An account was requested by the RAC in 2012 and an overpayment was alleged, but Intermountain personnel determined the denial was not correct and began the appeals process. The denial was overturned in our favor during the first level of appeal; however, 10 months later, the RAC requested the medical record again to perform an audit for the same reason as the first audit. According to the RAC Statement of Work, this is not permissible.

Intermountain has been burdened administratively in various ways. Claims found through the Automated process (data mining) are focused on appropriate coding and charging of accounts. When reviewing these accounts we must assess the account, use resources to pull the medical record chart, assess that the appropriate codes have been used, ensure that charging is appropriate, and then rebill the account (if needed). It takes on average, one hour to analyze each of these accounts.

Claims found through the Complex process (review of entire patient medical record) require the RAC to audit if the level of care was appropriate (inpatient versus outpatient) and to validate that the Diagnosis Related Group code was appropriately assigned. Resources to appeal these accounts include the pulling of the medical records, the assessment of the care by a clinician (physician and nursing), the re-assessment of the coding and the time invested in appealing the account. It takes on average, five hours to analyze, assess, and appeal each of these accounts.

The RAC Statement of Work (SOW) is to identify over/under payments and to identify fraud and abuse (SOW Program Purpose). In practice, the scope of the RAC Program seems to have expanded. We now have to justify that the care given to the patient was appropriate, that the patient stayed the right amount of time, and that the physician status order which was obtained upon admission was checked appropriately, all without being given criteria from CMS as to what those specifications should be. One example is the level of care deemed appropriate for a cardiac stent placement.

- *Case Study:* For cardiac stent placement, patients are given Integrilin as an anti-platelet to eliminate blockage of the stent. At the first level of appeal, regardless of the time that the patient is receiving that medication, these claims are denied inpatient status, and we are told that billing for inpatient care is fraud/abuse. At our second level of appeal, the contractor has criteria that the patient should be an inpatient if the patient is on the medication more than six hours (a change from last year where they stated the patient had to be on the medication for more than 18 hours). At the third level of appeal, the administrative law judge (ALJ) may have differing opinions on Integrilin, dependent on the ALJ. We have not yet had a fourth level of

appeal with these cases and do not know what the Medicare Administrative Contractor's view will be, but we have seen that the criteria used by different contractors are inconsistent.

Intermountain has had many hearings and received denials based on the *outcome* of the patient's treatment, not on the original intent of the physician at the time of the admission. For example, if a Patient Status Order does not match the outcome, we experience a denial. In other words, if a patient's condition indicates to a physician that an inpatient admission is called for, but the patient subsequently improves more quickly than the original expected length of stay, the RAC will in hindsight determine that the physician's original assessment was incorrect. Providers who have worked diligently to improve patient outcomes so that patients improve rapidly are essentially penalized for their efforts to improve patient care and shorten patient length of stay. In addition, while the physician's decisions determine the patient care, the hospital or clinic is held financially liable for the patient's status. Thus, on the one hand, the administrative burden is detracting from the focus on patient care, while on the other hand, strict adherence to administrative details results in the denial of coverage for care provided.

The initial RAC program and timelines have not been adhered to by the private contractors. While a provider can have its payments recalled because it did not submit medical records to contractors on time, the private contractors have not in turn adhered to their timelines. We have had contractors state, 'We are short-staffed, so you might as well bypass our level and go straight to the ALJ.' When we do that and go to the ALJ, the ALJ sometimes remands it back to the second level because they do not have the clinical expertise to decide on the appropriate level of care.

The RAC is not providing the Informational Letters for Automated (data mining) audits that they perform. These letters provide the necessary information that tells us the specific issues related to the denials. Without this letter, it has proved difficult to determine to which of the more than 600 issues the account is related. Additionally, the letters we receive from private contractors do not give us the reasons for denials.

While the RAC SOW states that the RACs should not be a burden to providers (42 CFR § 405.980), excessive resources have been used to re-code accounts, reassess levels of care, re-bill accounts, pull medical records, etc. The account is then reviewed by a third party who assesses the care from a subjective viewpoint. The SOW also stated that RACs would only recall the "difference" between the inpatient and outpatient payments, but Intermountain has had to refund the entire payment amount until we appeal the account.

Under 42 CFR § 405.980, the RACs are required to comply with reopening regulations, which state that before "a RAC makes a decision to reopen a claim, the RAC must have good cause." We believe that the data mining has not identified errors on our part, with our "favorable, overturned rate" of over 90%. In our first level of appeal, we get 5% of our denials overturned. On the second level, we get 10-15% of our denials overturned and on the third level, nearly 85% of denials are overturned. The ALJs are finding that

appropriate care was given to the patient and, without specific criteria to determine outpatient versus inpatient at the time of admission (or an outcome), are ruling in our favor.

At the third level of appeal with the ALJ, the wait time for an ALJ hearing is two years out, so many of the accounts are not resolved for more than three years. To alleviate the overburdened process, CMS established the Part B interim billing process, which took the authority away from the ALJs and promised to return "some type of payment" to the providers. Issues with this ruling are in direct conflict with the RAC SOW because of the burden it places on the providers to rebill (indeed, the rebilling is so complicated that CMS is having difficulty programming their system to accept these claims). To rebill an account under the interim ruling will require Intermountain to employ an additional six FTEs for coding, billing and clinical resources, spending more than five hours to assess each account. It also places an additional financial burden on the beneficiaries for their copayments on claims that are over three years old. This creates dissatisfaction between the patients and the providers.

There appear to be more RAC audit errors than provider errors. Where other providers may be backing out of the appeal process due to financial or other constraints, Intermountain has taken the approach of appealing all denied cases where we deem the original payment we received was justified. We currently appeal 81% of all claims the RAC finds in error. Of the 81% we have appealed, we have more than a 90% success rate of the denials being overturned in our favor. Despite this success rate, the RAC has not changed the process or criteria for denials. There is no direct communication between the RAC and providers to improve the process or reduce the number of unnecessary denials.

Physician decisions are being overturned by auditors who perform the medical necessity reviews for the RAC. Intermountain uses a process in which external and internal physician advisors review cases for appropriate inpatient admissions, and we are still receiving denials on these cases.

RAC denials are not always appropriate due to the following reasons:

- Recent denials by RAC have raised concerns about patient safety and care.
    - *Case Study:* Recently we have seen frequent denials of cases such as those for pulmonary embolisms (a condition related to blood clots in lungs). Pulmonary embolism is the third most common cause of death in hospitalized patients, with at least 650,000 cases occurring annually. Autopsy studies have shown that approximately 60% of patients who have died in the hospital had pulmonary embolism.[1] Although low-risk pulmonary embolism can be treated safely on an outpatient basis, the majority of Medicare patients are high risks, and most medical literature recommends hospital admission for these patients. Failure to admit and treat the patient with this condition in hospitals puts the beneficiary at high risk of complications and possible death. It also exposes the provider to the risk of medical malpractice liability; in the event of a negative outcome, plaintiffs' attorneys will question any decision that seems to go against the weight of medical opinion.

[1] Medscape: Pulmonary Embolism Author: Daniel R Ouellette, MD, FCCP; Chief Editor: Zab Mosenifar, MD.

- The RAC does not recognize Intermountain's utilization review system as a valid process. Intermountain, like most providers, usually follow nationally established screening tools (such as InterQual or Miliman), but the RAC has denied many of those cases which met screening criteria for inpatient and outpatient status.

- The RAC does not consider or apply established clinical guidelines published by nationally known associations or medical journals (e.g., the American Heart Rhythm Society guidelines for cardiac procedures or chest guidelines related to pulmonary embolism).

- Currently, most RACs do not have not enough resources to review all denied cases by a physician as required by CMS. CMS requires all downgrades of medical necessity cases to be reviewed by a physician. "The case is referred to a physician reviewer when the non-physician reviewer cannot approve the hospitalization as necessary and/or another level of care would have been appropriate without posing a threat to the safety or health of the patient."[2]

The RAC cannot determine which accounts we have corrected or adjusted in the past. As Intermountain conducts internal audits to identify problematic claims, identified coding and billing errors are corrected resulting in an adjusted claim. The RAC data-mines these adjusted claims and concludes that we have billed and received payment for two discharges or for excessive units, which, if they could see the corrected or adjusted payments, they would not have denied. The RAC's solution for Intermountain was to submit an appeal on each claim.

- *Case Study:* Our Medical Group has identified more than 1,250 claims that fall into the aforementioned category. Intermountain would need to appeal each of the 1,250 claims (and any similar future claims) which would create a financial burden on our business as well as to our Medicare Administrative Contractor who would be processing a large number of redetermination requests that could easily be avoided. The Intermountain Medical Group continues to receive 20 to 30 newly identified claims that are a part of this issue each week. We have tried to work through this issue with the RAC, but to no avail.

Conclusion

Preparing to operate in the RAC program environment has produced a few benefits for Intermountain in that we have improved some specific processes in order to accommodate the program. However, the burden the RAC program has placed on Intermountain–and by extension, its patients and payers—is substantial as detailed in the foregoing testimony. At least in our experience, the RAC program is not producing significant payment recoupment by the Medicare program and is, instead, adding to the cost of healthcare.

Within the RAC Statement of Work it is clearly stated that the RAC Program should not be a burden. We've added 22 FTEs, resolved over 17,000 claims, we are currently appealing over 6,000 claims, and

[2] Quality Improvement Organization Manual Chapter 4 - Case Review 4110 - Admission/Discharge Review.

the RAC is currently reviewing over 1,700 claims. Intermountain has had a total Medicare payment review of approximately $120 million; after all this, Medicare has recovered only a net of about $16,000 (underpayment amount gained = $1,887,176; overpayment amount lost= $1,903,620).

Contacts

Suzie Draper
Vice President, Business Ethics & Compliance
Intermountain Healthcare
36 South State Street
Salt Lake City, UT 84111
W (801) 442-1502
suzie.draper@imail.org
www.IntermountainHealthcare.org

Bill Barnes
Director, Federal Government Relations
Intermountain Healthcare
36 South State Street
Salt Lake City, UT 84111
W (801) 442-3240
bill.barnes@imail.org

Karen S. Sealander
McDermott Will & Emery LLP
600 13th Street, N.W.
Washington, D.C. 20005
W (202) 756-8024
ksealander@mwe.com

STATEMENT OF HON. ORRIN G. HATCH, RANKING MEMBER
U.S. SENATE COMMITTEE ON FINANCE HEARING OF JUNE 25, 2013
PROGRAM INTEGRITY: OVERSIGHT OF RECOVERY AUDIT CONTRACTORS

WASHINGTON – U.S. Senator Orrin Hatch (R-Utah), Ranking Member of the Senate Finance Committee, today delivered the following opening statement at a committee hearing examining Medicare Recovery Audit Contractors (RACs):

I welcome this opportunity to discuss one of the key tools used by the Centers for Medicare & Medicaid Services (CMS) to identify and recover improper payments in the Medicare program: the Recovery Audit Contractors (RACs).

Medicare improper payments are a serious issue.

In 2012, Medicare covered more than 49 million elderly and disabled beneficiaries at an estimated cost of $550 billion.

Of that amount, CMS reported that the improper payments for Medicare were estimated to be more than $44 billion.

That means eight cents out of every dollar spent on Medicare was paid improperly. That rate is unacceptable especially given the recent Medicare Trustees Report which said that the Medicare trust fund could be depleted by as early as 2022.

Reducing the amount of improper payments is imperative to extending the financial longevity of the Medicare trust fund and to ensuring that Medicare continues serving patients for years to come.

CMS identifies and recovers improper payments by hiring contractors to conduct audits of the one billion-plus claims submitted to the Medicare program each year. Auditing is essential to ensuring Medicare payments are submitted properly and that federal dollars are being spent wisely.

The RACs are a key part of CMS' strategy and audit millions of Medicare claims each year. However, we need to make sure that RACs are going about their work in a smart, productive way.

Over the past three years, CMS has made many important changes to the RAC program that have significantly improved their efforts to recover improper payments. RACs have increased the amount of collected overpayments from $75 million in 2010 to $2.3 billion in 2012.

Along with recovering federal dollars, RACs returned $100 million in overpayments to providers in 2012.

Clearly, these are positive steps, but we are still a long way from eliminating even half of the estimated $44 billion in improper Medicare payments.

Now, RACs must a walk a fine line between chasing down every last dollar and putting an unnecessary burden on our nation's caregivers.

Even though RACs have reviewed less than one percent of claims nationwide, their efforts can be burdensome to providers caring for sick patients. No one goes into the health care business to respond to auditors' requests for dozens of documents.

Yet, we have heard from providers across the country that responding to RAC audits can be a long and painful process. Providers have also stated that, at times, the RAC audits seem arbitrary and that the people conducting these reviews do not fully understand Medicare requirements or acceptable medical practice.

These kinds of reports concern me.

I support requirements that minimize burdens on providers by reducing the look-back period to three years, limiting the number of medical records requested, and accepting electronic copies of requested documents.

Another issue that concerns me is the high rate at which RAC decisions are overturned on appeal.

The HHS Inspector General reported that, of the 41,000 appeals that providers made to Administrative Law Judges, over 60 percent were partially or fully favorable to the defendant. Such a high rate of reversals raises questions as to whether RACs are being too aggressive or do not understand current medical practice.

Currently, CMS is reviewing RACs' bids for new contracts for the coming years. As they review the bids, I'd like to see CMS take into consideration the balance between program integrity and administrative burden.

There is a lot of unrecovered money still out there and RACs are an important component in the effort to get some of that money back where it belongs. But, we need to make sure they are going about it the right way.

Once again, I thank the Chairman for calling this hearing and look forward to working with him on this important issue.

###

Written Testimony of Robert Rolf
Vice President
CGI Federal Inc. (CGI)

Prepared for

The Senate Committee on Finance

June 25, 2013

Chairman Baucus, Senator Hatch, Members of the Committee, thank you very much for the opportunity to appear before you today. My name is Robert Rolf and I am a Vice President at CGI Federal Inc. (CGI), a global information technology and business process services firm. In my role, I am responsible for CGI's efforts to implement the Recovery Audit Contractor (RAC) program in Region B, which is comprised of seven states in the Midwest, as well as similar audit and recovery efforts that CGI performs for its state government and commercial clients. It is my pleasure to appear today before you at this hearing to discuss the role of Recovery Auditors and lessons learned as CGI continually looks to improve efforts to identify and recover improper payments as a way to strengthen the Medicare trust funds.

Originally authorized by the Tax Relief and Healthcare Act of 2006, the Medicare RAC program is focused on the identification of improper payments made to hospitals, physicians, clinics, durable medical equipment suppliers, and other providers of services under Medicare Parts A and B. The nationwide program follows a successful 3-year pilot that resulted in the identification of $1 billion in improper payments from six states.

Under CGI's contract with Centers for Medicare and Medicaid Services (CMS), CGI is tasked with the identification of improper payments using both automated and manual claims review processes intended to identify provider overpayments and underpayments. Although most of this work involves catching improper payments on the back end, CGI fully supports all efforts to prevent such improper payments from happening in the first place. CGI currently assists CMS in the development of an improper payment prevention plan, a mission that CGI takes very seriously, and also participates in the Prepayment Review Demonstration Project for Recovery Auditors established by CMS in August 2012.

Since contract inception in February 2009, CGI, much like our fellow Recovery Auditors, has worked diligently to implement the program in an open and transparent fashion. CGI's efforts to date involved extensive outreach to the provider community in each State served, through town hall style meetings, as well as internet and audio conferences, providing education on the program and CGI's processes. To date, CGI has conducted over 100 such meetings and taken over 16,500 calls and 13,000 emails at its call center, which CGI established to field provider questions and concerns.

Nationally, Recovery Auditors have identified more than $4 billion in improper payments. The program's success is even more impressive considering that Recovery Auditors bear all of the risk associated with investing in the systems and personnel necessary to conduct the program and are paid on a commission basis only for underpayments and overpayments actually recovered. Additionally, the RAC program serves as a model in terms of the Recovery Auditors' transparency of provider interactions and CMS' strong program governance to ensure that providers are treated fairly and do not experience burdensome compliance costs.

Based on CGI's experience with the RAC program, I'd like to share a few observations with the Committee about this important CMS program and some lessons learned about recovery audit efforts:

- *Transparency and communication are critical to the success of the program.* It is important that Recovery Auditors provide transparent information to Medicare providers regarding the program and the issues under investigation, as well as information about the basis for an improper payment determination. In this way, providers are kept informed during each step of the audit process. CGI has established monthly conference calls with provider associations and continues to conduct provider outreach sessions that facilitate two-way communication. Additionally, CMS requires each Recovery Auditor to host a public website that includes information such as the issues Recovery Auditors are auditing in their regions, instructions on how to submit electronic records, and frequently asked questions. The secure portal allows providers to log in with their Medicare Provider ID to check the status of information that a Recovery Auditor has requested from the provider.

- *The contingency payment approach works well in practice.* Medicare Administrative Contractors (MACs) have many significant duties under the Medicare program, including claim review prior to payment. The MACs simply aren't able to catch every error or omission on the front end (*i.e.*, prior to payment). Recovery Auditors have one primary mission – to catch improper payments on the back end (*i.e.*, after payment) and correct them. The contingency payment approach allows Recovery Auditors to dedicate the necessary resources to this task. Contrary to some assertions, the contingency approach does <u>not</u> encourage the pursuit of questionable recoveries or discourage the pursuit of underpayments for three important reasons. First, Recovery Auditors do not get paid unless and until a recovery is received by the Government. Second, fees earned on recoveries that end up reversed on appeal must be returned to the Government. Third, Recovery Auditors receive an equal fee for finding both provider underpayments and overpayments. To ensure that incentives remain properly aligned, CMS conducts a monthly audit of each Recovery Auditor to determine how accurate its determinations are. In the latest set of cumulative annual data published by CMS, all four Recovery Auditors received accuracy scores of greater than 90%. I am proud to report that CGI's accuracy score was 95.8%.

  Finally, in an effort to catch more of these improper payments on the front end, CMS has initiated a Prepayment Review Demonstration project for Recovery Auditors. Under this demonstration project, the MAC sends the request for additional documentation to the provider, who then submits the medical records to the Recovery Auditor for review. The Recovery Auditor reviews the information and provides instruction to the MAC regarding whether to pay or deny the claim. To date, CGI has reviewed 1,056 claims and prevented $1,806,574.73 in improper payments from being made in the first place.

- *CMS successfully built in provisions to prevent "over auditing."* At the outset of the program, CMS developed certain safeguards to prevent "fishing expeditions" that could lead to unnecessary workload on behalf of providers. First, a Recovery Auditor cannot simply pick and choose the issues that it wishes to review. Rather, a CMS policy team reviews all the improper payment issues and audit scenarios identified by the Recovery Auditors. A Recovery Auditor may only

conduct an audit if the CMS policy team approves one for that issue and the nature of that audit is communicated to the provider community so that providers receive fair notice of the issues being reviewed. Second, CMS has developed a specific formula to limit the number of medical records that a Recovery Auditor may request. This documentation formula is proportionally based on the volume of Medicare claims billed by the provider to CMS. Third, a Recovery Auditor must pay a provider 12.5 cents per page for most documents requested, which ordinarily covers the provider's entire cost of using a records contractor to comply with Recovery Auditor documentation requests. The documentation limit and the reimbursement requirement force Recovery Auditors to be selective about the medical records requested from providers.

- *The RAC program promotes continuous process improvement for claims processing and payment.* CGI participates along with the other Recovery Auditors in major finding discussions with CMS. This process informs CMS of areas representing the greatest vulnerability to the program along with recommendations for corrective action. Additionally, CGI has identified situations where providers were paid in a manner that seemed incorrect, but were not addressed by an existing CMS rule forbidding payment. In those cases, CGI informed CMS of the potential need for rule changes to close loopholes and front end coding edits to avoid future under/over payments. In other cases, CGI has reviewed provider billing and reimbursement situations that seemed to warrant investigation only to conclude that the arrangements were entirely appropriate. This review process provides an important "check and balance" function for and promotes continuous improvement of the claims payment system.

Overall, the Medicare RAC program works well. It has helped CMS identify and recover billions of dollars of improper payments and done so in a manner that is a model for program integrity efforts when it comes to transparency and program governance. CGI remains open to commonsense suggestions to improve the RAC program for all parties involved. In fact, CGI sees some opportunities to improve not only the RAC program, but also other program integrity efforts at CMS. Specifically, CGI recommends that the Committee focus on the following improvement opportunities:

- *Improve the appeals process.* Although the Recovery Auditor accuracy scores are quite high and, according to CMS data, a low percentage of claims identified as improper payments have been overturned on appeal since the start of the program, there are some issues with the appeals process that have been well-documented by the Inspector General at the Department of Health and Human Services (HHS). Among them is the flexibility that Administrative Law Judges (ALJs) have to make decisions that are not in line with Medicare policy. In cases where Recovery Auditors do have findings overturned on appeal, it is most frequently when an ALJ has made such a decision. To increase program effectiveness and consistency, Congress and CMS should look at the Inspector General's findings in this area and see if there are opportunities to limit ALJ discretion on appeals involving existing Medicare policies to promote the integrity of RAC and other Medicare programs.

- *Extend the RAC program's transparency and program governance to other Medicare program integrity initiatives.* In many cases, the transparency and governance provisions described above are unique to the RAC program among the "alphabet soup" of program integrity contractors at CMS. On numerous occasions, CGI's help desk has received questions or complaints about audits and reviews performed by other contractors. CGI supports efforts to consolidate transparency and governance mechanisms across the different programs to assist providers in their compliance efforts.

The Medicare RAC program is an essential element in the broader effort of program integrity. For nearly two decades, CGI has been advocating a comprehensive approach to program integrity that involves: clearly defined program policies; pre-payment edit rules and audits of claims; post-payment recovery audits; and investigation of fraudulent activity. CGI believes that each element is essential to ensuring compliance with the program and the ultimate goal of protecting the trust funds.

CGI is proud of its ability to deliver successfully on the RAC program by featuring the company's healthcare expertise and broad experience in audit recovery programs. Moreover, CGI remains passionate about the opportunity to partner with CMS, and other public agencies, in one of the most critical "good government" efforts underway today.

I appreciate the opportunity to appear before you all today and would be pleased to answer any questions that you may have.

Statement of The American Association for Homecare Before
The United States Senate Committee on Finance

Program Integrity: Oversight of Recovery Audit Contractors
June 25, 10:00 am ET– 215 Dirksen Senate Office Building

AAHomecare would like to thank Chairman Baucus, Ranking Member Hatch and members of the Senate Committee on Finance for holding this hearing on oversight of Medicare's Recovery Audit Contractors. We are pleased to share our members experiences with the Centers for Medicare & Medicaid Services' (CMS') audit processes and make recommendations on how Congress can more effectively combat fraud and abuse within Medicare program.

AAHomecare is the national trade association representing the homecare community. AAHomecare represents health care providers and manufacturers that serve the medical needs of Americans who require sleep therapy technologies, oxygen equipment and therapy, mobility assistive technologies, medical supplies, inhalation drug therapy, home infusion, and other home medical equipment, therapies, services, and supplies in their homes. Our membership reflects a broad cross-section of the homecare community including national, regional, and local providers operating in all 50 states. AAHomecare and its members are committed to advancing the value and practice of quality health care services at home.

AAHomecare strongly supports vigorous program integrity activities to protect Medicare and its beneficiaries. We agree that Medicare must be vigilant to ensure that benefit dollars are not diverted to abusive or fraudulent providers. AAHomecare has a long history of supporting program integrity measures to protect Medicare payments for durable medical equipment, prosthetics, orthotic and supplies (collectively, "DMEPOS"), many of which have been incorporated into law or regulation. In addition, AAHomecare has allocated resources to educating DMEPOS suppliers to improve their awareness of the need for them to adopt compliant and ethical business practices. Consequently, the high claims payment error rate for the Medicare DMEPOS program is as troubling to the association as it is to other stakeholders in the Medicare program.

While this hearing focuses on oversight of Recovery Audit Contactors, AAHomecare respectfully requests the Senate Finance Committee investigate issues with other Medicare audit contractors. Our

1707 L Street NW, Suite 350, Washington, DC 20036
Tel: 202.372.0107 Fax: 202.835.8306 www.aahomecare.org

statement below identifies the current Medicare framework for paying and auditing DMEPOS claims. It also identifies the steps that association has taken, and continues to take, to work with CMS and other stakeholders to improve the efficiency of Medicare's audit processes and promote compliant and ethical business practices among DMEPOS suppliers. Lastly, we include key recommendations for Congress to consider to more effectively combat fraud and abuse.

I. BACKGROUND

CMS contracts with private companies to administer Medicare program functions, such as processing and paying claims. Medicare Administrative Contractors (MACs) pay claims, develop local coverage determinations (LCDs), offer provider education, and perform complex medical reviews (*i.e.*, audits) to identify and recover overpayments. MACs are third-party administrators who perform the routine administrative tasks necessary for the day-to-day operation of the program.

CMS engages other contractors in more targeted roles to perform Medicare Integrity Program (MIP) activities. These contractors, known as Medicare Integrity Contractors (MICs), have a narrower scope of work, focusing almost entirely on preventing, identifying, and recovering payments that should not be paid or that were paid in error. These contractors might also engage in extensive data collection and analysis in order to both identify DMEPOS items subject to abuse and target suppliers with aberrant billing practices.

Zone Program Integrity Contractors (ZPICs) and Program Safeguard Contractors (PSCs) are MICs tasked with these benefit integrity functions. ZPICs and PSCs also develop cases for possible civil or criminal investigations. Other contractors perform MIP activities, but provide a narrower range of services. All of the contractors can perform complex audits to carry out their duties. ZPICs, PSCs, and DME MACs conduct both pre and post-payment audits. Comprehensive Error Rate Testing (CERT) contractors and Recovery Audit Contractors (RACs) only audit claims post payment, consistent with their more limited scope of work.[1]

II. THE MEDICARE DMEPOS BENEFIT ERROR RATE

CMS is required by the Improper Payments Information Act (IPIA) of 2002 to identify improper Medicare payments, compute a national claims payment error rate for the Agency, and develop strategies to reduce and collect improper payments. CMS engages CERT program contractors to calculate the payment error rate for each Medicare benefit, including DMEPOS. CERT contractors perform post-payment audits of claims selected randomly on the date of submission to determine whether the affiliated contractor properly adjudicated the claim.

Prior to 2009, CERT contractors followed Medicare contractor instructions to use "clinical judgment" in conducting audits. That is, contractors were required to employ clinicians to perform audits and the

[1] CMS employs contractors to administer the comprehensive error rate testing program (CERT). These contractors audit the MACs to determine their claims payment accuracy. CMS also has contracts with Recovery Audit Contractors (RACs) that work on contingency to recover improper payments that other CMS contractors have not identified.

clinicians were, in turn, required to use their clinical expertise to evaluate the medical necessity of equipment or services *in light of the beneficiary's claim history*. Specifically, the Medicare Program Integrity Manual, effective in 2008, stated as follows:

> During complex review, nurse and physician reviewers may call upon other health care professionals (e.g., dieticians, and physician specialists) for advice. Any determination must be documented and include the rationale for the decision. While MR [medical review] staff must follow national coverage determinations and local coverage determinations, ***they are expected*** to use their expertise ***to make clinical judgments*** when making medical review determinations. ***They must take into consideration the clinical condition of the beneficiary as indicated by the beneficiary's diagnosis and medical history when making these determinations.*** For example, ***if a medical record indicates that a beneficiary is a few days post-op for a total hip replacement and femur plating, even though the medical record does not specifically state that the beneficiary requires the special skills of ambulance transportation, MR nurses and physicians must use their clinical knowledge to conclude that ambulance transportation is appropriate under such circumstances.***

In 2009, the Department of Health and Human Services (HHS) Office of Inspector General (OIG) published a report that was critical of CMS' clinical judgment review policy, holding that CMS misstated the error rate because the Agency did not require contractors to adhere strictly to its coverage and documentation policies. Reacting to the OIG's input, CMS adopted new auditing practices. Under this new formulation of CMS' medical review policy, the Medicare DMEPOS error rate shot up from 10.2 percent to 51.9 percent because the bar for documenting medical necessity had increased. Since then, the Medicare error rate for DMEPOS has continued to climb and is now at level that has many reasonable people questioning the efficiency and reliability of CMS' approach to payment audits.

It is important to remember that the high error rate is not indicative of rampant fraud among DMEPOS providers. Rather it is a reflection on Medicare's emphasis on technical documentation issues. In other words, the beneficiary has a documented medical need for the equipment or supply, but because the documentation of medical necessity does not meet contractors' heightened technical requirements, auditors determine that claims were improperly paid. Restoring the audit contractors' ability to use clinical review judgment would bring the down what we believe to be an artificially high payment error rate.

III. MEDICARE OVERSIGHT OF CONTRACTORS' AUDIT ACTIVITIES IS FRAGMENTED AND UNWIELDY

As noted above, Medicare contracts with private entities, MAC, CERTS, RACS and ZPICS, to perform payment and audit activities on behalf of the Medicare program. There are four MACs, a CERT, seven ZPICS, as well as a number of RACs. As a result of the number of audit contractors with jurisdiction to audit DME claims, DME providers do not have a good understanding of who the contractors are or the reasons underlying the audits they perform. For example, many DME providers do not understand that the CERT contractor's role is to determine the Medicare error rate or that the error rate drives the MACs pre- and post-payment audits.

The Jurisdiction B MAC provides a typical example. In the 3rd quarter of 2011, the contractor reported an astonishing 93 percent error rate for support mattresses. However, the contractor's analysis shows that 20 percent of the DME providers audited did not respond to the additional documentation requests (ADRs). Notably, the high rate of non-responders improperly skews the DMEPOS error rate upwards. Excluding non-responders from the error rate calculation would result in a more accurate measure. DME providers who do not respond to audit requests require more targeted education. Chronic non-responders raise a red flag and should, at a minimum, receive an onsite visit to make sure they are legitimate DME providers.

IV. AAHomecare's Activities To Promote Compliance And Ethical Business Practices Among DMEPOS Providers

AAHomecare supports strong program integrity measures to ensure that improper claims are not paid and those that are paid are promptly recovered. AAHomecare has made several recommendations that have been adopted by Congress or CMS. For example, AAHomecare has been a strong advocate for mandatory accreditation of DMEPOS providers and meaningful quality and service standards for equipment and suppliers. AAHomecare has supported stronger supplier standards, including mandatory site visits for all new suppliers enrolling in Medicare and suppliers renewing their enrollment.

Currently, DMEPOS suppliers must be accredited in order to obtain a Medicare billing number, and they must adhere to quality standards promulgated by CMS and administered by the accrediting bodies. Suppliers must be accredited to furnish the equipment and services they provide to beneficiaries. This means that a supplier that furnishes oxygen must demonstrate to the accrediting body that it meets the standards applicable to oxygen. Likewise, a supplier that furnishes power wheelchairs must be accredited to do so. Providers may furnish only the products and services that they are accredited to furnish.

AAHomecare believes that a more stringent enrollment process, including additional unannounced site visits for suppliers that are new to Medicare, as well as close monitoring of their claims submission patterns will help Medicare end the relentless "pay and chase" cycle that has permitted "fly by night" companies to bill Medicare fraudulently and disappear.

In addition, AAHomecare promotes the need for DMEPOS suppliers to adopt ethical and compliant business practices that focus on a company's interactions with beneficiaries, payers, and referral sources. AAHomecare has a voluntary Code of Business Ethics that identifies the types of compliant and ethical business practices that supplier's should adopt within their organizations. AAHomecare's goal is for every DMEPOS supplier to understand the importance of promoting a culture of ethics and compliance within their companies. The AAHomecare Code reinforces the need for suppliers to adhere to quality standards when they furnish DMEPOS services to all patients. The Code also highlights the importance of understanding payers' coverage, documentation, and reimbursement policies and adopting internal policies to prevent, identify, and promptly resolve billing errors.

AAHomecare is also committed to assisting DMEPOS suppliers in their efforts to comply with Medicare documentation and billing requirements. AAHomecare members who are experts in Medicare billing,

compliance, and documentation practices have developed documentation tools for equipment and supplies that are audited frequently and have high payment error rates. These documentation tools are derived from the applicable Medicare coverage policy for the equipment or supply item and highlight specific clinical issues that must be documented in the medical record to support the medical necessity of the item prescribed.

V. Proposed Anti-Fraud, Waste, and Abuse Solutions

To more effectively combat fraud and abuse in the DMEPOS benefit, AAHomecare has developed the following key recommendations for Congress to consider:

- **Conduct independent reviews of Medicare contractors to hold them accountable;**
- **Establish clear, unambiguous medical policies for DME;**
- **Enhance review of DME providers who do not respond to audit requests;**
- **Establish limitations on the number of audits a DME provider can receive during a given time period;**
- **Reinstate "clinical inference" policy;**
- **Require that electronic health records systems include elements for DME medical necessity documentation;**
- **Mandate use of an electronic clinical medical necessity template;**
- **Mandate use of a template in power mobility device (PMD) prior authorization demonstration;**
- **Provide additional physician education on medical necessity requirements; and**
- **Establish definitive policy prohibiting retroactive implementation of policies.**

Conduct independent reviews of Medicare contractors to hold them accountable: Congress should consider some method of independent review of audit contractors to hold them accountable for their audit tactics and results. These independent reviews should be conducted under strict guidelines to determine whether audit tactics were applied consistently and correctly. Claims that are subsequently overturned at any level of appeal should also factor into the review. As a part of this Congressional oversight of CMS and its audit contractors, the Senate Finance Committee should consider conducting a hearing annually, at a minimum, to evaluate CMS and its contractors in a public forum. Additionally, Congress should consider penalizing CMS and/or its contractors for audit denials that are overturned at any level of appeal.

Establish clear, unambiguous medical policies for DME: Ambiguous and inconsistently applied documentation policies are a large contributor to the DME error rate. In order to reduce the error rate significantly, CMS and its contractors must establish policies that can be clearly and consistently interpreted by CMS, its contractors, DME providers, and the ordering/referring physicians who prescribe DME. If policies can be interpreted subjectively to the point where the same claim and documentation is approved by one clinical reviewer and rejected by another, it is impossible for DME providers and physicians to comply with these policies consistently.

Enhanced review of DME providers who do not respond to audit requests: When Medicare contractors audit DME providers, we have found that some DME providers do not respond to the audit, which results in an arbitrarily high error rate and leads to ongoing payment reviews of that item or service for all other DME providers. Widespread audits have shown that the non-response rates range from 20 percent to nearly 50 percent, presenting a significant challenge to reducing the error rate for DME.[2]

Congress should mandate that CMS and its contractors place a higher level of scrutiny on DME providers who do not respond to audits. This should be done through the following actions: 1) allow for a second audit request to be submitted to the provider ensuring that the appropriate address and contact information is indicated in the initial audit request; 2) if there is no response to the second request, the audit contractor contacts the DME provider by phone to inform him of the non-response to the audit; 3) the contractor places the DME provider on a probe review for the item or service that was not responded to in the audit; and, 4) if responses are not received for the probe review, the DME provider is referred to the National Supplier Clearinghouse for an unannounced site visit to determine if that DME provider is committing outright fraud.

Establish limitations on the number of audits a DME provider can receive in a given time period: Providers receive audits from many different contractors including the Comprehensive Error Rate Testing contractor (CERT), Zone Program Integrity Contractors (ZPIC), Recovery Audit Contractors (RAC), and the DME Medicare Administrative Contractors (DME MAC), at times for the same patient and the same date of service. These contractors appear to operate largely on their own with little coordination to determine whether a claim has already undergone an audit by a different contractor. In addition a DME provider could be audited in different rental months for the same item for the same patient. While CMS sets some limitations on the number of audits that a specific contractor can conduct on a DME provider, we believe a limit must be placed on the level of audit activity a DME provider can undergo within a given time frame across all contractors to ensure that the number of audits are not overly burdensome. Additionally, a limit should be placed on auditing the same patient month-after-month for an item that is billed on a rental or recurring basis. Auditing the same patient multiple times is duplicative and an unnecessary waste of contractors' resources and DME providers' time and effort.[3]

Reinstate "clinical inference" policy: Prior to 2009, auditors could use clinical inference to determine whether an item or service was medically necessary and should be paid by Medicare. This led to a much lower error rate for DME because the auditors' clinical review staff could weigh the entire medical history as a factor in determining medical necessity. In 2008, the Medicare DMEPOS CERT claims error rate was approximately 9 percent. In 2009, CMS adopted new auditing criteria that resulted in a DMEPOS claims error rate of 52 percent. For 2011, the claims error rate is reported to be 61 percent,

---

[2] For example: NHIC, Corp., the Jurisdiction A DME MAC, reported a 46 percent non-response rate in a widespread prepayment review for nebulizers (HCPCS code E0570) on December 22, 2011.
Noridian Administrative Services LLC, the Jurisdiction C DME MAC, reported a 29 percent non-response rate in a widespread prepayment review of diabetic supplies (HCPCS code A4253KX) on March 5, 2012.
NHIC, Corp., the Jurisdiction A DME MAC, reported a 24 percent non-response rate in a widespread prepayment review of enteral nutrition infusion pumps (HCPCS codes B9000 and B9002) on June 20, 2012.

[3] See example #1 in Appendix.

incorrectly suggesting that three out of five Medicare DMEPOS claims are paid improperly, which CMS notes is not an indicator of fraud or abuse.

For example, in 2008 and previous years, if a patient with a lifetime Certificate of Medical Necessity (CMN) for oxygen had Chronic Obstructive Pulmonary Disease (COPD) as a diagnosis in his/her medical record, the clinical reviewer could use that in determining that the patient's oxygen was medically necessary. When CMS eliminated the use of clinical inference in 2009, based on a recommendation from OIG, many of these claims are now denied for reasons such as the physician did not document that the patient was still using oxygen during his/her last office visit. A similar issue occurs with other medical equipment that is furnished on a rental basis and/or for the treatment of chronic conditions that require power wheelchairs, hospital beds, CPAP devices, diabetic supplies, and enteral nutrition.

Require that electronic health records systems include elements for DME medical necessity documentation: While CMS encourages physicians, hospitals, and other providers to adopt electronic health record (EHR) technologies, the current Medicare-approved vendors do not contain the criteria necessary to properly prescribe DME and document all necessary elements in the patient's medical record. Mandating that approved EHR vendors include elements for ordering DME items and services would go a long way toward ensuring physician document the necessary elements in the patient's medical record and thereby aid in reducing the error rate for DME.

Mandate use of an electronic clinical medical necessity template: Recognizing that it will take time to design and adopt DME criteria in EHR systems, CMS must allow clinical medical necessity templates for physician use in prescribing DME in the interim. The documentation requirements for DME items and services are complex and constantly changing. A clinical medical necessity template would help guide physicians through documenting the necessary elements when prescribing a specific item or service. Additionally, DME is often prescribed by family physicians, internists, and other general medical non-specialty physicians, many of whom order less than ten of a given DME item in a year. Templates would help ensure that all physicians are familiar with the required documentation elements for DME items and services. To be effective, these templates must also be considered a part of a patient's medical record.

Mandate use of a template in the power mobility device (PMD) prior authorization demonstration: CMS is in the process of developing and implementing a massive prior authorization demonstration for PMDs that will impact seven states and 43 percent of all claims for power mobility devices. CMS has begun developing an electronic clinical medical necessity template for PMDs, but the Agency has stated that this tool is on a separate track from this demonstration and will not be used when the demonstration begins. CMS also has stated that the use of the electronic template will be voluntary. AAHomecare believes that if CMS wants to: 1) ensure beneficiary access to PMDs; 2) reduce incidence of fraud and abuse; and, 3) significantly reduce the error rate, it must allow physicians to use a clinical medical necessity template when this demonstration begins. Additionally, the clinical medical necessity template must be mandatory and be considered part of a patient's medical record.

Provide additional physician education on medical necessity requirements: For DME providers, a constant problem in audit denials is related to an error that occurred in some portion of the physician's documentation. Currently, the DME MACs encourage homecare providers to educate physicians on the documentation requirements. Despite attempts by DME providers to educate ordering physicians, this aspect of the error rate remains high. CMS should educate physician groups on medical necessity documentation to help reduce the DME error rate.

Establish definitive policy prohibiting retroactive implementation of policies: In order to reduce the error rate for DME, CMS must definitively prohibit contractors from implementing new policies retroactively. Often, DME MACs release a "clarification" to a medical policy that is truly a revision to the policy rather than a clarification. It is impossible for DME claims to withstand scrutiny in an audit when the contractors make policy changes that are implemented retroactively. An example of this is the DME MACs' policy on refills for non-consumable supplies. The DME provider is now required to "assess whether the supplies remain functional, providing replacement (a refill) only when the supply item(s) is no longer able to function" and document the dysfunction of the item. This revised policy was released on June 7, 2012, with an implementation date that was retroactive to August 2, 2011. Claims for non-consumable supplies submitted during the ten-month period between the initial policy issue date and the revision date are almost certain to fail in an audit. Congress must place strict guidelines on Medicare contractors that prohibit retroactive implementation of medical policy revisions.

Further, audit contractors often target claims submitted three or four years after the date of service. If these claims do not pass medical review, the DME provider is unable to resubmit the claim because of timely filing requirements or the patient may have moved into an institutional setting or died.

Finally, AAHomecare recommends that any local coverage determination (LCD) policy changes be issued in the proposed format with a minimum of a 30-day public comment period prior to implementation. This includes revisions, regardless of whether they are deemed "clarifications," that could likely result in medical necessity denials if implemented retroactively.

VI. CONCLUSION

AAHomecare is concerned about the high Medicare claims payment error rate for DMEPOS. The error rate can be attributed, at least in part, to Medicare contractors' highly technical interpretation and application of Medicare medical necessity requirements and the fragmented nature of CMS' oversight of its payment and audit contractors. Streamlining the audit process and allowing contractors to use clinical judgment when they perform audits will reduce the high claims payment error rate for DMEPOS.

AAHomecare is also committed to eliminating fraud and abuse from the Medicare DMEPOS benefit. The association has consistently supported measures to strengthen Medicare program integrity and increase the scrutiny of DMEPOS suppliers when they enroll in Medicare for the first time. Finally, AAHomecare is committed to promoting compliant and ethical business practices throughout the DMEPOS industry. The AAHomecare Code of Business Ethics addresses suppliers' interactions with patients, payers and referral sources and highlights suppliers' obligation to understand and follow payers' coverage, documentation and billing requirements. To that end, AAHomecare has developed documentation tools that suppliers can use in their businesses to improve the quality of their billing practices.

American Hospital Association

Liberty Place, Suite 700
325 Seventh Street, NW
Washington, DC 20004-2802
(202) 638-1100 Phone
www.aha.org

Statement

of the

American Hospital Association

before the

Committee on Finance

of the

United States Senate

Program Integrity: Oversight of Recovery Audit Contractors

June 25, 2013

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 this opportunity to submit for the record comments on the importance of oversight of Recovery Audit Contractors (RACs).

HOSPITALS TAKE SERIOUSLY THEIR OBLIGATION TO BILL PROPERLY

Hospitals take seriously their obligation to properly bill for the services they provide to Medicare and Medicaid beneficiaries and are committed to working with the Centers for Medicare & Medicaid Services (CMS) to ensure the accuracy of Medicare and Medicaid payments. The AHA recognizes the need for auditors to identify billing errors; however, redundant government auditors, unmanageable medical record requests and inappropriate payment denials are wasting hospital resources and contributing to growing health care costs. More oversight is needed of audit contractors to prevent inaccurate payment denials and to make the overall auditing effort more transparent, timely, accurate and administratively reasonable.

BURDEN OF INCREASED AUDIT ACTIVITY

In recent years, CMS has drastically increased the number of program integrity auditors that review hospital payments to identify improper payments. CMS's audit contractors focused on improving payment accuracy include RACs and Medicare Administrative Contractors. Medicare and Medicaid RACs are charged with identifying improper Medicare and Medicaid fee-for-service payments – both overpayments and underpayments. RACs are paid on a contingency fee basis, receiving a percentage of the improper payments they identify and collect.

No one questions the need for auditors to identify billing mistakes; however, many auditors conduct redundant audits that drain time, funding and attention that could more effectively be focused on patient care. For example, according to a recent AHA survey of 2,300 participating hospitals, there was a 61 percent increase in the number of records requested for RAC audits during 2012. These Medicare claims now collectively represent more than $6 billion in Medicare payments, an 83 percent increase from the claims requested for RAC audits through 2011.

Hospitals have been forced to hire additional staff just to manage the audit process. According to the latest AHA survey data of 1,324 hospitals, 63 percent of all hospitals reported spending more than $10,000 managing the RAC process during the first quarter of 2013, 46 percent spent more than $25,000 and 10 percent spent more than $100,000.

INACCURATE CLAIMS' DENIALS BY RACS

Hospitals are experiencing a significant number of *inaccurate* RAC denials, which total millions of dollars. The latest AHA survey data indicate that 68 percent of medical necessity denials reported were for one-day stays where the care was found to have been provided in the wrong setting – not because the care was medically unnecessary.

RACs have a significant focus on reviewing short inpatient stays, and they deny these types of claims sometimes up to three years after the patient was treated. Physicians who treat Medicare patients do not have the benefit of knowing in advance the health outcome of the patient; therefore, they treat patients in the setting they determine to be medically appropriate. RAC auditors – typically non-physician auditors – second guess physicians by evaluating medical records with information that was not available to the physician when the patient presented. Hospitals disagree with a large portion of subjective denials made by these auditors.

HOSPITALS HAVE HIGH SUCCESS RATES ON APPEALS

Despite being charged with ensuring the accuracy of Medicare payments, and despite a purported expertise in identifying inaccuracies, RACs do not have a strong record finding legitimate errors in hospital claims. For example, according to results from the most

recent AHA survey on RAC activity, 72 percent of RAC denials that were appealed were overturned in favor of the hospital. In fact, some hospitals have appeal success rates above 95 percent. Unfortunately, not all hospitals have the resources to appeal denials because it is costly and time consuming.

UNEVEN PLAYING FIELD FOR APPEALS

Hospitals are successful in their appeals even though hospitals face a highly uneven playing field when they appeal an erroneous RAC denial. To recapture full payment for reasonable and necessary care, hospitals must separately appeal each RAC denial through an appeals process that can take more than two years. A single auditor can produce dozens of denials per day, while a hospital must appeal every incorrect denial through a one-claim-at-a-time appeal. The latest AHA survey indicates that about 75 percent of all appealed claims are still in the appeals process.

SUPPORT FOR MEDICARE AUDIT IMPROVEMENT ACT

The AHA supports the *Medicare Audit Improvement Act*, S. 1012 /H.R. 1250, legislation that would improve the RAC program and other Medicare audit programs. Sens. Mark Pryor, D-AR, and Roy Blunt, R-MO, last month introduced the bill in the Senate, and Reps. Sam Graves, R-MO, and Adam Schiff, D-CA, in March introduced the bill in the House.

The *Medicare Audit Improvement Act* provides much needed guidance for medical necessity audits, keeping auditors out of making medical decisions that should be between patients and their physicians. It would establish annual limits on documentation requests from RACs, impose financial penalties on RACs if they fall out of compliance with program requirements, make RAC performance evaluations publicly available and allow denied inpatient claims to be billed as outpatient claims if necessary, among other measures.

CONCLUSION

America's hospitals take seriously their obligation to properly bill for the services they provide to Medicare and Medicaid beneficiaries. They 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 urges CMS to offer increased provider education to assist hospitals in proactively identifying the most common payment errors and the remedies needed to eliminate errors and related payment denials.

More oversight is needed of audit contractors to prevent inaccurate payment denials and to make the overall auditing effort more transparent, timely, accurate and administratively reasonable. The AHA and its members stand ready to work with policymakers to support these efforts.

American Orthotic &
Prosthetic Association

STATEMENT FOR THE RECORD

SENATE FINANCE COMMITTEE HEARING ON RECOVERY AUDIT CONTRACTORS AND OTHER MEDICARE AUDITING CONTRACTORS (JUNE 25, 2013)

The American Orthotic & Prosthetic Association (AOPA) has noted with great interest the Senate Finance Committee's hearing relating to Recovery Audit Contractors (RACs) and other Medicare contractors that conduct audits. During the hearing, the committee heard about difficulties the RACs cause for hospitals and health systems. We wish to bring to the attention of the Senate Finance Committee the disastrous effects that RAC audits have had on orthotic and prosthetic (O&P) practitioners, the majority of which are small businesses with total revenues of $1 million or less. We agree with the Committee that the Medicare program should not reimburse health care providers for items and services that are not reasonable and medically necessary or furnished in compliance with Medicare requirements, and that health care providers should not be permitted to retain payments to which they are not entitled. However, we believe that the goal of the RAC program to identify erroneous payments must not needlessly overburden health care providers. Simply put, the program is harming health care providers and the beneficiaries they serve, and a balance must be restored. Like many other health care providers who are subject to RAC audits, orthotic and prosthetic practitioners cannot continue to bear the cash-flow disruptions caused by RAC audits and their resulting recoupments.

The American Orthotic & Prosthetic Association, founded in 1917, is the largest national orthotic and prosthetic trade association with a membership that draws from all segments of the field of artificial limbs and customized bracing for the benefit of patients who have experienced limb loss or limb impairment resulting from a trauma, chronic disease or health condition. These include patient care facilities, manufacturers and distributors of prostheses, orthoses and related products, and educational and research institutions. Given the proportion of our members' patients who are Medicare beneficiaries, we have a direct interest in the issue of audits conducted by RACs and other Medicare contractors.

Background

Audits being conducted by CMS contractors concerning claims for prosthetic devices are jeopardizing the economic viability of small O&P businesses, which are critically important healthcare providers. It is well-known that RAC audits have been very controversial and troublesome for hospitals, but O&P practitioners and their patients have been devastated by RAC audits, as well. Orthotics and prosthetics practitioners caring for Medicare beneficiaries have faced increasing audits and recoupment of funds for claims previously paid.

To grasp the full effect of these audits, it is important to understand how O&P care is delivered to Medicare beneficiaries. O&P practitioners must purchase components that make up a prosthetic device prior to dispensing the prosthesis to the Medicare beneficiary. Prosthetic providers are not allowed to

IN CARLYLE STREET, SUITE 200 ALEXANDRIA, VIRGINIA 22314 • PHONE (571) 431-0876 • FAX (571) 431-0899 • WWW.AOPANET.ORG

bill Medicare for a prosthesis until the date of service, which very often is the date of delivery of the completed prosthetic device. Therefore, these small businesses often face significant financial outlays and depend on timely Medicare payments for services rendered. When faced with audits, providers often are forced to go through a lengthy appeals process in order to retain payment for their services. As you know, a high percentage of RAC determinations are reversed at the AU level because the AU finds that the services challenged by RACs actually were medically necessary services furnished in compliance with Medicare standards. These challenges to legitimate care can cause huge cash flow deficiencies for those small businesses that not only have legitimate payments held up through the appeals process, but also must devote valuable employee time to pursue the arduous appeals process. O&P businesses are struggling to stay afloat in light of these overly burdensome audits.

O&P Practitioners' Experiences with RACS since 2011

Orthotics and prosthetics practitioners' difficulties with RAC audits intensified tremendously after the Department of Health and Human Services Office of the Inspector General (OIG) published a report in August 2011 claiming that many Medicare claims for lower limb prostheses were erroneous. The report was inaccurate in many respects and revealed a profound misunderstanding by the OIG about how referrals for prosthetics are made and how the devices are furnished. For example, the report claimed that O&P providers oftentimes billed incorrectly for prosthesis "when the beneficiary had no claims from the referring physician," yet the referring physician most often is the surgeon who amputated a limb, which explains the lack of claims from the referring physician. It also insinuated that recent increased costs for prostheses must be attributable to fraud, when in fact the wars in Iraq and Afghanistan — and the large number of lower-limb amputee service members — led to a quantum leap in the available prosthesis technology. On the heels of this deeply flawed OIG report, RAC audit activity aimed at O&P practitioners increased greatly. And, concurrently with the OIG report, CMS issued a "Dear Physician" letter that made material changes to Medicare standards for reimbursing prosthetic claims. This sowed additional confusion among O&P practitioners, Medicare contractors, and RACs as to the criteria for prosthetic claims in the Medicare program.

AOPA, along with all of our partners in the O&P Alliance and the majority of our member firms, have fought at every turn over the past 20 months to try to explain to CMS that its actions on this matter are unfair, contrary to the statutes, and detrimental to the care provided to Medicare beneficiaries. We have met with several CMS officials, including three meetings with the CMS Administrator. In early April 2013, 35 Members of the U.S. House of Representatives signed a letter to the Secretary of HHS seeking relief for O&P practitioners and our Medicare patients. Despite knocking on every door, little has been done by CMS to remedy this unworkable situation.

Again, in a profession dominated by modest-sized businesses, this massive "claw-back" of amounts already paid, coupled with Medicare invoking increasing pre-payment audits of prosthetic claims, has strangled the cash-flow of our O&P practitioner members. Manufacturers of the O&P components, which have been so instrumental in advancing O&P technology and the quality of patient care, have found that the O&P practitioners have had to select lower-functioning components in order to reduce costs, and many have been unable to continue to pay their bills on a timely basis. Some plants formerly with two manufacturing shifts have been forced to cut back to one and layoffs have followed.

The OIG report and CMS's changes to reimbursement criteria have forced many practitioners to meet the patient's immediate need for a prosthesis by providing a less sophisticated device, rather than endure long delays in care triggered by the paper chase with physicians. CMS wants physicians to provide more documentation in connection with orthoses and prostheses, but it isn't willing to

compensate them for the resulting administrative burden. Physicians have pushed back against request from O&P practitioners, refusing to provide more documentation for prosthetic care.

Conclusion

AOPA has filed suit against HHS in the Federal District Court for the District of Columbia, seeking relief from CMS's unfair and unauthorized actions, primarily relating to the actions of its RAC auditors and DME MACS relating to physician documentation requirements. AOPA has never before sued the federal government. It appears to be our only option, when after 20 months of pursuing all avenues at CMS has still not yielded a solution. We are pleased to see the Senate Finance Committee looking into the RACs' excessive auditing activities and into their commission structure, which we believe creates a perverse incentive for them to find mistakes when none have been made. We stand ready to assist the Committee in any way we can, and we hope that the Senate Finance Committee can assist small health care businesses that comprise the orthotics and prosthetics field.

Thank you for your consideration of our comments.

PROGRAM INTEGRITY: OVERSIGHT OF RECOVERY AUDIT CONTRACTORS

United States Senate Committee on Finance
Hearing
June 25, 2013

Statement Submitted by the Center for Medicare Advocacy, Inc.

The Senate Finance Committee's June 25 hearing on the Recovery Audit Contractors (RACs) program highlights the high financial costs that the RAC program has imposed on acute care hospitals – costs related to hiring additional staff to make inpatient/outpatient decisions, hiring outside consultants to help hospitals make decisions about patients' status, responding to RACs' request for documents, and appealing denials (often successfully) through the administrative appeals process.

The Center for Medicare Advocacy, Inc. (Center) offers this statement about the significant impact of the RAC program on Medicare beneficiaries. The Center, established in 1986, is a national nonprofit, nonpartisan organization that provides education, advocacy, and legal assistance to help older people and people with disabilities obtain fair access to Medicare and necessary health care. The Center is headquartered in Connecticut and Washington, DC.

RACs, observation status, and the impact on Medicare beneficiaries

Acute care hospitals know that if they classify a patient as an inpatient and a RAC later decides that, in its view, the patient should have been classified as an outpatient, they will receive basically no Medicare reimbursement for any of the medically necessary care they provided to the patient. As a result of this concern and in efforts to avoid RAC reviews, many hospitals are increasingly labeling their patients "outpatients."

Patients in outpatient "observation status" generally receive care that is indistinguishable from the care they receive as inpatients. Often sent to a hospital bed from the emergency room, where the physician has told them that they need to remain in the hospital for further care, patients are placed in a hospital bed and receive nursing and medical care, diagnostic tests and treatments, medications, and food. They may stay multiple days and even weeks.

The financial consequences for Medicare beneficiaries who are labeled "outpatient" are enormous. Because Medicare will pay for medically necessary post-acute care in a skilled nursing facility (SNF) only for patients who are called "inpatients" in the hospital, patients who are called outpatients do not qualify for Medicare coverage of their SNF care. They must pay

privately for their care – often hundreds of dollars a day plus Medicare Part B copayments for the rehabilitation services they receive plus the costs of their medications. Sometimes the adult children pay for their parents' SNF stay; sometimes nieces and nephews pay; sometimes patients cash in life insurance policies to pay for their SNF stay. Patients who cannot afford to pay private-pay rates to the SNF may go home, often to be rehospitalized a day or two later.

The Center heard from hundreds of beneficiaries and their families across the country about hospital stays of five or six days, or even 13 or 22 days. The patients were labeled outpatients in observation status for their entire hospital stay. One recent call involved an 86-year old woman who was hospitalized with a broken shoulder. Initially admitted as an inpatient, the woman was reclassified by the hospital as an outpatient. She stayed three midnights and then went to a SNF for rehabilitation, where she paid, out-of-pocket, $7600 for the first month and was told she would be billed $10,000 for the second month. A second recent call involved an 87-year old woman who fractured her shoulder. Called an outpatient by the hospital for her entire four-day stay, she paid $10,650 for her subsequent one-month stay in the SNF. A third beneficiary, an 89 year old woman was hospitalized for three days with pneumonia and sent home. She returned to the hospital the next day, having fallen and broken her hip. She remained in the hospital for six days as an "outpatient in bed" and then went to a SNF, paying out-of-pocket for her care.

Researchers have documented that hospitals' use of outpatient observation status parallels the decline in inpatient stays. Reviewing 100% of Medicare claims data for 2007-2009, researchers found that the number of outpatient observation stays for Medicare beneficiaries increased over the three-year period, while inpatient admissions decreased, suggesting "a substitution of outpatient observation services for inpatient admissions."[1]

The Brown University researchers also reported that the average length of stay in observation increased during the 36 months by more than 7%. Significantly, they found that more than 10% of beneficiaries were placed on observation status for more than 48 hours (despite the fact that the Medicare Manual suggests that observation should generally not exceed 24 hours, may sometimes be up to 48 hours, and, in "only rare and exceptional cases," more than 48 hours.[2]) With nearly one million beneficiaries held in observation status each year, the 10% figure meant that approximately 100,000 people were in observation for more than 48 hours. Finally, the researchers identified a sharp increase in beneficiaries held in observation status for 72 or more hours – 23,841 beneficiaries in 2007; 44,843 beneficiaries in 2009 – an 88% increase. The researchers confirmed that their counts of observation stays were conservative and might be too low.

The Brown University researchers recognized both hospitals' motivation to avoid RAC auditors and the significant harmful impact on Medicare beneficiaries of hospitals' increasing use of observation status:

---

[1] Zhanlian Feng, David B. Wright, and Vincent Mor, "Sharp Rise In Medicare Enrollees Being Held In Hospitals For Observation Raises Concerns About Causes And Consequences," *Health Affairs* 31, No. 6 (2012).

[2] CMS, Medicare Benefit Policy Manual, CMS Pub. 100-02, Chapter 6, §20.6, http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c06.pdf (scroll down to §20.6 at p. 18); same language in Medicare Claims Processing Manual, CMS Pub. 100-04, Chapter 4, §290.1.

> [I]t is reasonable to be concerned that observation services may create barriers for access to postacute skilled nursing facility care, especially for those having been held for observation for an extended period of time. The dual trends of increasing hospital observation services and declining inpatient admissions suggest that hospitals and physicians may be substituting observation services for inpatient admissions – perhaps to avoid unfavorable Medicare audits targeting hospital admissions.

The researchers predicted, correctly, that incentives in the Affordable Care Act to reduce inpatient hospitalizations[3] "may drive even greater use of observation services" in the future. Hospitals' use of observation status has in fact increased dramatically in recent years.

In proposed rules published on May 10, 2013, the Centers for Medicare & Medicaid Services (CMS) reported that the percentage of patients in observation for more than 48 hours increased from 3% to 8% between 2006 and 2011.[4] Moreover, not only has the percentage of patients in observation nearly tripled, but the total number of observation stays of any duration also increased by nearly 50% over the same five-year period. In 2006, approximately 920,000 Medicare beneficiary hospitalizations were in observation status. In 2011, approximately 1.4 million Medicare beneficiary hospitalizations were in observation status. Between 2006 and 2011, there was a more than 400% increase in the number of patients in observation status for more than 48 hours (27,600 people in 2006; 112,000 people in 2011).

Pending bipartisan legislation would resolve beneficiaries' primarily concern with observation status

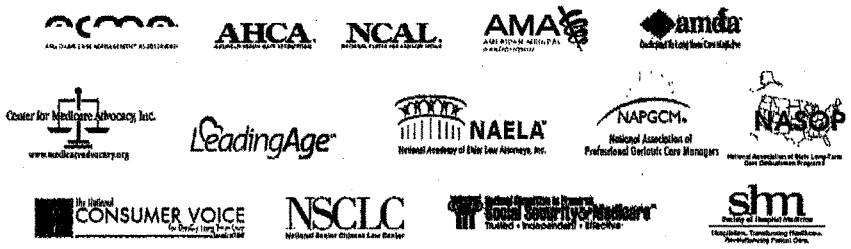
Bipartisan legislation pending in the Senate and House – S.569, H.R. 1179, the "Improving Access to Medicare Coverage Act of 2013" – would resolve beneficiaries' primary problem with observation status by counting all time in the hospital towards meeting the three-day qualifying inpatient stay.

Support for the legislation is broad. The attached Fact Sheet supporting the legislation is endorsed by 14 national organizations, representing physicians and other health care providers as well as advocates for Medicare beneficiaries. No national organization has announced opposition to the legislation.

---

[3] These provisions include, for example, Hospital Readmissions Reduction Program, §3025, 42 U.S.C. §1395ww(q); National Pilot Program on Payment Bundling, §3023, 42 U.S.C. §1866C; and Independence at Home Demonstration Program, §3024, 42 U.S.C. §1866D, all of which have reducing rehospitalizations as an explicit goal.

[4] 78 Fed. Reg. 27486, 27644 (May 10, 2013).



OBSERVATION STAYS DENY MEDICARE BENEFICIARIES

ACCESS TO SKILLED NURSING FACILITY CARE

Medicare beneficiaries are being denied access to Medicare's skilled nursing facility (SNF) benefit because acute care hospitals are increasingly classifying their patients as "outpatients" receiving observation services, rather than admitting them as inpatients. Patients are called outpatients despite the fact that they may stay for many days and nights in hospital beds and receive medical and nursing care, diagnostic tests, treatments, medications, and food, just as they would if they were inpatients. Under the Medicare statute, however, patients must have an **inpatient** hospital stay of three or more consecutive days, not counting the day of discharge, in order to meet Medicare criteria for coverage of post-acute care in a SNF. As a result, although the care received by patients in observation status is indistinguishable from the care received by inpatients, outpatients in observation who need follow-up care in a SNF do not qualify for Medicare coverage. Hospital stays classified as observation, no matter how long and no matter the type or number of services provided, are considered outpatient. These hospital stays do not qualify patients for Medicare-covered care in a SNF.

Hospitals' use of observation status and the amount of time patients spend in observation status are both increasing. A study found a 34% increase in the ratio of observation stays to inpatient admissions between 2007 and 2009, leading the researchers to conclude that outpatient observation status was becoming a substitute for inpatient status. The same study also documented increases in long-stay outpatient status, including an 88% increase in observation stays exceeding 72 hours.

A primary motivation for hospitals' increasing use of observation status has been concern about the Recovery Audit Contractor (RAC) program. If the RAC or another Medicare reviewer determines that a patient has been incorrectly classified as an inpatient, the hospital is denied reimbursement for most services provided to the patient, despite the fact that the services were medically necessary and coverable by Medicare.

In addition, readmission penalties imposed against hospitals may increase the incentives for hospitals to label patients as outpatients. Patients who are called outpatients do not trigger any readmission penalty when they return to the hospital. Likewise, patients who have been inpatients do not trigger a readmission penalty if they return to the hospital as outpatients.

There is bipartisan support in both the House and Senate to fix this problem. Representatives Joseph Courtney (D-CT) and Tom Latham (R-IA) have introduced the ***Improving Access to Medicare Coverage Act of 2013*** (H.R.1179) to help Medicare beneficiaries who are hospitalized in observation status. This bill would require that time spent in observation be counted towards meeting the three-day prior inpatient stay that is necessary to qualify for Medicare coverage of SNF care. Senator Sherrod Brown (D-OH) has introduced a companion bill, S.569, cosponsored by Senator Susan Collins (R-ME).

July 2013

○