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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.