Illinois Hospital Association

December 11, 2007

TO: Chief Executive Officers

PLEASE ROUTE TO: Chief Financial Officers
Government Relations Personnel
Post Acute Care Constituency

FROM: Tom Jendro, Senior Director, Finance

SUBJECT: **Technical Bulletin #307: CMS Recovery Audit Contractor (RAC) Update**

Over the past several weeks, the Illinois Hospital Association (IHA), the American Hospital Association (AHA) and other state and local hospital associations have given significant attention to a Medicare payment review project that was undertaken by the Centers for Medicare and Medicaid services in 2005. Known as the "Recovery Audit Contractor (RAC) Program", its mission is "...to reduce Medicare improper payments through the efficient detection and collection of overpayments, the identification of underpayments and the implementation of actions that will prevent future improper payments." (CMS Statement of Work, page 1, November 7, 2007) CMS' objective is "To pay the claim right the first time." This project is currently in the "home stretch" of completion in the three original demonstration states (California, Florida and New York), while RAC contracts have been awarded in two additional states (Massachusetts and South Carolina). The reviews have already begun in South Carolina.

The RAC audits were discussed at three member group meetings during the past couple of months: IHA Governing Board, Small and Rural Hospitals Constituency and Post Acute Care Constituency. As more information on the RAC audits became available, there was growing concern among healthcare industry representatives that serious and counter-productive flaws were inherent, resulting in extreme financial and administrative pressures on providers. This bulletin is being sent to you to provide an update on the RAC process to date, IHA's level of involvement in the process and also what to expect for Illinois in the future.

- **LEGISLATIVE AUTHORIZATION:**

  - **Medicare Modernization Act of 2003 (MMA):** As you may recall, the Medicare Modernization Act of 2003 (MMA) included provisions that commissioned CMS to conduct a three-year "demonstration project" evaluating the accuracy of Medicare provider payments by the MMA of 2003. Three states were selected: California, Florida and New York; the demonstration audit period extends from March 2005 through March 2008. Medicare claims were reviewable for a period of up to four years preceding the Medicare payment date. Provider services subject to audit included: hospital inpatient and outpatient, skilled nursing, ambulance, physician services and Durable Medical Equipment (DME). **Critical Access Hospitals are also subject to RAC reviews.** There is an appeal process although in California, the majority of

appeals were settled by the administrative law judge. RACs were instructed to review Medicare claims that failed to comply with regulations governing:

1. Medical Necessity
2. Medicare as a secondary payer
3. Medicare DRG coding and payment

- **Tax Relief and Health Care Act of 2006 (TRA):** In December of 2006, Congress authorized CMS to extend the RAC project to all states by 2010. Initially, Illinois providers were scheduled to be audited beginning late summer of 2008; however, within the past few weeks, CMS revised its plan of work, resulting in an amended projected RAC audit start date of March 2009. And, according to the TRA legislation, the "window" of review was shortened by one year; there will be a "look-back" period of three years for those "expanded" states dating back from the Medicare payment date.

- **"DEMO" PROJECT RESULTS TO DATE:** At its October 16 Region V state and metropolitan hospital associations meeting, CMS staff shared the following interim results of the RAC demonstration audits:
  - During 2006, the RACs identified over $68 million in overpayments and $2.9 million in underpayments. After allowing for contractor costs, the net program recoveries exceeded $50 million.
  - 89% of the overpayments related to hospital services; 77% of those were inpatient services, while the remaining 12% related to outpatient services.
  - These are "interim" results; the demonstration period concludes in March of 2008.

- **CMS' REVISED STATEMENT OF WORK (Illinois impact):** On November 7, CMS amended its Statement of Work for the RAC audits, specifically changing its implementation schedule. According to the revised CMS Statement of Work, Illinois is one of the states included in Jurisdiction B. Other Midwestern states included in this jurisdiction include: Minnesota, Wisconsin, Michigan, Indiana, Ohio, and Kentucky. One contractor will be assigned to this region; however, Illinois, Ohio, and Kentucky are not scheduled for review until at least January 2009. Other states in this region will have their reviews beginning sometime in 2008.

- **FLORIDA AND NEW YORK EXPERIENCES:** Within the past several days, IHA has been in contact with representatives of both the Florida and New York state hospital associations to better understand their specific experiences. The following are information updates from those two states:
  - **Florida**:
    1. The Florida RAC is Health Data Insights, Inc.
    2. For some hospitals, a very large volume of claims was selected; one hospital was asked to supply over 800 records. Generally, appeals on denied claims are upheld about 50% of the time.
    3. December 1 marked the end of the period for which the RAC could request hospital records.

4. The Florida Hospital Association (FHA) surveyed its hospitals as to their experiences with the RAC; it received responses from sixteen hospitals. Based on responses from those hospitals, for the period from August 2005 through June 2007, a total of 8,035 records were reviewed or an average of 502 records per hospital. Initially, 899 payments were denied, 309 were appealed, 70 were reversed on appeal and 167 have appeals pending. Additionally, 45 underpayments were identified for those same hospitals for that same period.
5. According to the survey results, just under $3.4 million has been recorded as overpayment, while just over $123,000 has been recorded as underpayment. However, keep in mind that while these dollar amounts appear low, they are only representative of the sixteen hospitals that responded to the FHA's request for information and not of the entire number of Florida hospitals.
6. It is the FHA's belief that patient notification occurs when the hospital appeals the denial and not when the claim is initially denied. Some of the Florida hospitals have taken a pro-active approach, informing patients that while they may receive correspondence that their Medicare claim was denied, they will not be held financially liable.

- **New York:** A conference call was held between IHA staff and staff members of the Hospital Association of New York State (HANYS) that have been involved with the demonstration project since its inception. Major points from that call are as follows:

    1. The New York RAC is Connolly Consulting, with which HANYS has established a good working relationship.
    2. HANYS sponsors a RAC conference annually for its members; representatives from Connolly, as well as CMS Region II, are invited and do attend.
    3. Many of the claim denials could have been avoided if the RAC auditors were better trained and experienced in Medicare coverage rules and Local FI coverage decisions.
    4. HANYS has not been pressuring its members to send specific RAC data to that association because it is felt that this is just another administrative burden on its members. But the staff did indicate that it would encourage its members to support the AHA data gathering project.
    5. All hospital providers are in the RAC selection data base.
    6. ALL communication between the RAC and the providers is manual; there is no electronic transmission of records, requests, letters, etc. HANYS staff felt that this is a major limitation, especially when there are specific time requirements within which information must be received by the RAC from the provider.
    7. HANYS encourages its members to always double-check the RAC's reasons for denial with current Medicare regulations; never assume that the RAC is correct.
    8. HANYS staff has encouraged its members to designate a "RAC Liaison." This individual becomes the "go-to" person for RAC activities such as communication with HANYS and the RAC itself, attendance at HANYS conferences and meetings, specific provider data compilation and follow-up.
    9. While it may be helpful to communicate with the CMS Regional Offices (i.e., II for New York and V for Illinois), the RAC project is administered by the CMS Central Office. To effect change in this process will require approval from CMS Central in Baltimore.
    10. HANYS staff worked with the AHA to compile a comment letter to CMS on its revised Statement of Work.

- **PROBLEM AREAS IDENTIFIED THUS FAR:** While the end-result of the audit project presumably is payment accuracy, there are several major problem areas that have been identified with the process itself:

  - A large volume of old claims selected for review.
  - The contingency payment contracts that increase the RAC's incentive to retroactively deny claims.
  - An expensive and labor-intensive appeal process that, while having proven worthwhile financially for providers, is administratively cost-prohibitive.
  - Limited feedback from the RACs to the providers as to the reasons for denial.
  - Insufficient knowledge of Medicare reimbursement principles and Medicare coverage policies on the part of RAC audit staff.

- **ADVOCACY ACTIVITIES TO DATE:**

  - **IHA:**
    1. On October 16, CMS Region V held its annual meeting with state and metropolitan hospital association staff; IHA staff were in attendance. During that meeting, CMS staff (Melanie Combs and Scott Wakefield) indicated the demonstration project had resulted in substantial monetary recoveries for the Medicare program -- $54.1 million net paid back to Medicare versus $2.9 million paid to providers. These are six-month results and are not final, as the demonstration project will not be finalized until March of 2008.
    2. IHA participated in the AHA-sponsored conference call with CMS on November 27, during which various state and local hospital associations expressed their concerns with serious problems in the RAC process to date.
    3. IHA has sent out an "Alert" to members to contact their U.S. representatives to co-sponsor H.R. 4105, which places a one-year moratorium on the RAC program. During this one-year period, CMS would be required to provide Congress with a detailed report on the process to date, as well as allow the agency to develop more appropriate RAC reimbursement methodologies and greater oversight and public information on the process as a whole. H.R. 4105 is sponsored by Reps. Lois Capps (D-CA.) and David Nunes (R-CA.).
    4. IHA is considering creating a "RAC Task Force" in 2008. In addition to allowing for greater information-sharing among the membership, this task force will also serve to provide guidance to the Association as it works with AHA, CMS and other hospital associations to ensure that the RAC process is fair and does not duplicate the review efforts of other agencies. It is anticipated that representatives from other state associations (including the "demo" states) would be invited to present updates at task force meetings.

  - **AHA:** Following are some specific advocacy activities that have been undertaken by the AHA to date:

    1. AHA has been electronically sending various transmittals to hospital association executives and staff during the past several weeks updating them on RAC problem areas, advocacy efforts to date and CMS

responses. In addition to including information on the RAC process itself, the transmittals have also been including dates and times of phone conferences.

2. In response to CMS' Statement of Work, the AHA and HANYS submitted a formal comment letter expressing various concerns. Subsequently, CMS did incorporate certain changes in the process.
3. The Association facilitated a conference call with state hospital association and CMS staff on November 27. A summary of the major discussion points of that call follows later in this bulletin.
4. AHA strongly supports H.R. 4105 (see above).
5. The AHA will be initiating a data collection project specific to RACs. Participation from as many hospital members as possible will be necessary to ensure enough data is received to effect meaningful change. (See discussion below.)

- **RAC CONFERENCE CALL HELD ON 11/27: NOTES:** On November 27, the AHA facilitated a conference call specifically to discuss the RAC project. IHA participated in this call. On this call were:

  - Participants: State, Regional and Metropolitan Hospital Association Staff.
  - Speakers: AHA: Don May, Linda Fishman and Caroline Steinberg.
    CMS: Mr. Jerry Walters, Director of the RAC program.

  - Following are major comments from the various participants:

    1. **Jerry Walters:** The initial demonstration project including the states of Florida, New York and California will continue until March of 2008. CMS is scheduling a full roll-out of the RAC project by 2010. For the non-demonstration states, the claims subject to review will be those with Medicare payment dates on or after October 1, 2007, thus reducing the number of "old" claims selected. Also, the volume of claims to be selected will be more limited. There will be four RACs assigned to the four remaining jurisdictions, and in response to concerns about the RAC's knowledge of medical coverage policies, those four RACs will be required to have a full-time medical director on staff. (HANYS staff pointed out that while the addition of a medical director to the RAC staff is a positive move, in reality four medical directors for what amounts to 47 states is significantly inadequate.) In response to concerns about communication, the RACs will be required to convert to electronic communication by 2010. One of the most important comments Mr. Walters made concerned the payment to the RACs under the contingency contracts. IHA, AHA and others had expressed serious concerns about the fact that, despite a significant number of denials reversed on appeal, the Medicare RAC was still allowed to retain its contingency payments on those reversed claims. *Going forward, if the hospital's appeal of a denied claim is upheld, the RAC must return its percentage fee to CMS.*

    2. **Don May:** The AHA will be meeting with CMS staff to further discuss issues involving the RAC project. Two of the most serious concerns involve the contingency contracting and medical necessity. It is the industry's belief that RACs should be compensated according to a fixed fee arrangement; this alternative method of compensation discourages "bounty hunting" on the part of contractors in order to maximize their fees. While the AHA continues to encourage CMS to take "medical necessity" issues off the table, it is pessimistic that CMS will do so;

CMS has stated that medical necessity (in particular, a focus on a less-costly, level of service) is a major objective of the review. Other AHA items of note included encouraging CMS to make the process as "paperless" as possible, publicizing the results of the demonstration project and promoting the CMS web site for more information, most notably, an updated Q & A section.

3. **Linda Fishman:** As referenced above, the AHA is supporting a bill (H.R. 4015) that establishes a one-year moratorium on the RAC project. However, more co-sponsors are needed at this time.

4. **Caroline Steinberg:** The AHA will be designing a data collection tool and it is soliciting help from the individual state associations. This tool will be web-based, and will serve as both an information and advocacy document. Financial information collected from hospitals will include quantifying the administrative burdens (including staff hours and costs), actual dollar impact, the overturn rate and types of claims reviewed, appealed and denied. **IHA will be working with the AHA on this project and as the tool is developed, will be sharing that information with you. Also, your participation in sharing this data with the Association is critical if meaningful changes in the process are to be achieved.**

5. **Participants:** Specific comments raised by various association staff on the call included the following:

   i. A large volume of records are being requested; one hospital was asked to supply over 800.

   ii. In California, the process is creating extreme financial harm to hospitals. Those hospitals have experienced a high number of denials (in some cases, over 80% of claims reviewed were denied) and a very high number of denial reversals.

   iii. There is a concern that hospitals in several states (including Illinois) will be undergoing a conversion to a new Medicare Administrative Contractor (MAC) concurrently with these RAC reviews. CMS must ensure that these hospitals are not administratively overwhelmed as a result of these two independent, but potentially burdensome events. Mr. Walters responded that the agency is aware of this situation and is considering a six-month, RAC "suspension" for those hospitals in those states that will be experiencing a new Medicare Administrative Contractor.

   iv. As mentioned above, one of the demonstration states (California) has experienced a comparatively high number of denials that have been reversed on appeal. This appeal process has been very costly in terms of time and resources. As this process moves forward, CMS must examine the reason for these denials and address whether or not an initial denial was even necessary. It should also modify its review processes and provide better training for its RAC staffers to ensure that there is a legitimate reason for a claim to be denied.

   v. CMS should institute a hospital-specific limit on the number of records requested.

   vi. This process appears to duplicate or even circumvent the work of existing fiscal intermediaries and quality improvement organizations. The burden on providers to continually prove the legitimacy of their

services to multiple reviewing agencies compromises the hospitals' efforts to direct resources to provide quality care and positive outcomes for Medicare beneficiaries.

vii. If a claim is denied under Part A, can payment still be made for certain services under Part B? If so, what criteria must be met?

- **NEXT STEPS:** The RAC project will continue to receive significant attention from Illinois Hospital Association staff over the next several months. IHA staff will work with the AHA and other state associations to advise CMS to eliminate duplicative, erroneous and/or poorly incentivized audit approaches. IHA will continue to participate in meetings with CMS staff and, hopefully, the Illinois RAC, if possible in the future. You will be receiving updates as they become available. They will include the identification of the Illinois RAC as it becomes known, progress on the passage of H.R. 4105, possible formation of an Illinois provider RAC task force, other revisions (if applicable) to the CMS Statement of Work, changes in the RACs' audit approaches, developments in other states and any other relevant information. And as you read or hear of information specific to this project, please inform the Association.

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