MEDICARE RACS:

Fraud Fighters OR Bounty Hunters?

By Stephanie Limb

The Centers for Medicare & Medicaid Services recently announced a set of changes to the Medicare Recovery Audit Program, which is much loved or much hated depending on whom you ask. The Council for Citizens Against Government Waste has called the program "one of the government's few successful initiatives to identify and recover waste, fraud and abuse in Medicare." The American Hospital Association, however, calls it bounty hunting.

Begun in 2003 as a demonstration project in three states, the Medicare Recovery Audit Program now is fully operational in all 50 states. Because of the demonstration project's claim to have identified in excess of $1 billion in improper payments in just three years, Congress passed the Tax Relief and Health Care Act of 2006 requiring the secretary of health and human services to establish a national program by Jan. 1, 2010. In a remarkable display of government efficiency, the program was fully operational by October 2009.

To implement the program nationwide, CMS divided the country into four regions and awarded competitive contracts to four recovery audit contractors. Texas is in Region C, with Connolly Consulting serving as the RAC.

The American Coalition for Healthcare Claims Integrity, the association for RACs, argues that the RAC program is critical for reducing wasteful Medicare spending. It applauds RACs for returning valuable resources to the Medicare trust fund at a time when it is nearing insolvency. It also contends that because only 2 percent of all medical records are reviewed, the program is not an administrative burden.

Hospitals, however, have a very different point of view.

Although all Medicare providers are subject to RAC audits, hospitals are by far the biggest target. According to the HHS Office of the Inspector General, claims from inpatient hospitals accounted for 88 percent of all recovered or returned improper payments. During the first year of the national program, RACs collected $75 million from hospitals. By 2011, that number had increased to $141 million and has exceeded $2 billion each year since 2012. In addition, although the purpose of the RAC program is to identify both overpayments and underpayments, the overwhelming majority of claims identified are overpayments. Just 5 percent of the improper payments identified by Connolly Consulting in fiscal year 2013 were underpayments to providers. Hospitals contend RACs are incentivized to pursue large inpatient claims because they are paid on a contingency fee basis.

Hospitals also maintain that RAC audits are costly and inefficient. According to AHA, 63 percent of hospitals spent at least $40,000 in 2012 on RAC audits; 46 percent spent more than $100,000. At the same time, the vast majority of denied claims that are appealed are eventually overturned in favor of the provider. In Region C, in 2013, 72 percent of appealed denials were eventually overturned in the provider's favor.

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Hospitals also object to a disparity in the program's rules that allows them to rebill a denied claim only if it is less than a year old but allows RACs to audit claims going back three years. Nationally, 75 percent of RAC-denied claims fall outside the one-year window and therefore cannot be rebilled. This is particularly important because many RAC denials are for inpatient care (Part A) that was medically necessary but that the RACs allege could have been provided in the hospital outpatient (Part B) setting. Because of the one-year restriction, however, hospitals cannot rebill the older claims as an outpatient service. AHA argues that this disparity not only costs hospitals millions of dollars, but also violates CMS' statutory requirement to pay for all reasonable and necessary care.

Don McBeath, director of government relations for the Texas Organization of Rural & Community Hospitals, describes the one-year billing window as a tragedy for rural hospitals.

"In many cases, the hospitals would have been paid more if they had billed as the auditors claim they should have. Instead, they get nothing because of the one-year billing restriction," McBeath said.

At the same time, the appeals process is lengthy. Appealing a denied RAC claim can involve up to five levels. Hospitals are particularly critical of the third level of the appeals process that requires a hearing with an administrative law judge. In July 2013, the Office of Medicare Hearings and Appeals suspended assignment of new Medicare appeals to ALJs because of a backlog of cases. OMHA is now predicting that it will be unable to resume assignments for at least 24 months.

Elaine Anderson, senior vice president and chief compliance officer at Texas Health Resources, describes the RAC program and the other CMS audit programs as hugely burdensome for hospitals. The system credits its full-time staff of five for effectively managing the audit and appeal process, but Anderson says that even for Texas Health and other large health care systems, handling the exponentially growing number of requests from RACs and other auditors is a major challenge.

"These audits are a huge burden and require a major investment of time, effort and resources," she said.

McBeath says rural hospitals are especially vulnerable to RAC audits.

"While the dollar amount RACs attempt to recoup from rural hospitals may be smaller, rural hospitals are more vulnerable to the process because they typically do not have big accounting departments, resources or staff," he said. "The responsibility of pulling the list of medical files for audits often falls to medical staff and takes them away from patient care. And because rural hospitals must rely on outside legal counsel and accounting firms, even when the hospitals prevail, they still lose because of what the process cost them. RAC audits in Texas are costing rural hospitals between $150,000 and $200,000 a year."

In early 2013, the AHA-supported Medicare Audit Improvement Act of 2013 was introduced in the U.S. Senate and House of Representatives to reform the RAC audit process. The bill has languished, but CMS has begun taking steps of its own to respond to hospitals' concerns about RACs' aggressive reach and tactics.

First, CMS has delayed enforcement of the two-midnight rule until Oct. 1. This delay is projected to affect at least 80 percent of all claims subject to RAC audits. Second, as of Feb. 21, RACs are prohibited from making any new requests for documents until new contracts with CMS are in place. Contracts between the four RACs and CMS originally were scheduled to expire in February but were extended until June. The agency has not announced when new contracts will be finalized. Once new contracts are in place, however, RACs will be able to audit claims for dates of service during this "pause" period. Other process changes also were announced to address hospitals' concerns.

AHA welcomes these changes but says they do not do enough to alleviate the significant burden that RAC audits impose on hospitals. Not surprisingly, those in favor of the RAC program take a different stance. The Council for Citizens Against Government Waste says the changes give "unscrupulous Medicare providers and suppliers a free ride – at taxpayer expense."

Anderson recommends that hospitals use the pause period to reevaluate how they respond to RAC audits. She suggests that hospitals look at what is working and what is not in order to be able to respond more effectively to the audits when they start up again in the summer.

"There is no end in sight to the audits," Anderson said. "It is not just Medicare RACs but Medicaid RACs and expansion of the 'RAC- like' audit processes within Medicare Advantage Plans as well." ★