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Statement

of the

American Hospital Association

before the

Committee on Finance

of the

U.S. Senate

"Creating a More Efficient and Level Playing Field: Audit and Appeals Issues in Medicare"

May 15, 2015

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 43,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to submit this statement for the record on needed reforms to the Medicare appeals and audits systems.

Hospitals work hard to ensure that they bill Medicare claims properly, and acknowledge the importance of audits in the Centers for Medicare & Medicaid Services' (CMS) oversight of the program. However, excessive erroneous denials by Medicare Recovery Audit Contractors (RACs) have forced hospitals to shoulder the significant burden of pursuing appeals in order to receive payment for the medically necessary services they provide to Medicare beneficiaries. A statistic that speaks to the impunity and extensive inaccuracy with which RACs deny claims is the finding reported by the Department of Health and Human Services Office of Inspector General (OIG) that, when hospitals appeal inpatient claim denials to an administrative law judge (ALJ), they win 72 percent of the time.[1]

The contingency payment structure of the RAC program and the resulting massive volume of inappropriate claim denials are putting significant strain on the appeals process. In fact, an ever increasing backlog of appeals led in December 2013 to the announcement by the Office of Medicare Hearings & Appeals (OMHA), which oversees the third level of Medicare appeal, that it has temporarily suspended assignment of most new requests for ALJ hearings while it catches

[1] HHS Office of the Inspector General. Improvements are Needed at the Administrative Law Judge Level of Medicare Appeals. November 2012. http://oig.hhs.gov/oei/reports/oei-02-10-00340.pdf

up with that crushing backlog. As a result, hospitals are experiencing wait times of close to three years for their appeals to be heard by an ALJ, let alone for receiving a decision. This is significant because it is at the third level of appeal, in a hearing before an ALJ, that hospitals are afforded their first opportunity to present testimony based on clinical factors that are critical to accurate decisions in denial of complex hospital claims and receive a review of all evidence by an objective party (that is, a reviewer who is not a Medicare contractor). The first two levels of appeal – reviewed by Medicare Administrative Contractors and Qualified Independent Contractors – consist of desk audits of the paper record, and largely are considered by appellants – including beneficiaries and hospitals – to be cursory reviews that are biased toward upholding the denial.

The president's fiscal year 2016 budget included a number of proposals intended to reform the Medicare appeals system. These include imposition of a refundable filing fee for providers at all levels of appeal. **The AHA strongly opposes this proposal, which is designed to discourage providers from pursuing their statutory rights to appeal denied claims for Medicare payment.** Once a RAC has made an inappropriate denial, the hospital has few options for obtaining payment for the medically necessary services it provided to the Medicare beneficiary other than to pursue an appeal of the claim denial. Hospitals carefully evaluate claim denials to determine whether to invest the substantial time and significant resources required for filing an appeal, and they appeal denials because they stand behind the medical judgment of the treating physician. The expense associated with appeals – both in terms of cost and in diversion of resources from patient care – already may prevent some hospitals from pursuing meritorious appeals. The additional proposals in the president's budget simply tinker at the margins and do not address the heart of the problem – the high volume of Medicare appeals going into the system as a result of inappropriate RAC denials.

Fundamental RAC reform is needed to halt the perpetual, wasteful cycle where RACs deny claims for medically necessary services and hospitals must expend significant resources pursuing payments through the appeals system. **Specifically, the AHA supports the following reforms to address challenges created by the RAC program:**

1. **Remove the perverse financial incentives that encourage RACs to deny claims.** The current contingency fee structure is one-sided in that RACs can deny claims with impunity. Instead, RACs should be paid similarly to other Medicare contractors, such as through a cost-based contract.

2. **Spur performance improvement among the RACs by reducing payments to RACs with a high rate of overturned denials.** Hospitals bear the significant cost of appealing inappropriate RAC denials, while RACs are not penalized for inappropriately denying claims. This reform would curb overzealous RACs and create a level playing field for both RACs and providers in addressing incorrect payments.

3. **Limit RACs to considering only the medical documentation available at the time the admission decision was made in determining whether an inpatient stay was medically necessary.** Currently, RACs can review claims three years after the date of service and are able to utilize information that may not have been available to the

physician at the time of the admission decision in order to deny claims. This reform would restrain RACs' current practice of second-guessing physicians' judgment based on the outcome rather than the facts the physician had at the time of treatment.

4. **Allow hospitals sufficient time to rebill denied inpatient admissions under Part B.** Currently, CMS allows hospitals to rebill only within one year of the date services were provided. In contrast, RACs are able to audit claims up to three years after services were provided. This means that many claims are ineligible for rebilling at the time the denial is made. Further, this time limitation forces hospitals to forgo any appeals before rebilling under Part B, often for much lower reimbursement. When a Part A claim is denied by a Medicare review contractor because the inpatient admission was determined to be not reasonable and necessary, the hospital should be able to submit a subsequent Part B claim for services provided within 180 days of the denial or once appeals are exhausted. This would allow hospitals to either rebill immediately after the claim is denied or pursue their appeals rights and receive a final determination on the Part A claim before rebilling under Part B.

The AHA supports the Medicare Audit Improvement Act of 2015 (H.R. 2156) – which includes each of these critical reforms – and urges the committee to consider similar legislation. Hospitals dedicate significant time and resources to ensure accurate billing. While audits are necessary as part of CMS's oversight, they should not impose an undue financial and administrative burden on hospitals. We appreciate the committee's attention to these important issues, and hope to continue a dialogue on reasonable reforms to the audits and appeals systems.