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American Hospital Association™
Advancing Health in America

Washington, D.C. Office
800 10th Street, N.W.
Two CityCenter, Suite 400
Washington, DC 20001-4956
(202) 638-1100

Ms. Sherri McQueen
Director, Financial Services Group
Office of Financial Management
Centers for Medicare & Medicaid Services
Mail Stop C3-14-16
7500 Security Boulevard
Baltimore, MD 21244

Re: OIG Medicare Hospital Audits

Dear Ms. McQueen:

I would like to thank you and your colleagues at the Centers for Medicare & Medicaid Services (CMS) and the Office of Inspector General (OIG) for meeting with me on January 15, 2019 to discuss improvements to the process that the OIG uses to audit the propriety of Medicare payments to hospitals as well as CMS's response to those audits. As you know, these audits have long troubled members of the American Hospital Association (AHA), and I was very pleased to learn that the two agencies have been working together to address many of the concerns raised by our member hospitals.

The AHA is hopeful that some of the contemplated process improvements could help obviate a number of the significant errors contained in the OIG's audit reports. That, in turn, will avoid unwarranted financial and reputational harm to hospitals as well as diversion of their scarce resources from patient care to the audit process and associated tasks.

We are particularly supportive of improved OIG-CMS coordination of potential audit areas *before* an audit begins, because it may prevent the OIG's misinterpretation of Medicare policies and focus OIG audits on policies that reflect *continuing* goals of CMS. We have seen quite a few OIG reports in which a hospital is being audited against a standard that CMS has revised or eliminated – often for sound policy reasons – since the period covered by the audit.

Not only is consultation with CMS before an audit important, but, as discussed during our meeting, it is just as important to involve *providers* at the early stages of the audit process. As

with involving CMS, consulting with providers may prevent the issuance of problematic individual and national audit reports. Indeed, we believe that the September 2018 national audit report on inpatient rehabilitation facility (IRF) stays provides a particularly helpful example for where process improvements can be made.

As you know, the AHA believes that the IRF report very significantly overstates the estimated Medicare overpayment for services IRFs furnished in 2013 and contains many other material errors. As noted in the letter I sent to Inspector General Levinson following issuance of the IRF audit report, the AHA further believes that IRFs are highly attuned to the detailed coverage criteria that apply to Medicare admissions. At the same time, we question whether the OIG contractor that reviewed the claims in the IRF audit applied the correct coverage standards. And the OIG's February 6, 2019 response to my letter to the Inspector General only increases our concern in this regard. In its response, the OIG continues to confuse Medicare *requirements* with Medicare manual guidance. *Requirements* may be imposed only by statute or regulation; guidance interpreting statutory or regulatory requirements is not binding, it is merely instructive. If the OIG contractor applied IRF manual provisions as binding requirements, that easily could account for the incorrect conclusion that the vast majority of IRF stays were not medically necessary or failed to meet documentation standards.

In an audit report issued on February 4, 2019, Community Hospital made this same point (and many others) in explaining why it disagreed with the OIG's findings that 63 of 90 of the hospital's IRF stays in the sample of claims audited should be denied. The OIG's response fails to address this significant legal issue as well as many of the other concerns raised by the hospital. We would hope that OIG-CMS coordination *before* initiation of an audit would include discussion of what is actually *required* and call into question audit findings that go beyond that.

We also believe that it would be very beneficial for the OIG to consult with CMS *after* an audit has been performed while it is still in draft. Your proposed action plan contemplates CMS subject matter review of draft OIG audit reports as well as auditee comments. We strongly support this process change. Not only could it help ensure that the OIG applies Medicare rules properly, but it also might allow CMS to consider sooner how it should respond to the OIG's findings and recommendations. For example, we would hope that earlier CMS involvement would allow the agency more time to consider detailed hospital responses to OIG audits – such as the hospital's response to the February 4 audit – in determining whether to demand repayment by the hospital and, if so, how much should be sought. As you know, we have had serious concerns about CMS' apparent lack of independent assessment of OIG provider audits and it's demand for repayment of extrapolated overpayment amounts. Earlier involvement by CMS might ameliorate this concern. And, for OIG audits of CMS contractors, where CMS plays no visible role in the process, making clear that CMS reviews the draft report will ensure that the public understands that contractors are not simply acceding to the OIG's recommendations.

In addition to benefitting from consulting with CMS and providers, we believe that the OIG would benefit from reviewing findings from subsequent audits and results of provider appeals. Again, the September 2018 IRF audit is a case in point.

We note that, in its October 2018 compliance review of Mobile Infirmary Medical Center, the OIG identified numerous claims for IRF stays as wrongly billed. The hospital disagreed, and the OIG then had a different contractor re-review the claims. After that re-review, the OIG conceded that 8 of 16 claims challenged by the hospital were not errors. The OIG's acknowledgement that 50% of its reviewers' findings were wrong confirms that the reviewers make basic mistakes in applying CMS rules. And these basic mistakes (as well as a spate of other problems with the national IRF audit that we previously identified) militate in favor of the OIG asking a second contractor to re-review the claims in the national IRF audit and having the agency reevaluate its findings and recommendations to CMS.

Similarly, as we explained during our meeting, when a provider successfully appeals claim denials from an OIG audit, we would encourage the OIG to consider whether it correctly understood the relevant Medicare rules. We further ask that the OIG make public information regarding the provider's successful appeals to "correct the record" and reduce some of the reputational harm associated with the incorrect information contained in the audit report. This is especially important in light of the OIG's decision to extrapolate the estimated overpayment in every audit.

As we have repeatedly highlighted, OIG errors in determining whether services are medically necessary and meet other coverage criteria are exacerbated by extrapolation of audit findings to the universe of a provider's claims. As I emphasized during our meeting, the OIG's decision to extrapolate from a sample of claims to the universe of a hospital's claims in *every audit* is exceedingly troubling to hospitals. Extrapolating in every audit – even where the error rate is low – runs counter to CMS's view on when extrapolation is appropriate as well as the OIG's own approach to extrapolation. Last September, CMS issued guidance to its contractors explaining that extrapolation is appropriate when there is a high error rate, which CMS defined as *50% or more*. And, in its corporate integrity agreements, the OIG does not require an independent review organization even to review a full sample of claims for purposes of extrapolation where a provider's error rate is below 5%. Yet, in provider compliance audits, the OIG extrapolates no matter the error rate. This is both confusing and unfair to hospitals.

We encourage CMS and the OIG to continue exploring ways to make the audit process and CMS's response to audit reports more efficient, accurate and meaningful for hospitals. We also believe that the agencies should set deadlines by which items in the action plan will be targeted

for completion. While we applaud the agencies' efforts over the last year, we know that, without actual deadlines and feedback from the hospital community, progress is likely to stall.

We recommend that CMS and OIG have quarterly update calls with hospitals to enable them to stay abreast of the progress both agencies are making on provider compliance audits. Of course, we would be happy to discuss with you other ways that the hospital community can assist CMS and the OIG as you address the concerns that the AHA has raised.

Sincerely,

Melinda Reid Hatton
General Counsel

Cc: Gloria Jarmon, Deputy Inspector General, Department of Health and Human Services
Jennifer Main, Chief Financial Officer, Centers for Medicare and Medicaid Services