



Arizona Hospital and Healthcare Association

Recovery Audit Contractors: Establish a Fairer Medicare Payment Compliance Process

The Medicare Modernization Act of 2003 established the Recovery Audit Contractor (RAC) program as a demonstration program in California, New York and Florida to identify improper Medicare payments. Before the completion of the demonstration program and a full evaluation, the Tax Relief and Healthcare Act of 2006 authorized the Centers for Medicare and Medicaid Services (CMS) to expand the program to all 50 states by 2010. The experience of healthcare providers in demonstration states has raised serious concerns with the program, causing CMS to revise the RAC Scope of Work (SOW). Despite these revisions, Arizona hospitals remain concerned about the program, which is scheduled to expand to Arizona in April 2008.

Congress Should Enact a One-Year Moratorium on RAC Activities

Under the Tax Relief and Healthcare Act of 2006, the RAC program became permanent, and CMS established a roll-out schedule for all 50 states. Implementation in Arizona was originally scheduled for September 2007 as part of the demonstration project under the California contractor, PRG Schultz. In response to concerns over PRG Schultz' activities in California and at the urging of Arizona hospitals, CMS delayed implementation in Arizona until April of this year, when the permanent program is scheduled to go live.

Under the program, RACs are paid a contingency fee for identifying potential improper payments. In California, it has been reported that PRG Schultz has been paid as much as 30 cents for each dollar of denied claims. Under the demonstration program, RACs were able to retain this "bounty fee" even if the denied claim was ultimately overturned on appeal. This is the first time CMS has reimbursed a contractor on a contingency fee basis for claim review and overpayment collections work.

Under the revised SOW, RACs may review claims that are up to three years old – but no further back than October 1, 2007. Audits may be conducted to identify potential over and under payments in the areas of duplicate payments, fiscal intermediary errors, medical necessity, and coding errors. Contractors may use "automated reviews" utilizing proprietary data mining systems in which no human actually reviews the claims data, or "complex reviews" in which an "auditor" reviews patient medical records.

Arizona hospitals strive for billing accuracy and are committed to fair efforts to reduce improper Medicare payments. Nonetheless, we have grave concerns about the RAC program. These include:

- *Duplication of Effort.* CMS employs a variety of contractors to conduct audits and/or medical necessity reviews of hospital services. Medicare Administrative Contractors (MACs), Fiscal Intermediaries (FIs) and Carriers, which process payment claims, conduct cost report audits and medical necessity reviews to identify billing errors made by providers. Quality Improvement Organizations (QIO), which are responsible for ensuring accurate coding, coverage and medical necessity determinations, also conduct medical necessity reviews. The Comprehensive Error Rate Testing and Hospital Payment Monitoring Program contractors perform medical records review to monitor the accuracy of payments made in the Medicare fee-for-service program. And finally, Program Safeguard Contractors conduct medical reviews under the Medicare Integrity Program (MIP) with additional oversight provided by the Office of the Inspector General. Adding one more contractor to this complex and convoluted process only increases the administrative costs born by providers and directs resources away for patient care. Rather, issues with current contractors overseeing Medicare payment compliance should be addressed.
- *Medical Necessity Reviews.* CMS should eliminate medical necessity determinations from the purview of the RAC program. Medical necessity reviews are too complex and patient-specific for contractors who employ staff without the appropriate clinical expertise. These reviews should remain with the MACs, FIs and QIOs.
- *Look-Back Period.* The look-back period for RAC reviews should be limited to a 12-month window rather than the current three-year period, which leads to confusion and error, as RACs incorrectly apply new payment rules to old claims. This confusion is intensified as states transition from FIs to MACs, which may have different local coverage determination policies.
- *Contingency Fees.* The contingency-fee payment should be eliminated and replaced with a pre-determined contractual payment amount. The contingency fee or “bounty payment” leads to overly aggressive and erroneous determinations. Such is the case in California, where PRG Schultz denied nearly all claims for the admission of patients with joint replacement procedures to inpatient rehabilitation facilities. As a result, CMS had to hire an independent contractor to evaluate the denials, which disagreed with PRG Schultz’ conclusion in 40 percent of the cases.

We urge Arizona’s congressional delegation to support H.R. 4105, the Medicare Recovery Audit Contractor Program Moratorium Act of 2007, which places a one-year moratorium on the RAC program; requires CMS to submit a report to Congress evaluating the program; and requires the Government Accountability Office to report to Congress on the use of RACs within the MIP.