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EDITORIALS

Give That Back! Recovery Audit Program Activity Trends

Jennifer L. Wiler, MD, MBA[1]*, Michael Granovsky, MD[2]

[1]Department of Emergency Medicine, University of Colorado, Aurora, Colorado; [2]Department of Emergency Medicine, George Washington University, Washington, DC.

Much has been published in the academic literature and lay press regarding rising healthcare costs.[1] As the nations' largest payer, the Centers for Medicaid and Medicare Services (CMS) have been aggressive in trying to decrease Medicare expenditures. Each year Medicare processes over 1 billion claims, submitted by over 1 million healthcare providers. Starting in 2005, demonstration projects supported by the CMS identified more than $1.03 billion in improper Medicare payments.[2] Subsequently, section 1893(h) of the Affordable Care Act authorized expansion of the Recovery Audit Program nationwide by January 2010. Facilitated by third-party vendors paid on a contingency fee basis, known as the Recovery Audit Contractors (RACs), the stated objective of the program is to identify and correct "improper" payments, not only identify overpayments to healthcare providers and organization, but also underpayments, in addition to reporting "common billing errors, trends, and other Medicare payment issues to CMS." [2] Although CMS does have a prepayment review program,[3] much of the reported RAC activities to date have been focused on postbill overpayment activities. In 2013 (the most recent reported annual activity period), CMS reported that collectively the RACs identified and corrected 1,532,249 claims for improper payments, collected $3.65 billion in overpayments, and identified $102.4 million in underpayments that were repaid to providers and suppliers.

Sheehy et al., present the collective experience of 3 large academic medical centers with RAC audit activity.[4] They found that from 2010 to 2013, there has been a 3-fold increase in RAC-related activities. The RACs are selected by CMS via a competitive bidding process and are contractually incentivize via a "contingency fee." This means that they receive a portion of the funds that they recover (anywhere from 9%–12% depending on the contract). If the RAC's claim is overturned on appeal, the RAC must repay the contingency fee, but does not face an economic penalty. This creates a potential incentive for RACs to be overly aggressive in pursuing potential overpayments from hospitals and providers.

The institutions in this study disputed 91% of allegations of overpayment. This dispute rate is notably higher than the 50% that was reported by a survey conducted by the American Hospital Association.[5] What is unknown is what the actual rate of overturned decisions based on appeal would be, as 49% of all contested claims from the study institutions were withdrawn and rebilled, and did not go through the complete appeals process. The authors cite the lengthy and presumably expensive process of adjudication as the reason for the decision to rebill the claims at the typically lower payment levels available under Medicare Part B. A 2012 report by the Office of the Inspector General (OIG) found that most (72%) of RAC-denied hospital inpatient claims were overturned on appeal, in favor of the hospital by an administrative law judge (ALJ). This high rate of turnover has initiated a national discussion about the unbalanced financial incentives of the process per current design.

Since 2009, there has been a 10-fold increase in the number of appeals waiting for a decision, with hearing delays reported to be as long as 32 months.[5,6] The ALJ is required to issue a decision within 90 days of an appeal request. However, despite the huge volume of audits and secondary appeals generated by the RAC process, CMS has done little to expand the appeal infrastructure and the ALJ resources to keep pace with the incentivized RAC contractors.

The ALJ appeal backlog became so substantial that the Office of Medicare Hearings and Appeals published the following statement: "As noted in a Federal Register Notice released by the Office of Medicare Hearings and Appeals (OMHA) in January 2014, the unprecedented growth in claim appeals continues to exceed the available adjudication resources to address [such] appeals....The CMS supports OMHA's efforts to bring efficiencies to the OMHA appeals process." Ultimately CMS offered hospitals a blanket 68% settlement for outstanding appeals to simply settle the backlogged cases.[7]

Finally, the authors note that an average of 5 full-time equivalents (FTEs) was required by each institution to support the compliance-related activities, which the authors claim is onerous and expensive. Their experience is consistent with other national reports that have found that 69% of surveyed hospitals report

*Address for correspondence and reprint requests: Jennifer L. Wiler, MD, Associate Professor, Department of Emergency Medicine, University of Colorado Denver SOM, 12401 E. 17th Ave. B-215, Aurora, CO 80045; Telephone: 720-848-6792; Fax: 720-848-7374; E-mail: jennifer.wiler@ucdenver.edu

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spending more than $40,000 per year, whereas 11% spend more than $100,000 annually.[5]

Ultimately, the authors conclude that reform is needed. Nationally many have agreed. As such, based on feedback, the CMS announced changes to the RAC program in December 2014[8] including: (1) reduction of the RAC "look back period" to 6 months (vs 3 years) from the date of service for payment adjustments, (2) RAC review period decreases to 30 days (vs 60 days), (3) addition of a 30-day discussion period for claims, (4) the RAC will not receive a contingency fee until the second level review is completed, (5) broadened scope beyond inpatient claims (eg, review of outpatient claims), (6) more transparency regarding the appeals process, (7) new requirements for RACs to maintain a <10% overturn rate at the first-level review (if not met, the RAC will be placed on a corrective action plan), and (8) RACs are now required to maintain an overall accuracy rate of 95%. In addition, CMS must publically report through an annual Report to Congress a Recovery Auditor accuracy rate for each Recovery Auditor."[9] There is no doubt that the current RAC program has generated significant savings for CMS. However, it has resulted in a notable cost and administrative burden to others including hospitals and provider groups. With the implementation of measures that hold RACs more accountable for the quality of their reviews, it is unclear if these new reform measures proposed by CMS will substantially improve the postpayment refinement process. Only with continued, but expensive, vigilance by providers and hospitals to ensure that claims are accurately processed as was described by the study institutions by Sheehy et al.,[4] will we know the potential value of the postpayment system.

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