American Hospital Association

Program Integrity and Contractor Overlap

Background

Every time nurses, physicians and other caregivers treat a patient, a host of regulations and statutes govern their actions, especially if the patient is a Medicare or Medicaid beneficiary. More than 30 agencies oversee some aspect of the health care delivery process at the federal level alone. In recent years, the Centers for Medicare & Medicaid Services (CMS) has drastically increased the number of program integrity auditors that review hospital payments to identify improper payments. No one questions the need for auditors to identify billing mistakes; however, many auditors conduct redundant audits that drain time, funding and attention that could more effectively be focused on patient care.

Hospitals face an alphabet soup of program integrity contractors.

Many contractors conduct redundant audits.

	Incorrectly Billed Claims	Processing Errors	Medical Necessity	Incorrect Payment Amounts	Non-covered Services	Incorrectly Coded Services	Duplicate Services
Recovery Audit Contractors (RACs)	✓	✓	✓	✓	✓	✓	✓
Medicare Administrative Contractors (MACs)	✓	✓	✓	✓	✓	✓	✓
Zone Program Integrity Contractors (ZPICs)			✓	✓	✓	✓	✓
Comprehensive Error Rate Testing Program (CERT)			✓	✓	✓	✓	✓

Source: AHA *TrendWatch*, May 2011.

Medicare Administrative Contractors (MACs) serve as providers' primary point of contact for enrollment and training on Medicare coverage, billing and claims processing. They also conduct pre-payment audits.

Zone Program Integrity Contractors (ZPICs) work with MACs to identify cases of potential fraud; investigate them by conducting audits and data analysis; and then refer suspected fraud to the Department of Health and Human Services' Office of Inspector General (OIG) for further investigation.

Medicare Recovery Audit Contractors (RACs) are charged with identifying improper Medicare fee-for-service payments – both overpayments and underpayments. RACs are paid on a contingency fee basis, receiving a percentage of the improper payments they identify and collect. RACs were extended to the Medicaid program through the *Patient Protection and Affordable Care Act*.

The Comprehensive Error Rate Testing (CERT) program estimates the national error rate for Medicare fee-for-service claims to measure the performance of the MACs and providers as well as to gain insight about the causes of errors.

In addition, hospitals are being audited by a myriad of other government auditors and programs including, but not limited to, the Permanent Error Rate Measuring (PERM) program, Medicaid Integrity Program (MIP) contractors, Quality Improvement Organizations (QIOs), the OIG, the Department of Justice (DOJ) and other law enforcement agencies. And most recently, CMS introduced Predictive Analytics – a program intended to identify improper payments in real time.

The AHA's *TrendWatch* report, "Program Integrity After the Enactment of Health Reform" takes an in-depth look at new and enhanced program integrity initiatives. The report is available at www.aha.org under "Trends & Research."

AHA View

Hospitals strive for payment accuracy and are committed to working with CMS and its contractors to ensure the accuracy of Medicare and Medicaid payments. Unfortunately, the flood of new auditing programs is drowning hospitals with a deluge of duplicative audits, unmanageable medical record requests and inappropriate payment denials. The payment accuracy programs are well intentioned, but there are too many of them. The programs need to be streamlined, duplicative audits eliminated and inappropriate denials halted. Furthermore, investments should be made in provider education and payment system fixes to prevent payment mistakes before they occur.

Inappropriate Medical Necessity Denials. Hospitals are experiencing a significant number of inappropriate RAC denials, amounting to hundreds of thousands of dollars in unjust recoupments of payments for medically necessary care. To exacerbate the problem, MACs have recently begun making these mistakes when conducting pre-payment reviews, depriving hospitals of payment for medically necessary care and causing significant cash flow problems for the hospital. The auditors are targeting one- to two-day hospital admissions, declaring that the care could have been provided in the outpatient or observation setting or that the care was not medically necessary at all. Hospitals disagree with the majority of "medical necessity" decisions that auditors are making. In fact, when hospitals decide to commit the time and resources necessary to fight RAC denials in the Medicare appeals process, they are successful at overturning the RAC denial 74 percent of the time, according to January AHA *RAC*Trac survey analysis.

Auditors should target legitimate payment mistakes and be prohibited from issuing medical necessity denials, which invalidate the medical judgment of a trained health care professional and force hospitals into the costly and complex Medicare appeals process. In addition, CMS must be required to establish a

process for re-billing denials at the alternative level of care or code determined by an auditor (e.g., inpatient rebilled as outpatient). Requirements for deductibles, co-pays and benefits should be waived to prevent any new beneficiary liability.

Streamline Program Integrity. Redundant government auditors are wasting hospital resources and contributing to growing health care cost. Many auditors have carte blanche ability to enter a hospital, interrupt patient care and demand hundreds of medical records at a time. Hospitals have been forced to hire additional staff just to manage the audit process. More than 50 percent of hospitals of the 2,000-plus hospitals participating in the AHA's *RAC*Trac survey reported a significant increase in administrative burden due to the RAC program. Fifty percent of hospitals reported spending more than $10,000 in the final quarter of 2011 to manage the RAC process alone, with 6 percent of hospitals spending $100,000 or more.

CMS should streamline these programs by channeling all improper payment audits into one program and eliminating all other auditing programs. Until that can occur, CMS needs to increase its oversight of unwieldy auditors, and auditors must be required to improve their accuracy or face financial penalties. A recent AHA *RAC*Trac survey indicates that two-thirds of medical records reviewed by RACs **did not** contain an improper payment. Hospitals also report that auditors routinely fail to adhere to program requirements for timely responses. CMS needs to ensure that the auditing programs are fair to all parties. In addition, auditors must be limited in the number of requests for medical records allowed.

With regard to Medicaid RACs, states that already have Medicaid auditing programs and states with Medicaid managed care organizations should not be required to adopt a Medicaid RAC program. In states where CMS requires implementation of a Medicaid RAC program, Congress should require CMS to adopt program restrictions that limit administrative burden, duplicative audits, and aggressive and inappropriate RAC audits.

Preventing Improper Payments. CMS must take more steps to accomplish the goal of all program integrity efforts – reducing improper payments before they occur. CMS should reinvest 7 percent of all auditor recoveries into payment system fixes and provider education.