• What we do
  – Provide post-acute, long-term care and continuing care perspectives into the development of AHA’s public policy positions to advocate on behalf of the health care field, often identifying and tracking issues of special interest to the constituency membership
  – Play liaison role with other health care and consumer organizations concerned with similar issues

• Who we represent
  – Long term care hospitals, rehabilitation hospitals and units, hospital-based skilled nursing and nursing facilities, home health and other in- and outpatient continuing care services
• **Post-Acute Care Update**
  - IRFs
  - SNFs
  - LTCHs
  - DME
  - Therapy Caps
  - Post-Acute Research

• **RACs**
  - Demo Summary
  - National Rollout
  - AHA 3-tiered Strategy
IRF PPS for FY 2009

- Congress makes permanent improvements to 75% Rule
  - Keeps qualifying comorbidities
  - Lowers threshold to 75% Rule (60%)
- Freezes IRF payments at 2007 level for 18 months (Apr 08 – Sep 09)
- CMS Final Rule for FY 2009 drops payments by $40 million
Medical Necessity Review

• Still a problem for Rehab and LTCHs
• AHA White Paper shows 63 percent overturn rate for denials
  ▪ 72 IRFs; 12 FIs
• CMS January 10 meeting with CA FI, RAC, and QIC has “clarified” Section 110
• Difficult issue to legislate
• National orgs working to clarify best remedy for legislative strategy
  ▪ FI Penalties
  ▪ Support Section 110
• Link to RAC strategy
SNF PPS for FY 2009

• 3.4 percent payment update
• CMS postpones $770 million cut to adjust for greater use of new RUGs
• CMS FY 2009 Final Rule increases payments by $780 million
• Changes for 2010
  – STRIVE data
  – MDS 3.0
LTCH PPS

- 2009: Fully transitioned to LTC-MS-DRGs
  - Similar to IRF comorbidity tiers
- 2009: $110 million increase over 2008 Medicare payments; $39,1146.36 standard payments
- Medical Review transitioning fr QIOs → FIs
- Congress
  - 3-years of relief on 25% Rule
  - 3-years of relief on SSO cut
  - 3-year moratorium on new facilities and beds
  - 3-year postponement of one-time Budget neutrality cut
  - New patient/facility criteria added
  - Additional study needed
- Third CMS study by RTI underway
  - Field collaborating on mirror study
Therapy Caps

- Congress extended T Caps to Dec 31, 2009
- CY 2008 caps
  - PT/ST: $1810
  - OT: $1810
- Permanent fix too costly
- Caps reduced utilization by 15% from 2005 to 2006
- T Caps Exceptions:
  - Non-Part A SNF patients may obtain medically necessary therapy services that exceed the caps in hospital outpatient department
  - In other settings, outpatient therapy services in excess of the caps are not covered, and the therapy provider may charge for those services.
Post-Acute Care

- PAC Demo
  - CARE Tool
  - Hold on RAC review
- Outpatient Therapy Study
- P4P
**UPDATE:**

- RTI recruiting volunteers in last few markets
  - Boston, Chicago & Rochester are underway
  - Tampa, Lincoln/Sioux Falls begins in August
- AHA and state associations assisting
- Tough sell for hospitals; lots of post-acute interest
**CARE Tool Concerns:**

- Are time estimates for completing the tool accurate?
- How much and what time of resources and personnel will be required of general acute hospitals that will be new?
- If hospitals lack resources to conduct full assessments, how will post-acute referral be affected?
- How will different views between referring and admitting facilities on patient’s clinical status and treatment needs be reconciled?
- Why is this significant burden being imposed on hospitals, when the intended impact pertains to post-acute providers?
RAC Demonstration
RAC Background

- 2003: Congress approved RAC demo
  - Medicare Modernization Act (Rx bill)
- 5 states w highest Medicare:
  - CA, FL, NY + SC and MA
- 3 Demo RACs
  - RACs - large, private firms, some publicly
  - LT use by Private sector, Fed. Govt.,
    2/3 Medicaid programs
  - Supplement other Medicare oversight
  - Paid contingency fees
- Identify overpayments and underpayments
- 2006: Congress approved national RACs
  - Tax Relief and Health Care Act
RAC Demonstration

- March 2005 through March 2008
- Demo evaluation report released July 11
- Reviewed last four years of claims
- Two types of RAC audits
  - Automatic reviews using software to identify potential payment errors
    - Duplicate payments
    - Coding errors
    - Other technical errors
  - Medical necessity reviews
    - Clinical judgments
- Identify audit targets through mining of Medicare claims, reports from other Medicare overseers.
RAC Demo Problems

- RACs add another layer and focus on end of process
  - Better to focus resources on front end – i.e., error prevention
- Contingency fees encourage aggressive audits
- Guilty until proven innocent
  - To challenge each RAC error, need resources for costly appeals
- Medical necessity reviews second guess doctors
  - RACs need much greater physician role for med. nec. reviews
  - 40% error rate found for California RAC
- RAC protocols changed throughout demo
  - Hospitals need to know rules of game
- Look-back too long
  - Complex to reopen 1+-year-old claims, need good cause
RAC Administrative Burden

- **80%**: Increased administrative cost
- **50%+**: Added personnel for RAC activities
- **20%**: Added 2 or more FTEs for RAC activity.
- **1/3+**: Hired RAC consultants, legal, other svcs.
- **25%+**: Restricted patient admissions
- **11%**: Made staff or service cutbacks.
- ↑ record requests: Up to 1,707 in one month.

*Survey response rate: 41% of community hospitals in CA, FL, NY.*
CMS: 14% of RAC denials appealed; 33% success rate

Thousands of demo appeals still in progress
  - Monthly CMS reports pending to track appeals status

Appeal RAC denials through existing Medicare process

Most appeals completed by first 3 of the 5-stage process

Appeals average 12-24 months

AHA estimate: $2,500 per appeal

“Good cause” needed to open claims over 1-year old

Need organized system for preparing and tracking appeals
Medicare Appeals Process

Appeal within 40 days to stop recoupment.

Appeal within 60 days to stop recoupment.

Provider must respond within 45 days to RAC (provider can request an extension). Claim is automatically denied if provider does not respond in 45 days.

If RAC has 60 days to make its determination.

The appeals process can take 12-24 months per claim.
Demo RAC Target Areas

Coding Targets:
• Correct coding for debridement (excisional or not)
  ▪ DRG 263/MSDRG 573; DRG 217/MS-DRGs 463, 464, 465
• DRGs designated as complicated or having comorbidity, yet only one secondary diagnosis
  ▪ DRGs 079, 416, 468, 475, 477 and 483
• Incorrect discharge status for post-acute transfer
• Unit Coding
  ▪ grams vs. milligram,
  ▪ duplicate procedures on same day

Medical Necessity Targets:
• Inpatient admissions for procedures eligible for outpatient surgery (eg. laparoscopy, cholecystectomy)
  ▪ Implantable devices
• One-day stays
  ▪ Chest pain
  ▪ Back Pain: DRG 243/MS-DRG 551
• Three-day stays to qualify for SNF care
• Inpatient rehabilitation (joint replacement patients)
### RAC Demo Collections*

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<td>Medicare Trust Fund</td>
<td>$51.2</td>
<td>247.4</td>
<td>693.6**</td>
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</table>

*In Millions  **Thousands of appeals and IRF re-reviews still in process.

RAC collections sharply escalated
In final months of demonstration.

Source: CMS presentation on 7/1/08.
Overpayments Collected

- **Inpatient Hospital**: 84%
  - **Incorrectly Coded**: 35%
  - **Medically Unnecessary**: 40%
  - **No/Insufficient Documentation**: 8%

- **Outpatient Hosp/IRF/SNF**: 14%
  - **DME**: 1%
  - **Physician/Ambulance/Lab/Other**: 1.5%

**90%+ Of RAC Collections from Hospitals**

**75% of Denials due to Coding and Medical unNecessity**

National RAC Program
National RAC Program

National RACs On Their Way!

- 4 RACs to be announced in August or later
- CMS/RACs outreach to precede audits
- Many key program details not yet known
- CAHs included in RAC program
CMS’ National Rollout Plan

Summer 2008

Fall 2008

Jan 2009 or later

All dates are flexible

Although CA was a RAC demo state, California claims will not be available for RAC review from March 2008 - Oct. 2008 due to a MAC transition.
CMS Response to Providers’ Demo Problems

• No contingency fee if denial overturned
• Contingency fees to be publicly announced
• Look-back period reduced to 3 years
• No claims audited with paid date before 10-1-07
• RACs to initially focus on automatic reviews
• No recoupments during 1\textsuperscript{st}/2\textsuperscript{nd} appeals stages
  \begin{itemize}
  \item If appealed within 40 and 60 days, respectively
  \end{itemize}
CMS Response to Providers’ Demo Problems

- Required to have a medical director
- Med. Director avail to discuss denials
- Auditor credentials available upon request
- CMS to monitor RAC targets / New Issue Review
- Web notification of new RAC target areas
- RACs to document reason for denial
- RACs must explain “good cause” to audit 1 yr+ old claims
National Program Improvements

CMS Response to Providers’ Demo Problems

- Record request limit per 45-day period
- RACs to accept electronically scanned records
- Web-based tracking tool by 1-1-2010
- Performance metrics for RACs; reported publicly
- Independent auditor to report RAC accuracy rates
- On-line provider survey on RAC performance
- CMS RAC updates: www.cms.hhs.gov/rac
Remaining RAC Concerns

• Need greater physician oversight of medical necessity reviews
  ▪ Esp. for claims screened by commercial tools
• Need reliable process for re-billing denied claims at lower payment level
• Look-back still too long
• Need provider education from CMS and FI/MACs on error-prone claims to prevent problems up front
• Need timely CMS’ edits for fixable systems errors to prevent avoidable denials
Remaining RAC Concerns

- Need manageable medical records limit per NPI and per organization with 1+ NPIs
- RACs need to coordinate information transition, and lessons learned with FI/MACs
- Centralized system critical for tracking RAC audit and appeals status
- Need more balanced focus on UNDERpayments and non-hospitals
- Appeals process costly and slow; bottleneck at QIC and ALJ stages
- How will CMS implement partial payments?
- Will RACs use extrapolation?
Key Appeals Changes

• 30-day rebuttal process will precede formal appeals process

• July 1, 2008: no recoupments for 1st two stages of appeals process, if appealed within 40 days
  • CMS finally implements MMA provision; delays expected
  • 7-3-2008: 32 SC hospitals/systems sued HHS for violating MMA, i.e., illegally recouping ~$30m in overpayments during RAC demo before reconsideration – the 2nd appeals stage.

• ALJs no longer able to cite “good cause”
  • RACs need “good cause” to review claims older than 1 year
  • Feb 2007: CMS/RACs to determine “good cause”; not ALJs
  • RACs will be required to document good cause
  • Hospitals must always argue clinical merits of each case
AHA’s RAC Strategy
AHA View

• Hospitals strive for accuracy in payment
• Hospitals support program integrity
• Confusion due to overlapping auditors
• Unacceptable RAC transparency and consistency with Medicare policies

Many CMS Auditors:

• Fiscal Intermediaries (FIs)
• Carriers
• Medicare Administrative Contractors (MACs)
• Program Safeguard Contractors (PSCs)
• Comprehensive Error Rate Testing Program (CERT)
• Hospital Payment Monitoring Program (HPMP) (Run by QIOs)
• OIG Investigations
Moving to National RACs

AHA’s Three-tiered Approach

- **Work with CMS on program improvements**
  - Assist with program refinements
  - Regular communication

- **Seek relief from Congress**
  - Tell the other side of the story
  - Further RAC fixes

- **Member Education**
  - Advisories
  - Call series
RAC Legislation

H.R. 4105
The Medicare Recovery Audit Contractor Program Moratorium Act of 2007

• Rep. Lois Capps (D-CA)  Rep. Devin Nunes (R-CA)
• 87 Co-sponsors
  (19Rs and 68Ds)
• 1-year Moratorium
• CMS Report
• GAO Study

CBO Score: $1 billion over 5 years

*Cosponsor list updated as of May 28, 2008*
Senate Strategy

Draft RAC Language

• Waited for CMS ‘Demo Report
• Potential provisions:
  ▪ Medical Necessity Review
  ▪ Limit Contingency Fee Payments
  ▪ Penalty for High Overturn Rate
  ▪ Shorter Look-Back Period
  ▪ Provider Education
Prepare for RACs Today!

- Establish internal RAC team
  - Interdisciplinary Team: Coders, Finance, Clinical, Utilization Review, Case Management
- Collaborate with your physicians
- Identify RAC point of contact for internal and external RAC communications
- Develop an internal tracking mechanism for all RAC correspondence
- Conduct self audit to identify potential problems
- Participate in RAC education call series
- RAC inquiries to AHA: racinfo@aha.org
- RAC materials on AHA’s RAC page:
  - www.aha.org/rac
AHA RACTrac – What is it?

- Advocacy Tool
- Web-based survey:
  - RAC financial impact
  - RAC appeals information
  - Trends in RAC audits, denials, and appeals
  - RAC administrative burden
- Aggregate data collected quarterly
- **Coming in Summer 2008:**
  - [www.AHARACTrac.org](http://www.AHARACTrac.org)
- Data collection begins in early 2009
AHA’s RACTrac Goals

• Tell *Hospital* story on RACs
  ▪ To CMS
  ▪ To Congress
  ▪ To MedPAC

• Tracking guide for hospitals

• Identify RAC trends

• Minimize hospitals’ financial risk, identify areas for improvement and help survive RACs

• Promote inter-operability between private tracking tools and RACTrac
RAC Program Still Needs Refinement

- Hospitals make great investments in compliance and support CMS’ program integrity program
- RAC management and transparency improved, but further fixes still critical
- Particular concerns about RACs’ limited clinical capacity for medical necessity reviews
- AHA to continue collaborating with CMS on remaining demo issues and on operational refinements for national RAC program
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