December 5, 2014

Marilyn B. Tavenner
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445–G
200 Independence Avenue, SW
Washington, DC 20201

Dear Administrator Tavenner:

On behalf of the members of the American Academy of Home Care Medicine, we support CMS efforts to avoid erroneous payments and then having to recoup them. At the same time, we strongly urge you to resolve the two-year backlog of Medicare and Medicaid appeals. We also appreciate the efforts of the Office of Medicare Hearings and Appeals (OMHA) to address this issue, and have enclosed our specific recommendations to that office under separate cover here. However, the problem does not solely lie with OMHA. Instead, the Centers for Medicare & Medicaid Services (CMS) has failed to address the fundamental issue driving the appeals backlog: the Recovery Audit Contractor (RAC) program. This program has particular negative impact on small practices devoted almost exclusively to the care of Medicare beneficiaries and the revenue flow to sustain their practice and the care of the sickest most vulnerable beneficiaries.

In 2013, more than 60 percent of RAC determinations appealed by physicians were overturned.[1] Based on CMS' data and the experience of our members, RAC auditors are often wrong and their contingency fee incentive based approaches have caused Part B providers undue hardship and expense. As CMS considers awarding new RAC contracts, we strongly urge the following changes to the program:

- **RACs should be subject to financial penalties for inaccurate audit findings and Part B providers should receive interest when they win on appeal of a RAC audit.**
- **Providers should be permitted to rebill for recouped claims for a year following closure.**
- **CMS should provide an optional appeals settlement to providers similar to that provided to hospitals for short-term care.**
- **CMS should retain the current medical record request limits and allow medical record reimbursement for providers.**

[1]Centers for Medicare & Medicaid Services. Recovery Auditing in Medicare for Fiscal Year 2013. Available at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Downloads/FY-2013-Report-To-Congress.pdf Note that this percentage included both Part B and DME claims.

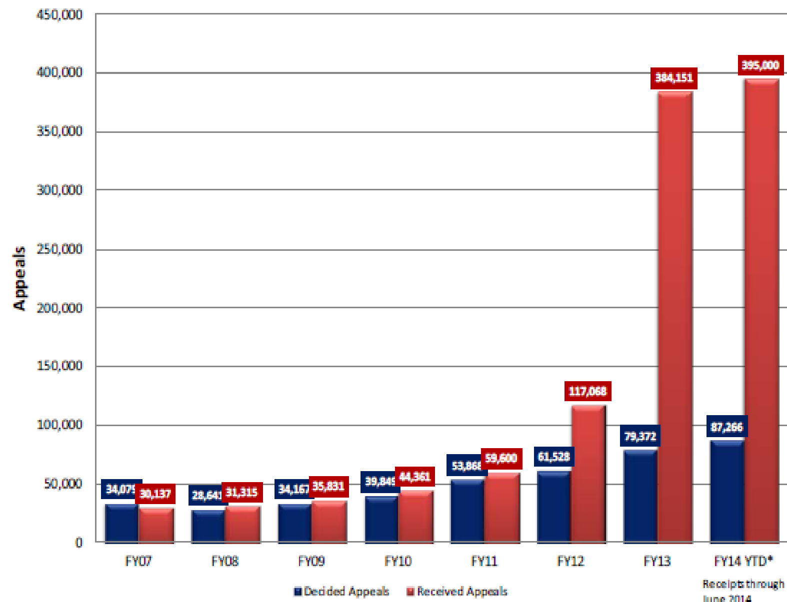
- **RAC audits of providers should be performed by a provider of the same specialty or subspecialty licensed in the same jurisdiction and moreover by one familiar with the same practice setting.**

RACs Largely Contribute to Appeals Backlog

The volume of provider appeals has grown to such a level that the system is overloaded, causing at least a two-year delay for appeals to be heard at the Administrative Law Judge (ALJ) level. Despite efforts by the OMHA to mitigate this backlog, current delays exceed statutory deadlines and are failing to provide due process for providers. One of the key contributing sources to this growing backlog is the RAC program. As shown in the chart below, appeals from the RACs began in 2011 and entered the ALJ level in 2012. Not surprisingly, the backlog of appeals also began in 2012, as OMHA experienced a 42 percent increase in the number of claims appealed compared to 2011. As confirmed by OMHA, "[i]n fiscal year 2013, the number of claims appealed to OMHA more than doubled from fiscal year 2012, with a 123% increase…the increase in appealed claims from the RA [or RAC] program was particularly high in fiscal year 2013, with a 506% increase in appealed RA program claims compared to fiscal year 2012 appealed claims from the RA program, versus a 77% increase in appealed claims not related to the RA program during that same period of time." Overall, this data demonstrates that the RAC program must be reformed in order to resolve the appeal backlog.

Receipt data corrected from original presentation

OMHA Workload – Received and Decided



*The FY14 receipts are based on estimated receipts through June 2014.
Received appeals represents cases with Request for Hearing Date in listed year.
Decided appeals represents cases decided in listed fiscal year no matter what year case was received.
Excludes Remands, Reopened and Combined Appeals.
Receipts may be incomplete due to data entry backlog.
FY14 Data as of September 30, 2014

Run Date: November 13, 2014

Office of Medicare Hearings and Appeals (OMHA) – Medicare Appellant Forum – October 29, 2014 – Washington, D.C.

RAC Determinations Are Often Inaccurate

The RAC contingency fee structure encourages RACs to find overpayments with little regard for the accuracy of their findings. Indeed, RACs are paid a sizeable commission of approximately 9.0-12.5 percent for denied claims. Only if a claim is later overturned on appeal must the RAC pay back their contingency fee, providing little incentive for RACs to ensure that they limit their audits. Due to this payment structure and the lack of financial repercussions, RACs are conducting burdensome fishing expeditions that are inaccurate focused and often overturned on appeal. The most recent data from the program confirms that RAC decisions are frequently appealed, resulting in over 60 percent of overturned decisions for Part B claims (that is in favor of the provider), as shown in the graph below.

Appendix K5: FY 2013 Total Appeal Decisions by Claim Type – All Levels

Claim Type	Total Appeal Decisions	% Total Overturn Decisions	% of Overpayment Determinations Overturned on Appeal
Part A	720,416	11.3%	10.0%
Part B/DME	116,433	60.2%	8.5%
Total	836,849	18.1%	9.3%

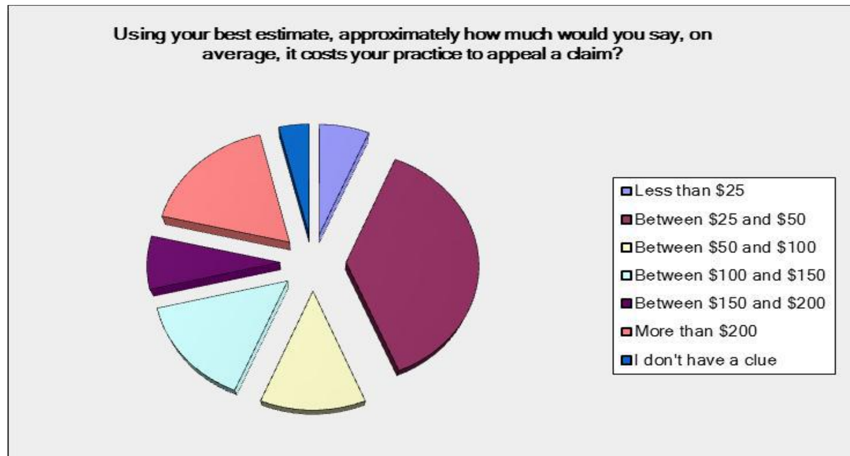
Source: Centers for Medicare & Medicaid Services. Recovery Auditing in Medicare for Fiscal Year 2013.

Without clear safeguards, such as enlisting physician medical reviewers, repealing the contingency fee basis and enacting financial penalties for incorrect RAC determinations, these inaccuracies and the growing appeal delays will continue to persist.

Significant Cost of RAC Appeals

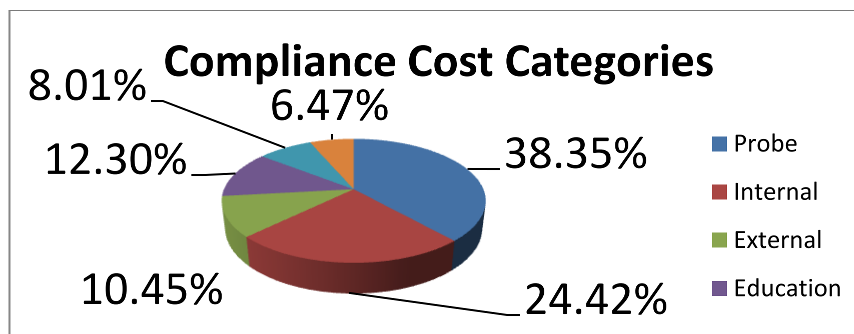
Appeals are financially, professionally and even emotionally traumatic for our members devoted to rendering care to those most in need. The appeals require significant resources, time, and expense that small practices who are simply trying to remain in practice, generally do not possess. As a result, practices have had to exit the field. This is most unfortunate for beneficiaries who lose access to care, to beneficiary caregivers and families and to the Medicare program itself as home care medicine practice and services are found to increase patient satisfaction and to reduce Medicare and other payor cost. The Independence at Home demonstration is currently producing these results for the CMS Innovation Center.

Based on a recent survey of providers, the average cost to appeal a RAC audit was approximately $110 per claim. In contrast, the average value of the claim being audited was only $86, suggesting that in many cases, even if the provider wins on appeal, they will face a net loss. Multiply the average cost of an appeal by the total number of claims appealed by survey respondents, and the total cost on appeals was just under half a million dollars ($455,468) in 2012. Note that this survey only reached a portion of physicians; the actual cost of RAC appeals across all Part B providers is much higher than this amount.



Source: Frank D. Cohen, MPA, MBB Senior Analyst. The Frank Cohen Group, LLC. Survey on Recoupment. March 2012

Beyond this direct cost of RAC appeals, providers also spend significant financial resources on compliance efforts to ensure they meet payment rules and regulations. Cost estimate of these efforts, which include probe audits, internal and external chart reviews, legal and educational expenses, have been estimated at approximately $1,622 per physician per year, although this amount varies depending on practice size. The following graph outlines how this $1,622 is typically spent based on a survey of physicians. Overall, this suggests that physicians are also dedicating significant expenses to ensure they are compliant to avoid RAC audits, funding which is not used to directly improve patient care.



Source: Frank D. Cohen, MPA, MBB Senior Analyst. The Frank Cohen Group, LLC. The Everyday Cost of Compliance Survey. October 2014.

Needed Changes to the RAC Program

Unless Congress and CMS acts to relieve the burden on providers, RACs will continue to operate under their current financial incentives and will resist changes that would improve audit accuracy, reduce the number of appeals, and reduce the burden on providers. Therefore, we strongly recommend the following program changes:

- **RACs should be subject to financial penalties for inaccurate audit findings, and Part B providers should receive interest when they win on appeal of a RAC audit.**
  The program's contingency fee structure encourages RACs to perform as many audits as possible with little regard to accuracy or the burden imposed on Part B providers. CMS has reported that the RAC "error rate" is not significant, but this is directly contradicted by the percentage of RAC claims overturned on appeal. Moreover, CMS fails to consider that many providers choose not to appeal erroneous RAC determinations due to the significant expense and time in seeking an appeal, not to mention the current backlog in cases. Financial penalties on RACs would ensure they target audits; make accurate decisions, and comply with program requirements, including appropriately informing and notifying providers. In turn, providers who are successful in appeals should be compensated, at a minimum, for the time spent going through the time consuming appeals process.

- **Part B providers should be permitted to rebill claims for a year following recoupment.**
  The timely filing rule requires that certain services be filed within one year from the date of service. However, RACs currently operate under a three year look-back period. Denied claims are likely to be ineligible for rebilling given the broader RAC review period and the time it takes for an audit to be completed. We urge CMS to allow providers to rebill claims for the year following audit closure.

- **CMS should provide an optional appeals settlement to providers similar to that provided to hospitals for appeals related to short-term care with recognition to the importance of providers for access, particularly for home limited Medicare beneficiaries.**
  As outlined in more detail in our comments to OMHA, CMS has taken steps to mitigate the appeals backlog by offering a settlement agreement on certain hospital claims. We recommend CMS establish a similar settlement mechanism for Part B provider claims that are pending appeal. Such a program could mitigate the appeals backlog by quickly resolving cases. However, we also urge that any settlement offer provide appropriate payment for the claims at issue, and an appropriate percent if established as option across Part B providers, given that services to Medicare beneficiaries and Medicare revenue represent a higher percentage to the overall practice for Part B providers, especially Academy members, as compared to hospitals and large practices. Such approach would be reasonable for Medicare, and support continued access for beneficiaries who lack access to office based services, by recognizing the need for small (mobile) practices to sustain themselves.

- **CMS should retain the current medical record request limits and allow medical record reimbursement for providers.**
  The AMA understands that CMS is considering revising existing RAC medical record request limits. Given the existing administrative burden and cost of RAC audits, the high denial rate, and the two-year appeals backlog, which has been largely attributed to the RAC program, we urge that these limits not be increased. In addition, hospitals are partially reimbursed for their medical records. We believe that Part B providers, similarly and as a matter of equity, should also be reimbursed for this significant expense that is actually more material to a practice to absorb than institutional setting.

- **RAC audits of Part B providers should be performed by a provider of the same specialty or subspecialty licensed in the same jurisdiction and moreover by a professional familiar with the same practice setting.**
  Most RAC audits are evaluated by a certified coder or nurse rather than a physician, nurse practitioner or physician assistant. Given that treatment decisions often require a high level of expertise and familiarity with medical area as well as beneficiary context and setting, we believe providers of the same specialty/subspecialty, in the same jurisdiction *and* familiar with the practice setting, would be best prepared to appropriately perform these reviews. Including such Part B providers would also improve RAC accuracy and promote communication with the provider community.

The Academy is committed to working with CMS to assure appropriate coding and billing of Part B services. We are also committed to assure access to medical care for the sickest and most isolated of Medicare beneficiaries, and the reasonable review of the services of their Part B providers. Thank you for your consideration of these reasonable recommended changes to the RAC program. If you have any questions regarding this letter, please contact Constance Row at edrow@aahcm.org or Gary Swartz at gary.swartz@aahcm.org, or either at 410-676-7966.

Sincerely,

Robert Sowislo
Chair, Public Policy Committee
American Academy of Home Care Medicine