Introduction

The Recovery Audit (RA) Program exists to detect and correct improper claims to the Medicare program. The contracted firms are paid a portion of their recoveries, so the program delivers savings to the Medicare Trust Fund at no cost. However, Recovery Audit Contractors (RAC) are currently being weakened by the Centers for Medicare and Medicaid Services (CMS) through several policy changes and are facing a transition period between contracts that will result in a limited scope of recoveries.

The Origin of the Recovery Audit Contracting Program

Detecting Medicare fraud and recovering faulty reimbursements became a priority for the federal government and the Health Care Financing Agency in the early 1990’s. While it was always possible to prosecute those defrauding the federal government under the False Claims Act, in order to recoup wasted funds, the government had to prove the difficult standard of “criminal intent to defraud.” In 1986, the Act was amended to specify that Medicare and Medicaid fell under the False Claims Act and that citizens could bring cases against medical providers and share in the recovered funds. With harsh penalties for submitting false or incorrect claims, most of the cases were settled rather than fought in court.

The 1996 Health Insurance Portability and Accountability Act (HIPAA) included Medicare-specific fraud and abuse funding from the Medicare Trust Fund and set up the Health Care Fraud and Abuse Control Account (HCFAC), which distributed money among many agencies including the Health Care Financing Administration, the Office of the Inspector General, the Office of General Counsel, Federal Bureau of Investigations, Department of Justice and other sectors of the Health and Human Services Agency.

The Medicare Modernization Act of 2003 implemented the RAC initiative as a pilot program. In 2009, the RAC program was launched nationwide. RACs are contracted to audit Medicare claims data for proper billing practices and receive a percentage of their recoveries as payment. The country is divided into four regions and each region has a RAC that audits claims in that area. Diversified Collection Services audits Region A, CGI Federal audits Region B, Connolly audits Region C, and HealthData Insights audits Region D. The RACs’ audit all claims; the recent focus has been on site of care, upcoding (billing for a higher intensity of services than were provided, and thus, earning greater reimbursement) and medical necessity. Table 1 below shows their correction totals in fiscal years 2010-2012.

Table 1: Recovery Audit Program Corrections, in Millions
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<tr>
<th>Year</th>
<th>FY 2010</th>
<th>FY2011</th>
<th>FY2012</th>
<th>FY 2013 Through June 30 2013</th>
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The accuracy rates of the four RACs are quite high. In 2010 and 2011, the percentages of overpayments found that were appealed and overturned ranged from .7 percent to 5.7 percent. [v]

Medicare improper payment recovery is controversial, as files can be audited up to three years after the care is given and hospitals may not be able to re-submit a new claim if their original claim was deemed improper. For example, if a patient is in the hospital and admitted as an inpatient, the hospital submits the claim and is paid for inpatient care. If a later audit finds that inpatient status was medically unnecessary, the hospital can only submit the claim for outpatient reimbursement if the claim was paid within the preceding year.

**Background on Observation Status**

Medicare Part A covers hospital services and Medicare Part B covers outpatient services. The status of hospitalized patients can be categorized as either inpatient or outpatient. If a beneficiary is an inpatient, Medicare Part A would cover the medical claims and if the patient is an outpatient, the claims are covered by Part B. Those under observation status are considered outpatients. Patients may find that, despite receiving services for a couple days in the hospital, they have been under observation status, resulting in the outpatient designation. As such, those patients would be burdened by the full cost of their post-acute care costs (if, for example, the hospital recommends a nursing home stay) because Medicare only covers nursing home costs after an inpatient hospital stay.[vi]

The status, whether the visit is covered by Part A or Part B, impacts patient copays, (physician services under Part B carry a 20 percent coinsurance) as well as whether administered drugs are covered, and whether or not the patient qualifies for post-acute care under Medicare, as post-acute care is only covered after a qualifying 3 day inpatient stay.[vii]

The Recovery Audit Contractors go through medical records and if they find an improper inpatient status, they recoup the incorrect amount from the provider. This recoupment is returned to CMS (Medicare Trust Fund). [viii] Often, the Medicare providers cannot re-bill under the correct claim, so there is an incentive to air on the conservative side and bill more patient stays as outpatients.

In the most recent past, the number of observation claims has risen dramatically, growing 69 percent in five years, according to a Kaiser Health News and SCAN informational piece.[ix] In addition to a much higher number of outpatient observation stays, such stays are lasting longer.[x]

Per Medicare guidance, observation status is rarely to exceed 48 hours, but in practice it often does since there’s no official time limit. Stays do often last several days, while still being billed as observation and classified as outpatient. In a study of observations status practices from 2007-2009 published in *Health Affairs*, researchers found that 10 percent of patients were under observation status for over 48 hours.[xi]

Having an observation stay in the hospital cannot count as a readmission, and with the Affordable Care Act (ACA) penalizing hospitals for above-average readmission stays, having fewer admitted patients lessens the likelihood of having those readmissions. If the first trip to the hospital is for observation, a second trip would not count as a readmission since the first was an outpatient billing; if the second trip to the hospital is for
observation after an inpatient stay, that second stay would also not count as a readmission.

**CMS’s “Two Midnigh Rule”**

In response to the confusion regarding observation stays, CMS issued a new rule on August 2, 2013 (effective with admissions as of October 1, 2013) to clarify time-frame specific rules for determining inpatient versus outpatient status. It is dubbed the “Two Midnight” rule, as any patient in the hospital on observation status is to be considered an inpatient only if they stay for two midnights or longer. This rule is accompanied by hospital reimbursement cuts, with the assumption that cuts are needed to offset increased spending for inpatient hospitalizations.

Hospitals are pushing back against the rule, citing the incentive for hospitals to discharge at 12:05 am rather than when it is medically appropriate or convenient for the patient. They are also concerned about the need to devote more resources to collect coinsurance from patients when short stays are billed as outpatient.[xii]

For patients, their time in the hospital may be lengthened unnecessarily, or they will be unaware if their stay is billed under Part A or Part B until they are discharged and see their medical bills. Two patients could both be in the hospital for the exact same amount of time, receiving the same amount of care, but depending on when the patient came in, the stay could span two midnights or not, and those patients (and Medicare) would be billed differently.

According to a New York Times article about the issue, there is universal dislike of the new rule.[xiii] The article quotes a senior administrator at Johns Hopkins Hospital saying: “Nobody looking at the patients who come through the door can predict who’s going to be here for two midnights.” It goes on to explain that if clinicians predict incorrectly and the admitted patient leaves before two midnights, they can face audits from Medicare.

**Audit Grace Period**

In response to concern about the “Two Midnight” rule, the CMS declared a grace period from audits, while hospitals learn and adjust to the new regulations. As a part of the enforcement delay, CMS originally announced that RACs could not look at the medical necessity of any short (one day or less) inpatient stays for a period of 90 days, the entirety of the fourth quarter 2013. In October 2013, CMS extended this grace period through March 2014. Essentially, hospitals have been given a free pass to bill whatever they want for short-stay patients for a full six months with the knowledge that those claims will never be reviewed.

This delay gives hospitals time to understand the new rule before it is enforced, but results in drastically lower recoveries to the Medicare Trust Fund as overpayments and improper payments are not being audited and returned.

**Contract Transitions**

In addition to the two midnight rule and audit grace period, the RACs’ ability to make recoveries is also impacted by the transition between contracts. This is the first re-compete period for RACs since the programs’ inception (in February 2009—the first contract), and issues have come up about how to transition from one contractor to another. For example, if a RAC is paid on a claim and the hospital appeals it, there was a question as to how CMS would handle that. This was resolved with an agreement that the RACs would be responsible for handling appeals up to 2 years after contract expiration.

Contract transitions are also complicated by the fact that anyone can protest the new contracts, including the
prior contractor. The first protest stage can last 100 days. In theory the outgoing RAC would wind down their audits while the newly contracted firms began their processes, and the two would overlap for a period of 6 months. However, if there is a protest to the new RAC’s contract, the new firm would not begin work and there would be a period of very limited audits while the outgoing contractor finished their business.

Combined with the limited audit ability, this contract transition period will result in reduced recoveries for the Medicare Trust Fund.

Policy and Budgetary Implications

The grace period results in multiple negative implications for the Medicare program and the effort to detect fraud and prevent waste. Most importantly, the Medicare Trust Fund stands to lose billions in wasted payments if hospital claims are not audited.

The American Action Forum projects the loss to the Medicare Trust Fund from suspending the auditing program for 6 months could be as high as $408 million, with 120,600 claims going uncorrected at a cost of $3,401 per overpayment.[xvi]

As RAC firms lose a significant portion of their workload for 6 months, many of the skilled professionals conducting audits will have their jobs terminated— according to industry sources, approximately 800 Medicare clinical review staff will lose their jobs.

It is expected that these layoffs will weaken the ability of these contracting firms to audit Medicare claims accurately for a period of time beyond the 6 month moratorium. As skilled professionals, these employees are likely in-demand and will find new employment. The auditing firms will need to staff up again once they begin auditing the claims for the second quarter of 2014 and will need to train new staff. No business model can seamlessly absorb losing half a year of work. More importantly, the ability to apply the Medicare expertise needed to deliver accuracy in audit findings is dependent on experience with the work. CMS will miss out on recouping overpayments while new professionals acquire the skills necessary to audit claims.

It sets a poor precedent to make a rule and then respond to industry complaint by delaying enforcement of it, rather than revising, delaying or repealing it. Furthermore, because the grace period applies to all short-stays, hospitals will have a whole swath of their claims go unaudited, not just those where the division between outpatient care and inpatient care could be debated.

Similarly, CMS needs to develop a thought-out strategy for transitioning the RACs during the contract re-compete period that does not put the Medicare Trust Fund recoveries at risk.

On the whole, the Medicare program needs to gather stakeholder input and develop a solution for hospital billing that allow clinicians to better clarify which patients qualify for inpatient status and which can be treated as outpatients. A solution would ensure that clinical severity and the likelihood of needing post-acute care is factored in, such that patients are cared for appropriately and can get the follow-up care needed.

A solution that patients and hospitals can live with would not necessitate a moratorium on audits for 6 months or longer, and would allow the auditing firms to continue their appropriate oversight of the Medicare program.

http://content.healthaffairs.org/content/20/4/28.full.pdf+html