Insight

MedPAC's RAC Proposals: The Good and the Bad

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EXECUTIVE SUMMARY

· The Recovery Audit Contractor (RAC) program was created by the Medicare Modernization Act to, among other things, recover improper Medicare payments to hospitals under Part A for short hospital admissions.

· The program has been extremely successful with $9 billion in recovered funds since its inception while review has been limited to less than 2% of all Medicare claims during the program life

· Administrative rules imposed by the Centers for Medicare and Medicaid Services (CMS) have had some negative, unintended consequences which have diminished the program's benefits, such as:

- Increasing episodic costs for seniors
- Setting arbitrary limits on physicians' discretion in making medical decisions
- Making it difficult or impossible for providers to receive appropriate compensation for care provided due to the confusing two-midnight policy
- Creating backlog in administrative appeals courts

· To address these issues, MedPAC has proposed recommendations to Congress, some more meritorious than others, including:

- Shortening the time in which RACs may review claims: would reduce administrative burden on hospitals, but limit RACs' effectiveness
- Expanding Part A coverage for follow-up care after non-inpatient hospital visits: this would help protect seniors from arbitrary discrimination
- Formulaic penalties for hospitals with the most short-stay patients: would punish hospitals for providing efficient care and enabling prompt discharge; would impede RACs' ability to make more informed judgments
- Adjusting RACs' contingency fees based on their accuracy rates: would likely have little to no impact on RACs' overturn rate, but would incentivize frivolous appeals, further burdening administrative appeals courts

BACKGROUND

The Recovery Audit Contractor (RAC) program, which you can read more about here, was developed as an integrity initiative to protect the Medicare trust fund from improper payments to hospitals on short-term hospital stays. The program has been very successful and RACs have recovered $9 billion in improper Medicare payments in the past 5 years. Like any program though, it has its problems: providers are often concerned about receiving payment for their work, the unintended consequences of interplay between the RACs and CMS' flawed two-midnight rule can have dire effects on seniors, and Administrative Law Judges (ALJs) have massive backlogs of RAC review appeals to sort through, which impede the entire process.

The Medicare Payment Advisory Commission (MedPAC), the independent federal body that advises Congress on Medicare issues, has attempted to address some of these problems through its recommendations, which were discussed at a March 2015 MedPAC meeting, and will be voted on in early April. Some of the proposals would have a positive impact, but others may raise new problems. Below is a brief discussion of the various proposals.

RECOMMENDATIONS

Shorten Time to Review Claims

Under the current rules, RACs have three years from the day care is provided in which to complete a review. By shortening the length of time in which a RAC may review a claim, MedPAC recommends reducing some of the administrative burden on hospitals to keep records available for several years. This rule might also help hospitals by decreasing the number of reviews that are initiated after the deadline for hospitals to file claims, at which point the hospitals becomes unable to recover any payment at all for the claims that were denied.

This step, however, is unnecessary. The purpose of protecting hospitals' ability to recover costs could be better served by instead extending the deadline to file claims, or creating a special rebilling period for claims that have been denied. This approach might also lessen pressure on hospitals to file as many appeals if they are confident they will be able to re-submit their claims. Instead, the MedPAC proposal would limit the RACs' ability to review and discourage improper billing, thereby saving the Medicare program money.

Request Congress Expand Part A Coverage for Skilled Nursing Facilities

Under the current rules, if a senior is in the hospital for less than two midnights and is not inpatient, that senior's care related to the episode will not be covered under Medicare Part B hospital care, but rather under Part A physician care. Medicare does not cover Skilled Nursing facilities and other necessary treatment options unless the patient has been admitted to a hospital as an inpatient in the immediate past.

The recommendation would ask that Congress change Medicare to allow for Part A payments for follow-up care when a Medicare beneficiary stays in the hospital for up to three days on observation or outpatient status but was inpatient for at least one night. This is a move in the right direction toward limiting unnecessary inpatient stays without financially harming seniors for seeking outpatient treatment.

Request Congress Require Beneficiary Notification of Outpatient Status

Like the previous recommendation, this proposal nobly aims to insulate seniors from the sticker shock that may attend seeking out skilled nursing or other care in the aftermath of a hospitalization. Unfortunately, many seniors do not recognize the important financial differences between observation or outpatient status and being admitted to the hospital as an inpatient. The rule asks that Congress require hospitals to inform patients of their outpatient status. However, this information is unlikely to do much to change patients' behavior, and may even have the effect of discouraging them from seeking care outside a hospital setting. The proposal would also add administrative costs for hospitals without doing anything to address the root problem: there is arbitrary discrimination among seniors based on what time of day they show up in a hospital for care.

Target Hospitals with the Most Short-Stays

This MedPAC proposal would encourage RACs to focus their audits on hospitals with the most short-stays. This proposal would focus RACs on what seems to be the problem (*too many* short-stays), but in reality misses the bigger problem (*improper* short-stays). This proposal would create incentives for hospitals to give patients outpatient or observation status, which could impact how Medicare will pay their bills. A recent Health Affairs study pointed out that observation stays have more than doubled from 3 percent to 8 percent between 2006 and 2011.[1]

RACs are independent investigative agencies with unique knowledge of the industry. Forcing them to focus their attentions to certain types of providers would rob them of the ability to make informed professional decisions about where to find improper payments and how to go about rooting them out.

Formulaic Penalty on Excess Short-Stays

By imposing a penalty on all hospitals that have above a given number of short-stay admissions, MedPAC is suggesting that hospitals should be punished for having patient populations that differ from those of other hospitals. This rule appears to seek to punish not just improper short stays, but *all* short stays above a given number, even if they were all entirely medically appropriate. Much like the critiques of the two-midnight rule, this rule would place a substantial barrier between providers and their patients by limiting physicians' ability to make objective medical decisions.

Contingency Fees Based on Denial Overturn Rates

MedPAC has suggested that it would be wise to tie a RAC's contingency fee to its rate of overturns on appeal. This proposal has both good and bad elements, but falls just short of practicality.

For starters, RACs have an average accuracy rate of 96.4 percent and 3 out of 4 RACs have accuracy rates above 95 percent (one was over 99 percent accurate!). If Medicare based RACs' contingency fees on accuracy, it would be unlikely to have any significant impact on the RACs since they already have such a low overturn numbers.

However, basing reimbursement rates on overturns on appeals would be grossly unfair, as it would allow hospitals to cherry pick cases to appeal, leading the ratio of appealed to overturned cases to be very high, thereby decreasing RACs' fees.

Still, it is unlikely that this rule will help to decrease the volume of RAC denials reaching Administrative Law Judges (ALJs). Currently about one-third of ALJ appeals on RAC decisions are blanket appeals where the hospital in question automatically appeals any denial of its claims. As long as hospitals think it is profitable for them to appeal every denial, they are unlikely to sacrifice their own profits in an attempt to reduce the RACs' contingency fee.

ALJ backlog is a real problem, and taking a step like this to encourage RACs to be as accurate as possible in denying claims is certainly a step towards more accountability. But it would be more effective and would have a better market impact if instead there was a penalty on both sides attached to the outcome of appeals of RAC denials.

CONCLUSION

The RAC program works well and is cost-neutral but there are is always room for improvement. Some of MedPAC's recommendations, described above could have a positive impact on the administration of the program. Some of them appear to miss the point completely. RACs have a substantial role to play when it comes to Medicare payment accountability. When estimates of Medicare's improper payments hover around $50 billion per year, it's crucial to proceed with caution when it comes to recommendations that substantially alter the nature and incentives of the cost-saving RAC program.[2]

[1] http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=133