Research

Primer: Recovery Audit Contractor Program and the "Two Midnight" Rule

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INTRODUCTION

The Recovery Audit (RA) Program exists to detect and correct improper claims to the Medicare. The contracted firms are paid a portion of their recoveries, so the program delivers savings to the Medicare Trust Fund at very little cost. In fact, to date, the recovery audit program has returned more than $8.9 billion to the Medicare Trust Fund.

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.[2] 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."[3] 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.[4] 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 about 2 percent of all claims. CMS approves a series of issues to audit and those approved issues are made public to providers via each RAC website. 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. [v] Table 1 below shows their correction totals in fiscal years 2010-2014.

Table 1: Recovery Audit Program Corrections, in Millions [6]

Overpayments Collected	$993.0	$75.4	$797.4	$2,291.4	$3656.6	$2,097.0	**$8,918.7**
Underpayments Collected	**03/05 to 03/08** $38.0	$16.9	$142.0	**2012** $109.4	**2013** $177.0	**2014** $307.5	**$810.4**
Total Corrections	$1,031.0	$92.3	$939.3	$2,468.4	$3,823.8	$2,404.5	**$9,729.2**

The accuracy rates of the four RACs are quite high. In 2013 it was estimated that 10.1 percent of Medicare claims were erroneous, yet an independent validation contractor found that RACs are 96.4% accurate and in 2010 and 2011, the percentages of overpayments found that were appealed and overturned ranged from .7 percent to 5.7 percent.[7] Only 9.3 percent of all RAC determinations were challenged and later overturned on appeal.[8]

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, and a later audit finds that inpatient status was medically unnecessary, the hospital may re-submit the claim for outpatient reimbursement only if the claim was paid within the past twelve months, otherwise the hospital loses the entire value of the claim.[9]

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 these costs after an inpatient hospital stay.[10

The RACs analyze Medicare claims data to find improper payments. Medicare Administrative Contractors (MACs) recoup from the provider improper payments identified by the RACs. This recoupment is returned to CMS (Medicare Trust Fund). [11] Often, the Medicare providers cannot re-bill under the correct claim, so there is an incentive to err on the conservative side and bill more patient stays as outpatients.

The number of observation claims has risen dramatically, growing 69 percent in five years.[12] In addition to a much higher number of outpatient observation stays, such stays are also lasting longer.[13]

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, researchers found that 10 percent of patients were under observation status for over 48 hours.[14]

What drives some hospitals to have more observation stays is complex, and includes patient demographics and revenue management consideration. Of note, having an observation stay in the hospital cannot count as an admission, 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 MIDNIGHT RULE"

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, in general, 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 just one of the many stakeholder groups pushing back against the rule, citing the incentive for hospitals to discharge inpatients 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.[15]

For patients, their time in the hospital may be lengthened unnecessarily, or they may 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. Billing under Part B could mean considerable out of pocket costs for follow-up and rehabilitative care related to the episode; costs an identical patient billed under Part A would not face.

According to a New York Times article about the issue, there is universal dislike of the new rule.[16] 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.

ENFORCEMENT DELAYS

Though RACs only audit about 2 percent of all claims filed with CMS, there has been significant backlash in response to the expansion of the RAC program. Objections to the implementation of the "Two-Midnight" rule, RAC determinations, and RAC contracts have caused enforcement delays that will have serious policy and budgetary implications for the program.

Audit Grace Period

In response to concern about the "Two Midnight" rule, 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. This enforcement was once again delayed in March 2014 until March 31, 2015 as part of the 2014 SGR patch. Essentially, hospitals have been given a free 18 month long pass to bill whatever they want for short-stay patients for a year and a half 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.

Delays Due to ALJ Appeals Process

On July 15, 2013, the US Department of Health and Human Services (HHS) temporarily suspended RAC audit appeals in order to make time to work through a backlog of approximately 357,000 claims.[17]

In January 2012, hospitals appealed about 1,250 new cases per week. By December 2013, 15,000 appeals were submitted per week. Because of this extreme increase in appeals, average wait time for a hearing is 16 months. Many of these appeals involve disputes over short inpatient stays. Even with the suspension, it is anticipated that it will take HHS administrative law judges two years to significantly decrease the workflow, and even then, hearings will likely continue to be delayed up to six months.[18]

CMS Offers Settlement to Hospitals

The American Hospital Association has sued CMS due to the significant backlog of appeals on Medicare claims at the ALJ level. In an effort to reduce the appeals backlog, CMS has offered providers an incentivized settlement—an instant 68 cents on the dollar, or more than two-thirds of the amount of their claim—to drop their appeals and walk away. These appeals have been generated from all of the program integrity contractors who work for CMS in safeguarding the Medicare Trust fund.

While a potential quick fix, this deal likely excuses a massive amount of improper payments at a cost of hundreds of millions of taxpayer dollars. Rep. Kevin Brady (R-TX), chairman of the House Ways and Means Subcommittee on Health, expressed “serious concerns” with the way the Centers for Medicare and Medicaid Services is addressing the backlog of more than 800,000 Medicare short-stay appeals. The proposed settlement will pay hospitals roughly two-thirds of the money in dispute, yet the RACs contingency fees for recovering that money will continue to be governed by the original terms of their contracts.[19]

In a letter to HHS Secretary Sylvia Burwell, Rep. Brady raises questions about CMS’ authority to settle and CMS’ “all-or-nothing approach”. Brady further requested that the agency explain how it determined the proposed settlement.[20]

Contract Transition Delays

In addition to the audit grace period and appeals suspension, the RACs’ ability to make recoveries is also impacted by the transition between contracts. 2014 began the first re-compete period for RACs since the programs’ inception in February 2009, 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 their specific contract expired.

Contract transitions are also complicated by the fact that anyone can protest the new contracts, including the

prior contractor, and some have. 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, with an overlap 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. This problem is rendered rather moot by the extension of the current enforcement delay well beyond the 6 month transition period, but it will come back into play during the next contract transition period 4 years from now.

Policy and Budgetary Implications

The enforcement delays are marplots in the Medicare program's necessary effort to detect fraud and prevent waste. Most importantly, the Medicare Trust Fund stands to lose $6 billion in wasted payments every year hospital claims are not audited.[21]

As RAC firms have lost a significant portion of their workload for 18 months, many of the skilled professionals conducting audits have had their jobs terminated. According to industry sources, approximately 800 Medicare clinical review staff lost their jobs in the first 6 months alone.

These layoffs can be expected to weaken the ability of these contracting firms to audit Medicare claims accurately for a period of time beyond the 18 month moratorium. The auditing firms will need to staff up again once they begin auditing the claims for the second quarter of 2015 and will need to train new staff. No business model can seamlessly absorb losing over a year of work. More importantly, the ability to apply the Medicare expertise needed to deliver accuracy in audit findings is dependent on experience. CMS will miss out on recouping overpayments while new professionals acquire the skills necessary to audit claims.

A LIMITED RESTART

The previous RAC contracts ended June 1, 2014 halting all Medicare oversight by the program. In August 2014, CMS announced it would allow the RAC program to restart auditing, reviewing a limited number of billing issues including those pertaining to spinal fusions, outpatient therapy services, durable medical equipment, prosthetics, orthotics and supplies, and cosmetic procedures. Contract modifications have been issued for all four regions and the RAC contractors are reviewing most claims on an automated basis, but a limited number will be complex reviews of topics selected by CMS. The moratorium on review of short-stay claims, which account for 85 percent of all RAC recoveries, will continue until March 2015.[22]

CONCLUSION

It sets a troublesome 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 thoughtful strategy for transitioning the RACs during the contract re-compete period that does not put the best interests of Medicare beneficiaries or 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 both patients and hospitals can live with would not necessitate a moratorium on audits for 18 months or longer, and would allow the auditing firms to continue their appropriate and necessary oversight of the Medicare program.

An earlier version of this Primer was written by Emily Egan, formerly AAF Senior Health Policy Analyst.

[1] http://thehill.com/blogs/pundits-blog/healthcare/222603-racs-rock-so-stop-gutting-the-program