March 2016

# Attention Member of the Senate:

### H.R. 2156 - Medicare Audit Improvement Act

**Background**
The Medicare Modernization Act of 2003 first created the Recovery Audit Contractor (RAC) program to identify and recover improper Medicare overpayments and underpayments to healthcare providers. Initially this program was a 3 year demonstration program in 3 large states; New York, California, and Florida. However, the program was made permanent in 2006 as part of the annual "doc fix." The program is overseen by the Centers for Medicare and Medicaid Services (CMS) with RACs performing the actual work of reviewing, auditing, and identifying improper Medicare payments. RACs receive a share of the improper payments they recoup.

Hospitals have been seeing a large increase in the amount of documents being requested during a review. When a Medicare contractor detects the possibility of an improper payment, they will contact the hospital and request additional documentation, referred to as an Additional Document Request (ADR).

Previously, CMS set a limit of 300 claims within a 45 day period for which an auditor could request additional documentation. However, CMS has begun to waive that cap at the request of the auditors. Auditors have a timeline in which they must make a determination if a payment was improper, within 60 days of the ADR. In many cases, RACs and other Medicare contractors are not getting through all the documentation they are requesting from the hospitals despite the requirement to do so. Currently, there is no incentive for the auditors to adhere to the 60 day deadline. Furthermore, they are casting a broad net, at the expense of the hospitals, to increase the likelihood of payment recoupment which they benefit from financially.

Hospitals have the ability to appeal an auditor's initial determination to CMS. In many cases, hospitals accept the RAC denial without the opportunity to rebill Medicare, because the appeals process is lengthy and the administrative and legal costs already endured would only increase costs if they pursued an appeal. This administrative burden and the perverse incentives within the Medicare audit programs are the core of what this legislation seeks to address. The legislation still preserves the intent of the program, to address fraud within the Medicare system, but in a way that does not continue to negatively impact our hospitals which, at the end of the day, are responsible for taking care of patients. Adding additional administrative burdens will only negatively impact patient care.

**Conclusion**

- This legislation amends title XVIII (Medicare) of the Social Security Act (SSAct) with respect to the practices of recovery audit contractors (RACs) under the Medicare program in identifying underpayments and overpayments and recouping overpayments.

- Incentive payments to a RAC for recovery activities are prohibited.

- Payments for recovery activities shall be reduced, according to a sliding scale established by the Secretary of Health and Human Services, to any RAC with a complex audit denial rate at the end of a fiscal year, determined pursuant to a specified formula, that is .1% or greater.

- The one-year timely filing limit for certain rebilled SSAct title XVIII part B (Supplementary Medical Insurance) claims is eliminated, extending the deadline for the rebilling to 180 days after final denial of the claim.

- A determination of whether inpatient hospital services or inpatient critical access hospital services furnished to an individual are reasonable and necessary shall now be based solely on information available to the admitting physician at the time of the inpatient admission of the individual for such services, as documented in the medical record.

**Recommendation**

AAHAM urges you to introduce a Senate companion to H.R. 2156, the Medicare Audit Improvement Act sponsored by Representative Sam Graves, which is a bi-partisan piece of legislation.