Results of Best Practice Research on Hospital RAC Management

Preventing and Redressing Audit-Generated Takebacks
**Our Work To Date**

**Bringing Best Practice Insight to Hospitals and Health Systems**

### The Advisory Board Company In Brief

#### Best Practice Research
- 2,600 Hospitals and Health System Members
- Serving 100 Largest U.S. Health Systems
- 50+ Annual Best Practice Initiatives
- 150+ Research Consultants and Analysts

#### Business Intelligence Platform
- Ten Programs – Revenue Cycle, Self Pay, Patient Access, Revenue Integrity, Surgery, Spend Nursing, ED, Quality and Crimson
- Optilink Nursing Staffing and Scheduling
- 700+ Hospital Partners

#### Operations and Strategy Consulting
- 600+ Hospital and Health System Engagements
- 50+ Professional Consulting Staff
- Modern Healthcare Top 10 Consulting Firms

#### Training and Leadership Development
- 600+ Hospital and Health System Clients
- 30,000 Executive Participants
- 70 Faculty and Training Development Staff
- Largest U.S. Hospital Training Company

#### Revenue Cycle Compass
- Supporting hospitals in elevating performance across the revenue cycle

#### Self-Pay Compass
- Supporting hospitals in responding to undercompensated care

#### Patient Access Compass
- Supporting hospitals in ensuring front-end revenue cycle accuracy and efficiency

#### Revenue Integrity Compass
- Supporting hospitals in responding to RAC overpayment determinations

**The Advisory Board Revenue Compass Initiatives**

Combining Best Practice Research with Hospital Information to Elevate Data Visibility and Revenue Performance

**Generating Significant Impact on the Revenue Cycle**

- **$1.2 Billion in Bottom Line Benefit**
- **$287 M in Bad Debt Reductions**
- **$537 M in Denial Reductions**
- **$344 M in Charge Capture Increases**

**Unequaled Financial Management Expertise**
- 250+ Best Practices with Implementation Support
- 100+ New Case Study Profiles Each Year

**Representative Case Study Results**
- **$1.2 M Reduction in Cost-to-Collect in Revenue Cycle Operations**
- **$320 K Annual Reimbursement Increase through Automated Eligibility**

**Revenue Cycle Engagement Results**
- Average Reduction in AR Days……13%
- Average Reduction in Bad Debt……15%
- Average Reduction in Denials………33%
- Increase in Point-of-Service Cash…250%

**Sampling of Partner Hospitals**
- Bajaj Health System
- Blazing Health System
- Desert Health System
- Encompass Health System
- Max Medical Center
- St. Joe's Medical Center
- St. Joseph Medical System
- Valley Medical Systems
- University of Kentucky Medical
- VCU Health System

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**Advisory Board Memberships**

**H*Works**

**Business Intelligence Platform**

**Revenue Cycle Compass**

**Self-Pay Compass**

**Patient Access Compass**

**Revenue Integrity Compass**

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**The Academies**

**H*Works**

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**In Brief**

**Revenue Compass**

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Road Map for Discussion

1. Essay: The New Audit Imperatives
2. Avoiding RAC Flashpoints
3. Coda: Tip of the Iceberg
Three Audit Flashpoints

Potential Pitfalls in Responding to RAC

#1 Ignorance of True Risk
Assessing RAC exposure

#2 Poor Workflow and Tracking Mechanisms
Managing the audit process

#3 Scattershot Appeals Process
Strategically navigating RAC appeals

Source: Financial Leadership Council interviews and analysis.
# Avoiding RAC Flashpoints

*Preventing and Redressing Audit-Generated Takebacks*

<table>
<thead>
<tr>
<th>I</th>
<th>II</th>
<th>VII</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ignorance of True Risk</strong></td>
<td><strong>Poor Workflow and Tracking Mechanisms</strong></td>
<td><strong>Scattershot Appeals Process</strong></td>
</tr>
<tr>
<td>1. RAC Risk Assessment Toolkit</td>
<td>3. RAC Audit Leadership</td>
<td>7. Templated Appeals Documents</td>
</tr>
<tr>
<td></td>
<td>5. RAC Simulation Exercise</td>
<td>9. Expert ALJ Consult</td>
</tr>
<tr>
<td></td>
<td>6. Comprehensive Tracking Tool</td>
<td>10. Appeals Performance Analysis</td>
</tr>
</tbody>
</table>
Flashpoint #1:
Ignorance of True Risk
What They’re Not Telling You

The RACs Will Continue to Get Better Over Time

Overpayments Collected by Fiscal Quarter

<table>
<thead>
<tr>
<th>Fiscal Quarter</th>
<th>Overpayments Collected</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY06 Q1</td>
<td>$0.0B</td>
</tr>
<tr>
<td>FY06 Q2</td>
<td>$0.0B</td>
</tr>
<tr>
<td>FY06 Q3</td>
<td>$0.0B</td>
</tr>
<tr>
<td>FY06 Q4</td>
<td>$0.0B</td>
</tr>
<tr>
<td>FY07 Q1</td>
<td>$0.0B</td>
</tr>
<tr>
<td>FY07 Q2</td>
<td>$0.0B</td>
</tr>
<tr>
<td>FY07 Q3</td>
<td>$0.0B</td>
</tr>
<tr>
<td>FY07 Q4</td>
<td>$0.0B</td>
</tr>
<tr>
<td>FY08 Q1</td>
<td>$0.0B</td>
</tr>
<tr>
<td>FY08 Q2</td>
<td>$0.0B</td>
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</tbody>
</table>

Medicare Improper Payments

<table>
<thead>
<tr>
<th>Source Details</th>
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</thead>
</table>

$10.8B

CMS Estimate in Demonstration Project States (2008-2009)

$993M

RAC Takebacks (2008-2009)
A Window to the Future?

Top Demonstration Program Target Areas

Overpayments Collected by Error Type  
*Cumulative through 3/27/08*

- Incorrect Coding: 40%
- Medically Unnecessary: 17%
- No/Insufficient Documentation: 8%
- Other: 35%

Value of Overpayments Collected (Net of Appeals)  
*Cumulative through 3/27/08*

- Medically Unnecessary: $391.3M
- Incorrect Coding: $331.8M
- Other: $160.2M
- No/Insufficient Documentation: $74.3M

A Universe of Opportunity

RACs Not Limited to Demonstration Targets

Less Publicized RAC Program Target Areas Capable of Overwhelming Hospitals

HFMA Expected RAC Targets

- Acute care discharge disposition conflicts with post-acute provider visits
- DRG 148 - Major Bowel Procedures
- Inpatient rehabilitation admissions
- DRG 416 - Sepsis
- Three day SNF qualifying acute care inpatient stays
- Claims not combined before billing
- DRG 397 - Coagulopathy

Measuring Your Risk

Preemptive Audits Assess Vulnerabilities

<table>
<thead>
<tr>
<th>Strategic Benefit</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sensitivity Analysis</td>
<td>Data Mining</td>
</tr>
<tr>
<td>Random Audit</td>
<td>Full Preemptive Audit</td>
</tr>
</tbody>
</table>

**Full Preemptive Audit**
- Brute force audit would entail pulling all claim and charts for manual review
- The process would take at least three to five months
- The audit would cost at least $100,000 and requires immediate reimbursement of overpayment findings to the Medicare Trust Fund

**Random Audit**
- Conducting a random audit would entail pulling 100-200 claims for manual review and extrapolating risk areas for the larger claims pool
- Small sample size and low at-risk percentages can make extrapolation inaccurate
- Inaccurate results could lead to the failure to identify serious vulnerabilities or problem claims

**Sensitivity Analysis**
- Completing a sensitivity analysis would involve developing algorithms to identify claims in the MEDPAR dataset that RACS may scrutinize
- Reasonably estimates total potential revenue-at-risk for RAC takebacks
- Minimal up-front investment is spread over unlimited ongoing, sensitivity analyses

**Data Mining**
- Using data mining to identify risk exposure would entail loading closed claims data into a data mining tool like the Revenue Integrity Compass (RIC)
- Customized rule set identifies claims at-risk for RAC takebacks
- Moderate up-front investment is distributed over unlimited ongoing, low-cost risk assessments

Source: Financial Leadership Council interviews and analysis.
Going One Step Further

Data Mining Tools Offer Dynamic Risk Assessments

Source: Advisory Board Company’s Revenue Integrity Compass (RIC) Data Mining

- Trended aggregate risk exposure
- Finer granularity: staff-level views
Continuous Risk Factor Analysis

Tracking key metrics that are linked to audit risk
Flashpoint #2: Poor Workflow and Tracking Mechanisms
A Demonstration Disaster

Hospital Staff Overwhelmed by Audit Process

- Overwhelming Records Requests
- Poor Communication
- Insufficient Technology
- Staff Confusion
- Mounting Appeals

**Case in Brief**

- A 680-bed hospital located in the Southeast
- Received as many as 800-1,000 record requests per month, totaling $11M in value
- Overwhelming volume resulted in missed deadlines, inability to use Excel-based tracking tool, increased administrative costs, and delayed reimbursement for appeals won

Kimble Hospital

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1 Pseudonym

Source: Financial Leadership Council interviews and analysis.
Landmines Throughout Audit Process

RAC Audit Workflow

- Records Requests
  - Unexpectedly high volume of requests
  - No triage capability (insufficient staff and technology)
- Documentation Retrieval
  - Poor coordination between staff
  - Decentralized document storage
- Documentation Submission
  - Incomplete documentation
  - Incorrect destination

Multiple Failures:
- Lack of accountability for RAC audit process
- Non-standardized work flow for processing record requests
- Insufficient tracking mechanisms
A Single Point of Contact

Establish a RAC Coordinator as Process Owner

<table>
<thead>
<tr>
<th>Professional Background</th>
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<tbody>
<tr>
<td>• Patient Financial Services (PFS)</td>
</tr>
<tr>
<td>• Health Information Management (HIM)</td>
</tr>
<tr>
<td>• Compliance</td>
</tr>
<tr>
<td>• Case Management</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Skills and Attributes</th>
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</thead>
<tbody>
<tr>
<td>• Excellent communication skills</td>
</tr>
<tr>
<td>• Excellent organizational skills</td>
</tr>
<tr>
<td>• Strong leadership qualities</td>
</tr>
<tr>
<td>• Positive professional relations with peers, medical staff</td>
</tr>
<tr>
<td>• Knowledge of Medicare reimbursement and coding structures</td>
</tr>
<tr>
<td>• Familiarity with patient medical charts</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Duties</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ Provide staff education</td>
</tr>
<tr>
<td>✓ Assemble and facilitate RAC response team</td>
</tr>
<tr>
<td>✓ Develop and implement workflows</td>
</tr>
<tr>
<td>✓ Create and oversee communication plan for RAC requests and denials</td>
</tr>
<tr>
<td>✓ Implement tracking system to prevent missed deadlines</td>
</tr>
<tr>
<td>✓ Monitor overall RAC impact</td>
</tr>
<tr>
<td>✓ Implement changes to organizational practice, policies, and procedures where needed</td>
</tr>
<tr>
<td>✓ Communicate regularly with stakeholders</td>
</tr>
</tbody>
</table>

Source: HCPro, Recovery Audit Contractors: Lessons learned to help your hospital prepare now, March 2008; Financial Leadership Council interviews and analysis.
## Enfranchise Key Players

**RAC Committee Responsible for Audit and Appeals Oversight**

<table>
<thead>
<tr>
<th>Department</th>
<th>Responsibilities</th>
</tr>
</thead>
</table>
| Health Information Management (HIM) | • Processing RAC requests  
                                      • Coding, DRG assignment reviews                                                  |
| Compliance                        | • Regulatory oversight  
                                      • Tracking RAC correspondence                                                     |
| Patient Financial Services        | • Financial tracking of RAC payments, denials  
                                      • Coordinating medical documentation and appeals submissions                     |
| Case Management                   | • Medical necessity reviews                                                     |
| Clinical Departments              | • Medical necessity reviews  
                                      • Appeals approval, support                                                       |

Source: New York Presbyterian Hospital, RAC Lessons Learned, March 2009; HCPro, Recovery Audit Contractors: Lessons learned to help your hospital prepare now, March 2008; Financial Leadership Council interviews and analysis.
### Going beyond Microsoft Office

*Excel & Access Lack the Robust Functionality Required for RAC Tracking*

#### RAC Solution Functionality Mapping

<table>
<thead>
<tr>
<th>Software Suite</th>
<th>Ability to Set Reminders</th>
<th>Pre-loaded Claims</th>
<th>Task Assignment</th>
<th>Worklist Generation</th>
<th>Appeals Reporting</th>
<th>Takeback Tracking</th>
<th>Appeals Analytics</th>
</tr>
</thead>
<tbody>
<tr>
<td>MS Excel/Access</td>
<td>☞</td>
<td>☞</td>
<td>☞</td>
<td>☜</td>
<td>☜</td>
<td>☞</td>
<td>☞</td>
</tr>
<tr>
<td>Focused Process Tracking Tool</td>
<td>☞</td>
<td>☜</td>
<td>☞</td>
<td>☞</td>
<td>☐</td>
<td>☜</td>
<td>☞</td>
</tr>
</tbody>
</table>

Source: Advisory Board interviews and analysis.
Usability Key Factor
Automatic Notifications: Setting Alerts

Alerts tied to key metrics (new claims, revenue at risk, total takebacks, etc.)

User-assigned alerts and priority flags
An Informed Workflow

Detailed claim status tracking through audit, determinations, and appeals process

Monitoring RAC deadlines against internal workflow components
Flashpoint #3:
Scattershot Appeals Process
The View from Above

Overpayment and Appeals Determinations from RAC Demonstration
Cumulative Through 3/27/2008

<table>
<thead>
<tr>
<th>Claims with Overpayment Determinations</th>
<th>Claims Appealed by Providers</th>
<th>Overpayment Determinations Overturned</th>
<th>Overpayment Determinations Upheld</th>
</tr>
</thead>
<tbody>
<tr>
<td>525,133</td>
<td>73,266</td>
<td>24,376</td>
<td>500,757</td>
</tr>
</tbody>
</table>

- 14% appeals rate
- 33% appeals success rate

$934M
$46M

RAC-in-Brief

- The Recovery Audit Contractor (RAC) program was created through the Medicare Modernization Act of 2003 to identify and recover improper Medicare payments paid to healthcare providers in fee-for-service Medicare.
- Over the 3-year demonstration project in five states, the RACs identified more than $1 billion in overpayments and recovered nearly $850 million from inpatient hospitals.
- In 2006, Congress mandated the establishment of a nationwide RACs program aimed at identifying and recovering overpayments to providers. The program will come online in all 50 states by December 31, 2009.

Moderate Appeals Success
Few Appeals in Demonstration Went Beyond ALJ\(^1\)

Provider Appeals of RAC-Initiated Overpayments
RAC Part A and B Claims Combined (8/31/2008)

Success Rate of Provider Appeals
RAC Part A and B Claims Combined (8/31/2008)

Source: CMS RAC Program: Update to the Evaluation of the 3-Year Demonstration, January 2009

\(^1\)Administrative Law Judge
Appeals Strategies Varied
Consider All Factors Before Moving Forward

Three Primary Appeals Strategies

#1: Global Appeals Strategy
- All RAC takebacks are appealed regardless of the medical or financial support for appeal
- Common practice during the RAC demonstration when CMS did not charge interest on lost appeals
- This strategy places added risk and an administrative burden on hospitals; not recommended going forward

#2: Medically Accurate Appeals Strategy
- RAC takebacks are appealed only after a medical review determines viable evidence to support case arguments
- Most popular practice during the RAC demonstration, especially among hospitals with high volume of takebacks
- This strategy should be the baseline criteria for hospitals to pursue an appeal

#3: Cost-Benefit Appeals Strategy
- RAC takebacks are appealed only after a medical and financial review reveals viable evidence to support case arguments and the cost of filing an appeal
- Rarely practiced during the RAC demonstration project
- This strategy is most recommended for hospital RAC appeals

Source: Financial Leadership Council interviews and analysis
Learning from Past Experience

Track Appeals Success to Support Future Efforts

Example Appeals Tracking Graph

*Appeals Success Rate (%)*

- Prioritize appeals efforts on the largest determinations with the highest success rates

Bubble Size = $ Value of Claims

Total Number of Overpayment Claims

- CHF
- Debridement
- Septicemia
- One Day Stays
- Respiratory Failure
- Coagulopathy
Coda

The Tip of the Iceberg
More than Just RACs

Providers Inundated by Government Audits

Timeline of Government Audit Contractor Growth

2003

12/8/2003: Medicare Modernization Act
• Authorized the review of Medicare claims for overpayments and fraud by Recovery Audit Contractors (RACs), Medicare Administrative Contractors (MACs) and Zone Program Integrity Contractors (ZPICs)

3/1/2005: RAC Demonstration Begins
• RAC Contractors start reviewing Medicare claims in California, Florida, and New York,

2/26/2006: Deficit Reduction Act (DRA) of 2005
• Medicare Integrity Contractors (MICs) authorized to audit Medicaid claims for instances of fraud and overpayments

2004

2005

2006

2007

2008

2009

2010

9/30/2008: First ZPIC Jurisdiction Contract Awarded
• ZPICs tasked with identifying billing practices and services that pose the greatest financial risk to the Medicare Program for further investigation

7/7/2009: Remaining MAC Jurisdiction Contracts Awarded
• MACs responsible for identifying discrepancies between Medicare Part A and Part B claims with the authority to revise reimbursement payments.

8/14/2009: Permanent RAC Program Rollout Begins
• RACs post CMS approved issues and start reviews

12/1/2009: Projected MIC Rollout Completion Date
• Medicaid Integrity Program will be fully operational nationwide by the end of calendar year 2009
• CMS notes that MICs are already handling 500+ audits in 17 states

Sources:
www.cms.hhs.gov/RAC
www.cms.hhs.gov/medicaidintegrityprogram
www.fbo.gov

7/15/2009: CMS Open Door Forum: MIP Audit Program
More Concerning than RAC?

Medicaid Integrity Program

Program Overview

Comprehensive Medicaid Integrity Plan

Audit Contracts

• CMS procurement and oversight of Medicaid Integrity Contractors (MICs)
• MICs awarded contracts to conduct reviews, claims audits, and provider education
• CMS to coordinate data-driven fraud research and detection identify emerging fraud trends

Support and Assistance for States

• CMS to employ 100 full-time equivalent employees to provide support to the states
• Planned field operations include state program integrity oversight reviews and provision of training and technical assistance to states

Differences from RAC

• No set limits on number of medical records or claims that can be requested for review
• Audit processes will vary by state
• State rules determine number of days provider has to respond to MIC medical record requests
• Fee-for-service compensation model for MICs (no contingency fees)
• MICs will perform desk audits and on-site reviews

Source: CMS, Comprehensive Medicaid Integrity Plan of the Medicaid Integrity Program, June 2008; Financial Leadership Council interviews and analysis.
Private Payers Following Suit

Commercial Payers Drafting Off of RACs Initiative

**Commercial Payers Performing Post-Payment Audits**

- UnitedHealth Group
- Cigna
- Humana
- Aetna
- Coventry Health Care
- Health Net
- Unicare

**Investment in New Business Intelligence Solutions**

<table>
<thead>
<tr>
<th>Reason</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fraud &amp; Abuse</td>
<td>39%</td>
</tr>
<tr>
<td>Underwriting</td>
<td>37%</td>
</tr>
<tr>
<td>Product Development</td>
<td>36%</td>
</tr>
<tr>
<td>Predictive Modeling</td>
<td>29%</td>
</tr>
<tr>
<td>Pay for Performance</td>
<td>25%</td>
</tr>
</tbody>
</table>

**A Fact of Life**

"Post-payment review is going to be a way of life, as commercial payers and Medicaid follow Medicare's lead"  

-Revenue Cycle Director,  
Large Health System in the West

Source: Financial Leadership Council interviews and analysis
For More Information

On Revenue Integrity Compass or any other Advisory Board initiative, please contact

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Presenter Details

Jim Lazarus
Senior Director, The Advisory Board Company
lazarusj@advisory.com / 202-266-5821
Appendix
Diagnostic Red Flags – Flashpoint 1

Where Should we Focus Our Attention: Identifying the Risks?

Attendees may wish to complete this “self-test” to highlight particular areas of vulnerability in their current RAC risk assessment practices.

- Have we analyzed our historical denials rates to determine root causes of correctible errors?  
  [ ] Yes  [ ] No

- Do we have visibility into our potential risk exposure based on demonstration-project target areas?  
  [ ] Yes  [ ] No

- Have we engaged in a sensitivity analysis of our current risk exposure relative to recently posted target areas?  
  [ ] Yes  [ ] No

- Have we audited our coding and case management operations for sources of potential weakness?  
  [ ] Yes  [ ] No

- Have we established and codified a payment reserve strategy?  
  [ ] Yes  [ ] No
Flashpoint #2: Poor Workflow and Tracking Mechanisms

**Diagnostic Red Flags – Flashpoint 2**

*Where Should we Focus Our Attention: Designing Efficient Audit Workflow?*

Attendees may wish to complete this “self-test” to highlight particular areas of vulnerability in their current RAC audit response practices.

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have we established a RAC team with assigned roles and responsibilities?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have we designated a central RAC coordinator responsible for liaising between departments to compile necessary documentation?</td>
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<tr>
<td>Do we have a streamlined process defined for retrieving, reviewing, and submitting record requests?</td>
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<tr>
<td>Have we undergone a comprehensive RAC audit simulation exercise?</td>
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<tr>
<td>Does our technology enable careful monitoring of all RAC-related activities?</td>
<td></td>
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</tr>
</tbody>
</table>
Diagnostic Red Flags – Flashpoint 3

Where Should we Focus Our Attention: Triaging Appeals?

Attendees may wish to complete this “self-test” to highlight particular areas of vulnerability in their RAC appeals processes.

- Do we have a process in place for estimating and evaluating the potential costs and benefits to appealing determinations at each appellate level?  
  Yes  No

- Have we settled on a policy for submitting payment for adverse determinations—with an analysis of risks and benefits?  
  Yes  No

- Do we have mechanisms in place for quickly submitting common types of appeals?  
  Yes  No

- Do have enough in-house expert guidance to advocate for us during appellate hearings?  
  Yes  No

- Do we have visibility into our historical appeal success rates to be able to estimate future payment recoupment opportunities?  
  Yes  No