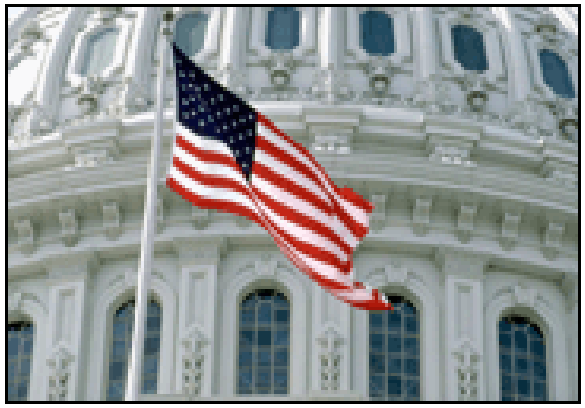


The Road Ahead: AHA Policy Agenda

Melissa James Jackson, JD, MPA

Dec. 6, 2013

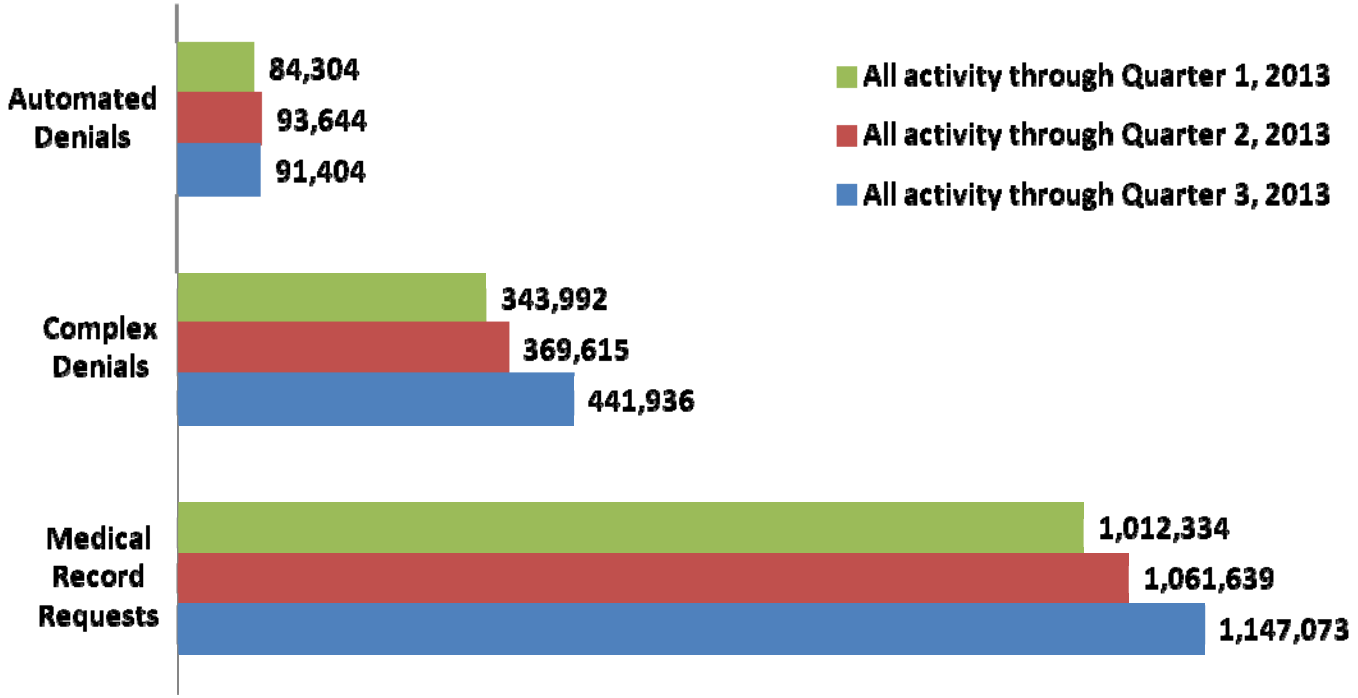
Overview

- **RAC*Trac* Update**
- **Regulatory Issues**
- **RAC Advocacy**

American Hospital Association

RACTrac Update

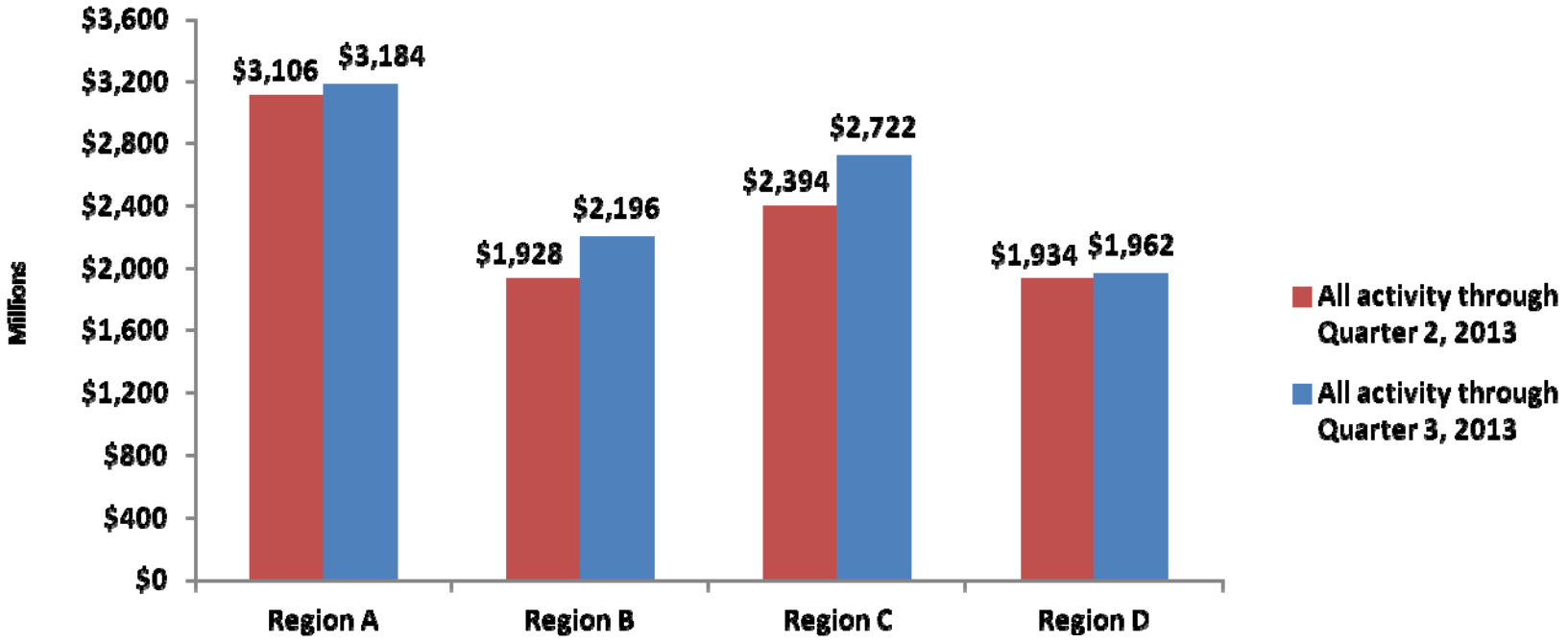
Reported Automated Denials, Complex Denials and Medical Records Requests through 3rd Quarter 2013



American Hospital Association

RACTrac Update

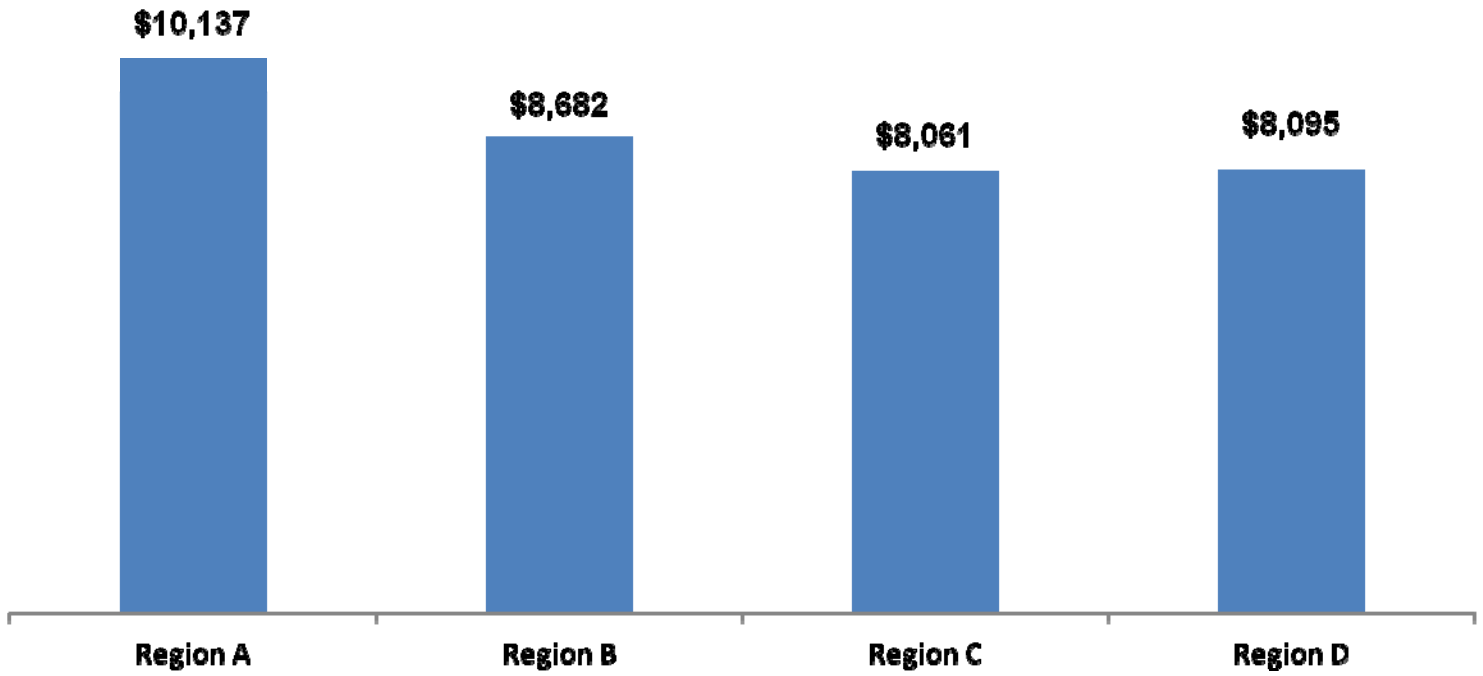
Medicare Payments Associated with Medical Records Requested from Participating Hospitals, through 3rd Quarter 2013, in Millions



American Hospital Association

RACTrac Update

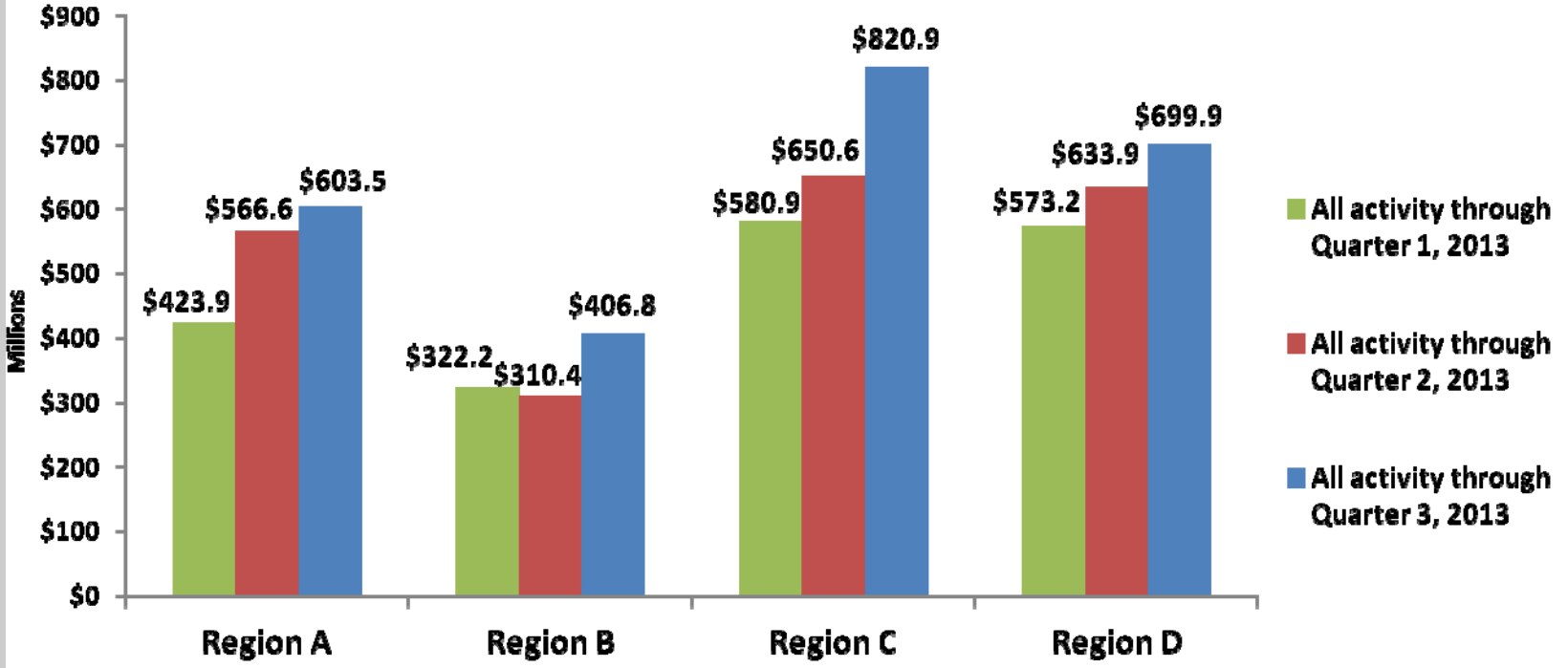
Average Value of a Medical Record Requested in a Complex Review Among Hospitals Reporting RAC Activity, through 3rd Quarter 2013



American Hospital Association

RACTrac Update

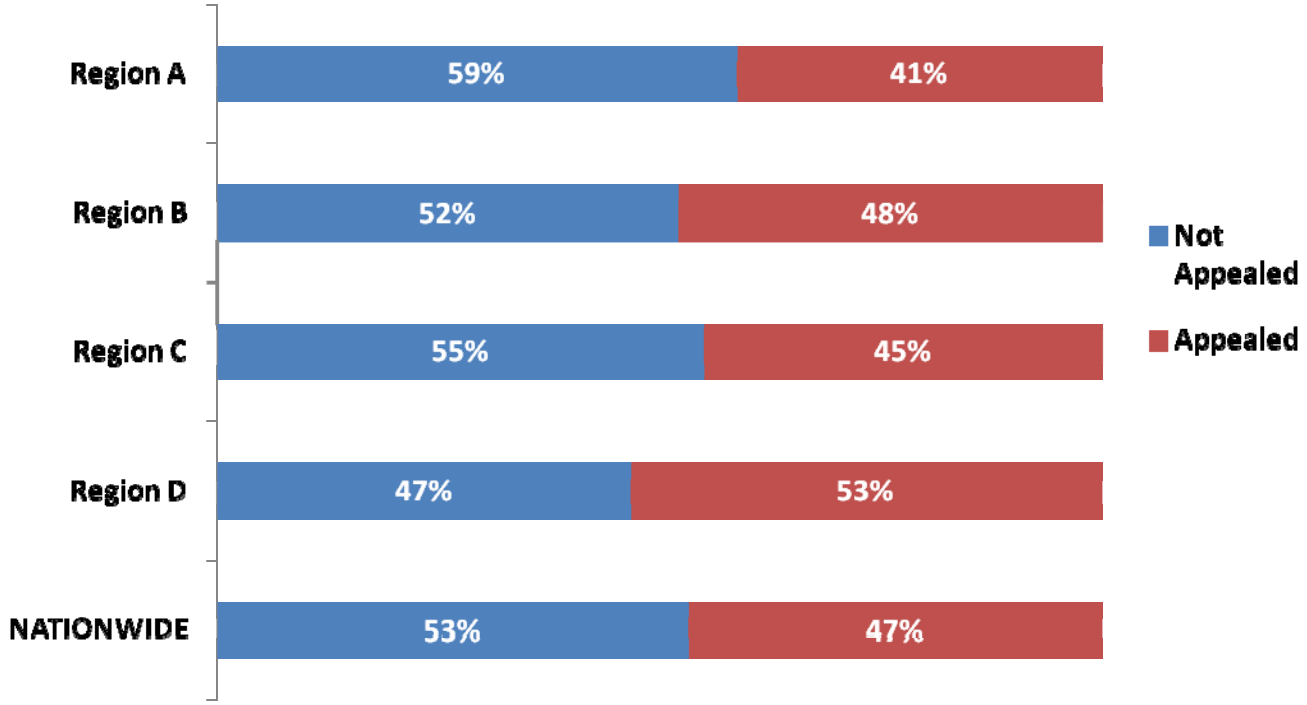
Dollar Value of Automated and Complex Denials by RAC Region for Participating Hospitals, through 3rd Quarter 2013, in Millions



American Hospital Association

RACTrac Update

Percent of Automated and Complex Denials Appealed by Hospitals with Automated or Complex RAC Denials, by Region, through 3rd Quarter 2013



American Hospital Association

RACTrac Update

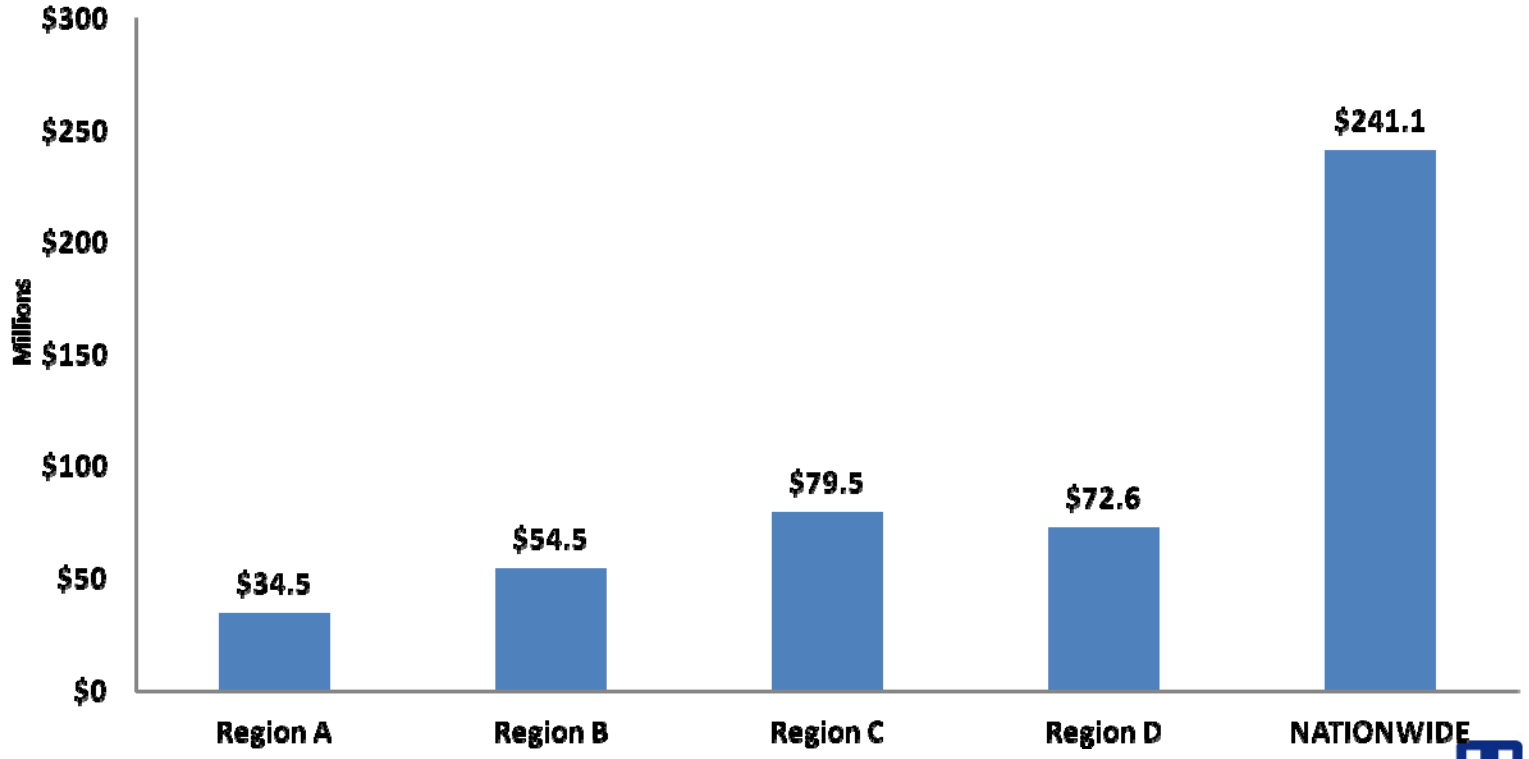
Summary of Appeal Rate and Determinations in Favor of the Provider, for Hospitals with Automated or Complex RAC Denials, through 3rd Quarter 2013

	Appealed	Percent of Denials Appealed	Number of Denials Awaiting Appeals Determination	Number of Denials Not Overturned from Appeals Process** (Withdrawn/Not Continued)	Number of Denials Overturned in the Appeals Process	Percent of Appealed Denials Overturned *(as a Percent of Total Completed Appeals)*
NATIONWIDE	217,016	48%	155,839	19,917	41,029	67%
Region A*	16,021	45%	11,992	1,471	2,557	63%
Region B	43,755	48%	28,238	5,121	10,368	67%
Region C	87,045	45%	64,389	6,378	16,215	72%
Region D	70,195	53%	51,220	6,947	11,889	63%

American Hospital Association

RACTrac Update

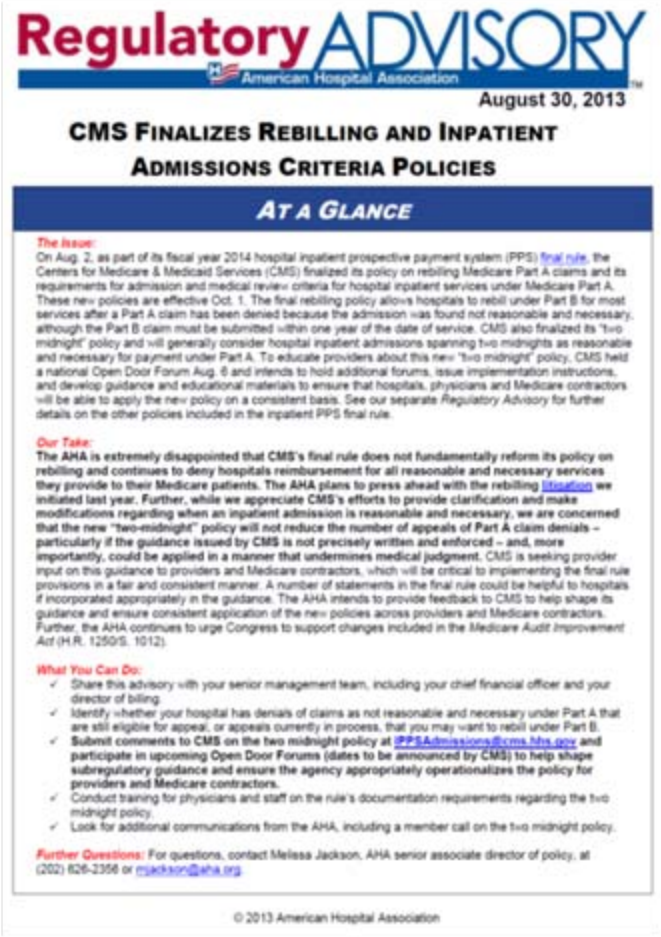
Value of Denials Overturned in the Appeals Process, by Region, through 3rd Quarter 2013, in Millions



American Hospital Association

Regulatory Issues

- IPPS Final Rule
  - Part B Rebilling
  - "Two-midnight" Policy
- Effective Oct. 1, 2013



Regulatory ADVISORY
American Hospital Association

August 30, 2013

CMS Finalizes Rebilling and Inpatient Admissions Criteria Policies

At a Glance

The Issue:
On Aug. 2, as part of its fiscal year 2014 hospital inpatient prospective payment system (IPPS) final rule, the Centers for Medicare & Medicaid Services (CMS) finalized its policy on rebilling Medicare Part A claims and its requirements for admission and medical review criteria for hospital inpatient services under Medicare Part A. These new policies are effective Oct. 1. The final rebilling policy allows hospitals to rebill under Part B for most services after a Part A claim has been denied because the admission was found not reasonable and necessary, although the Part B claim must be submitted within one year of the date of service. CMS also finalized its "two midnight" policy and will generally consider hospital inpatient admissions spanning two midnights as reasonable and necessary for payment under Part A. To educate providers about this new "two midnight" policy, CMS held a national Open Door Forum Aug. 6 and intends to hold additional forums, issue implementation instructions, and develop guidance and educational materials to ensure that hospitals, physicians and Medicare contractors will be able to apply the new policy on a consistent basis. See our separate *Regulatory Advisory* for further details on the other policies included in the inpatient PPS final rule.

Our Take:
The AHA is extremely disappointed that CMS's final rule does not fundamentally reform its policy on rebilling and continues to deny hospitals reimbursement for all reasonable and necessary services they provide to their Medicare patients. The AHA plans to press ahead with the rebilling litigation we initiated last year. Further, while we appreciate CMS's efforts to provide clarification and make modifications regarding when an inpatient admission is reasonable and necessary, we are concerned that the new "two-midnight" policy will not reduce the number of appeals of Part A claim denials – particularly if the guidance issued by CMS is not precisely written and enforced – and, more importantly, could be applied in a manner that undermines medical judgment. CMS is seeking provider input on this guidance to providers and Medicare contractors, which will be critical to implementing the final rule provisions in a fair and consistent manner. A number of statements in the final rule could be helpful to hospitals if incorporated appropriately in the guidance. The AHA intends to provide feedback to CMS to help shape its guidance and ensure consistent application of the new policies across providers and Medicare contractors. Further, the AHA continues to urge Congress to support changes included in the Medicare *Audit Improvement Act* (H.R. 1250/S. 1012).

What You Can Do:
- Share this advisory with your senior management team, including your chief financial officer and your director of billing.
- Identify whether your hospital has denials of claims as not reasonable and necessary under Part A that are still eligible for appeal, or appeals currently in process, that you may want to rebill under Part B.
- **Submit comments to CMS on the two midnight policy at IPPSAdmissions@cms.hhs.gov and participate in upcoming Open Door Forums (dates to be announced by CMS) to help shape subregulatory guidance and ensure the agency appropriately operationalizes the policy for providers and Medicare contractors.**
- Conduct training for physicians and staff on the rule's documentation requirements regarding the two midnight policy.
- Look for additional communications from the AHA, including a member call on the two midnight policy.

Further Questions: For questions, contact Melissa Jackson, AHA senior associate director of policy, at (202) 626-2356 or mjackson@aha.org.

American Hospital Association

Final Part B Rebilling Rule

- Allows hospitals to rebill under Part B for most services after a Part A claim has been denied because admission found not reasonable and necessary

- **Final rule did not fundamentally reform CMS policy on rebilling**

American Hospital Association

CMS's Rebilling Policy

- Requires hospital to submit Part B claim within one year of date of service ("one year timely filing")
- Continues to limit services that may be rebilled under Part B
- States that hospitals may appeal either a Part A denial or submit a Part B inpatient claim, but not both simultaneously
- Restricts scope of administrative law judges (ALJs)
  - ✓ ALJ may decide whether Part A claim is reasonable/ necessary under Part A, but may not decide whether claim is reasonable/necessary under Part B

American Hospital Association

Rebilling Litigation

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

THE AMERICAN HOSPITAL ASSOCIATION,
325 Seventh Street, NW, Suite 700
Washington, DC 20004;

MISSOURI BAPTIST SULLIVAN HOSPITAL,
751 Sappington Bridge Road
Sullivan, MO 63080;

MUNSON MEDICAL CENTER,
1105 6th Street
Traverse City, MI 49684;

LANCASTER GENERAL HOSPITAL,
555 North Duke Street
Lancaster, PA 17602; and

TRINITY HEALTH CORPORATION,
20555 Victor Parkway
Livonia, MI 48152,

Plaintiffs,

v.

KATHLEEN SEBELIUS, in her official capacity as Secretary of Health and Human Services,
200 Independence Avenue, SW
Washington, DC 20204,

Defendant.

Case No. 1:12-cv-1770

COMPLAINT

Plaintiffs the American Hospital Association, Missouri Baptist Sullivan Hospital, Munson Medical Center, Lancaster General Hospital, and Trinity Health Corporation ("Plaintiffs") bring this action to end an unlawful government practice: The Medicare program has been refusing to pay hospitals for hundreds of millions of dollars' worth of care provided to patients, even though all agree that the care provided was reasonable and medically necessary as

American Hospital Association

Patient Status

- **"Two-midnight" rule**
  - CMS's attempt to clarify the definition of observation status
  - Too many claims!!!

- "***Benchmark***" – Whether hospital gets inpatient payment for a claim
  - Physician had reasonable and supportable expectation of two-midnight stay
- "***Presumption***" – Whether Medicare review contractors can review a claim
  - Presume a claim spanning two-midnights is a reasonable/necessary admission

American Hospital Association

Patient Status

Still have many questions and concerns

- Only limited guidance (subregulatory) so far
- Was not feasible to operationalize before Oct. 1
  - Significant provider & contractor education
  - Time to change systems/procedures

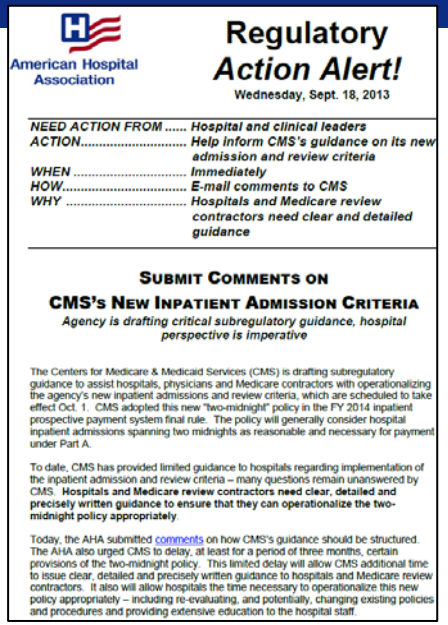



American Hospital Association

Patient Status

AHA Approach:

- Delay enforcement of rule for <u>one year</u>
  - Need guidance and time to comply
- Influence implementation
  - AHA submitted comments and scenarios to CMS on Sep. 18.
- Pursue long-term payment solution
- Educate hospital members
- Evaluate legislative, legal options



American Hospital Association

Regulatory *Action Alert!*

Wednesday, Sept. 18, 2013

NEED ACTION FROM	*Hospital and clinical leaders*
ACTION	*Help inform CMS's guidance on its new admission and review criteria*
WHEN	*Immediately*
HOW	*E-mail comments to CMS*
WHY	*Hospitals and Medicare review contractors need clear and detailed guidance*

SUBMIT COMMENTS ON

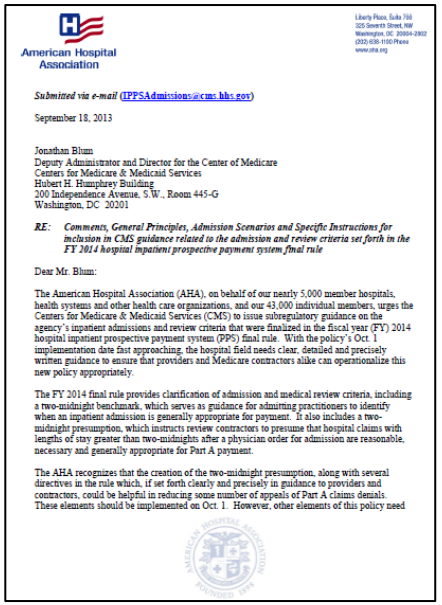
CMS'S NEW INPATIENT ADMISSION CRITERIA

Agency is drafting critical subregulatory guidance, hospital perspective is imperative

The Centers for Medicare & Medicaid Services (CMS) is drafting subregulatory guidance to assist hospitals, physicians and Medicare contractors with operationalizing the agency's new inpatient admissions and review criteria, which are scheduled to take effect Oct. 1. CMS adopted this new "two-midnight" policy in the FY 2014 inpatient prospective payment system final rule. The policy will generally consider hospital inpatient admissions spanning two midnights as reasonable and necessary for payment under Part A.

To date, CMS has provided limited guidance to hospitals regarding implementation of the inpatient admission and review criteria – many questions remain unanswered by CMS. **Hospitals and Medicare review contractors need clear, detailed and precisely written guidance to ensure that they can operationalize the two-midnight policy appropriately.**

Today, the AHA submitted comments on how CMS's guidance should be structured. The AHA also urged CMS to delay, at least for a period of three months, certain provisions of the two-midnight policy. This limited delay will allow CMS additional time to issue clear, detailed and precisely written guidance to hospitals and Medicare review contractors. It also will allow hospitals the time necessary to operationalize this new policy appropriately – including re-evaluating, and potentially, changing existing policies and procedures and providing extensive education to the hospital staff.



American Hospital Association

Submitted via e-mail (IPPSAdmissions@cms.hhs.gov)

September 18, 2013

Jonathan Blum
Deputy Administrator and Director for the Center of Medicare
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

RE: ***Comments, General Principles, Admission Scenarios and Specific Instructions for inclusion in CMS guidance related to the admission and review criteria set forth in the FY 2014 hospital inpatient prospective payment system final rule***

Dear Mr. Blum:

The American Hospital Association (AHA), on behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 43,000 individual members, urges the Centers for Medicare & Medicaid Services (CMS) to issue subregulatory guidance on the agency's inpatient admissions and review criteria that were finalized in the fiscal year (FY) 2014 hospital inpatient prospective payment system (PPS) final rule. With the policy's Oct. 1 implementation date fast approaching, the hospital field needs clear, detailed and precisely written guidance to ensure that providers and Medicare contractors alike can operationalize this new policy appropriately.

The FY 2014 final rule provides clarification of admission and medical review criteria, including a two-midnight benchmark, which serves as guidance for admitting practitioners to identify when an inpatient admission is generally appropriate for payment. It also includes a two-midnight presumption, which instructs review contractors to presume that hospital claims with lengths of stay greater than two-midnights after a physician order for admission are reasonable, necessary and generally appropriate for Part A payment.

The AHA recognizes that the creation of the two-midnight presumption, along with several directives in the rule which, if set forth clearly and precisely in guidance to providers and contractors, could be helpful in reducing some number of appeals of Part A claims denials. These elements should be implemented on Oct. 1. However, other elements of this policy need

RAC Strategy

Medicare Audit Improvement Act of 2013

Representatives Sam Graves (R-MO) and Adam Schiff (D-CA)
Senators Mark Pryor (D-AR) and Roy Blunt (R-MO)

- Establish a consolidated limit for medical requests
- Improve auditor performance by implementing financial penalties and requiring medical necessity audits to focus on widespread payment errors
- Improve RAC auditor transparency

New video

- Require physician review for Medicare denials based on medical necessity
- Allow hospitals to rebill under Part B without regard to one-year timely filing limit

American Hospital Association

Legislative *Action Alert!*

Tuesday, March 19, 2013

NEED ACTION FROM	*Hospital leaders*
ACTION	*Urge your representative to co-sponsor the Medicare Audit Improvement Act of 2013 (H.R. 1250)*
WHEN	*Immediately*
HOW	*Call or e-mail your representative*
WHY	*Bill would make needed improvements to RACs, other audit programs*

AHA-SUPPORTED BILL INTRODUCED TO MAKE NEEDED CHANGES TO RACs, OTHER AUDIT PROGRAMS

Urge your representative to sign on as a co-sponsor

Reps. Sam Graves (R-MO) and Adam Schiff (D-CA) today introduced the *Medicare Audit Improvement Act of 2013* (H.R. 1250), AHA-supported legislation that would make much-needed improvements to the Recovery Audit Contractor (RAC) program and other Medicare audit programs.

Among other measures, the bill would:

- Establish a consolidated limit for medical record requests;
- Improve auditor performance by implementing financial penalties and by requiring medical necessity audits to focus on widespread payment errors;
- Improve recovery auditor transparency;
- Assure due process appeals for claims reopenings;
- Allow accurate payment for rebilled claims; and
- Require physician review for Medicare denials.

In a separate move, the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule on March 13, 2013, that would allow hospitals to be paid full Part B (outpatient) payment for inpatient claims denied during a RAC audit, when the care is found to be appropriate at the outpatient level

Rep. Sam Graves (R-MO)

Rep. Adam Schiff (R-CA)

TOTAL CO-SPONSORS

166

Mark Pryor
(D-AR)

Roy Blunt
(R-MO)

Mark Begich (D-AK)
Barbara Boxer (D-CA)
Thad Cochran (R-MS)
Kay Hagan (D-NC)
Lisa Murkowski (R-AK)
Pat Roberts (R-KS)
Roger Wicker (R-MS)

American Hospital Association

Legislative *Action Alert!*

Wednesday, May 22, 2013

NEED ACTION FROM	***Hospital leaders***
ACTION	***Urge your legislators to co-sponsor the Medicare Audit Improvement Act of 2013 (S. 1012/H.R. 1250)***
WHEN	***Immediately***
HOW	***Call or e-mail your legislators***
WHY	***Bill would make needed improvements to RACs, other audit programs***

AHA-SUPPORTED BILL INTRODUCED TO MAKE NEEDED CHANGES TO RACs, OTHER AUDIT PROGRAMS

Urge your legislators to sign on as a co-sponsor

Sens. Mark Pryor (D-AR) and Roy Blunt (R-MO) today introduced the *Medicare Audit Improvement Act of 2013* (S. 1012), AHA-supported legislation that would make much-needed improvements to the Recovery Audit Contractor (RAC) program and other Medicare audit programs. Reps. Sam Graves (R-MO) and Adam Schiff (D-CA) have introduced companion legislation (H.R. 1250) in the House.

Among other measures, the bill would:

- Establish a consolidated limit for medical record requests;
- Improve auditor performance by implementing financial penalties and by requiring medical necessity audits to focus on widespread payment errors;
- Improve recovery auditor transparency;
- Assure due process appeals for claims reopenings;
- Allow accurate payment for rebilled claims; and
- Require physician review for Medicare denials.

In a separate move, the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule on March 13, 2013, that would allow hospitals to be

THE RAC BURDEN

How a Well-Intentioned Federal Program Has Become a Drain on Hospitals

The national Recovery Audit Contractor (RAC) program began in 2010 with the goal of ensuring accurate payments to Medicare providers. However, 4 years later, the program requires fundamental reform.

Unlawful policy prevents full payment for needed patient care.

- Many denials are for inpatient care (Part A) that was medically necessary, but RACs contend the care could have been provided in the hospital outpatient (Part B) setting.
- Medicare rules prohibit hospitals from rebilling these services for payment under Part B if they are older than 1 year, while RACs can audit medical records up to 3 years old.

This disparity costs hospitals millions and violates CMS's statutory requirement to pay for all reasonable and necessary care.

of RAC-denied claims fall outside of the 1-year filing window and therefore cannot be rebilled.

Source: Centers for Medicare and Medicaid Services, March 2013

RACs are bounty hunters paid a contingency fee based on the money clawed back from denied claims.

For each Medicare claim they deny, RACs receive a commission of

9.0-12.5%.

Due to this incentive structure, RACs frequently target high-dollar inpatient claims.

RACs are often inaccurate and inflict avoidable legal and administrative costs on hospitals.

RACs find no overpayment error with 60% of audited claims.

RAC-denied claims: 40%

Source: AHA RAC*Trac*, April 2013

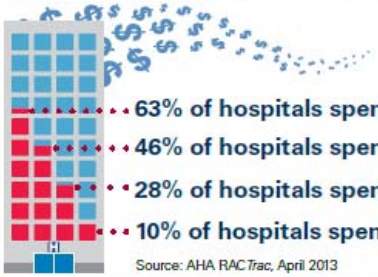
44% of denied claims are appealed.

of appealed hospital Medicare Part A denials are fully overturned at the third level of appeal.

Source: Office of the Inspector General, November 2012

RACs' errors and inefficiencies force hospitals to redirect resources that could have otherwise been used for patient care.

Annual hospital spending due to RAC process:



- **63% of hospitals spend $40,000+.**
- **46% of hospitals spend $100,000+.**
- **28% of hospitals spend $200,000+.**
- **10% of hospitals spend $400,000+.**

Source: AHA RAC*Trac*, April 2013

of RAC appeals are stuck in the Medicare appeals process.

Based on our current workload ... assignment of [hospitals'] requests for hearing to an Administrative Law Judge will be delayed for 10 to 12 months. — Office of Medicare Hearings and Appeals, August 2013

Your support of H.R. 1250/S. 1012 will help fix the flawed RAC system.

American Hospital Association

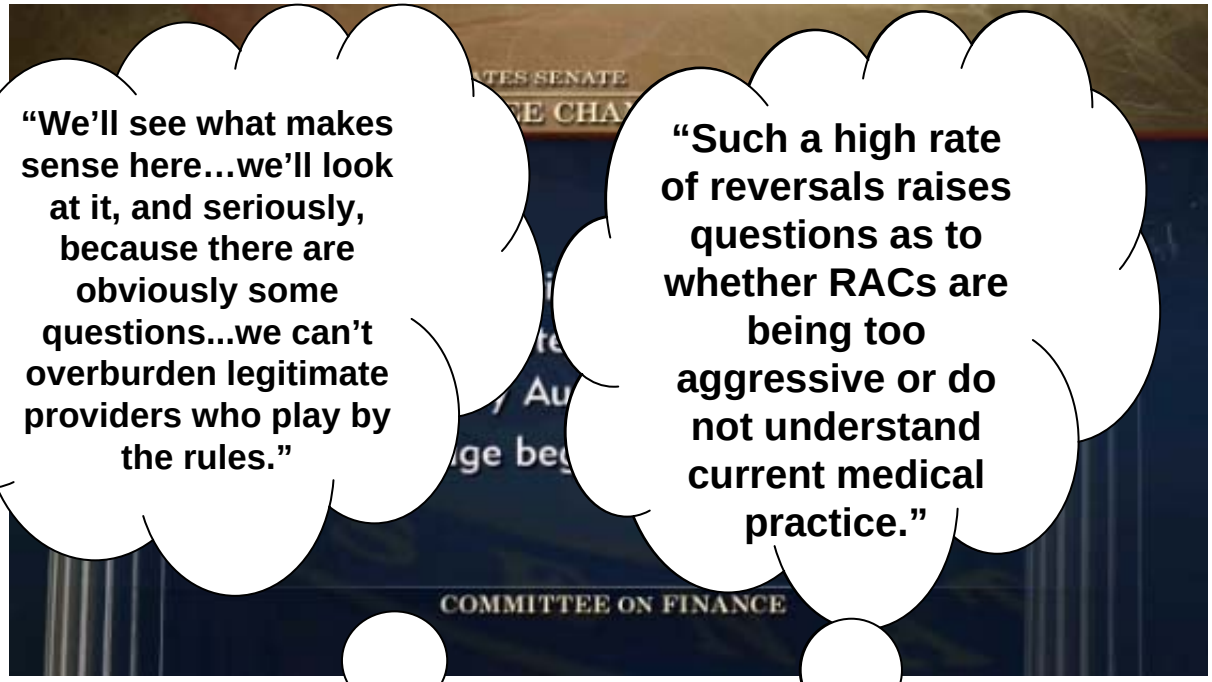
RAC Hearing

Billings Clinic

Intermountain Healthcare

UNITED STATES SENATE

RAC Hearing



HealthBeat
from Congressional Quarterly

Senators Sympathetic to Complaints That Medicare Audits Are Too Burdensome

By John Reichard

Senate Finance Committee members from both sides of the aisle expressed concern Tuesday that a Medicare program that audits provider reimbursement claims creates unreasonable administrative burdens on hospitals.

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An Inside Washington news service

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Wednesday, June 26, 2013

DAILY NEWS

Providers, Contractors Spar Over RAC Commission Fees, Appeals Process

Posted: June 25, 2013

Providers and a contractor debated over Recovery Audit Contractors commission fees and reforms to the RAC appeals process at a Senate Finance Committee hearing on Tuesday (June 25). Hospital representatives said the current system forces them to expend too many resources responding to audits, and an official from CGI Federal Inc., which currently holds a RAC contract, said the system needs to be more consistent if policymakers wish to reduce the number of RAC decisions that are overturned.

Billings Clinic

Intermountain Healthcare

Pushback

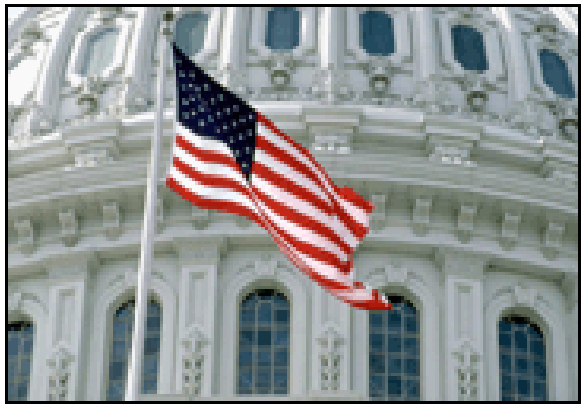
CITIZENS AGAINST GOVERNMENT WASTE

American Hospital Association

AHA RAC Resources

- RAC Updates on latest RAC news and other RAC resources: www.aha.org/rac
- AHA RACTrac: www.aha.org/ractrac; www.aharactrac.com
- 2012 AHA Audit Series: www.aha.org/auditseries
- Email RAC Questions: racinfo@aha.org

American Hospital Association



The Road Ahead: AHA Policy Agenda

Melissa James Jackson, JD, MPA

Dec. 6, 2013