

Medicare in Recovery

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Since its inception in 1984, CAGW has been concerned about how the government spends and keeps track of the taxpayers' money. CAGW co-founder J. Peter Grace often noted that the government borrows money it cannot pay back, does not bother to keep track of where and how it is spent, and does little to get back the money that is wasted. As a result, CAGW has long been concerned with improper payments, which includes both overpayments and underpayments. The Office of Management and Budget estimates that there were \$55 billion in improper payments government-wide in fiscal year 2007.

In order to analyze where the money has gone and how to retrieve overpayments, the government has begun to rely more and more on private auditors. In 2003, the use of private sector companies to recover improper payments was established for Medicare under the Medicare Modernization Act (MMA). A pilot program using recovery auditing contractors (RACs) was created for California, Florida, and New York, the states with the largest Medicare expenditures. That program is to be extended nationwide in 2008.

Recovery auditing has been around for more than 35 years in the private sector, where businesses with a vested, bottom-line interest recognized the value in rooting out billing errors, duplicative payments, miscalculations in charges, payments for services not rendered and payments to ineligible beneficiaries. Recovery auditing firms build complex data-mining analysis programs to tease out the improper payments that were missed in previous audits.

The Center for Medicare and Medicaid processing 1 billion fee-for-service medical claims every year. Under the MMA, beginning in 2005, CMS began using RACs to identify improper payments and recover as much of the money as possible. The numbers speak volumes. Since 1996, when improper payments were first measured, erroneous payments have declined from 14.2 percent to 3.9 percent. According to a November 16, 2007 statement by CMS Acting Director Kerry Weems, "During the past three years, recent error rate reductions have led to approximately \$11 billion less in improper payments."

In the three states participating in the demonstration project, CMS reported that in fiscal year 2006 the RACs identified \$299.5 million in improper payments overall (mostly overpayments). Any money recovered is pumped back into the Medicare Trust Fund. "The decline in improper payments reflects our emphasis on identifying and eliminating waste, fraud and abuse in all CMS programs. It is critical that we ensure every dollar is spent wisely so that the program is affordable for taxpayers and future generations of beneficiaries," Weems added. Congress mandated expansion of the RAC effort nationally in the Tax Relief and Health Care Act of 2006 and that rollout is expected to begin in March, 2008.

However, the success of the national program and perhaps the long-term viability of RACs are being threatened by H.R. 4105, which has been introduced by Reps. Lois Capps (DCalif.) and Devin Nunes (R-Calif.). Their legislation calls for a one-year moratorium on further recovery auditing. They claim that the program is "deeply flawed," and has had an adverse impact on the financial viability of hospitals and patient care in California. The legislators are responding to pressure from the California Hospital Association (CHA), along with its parent organization the American Hospital Association (AHA). It should come as no surprise that the program is receiving push-back from the California delegation since California hospitals have been forced to return tens of millions of dollars to Medicare as a result of improper overpayments exposed by recovery audits. According to a 2006 CMS report, the company had identified \$105 million in improper payments in California.

In California, one fertile area for overpayments turned out to be in-patient rehabilitation facilities (IRFs), step-down facilities for patients who have completed hospital treatments but are not well enough to return home. The company tasked with the audits in California, PRG-Schultz, chose to focus on patients moving

to IRFs because the Government Accountability Office had looked at the problem in 2005 and noticed that most of the patients sent to IRFs could have received the required rehabilitation at less expensive outpatient facilities.

Initially, the hospitals' complaints to Reps. Capps and Nunes, as well as CMS officials focused on perceived methodological weaknesses in the conduct of the audits. Hospital officials claimed that PRG-Schultz was demanding too many hospital records; that it should employ a medical doctor to help auditors review questionable overpayments (most of which were denied as being medically unnecessary); that it was reviewing claims that were at least three years old; and that it was collecting its contingency fees before the appeals process had run its course. All of these complaints have been addressed by CMS and, according to the agency, a vast majority of the overpayments identified by PRG-Schultz have been upheld during the appeals process.

CMS officials argue that the hospitals in California may have misapplied or ignored the rules for many years. Melanie Combs, CMS' technical advisor for the program is quoted in a May 18 Sacramento Bee article as saying, "These rules have been on the books since 1985...Maybe it's possible some have been overlooking them. Maybe there have been consultants out there helping hospitals to, quote, maximize reimbursements. And maybe perhaps some of that has entailed looking the other way."

Still, there appeared to be so much confusion, controversy, and resistance surrounding IRF claims denials that CMS agreed to review those claims. It found that there were inconsistencies in how payment and coverage decisions were interpreted in 40 percent of the cases they looked at. In September, CMS officials implemented a "pause" in the program to educate all parties on the correct application of those rules, and PRG-Schultz has been directed to re-review any contested claims.

In the end, though, California hospitals and their allies in Congress have continued to move the goalposts. As each of their concerns was resolved, it became clear that their issue appears to be that the auditors are paid on a contingency basis of between 25 and 30 percent, which critics call a "bounty." They argue that the contingency payment model drives the company to be over-zealous in its denial of claims.

In fact, contingency-based pricing for recovery auditing is non-controversial. Hospitals themselves often use outside contractors, working on contingency, to help them recover outstanding debts. Private companies which specialize in the practice are usually brought into the process after other conventional audits have failed to turn anything up. These companies bear significant financial risks by investing in expensive technical infrastructure and personnel, sometimes years in advance of reviewing the first claim and with no guarantee that they will recover their costs. All of the companies involved in RACs for CMS get paid on a contingency basis.

Government oversight over its own programs has always been notoriously poor because government bureaucrats have no incentive to follow the money, much less reach out to recover misappropriated money. The systems in which they operate are riddled with perverse incentives which reward program managers for shoveling billions out the door quickly, while putting no value on judging performance, outcomes, or to even accounting for money.

Hundreds of billions of taxpayer dollars have been leached out of the system because of mismanagement and fraud. Program integrity and trust in government has been shredded as a Medicare in Recovery (continued from page 13) result. Recovery auditing is shining much-needed light into the recesses of government spending, exposing the financial hemorrhaging that deeply flawed government accounting systems have failed to identify.

The Capps-Nunes legislation appears to be nothing more than a frantic and misguided attempt to shield hospitals in California from having to repay the piper after years of receiving too much money from the Medicare system. While the bill calls for a moratorium pending a study, the study could occur while the pilot program continues. The suspension of a program such as the recovery auditing is tantamount to

killing it altogether. If companies who perform this specialized auditing have no chance to recover their substantial investments, there is a good chance they will be less willing to bid on the work at all.

If members of Congress, pressured by constituents, who see that the gravy train is slowing, can slow-walk or suspend this program or gut it for parochial interests, taxpayers may never see a dime of the money they've lost. A critical, cost-effective tool in uncovering waste and fraud would be lost not just in Medicare, but throughout entire federal government.