PHYSICIANS ADVOCACY INSTITUTE

December 4, 2015

The Honorable Orrin Hatch
Chairman, Committee on Finance
United States Senate
219 Dirksen Building
Washington D.C., 20510

Dear Senator Hatch:

On behalf of the Physicians Advocacy Institute ("PAI"), thank you for the opportunity to offer additional comments on the Audit & Appeal Fairness, Integrity and Reforms in Medicare (AFIRM) Act. As demonstrated by the bipartisan support among Senate Finance Committee members for the conceptual proposal, there is growing consensus that significant reforms are needed to address the serious problems in the Medicare audit and appeals processes to address inaccurate audit findings and the costly, time-consuming appeals process. We applaud your statement during the June 2015 hearing on Medicare audits and appeals issues that one of the goals of the legislation would be to create a "more level playing field" between Recovery Audit Contractors (RACs) and health care providers. The AFIRM legislation makes good on that promise to provide a comprehensive approach that would revamp the Medicare audit and appeals process in important ways.

PAI is a not-for-profit advocacy organization whose mission is to advance fair and transparent payment policies and contractual practices in order to sustain the profession of medicine for the benefit of patients. Since its inception, PAI has specially focused on efforts to make medical audits and the audit appeals process more fair and transparent. PAI's members, like all physicians in the country, are significantly burdened by issues caused by the current overpayment recovery audits and appeals procedures. PAI is committed to advancing legislation, such as the AFIRM Act, that would help ensure that medical audits are conducted in a fair and transparent manner and lead to accurate calculation of any amounts overpaid to physician practices.

PAI applauds the provisions in the AFIRM Act that reflect the importance of communicating more accurate and transparent information regarding the audit and audit appeals processes to providers. PAI also supports the AFIRM Act's provisions that would realign

financial incentives to curb over-reaching by the RACs and ensure that provider audits are conducted consistently and accurately.

PAI offers the following recommendations for provisions that would further strengthen the legislation:

- **Revamp the contingency-based payment system and establish incentives for RAC accuracy**. PAI believes the current contingency-based payment system for RACs is the root of myriad problems that plague the Medicare audit process by incenting RACs to make inflated overpayment determinations. This has resulted in unacceptably high rates of inaccurate audits and subsequent appeals that are time-consuming and costly to both providers and the government. To address this, PAI supports eliminating the current contingency payment system and establishing incentives and monetary penalties on RACs in order to improve contractor accountability and auditing accuracy.

  PAI applauds the AFIRM Act for calling on the Secretary to provide a report to Congress on potential non-incentive based approaches that are budget neutral and do not impose additional financial burdens on providers. We would caution that while budget neutrality is an important policy consideration, the system should not perpetuate recoupments based on questionable auditor findings. In many cases, it is more expensive for a physician to pursue an appeal than it is to simply allow a disputed overpayment finding to be recouped. PAI also supports provisions in the AFIRM draft that would hold RACs financially accountable for high error rates and arbitrary auditing patterns.

- **Improve medical necessity reviews by requiring the use of physicians in the same or similar specialty as the physician under review.** The AFIRM Act endeavors to improve audit accuracy by requiring the use of qualified audit professionals to conduct audits, which is important for all audits, including those to detect coding or billing errors. PAI supports the intent of this provision but urges more specific qualifications for reviews that assess the medical necessity of particular test or procedure without the benefit of examining the patient. In our view, an audit contractor's decision to overrule a physician's medical judgment should be made only by a physician certified in the same medical specialty and subspecialty as the physician under review. Without such a requirement for medical review determinations, the reviewers applying the criteria and guidelines often lack the clinical expertise necessary to recognize when deviation from a standard is appropriate in the case of a particular patient or group of patients.

- **Shorten look-back period for all categories of claims.** For physician practices, the administrative burden of a lengthy look-back period is substantial and costly. To help ease the significant administrative and financial burdens, PAI strongly supports a shortened look-back period. The AFIRM Act creates a shorter look-back period for only certain categories of claims, most notably inpatient and outpatient

status determinations, and directs the Secretary to conduct a study to assess a shorter look-back period for "other reviews." Importantly, the legislation would confer the Secretary with authority to establish a look-back period to a length less than three years. PAI believes that the look-back period should be no more than 2 years, and PAI supports granting the Secretary with the authority to reduce the look-back period to this point.

- **Require timely and detailed notification to providers before and after audits are conducted.** The AFIRM Act language requires HHS to work with all review contractors to "develop a uniform, consistent and transparent review process to reduce the burden on providers of services and suppliers to the greatest extent possible." This is an important goal supported by PAI that will improve transparency and potentially enable providers to resolve issues before undergoing the appeals process. To this end, PAI further recommends that RACs be required to identify and inform providers of: (1) all errors discovered in the audit; (2) the medical and reimbursement policies used in the audit's findings; (3) all underpayments discovered in the audit; and (4) the methodology for calculating overpayment amounts. These requirements would enable providers to better understand audit findings and reduce the risk of repeated errors in future audits.

- **Establish standards to ensure that extrapolation is done in a statistically sound manner.** PAI believes appellants should be permitted to challenge the use of extrapolation during the audit process, and therefore PAI supports the AFIRM Act's provision that requires an appellant's approval for the use of extrapolation. PAI would separately support the implementation of standards to ensure that extrapolation is done in a statistically sound manner.

- **Compensate providers for the cost of duplicating records.** Physicians nationwide report significant challenges in meeting the administrative and financial burdens that RAC audits can impose. Responding to the often-onerous RAC correspondence and production request is very costly. PAI therefore supports the provisions in the AFIRM Act that limit additional document requests for RACs with lower than 95% accuracy rates, which will help alleviate the time and expense of production costs. In addition, PAI recommends that RACs be required to compensate providers for the cost of duplicating records, which would help ensure that RACs are more targeted with their documentation requests.

Comments on Appeal-Related Provisions

The AFIRM Act revamps the audit appeals process by establishing a new "Medicare Magistrate" level of appeal for contested overpayment decisions with amounts in controversy between the current level of review by ALJs and a newly established level of review for ALJs ($150-$1,500). This would allow physicians and other health care providers to appeal findings in many cases without going through the onerous and lengthy ALJ process. Another positive aspect of the legislation is the creation of an Ombudsman position to assist in education and training for providers and review contractors.

Establishing a meaningful and accessible provider complaint process through the Ombudsman's office will help curb errors and the need for appeals.

PAI offers the following recommendations to further strengthen the appeal-related provisions in the legislation:

- **Stay recoupment under after the Magistrate's final decision on appeal.** A critical consideration related to this provision is whether CMS will allow recoupment of alleged overpayments or payment of the RAC's contingency fee while an appeal is pending at the Magistrate level. PAI recommends clarifying language that recoupment of appealed amounts and/or payment of RACs contingency fee cannot occur prior to a final decision by the Medicare Magistrate.

- **Establish specific qualification standards for Medicare Magistrates.** The effectiveness of the new Medicare Magistrate appeals process will depend on whether Medicare Magistrates are sufficiently qualified and knowledgeable to make accurate determinations. The legislation tasks the Secretary with establishing qualification standards for Magistrates but does not specifically address specific areas of expertise relevant to the position.

Again, PAI appreciates the opportunity to offer these comments and stands ready to work with you and your staff on this important issue. If you have any questions, please contact PAI's Executive Vice President, Kelly Kenney at k2strategiesllc@gmail.com.

Sincerely,

Robert W. Seligson, MBA, MA
President, Physicians Advocacy Institute
Executive Vice President/CEO, North Carolina Medical Society