



Testimony of Chad Janak, Vice President  
*Improving Audits: How We Can Strengthen the  
Medicare Program For Future Generations*

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**Written Testimony of Chad Janak  
Vice President, Connolly Healthcare**

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Chairman Nelson, Ranking Member Collins and Members of the Committee, thank you for the opportunity to speak with you today about the Medicare recovery audit industry. My name is Chad Janak and I am the Vice President in charge of Connolly LLC's Medicare recovery audit operation, commonly referred to as the "RAC" Program. My background includes almost five years working at two large accounting consulting firms and 13 years with Connolly, five of which have been working on our Recovery Audit Contract with the Centers for Medicare & Medicaid Services (CMS).

Connolly began 38 years ago as a family-run business based on the values of integrity and hard work. Our commitment to quality and customer service has enabled the company to grow from a single employee in 1979, to the current 1,300 employees who adhere to the highest standards of excellence in auditing.

Connolly performs recovery audits for both private and public clients. We review nearly \$350 billion in paid medical claims annually as well as three quarters of a million medical charts every year. In 2013 alone we recovered \$3 billion in improper payments on behalf of our clients. We are proud that we have earned the trust of clients that include seven out of eight of the largest health plans in the country and nineteen of the top Blue Cross Blue Shield plans.

Connolly has served as a recovery auditor for the Centers for Medicare and Medicaid Services since the inception of the Recovery Audit Program as a demonstration project in 2005. Under our current contract, Connolly has responsibility for Region C, the largest of four regions covering 15 states primarily in the South and extending westward. For CMS's Recovery Audit Program, I am proud to say that Connolly has returned more than \$3 billion to the Medicare Trust Fund and also returned more than \$300 million to hospitals as the result of underpayments that we have identified.

The Medicare Recovery Audit Program is one of many pay-for-performance contracts used by state and federal government to address the issue of improper payments in our healthcare system. The need for a Medicare Recovery Audit Program is clear: In the latest report for Fiscal Year 2013 by the U.S. Department of Health and Human Services (HHS), the Medicare fee-for-service program is estimated to have improper payments of \$36 billion, or 10.1 percent of total expenditures, up from 8.5 percent in 2012.

Mr. Chairman, simply put the Recovery Audit Program works well. Mirrored after successes realized in the private sector, recovery auditors have together returned more than \$8 billion in overpayments to the Medicare Trust Fund, and done so in a manner that is a model for program integrity in both transparency and program governance. But the Medicare program is not the

only beneficiary of the Recovery Audit Program; hospitals benefit from recovery audits, too. That's because since the Program's inception, recovery auditors have also returned over \$600 million in *underpayments* to providers, and consistently point hospitals to ways they can mitigate or eliminate *future* errors.

But to truly understand the value of the Recovery Audit Program, you have to look beyond the savings and examine how it ensures that all providers are playing by the same reimbursement rules. For example, the Program encourages accurate coding and billing. Having a well-defined, contained and transparent Recovery Audit Program provides an important check against providers that historically do not bill Medicare accurately while encouraging improved behavior in providers with lower accuracy rates.

Unlike other contractors in Medicare program integrity that audit specific providers or dive deeply to uncover fraud, the Recovery Audit Program is limited to reviewing only two percent of paid claims to ensure that providers who participate in the Medicare program comply with CMS policy. Each specific audit issue that is subject to a recovery audit review is approved by a team at CMS consisting of physicians and registered nurses before we begin our work. In addition to recovering overpayments and underpayments, we also invest considerable time and expertise reviewing with CMS what we find to avert future improper payments of Medicare funds.

Mr. Chairman, since it is essential this committee has the proper facts in today's record, later in my remarks I will address some of the misconceptions about the Recovery Audit Program that persist today. But at the outset, I want to stress why and how the RAC Program works to protect Medicare dollars and benefit both the Medicare Trust Fund and also those providers that adhere to CMS policy. My remarks will focus on seven key points:

1. Recovery auditors simply audit already established CMS policy and rules; we do not interpret policy.
2. Safeguards are in place to limit any burden on providers, including limiting recovery auditors to review only percent two percent of Medicare claims and payments for any given provider.
3. As confirmed by the Government Accountability Office (GAO) in July 2013, CMS requirements make the Recovery Audit Program the most transparent of all of its Medicare Integrity Programs. This includes our obligation to post on our website an explanation of each audit we are conducting and having bi-monthly discussions with state hospital associations to discuss audit issues.
4. The pay-for performance model works and conforms to industry best practices. In fact, Congress created the Recovery Audit Program after seeing the success of similar programs in the private sector. This compensation structure is used throughout the private sector and does not incentivize contractors to submit invalid improper payment determinations or search for minor omissions simply to add volume to our findings. Instead, the opposite is true; recovery auditors do not get paid unless we prove –

sometimes time and again at our expense through the appeals process – that the improper payment is valid.

5. CMS employs rigorous programmatic quality controls, including hiring an outside third-party contractor to randomly sample recovery audit determinations for accuracy on a monthly basis. For this and other reasons related to our claims review precision, I am proud to say that recovery auditors have an average accuracy rate of 96 percent.
6. The Appeals Process: In general, the vast majority of recovery audit determinations are overwhelming upheld through the first two levels of appeal, and at nearly 80 percent if the appeal goes through the Administrative Law Judge (ALJ) level *with a hearing being held*.

### **ADHERENCE TO ESTABLISHED MEDICARE POLICY**

CMS has ensured that the process of conducting recovery audits is transparent to providers and follows clear-cut and pre-approved improper payment rules. Recovery auditors can *only* conduct audits of improper payment “issues” previously approved by CMS and posted to the recovery auditor’s public-facing website. These issues are developed by our expert clinicians referencing up-to-date Medicare payment policies. The issues must then go through a rigorous approval process both with the Medicare Administrative Contractor (MAC) and a CMS “New Issue Team,” and must represent straightforward cases of improper payment based on Medicare policy. In addition, recovery auditors carefully screen Medicare claims so that requested records represent those with the highest propensity for error. In fact, approximately 60 percent of the medical records audited by Connolly contain improper payment errors.

### **PROVIDER BURDEN**

Since the inception of the Recovery Audit Program, minimizing what is commonly referred to as “provider burden” is a concerted effort by CMS and the recovery auditors. This is consistent with our practice in the private sector, where quite literally we will not be invited back by our clients if we disturb their important provider relationships. Burden safeguards implemented by CMS on the recovery auditors, which are even stricter than those in the private sector, include strict limits on medical record requests. Of the roughly 52 million Medicare Part A claims paid annually by CMS in RAC Region C, Connolly reviews approximately 600,000, or less than 2 percent.

Nearly 75 percent of the medical records we receive from hospitals are now submitted electronically and we reimburse the providers up to \$25 per record. Importantly, recovery auditors also provide feedback in writing for *each and every record*, regardless of whether an improper payment is identified, with the intent of helping providers avert *future* improper payments. Even before CMS’s appeals process begins, when an improper payment is identified the provider has an opportunity to discuss or rebut our finding during a 30-day “discussion period.” The value of this discussion period extends beyond the recovery auditor and the provider, as claims resolved at this level avoid the appeals process to also save systemic costs.

**THE MOST TRANSPARENT OF ALL INTEGRITY PROGRAMS**

In its July 2013 report entitled *Medicare Program Integrity: Increasing Consistency of Contractor Requirements May Improve Administrative Efficiency*, the GAO found that “CMS sets more limits on RAs through review requirements than on other contractors.” As seen in the following chart from the report, restrictions on the recovery auditors to ensure transparency are much more stringent than those imposed on CMS’s other fraud, waste and abuse contractors:

**CMS Requirements on Postpayment Reviews Unique to Recovery Auditors, Compared to Other Contractor Types, as of May 7, 2013**

Requirement	Contractor Type			
	Medicare Administrative Contractors (MAC)	Zone Programs Integrity Contractors (ZPIC)	Comprehensive Error Rate Testing (CERT) Contractor	Recovery Auditors (RA)
<b>Selection of claims for postpayment review</b> CMS approval of criteria for selecting billing issues prior to widespread use	No	No	n/a	Yes
<b>Provider notice of issues targeted for review</b> Provider notice (on website) of billing issues targeted for postpayment review	No	No	n/a	Yes
<b>Additional documentation requests (ADR)</b> Provider reimbursement for copies of medical records	No	No	No	In some cases
Limits on number of ADRs contractor can request from provider	No	No	No	Yes
<b>Reviews</b> Authority to deny claim for minor omissions	Yes	Yes	Yes	No
<b>Provider communication</b> Provider notification regardless of review outcome	No	No	No	Yes
Reviewer’s credentials available upon provider request	No	No	No	Yes
Access to contractor’s medical director to discuss claim denials upon request	No	No	No	Yes
40 days to discuss any revision to initial determination informally prior to having to file an appeal	No	No	No	Yes
<b>Quality assurance</b> External validation of randomly selected claims by independent contractor	No	No	No	Yes

Source: GAO: Medicare Program Integrity: Increasing Consistency of Contractor Requirements May Improve Administrative Efficiency, July 2013

In addition, recovery auditors are required to maintain information on individual provider claim status on a secure, password-protected website portal.

## PAY-FOR-PERFORMANCE MODEL REPRESENTS A “BEST PRACTICE”

Unlike many other fee-based Medicare integrity contractors, recovery auditors are paid a contingency fee only when overpayments and underpayments are actually recovered. This model, which was mandated by Congress to be used for the Recovery Audit Program, does not incentivize contractors to submit unsupported claims that will be overturned on appeal. To the contrary, recovery auditors are penalized for submitting invalid determinations as no payment is made for unsubstantiated claims and any work performed to create such a claim will go unpaid.

In the private sector, every large payer uses the pay-for-performance model for recovering improper payments. Writing invalid improper payment determinations disadvantages the recovery auditor as no payment is received for its work, after costs are realized on the front-end, and client satisfaction suffers. As a benefit of this pay-for-performance model, the Recovery Audit Program has realized enormous savings to the Trust Fund with very little upfront investment by the taxpayer.

## RIGOROUS QUALITY CONTROL

CMS requires that a random, monthly sample of recovery audit determinations be evaluated by an independent RAC Validation Contractor (RVC) that the agency hires for this express purpose. The RVC employs policy experts and clinicians, and presents CMS with an independent decision regarding the sample of improper payment determinations – both overpayments and underpayments. As reported in *Recovery Auditing in Medicare and Medicaid for Fiscal Year 2012*, the RVC found the recovery auditors had an average accuracy score of 95.5 percent.

Region	% of Accuracy
Region A	96.3%
Region B	96.3%
Region C	92.5%
Region D	97.2%
<b>Average Accuracy Score</b>	<b>95.5%</b>

Source: CMS Recovery Auditing in Medicare and Medicaid for FY 2012 Report to Congress, March 2014

## WHAT’S DRIVING THE ALJ APPEALS RATE?

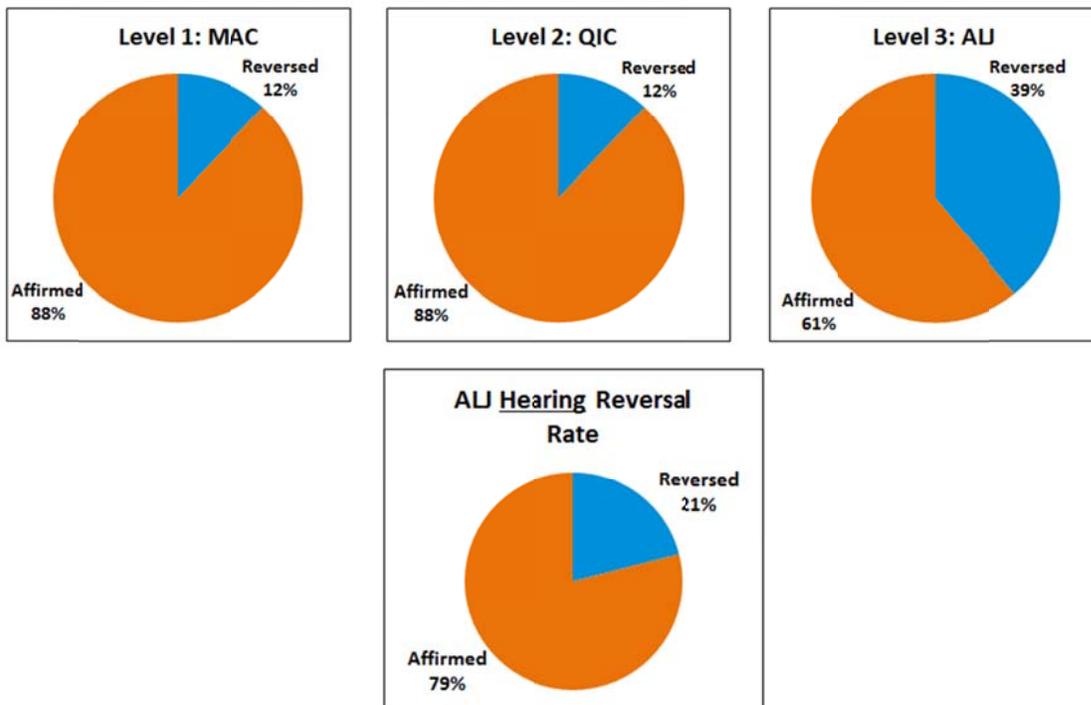
By way of background, the ALJ level represents the third level of appeal for recovery audit determinations, or the fourth if you count the “discussion period,” where providers can discuss or refute a recovery auditor’s determination. Each appeal is heard by Medicare policy experts, first at the MAC and then at the Qualified Independent Contractor (QIC).

We have heard from policymakers that providers have expressed confusion about the Medicare appeals process, and have disputed CMS data concerning the high success rate of recovery auditors at the ALJ level. Part of the confusion may result from the fact that the ALJs hear cases generated not only from the Recovery Audit Program, but also from providers themselves appealing MAC determinations or from beneficiaries – the latter two are independent from the Recovery Audit Program. As a result, policymakers have expressed their confusion as to the percentage of cases won on appeals by providers and Recovery Audit Contractors, relating the claim that recovery auditor determinations are overturned on appeal 72 percent of the time. This figure is inaccurate and outdated: Its source is an HHS OIG report that used Fiscal Year 2010 data, when only three recovery auditor appeals had reached the ALJ level. Our own recent data

paints a different picture: Connolly’s appeal “win” rate at the ALJ when there is a hearing scheduled shows that judges confirm almost 80 percent of our determinations. We believe that other Recovery Audit Contractors’ data similarly reflects this high rate of success on appeal on cases heard before ALJs. The industry’s notable rate of success on appeal substantiates that auditing determinations by in large are correct and serve the public interest of protecting Medicare dollars and of helping to preserve the Medicare Trust Fund.

Another example of misinformation concerns the recent growth of ALJ appeals. The current backlog in hearing cases, which is of concern to all stakeholders, is incorrectly attributed solely to the recovery auditors. In truth, the number of appeals from *non-recovery audit* appeals (i.e., providers and beneficiaries) has doubled as well, contributing to the problem.

Although we support efforts to address the appeals backlog in a manner fair to all stakeholders, it is equally important to preserve consistency in decision making and, ultimately, the integrity of the system to ensure that all ALJs follow Medicare policy. Connolly’s experience, which is shared by the other recovery auditors, is that our determinations are affirmed nearly 90 percent through the MAC and QIC levels. At the ALJ level, however, our determinations are reversed 39 percent of the time. But that reversal figure is only 21 percent for appeals where a hearing is scheduled rather than decisions being made “On the Record” (i.e., without a hearing).



Members of this Committee may ask why the reversal rate jumps at the ALJ level. HHS did just that and the HHS OIG answered the question in its November 2012 report entitled *Improvements Are Needed At The Administrative Law Judge Level Of Medicare Appeals*. Specifically, the OIG found several factors contributing to this issue:

- 1) Insufficient training of ALJ judges on Medicare policies,
- 2) A lack of a quality assurance process to review ALJ decisions, and
- 3) Insufficient participation by CMS at hearings. Recovery auditors on the other hand attend 80 percent of hearings where we receive proper notice.

Interestingly, the OIG also found that the success realized by providers at the ALJ level has had the consequence of increasing appeals. The OIG found that a mere two percent of providers were submitting 33 percent of ALJ appeals, and several were appealing every case, a situation perhaps unnecessarily contributing to the backlog of cases.

Finally, our data shows that 28 percent of ALJ decisions in FY 2014 were dismissals. A dismissal occurs when a provider either fails to meet regulatory requirements for filing an appeal, or, during its preparation for the ALJ hearing, finds the recovery auditor's findings were correct. In the latter case, the claim would then be rebilled under Medicare Part B. These dismissed claims were reviewed by three different contractors before the provider decided to rebill and are significantly contributing to the backlog of cases.

## RECOMMENDATIONS

We join all stakeholders in supporting common sense ways to strengthen the Medicare program for future generations. Objectively, based on numerous reports by the HHS OIG as well as the GAO, the Recovery Audit Program is making positive contributions to strengthen Medicare. Even so, we believe that by addressing the following areas of the Recovery Audit Program, Congress can take additional steps forward to enhance this program for the benefit of all stakeholders:

- To ensure greater fairness for the ALJ level of appeals, implement improvements recommended by the HHS OIG such as increasing the ALJs training on Medicare policy, reducing the number of ALJ decisions made "On the Record," and increasing the number of ALJ judges available to hear cases.
- To reduce confusion over statistics surrounding the ALJ process, encourage CMS's Office of Medicare Hearings and Appeals (OMHA) to release more data regarding pending cases and decisions so all parties involved have a better understanding of the situation.
- To provider greater fairness in the Medicare appeals system while reducing provider confusion, consider compelling other audit entities to be subject to the same transparency and accuracy requirements as mandated by the Recovery Audit Program.

Mr. Chairman, thank you again for the opportunity to speak with this committee. I welcome any questions you may have.