Margaret Hambleton
Vice President, Corporate Compliance
Dignity Health
Improving Audits: How We Can Strengthen the Medicare Program for Future Generations
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Introduction

- Good afternoon and thank you for the opportunity to participate in this timely discussion.
- My name is Margaret Hambleton. I am the Vice President of Audit and Corporate Compliance for Dignity Health.
- Dignity Health is one of the nation's five largest health care systems with 38 hospitals in 3 states and has experience with Medicare audits and the RAC program since the demonstration.
- Over 60% percent of our revenue comes from providing care to Medicare and Medicaid beneficiaries.
- We have devoted significant resources in staff and technology to follow Medicare rules, which have been a moving target as healthcare works to transform itself.
- While Dignity Health agrees audit programs are important and appropriate, existing programs are inefficient, complicated and require providers to take limited resources away from patient care.
- They have also unintentionally have shifted the conversation away from what should be at the center of the discussion: the patient.

Dignity Health Impact

- Let me just quickly share with you some of our RAC statistics:

- Since the program began, Dignity Health has devoted over **$39 million** in staff time to respond, track and appeal inappropriate payment denials, including the cost of legal counsel, registered nurse and physician reviewers and clerical support.
- Last year alone, Dignity Health appealed **82%** of all RAC denials, and **92%** of RAC Complex Review denials.
    - Complex Reviews account for **88%** of our RAC audit volume.
- We have well over **7,000** RAC appeals pending today across all levels, with **denied dollars reaching nearly $60 million.**
    - **65%** of those are pending at Level 3.
- Contrasted by nearly **4,000 cases won on appeal**, totaling just over **$30 million.**
    - Only **9%** of those wins are at the first level of appeal, while we win **79%** of the time at the ALJ level.

Patient Experience

- Patients are – and should be – mostly unaware of Medicare auditing activities. However, they are affected in two significant ways:
- Patients receive a **claim denial notice** at the initial determination and various other notices during the course of an appeal.
- Often, these notices are for services well over three years old (due to the RAC look back period), causing significant confusion and alarm on the part of the patient.

- Only worse is when the denied claim is for services for a patient that has since been deceased.
- When they receive the notice, patients feel they have a financial responsibility for the denied services and often question the quality and appropriateness of the care.
- They also have a hard time understanding what the denial notice means because it is written in Medicare jargon.
- Patients also worry about the effect denials have on their relationship with their doctor.
- The other way patients are impacted is when it comes to the **rebilling** of a claim.
- From the patient's perspective, receiving a new bill for a service they received months – sometimes years ago- can be confusing and cause for alarm.
- Beneficiaries and their families should not have to bear the burden of this confusion.

RAC Process: Room for Improvement

- The extended pause to RAC activities is an opportunity for CMS and Congress to take bold action to improve the program in a way that balances appropriate oversight while minimizing the impact on beneficiaries.
- We recommend the following improvements:
    1. **Reduce the look-back period to 12 months.** This gives providers the opportunity to learn from an audit and improve processes, instead of being penalized multiple times for the same mistake.

2. **Streamline communication to the patient** so claim denial notices are in plain English and not sent until *all* levels of appeal have been exhausted. CMS should also be sensitive to patients' interpretation of the notices and be clear that the claim denial is not a statement of the quality of the care received.
3. **Clarify rebilling guidance** to hospitals with respect to determining beneficiary financial liability, and give hospitals the ability to use our discretion on when to waive patient liability on a rebilled claim.
4. **Streamline the appeals process** by holding the first two levels of appeal accountable for appropriate review of auditor decisions. The first two levels of appeal largely agree with the auditors, severely impacting the third level, where providers are mostly successful. This is inefficient.
5. **Restructure the RAC contingency fee** so payments to the RAC are withheld until *all* appeals are exhausted. The recent change to the RAC contingency fee is mostly meaningless, maintaining the RAC's ability to take back millions of dollars of Medicare payments that mostly are returned *interest-free* to providers.
6. **Enforce timeframe requirements** by holding RACs and lower-level appeal contractors accountable. Providers are required to adhere to a strict timeframe to respond to Medicare audits and submit requests for an appeal. If we miss a deadline, we forfeit our right to appeal. Contractors and appellate bodies, on the other hand, routinely miss deadlines, yet there is no penalty or sanction for missing them, nor do providers have any recourse.

Conclusion

- I look forward to the discussion and to continue working with you and the regulators to improve the Medicare audit process.