Response to the RACs:

American Hospital Association's Stance!

Written by Carl James Byron, III, EMT-I, ATC-L, CHA, CPC June, 2009

With CMS' three year study concluded it is more than clear the RACs are here to stay. Although providers have successfully defended themselves against RAC findings to a surprisingly higher extent than anticipated, the RAC recoveries in the several trial states show the program works and as we know the RAC program is to be expanded in 2010.

Now what?

At this point much has been said about the recovery audits; but what is in the future?

Professionals at all levels have theories and IT ideas which claim to solve the problem, but do little in the way of preparing us to successfully maneuver througha RAC audit. The RACs are paid only when they successfully find and recoup errors: providers are supposed to be the diagnosing authorities, but their documentation is being audited (before any appeals, ALJ, etc.) by non-physicians.

With much of this in mind, the American Hospital Association (AHA) is establishing a RAC tracking mechanism to keep a constant tab on RAC activities, successes and losses. This will come in the form of a formal quarterly report, set to begin in fall 2009. According to AHA sources the report will assist in determining financial impact on hospitals nationwide; but a further benefit may also be in using the reports for advocacy efforts. The report will focus on areas of vulnerability and high risk for hospitals and will provide a platform for effectively and efficiently preparing for RAC audits, and building a tracking database when the results of the audit become known to the hospital.

In its April 4th, 2009 Member Advisory, the AHA made the telling statement "The RAC evaluation and status reports issued by CMS during and after the demonstration were limited in their scope and detail. Much of the information CMS used to proclaim the success of the demonstration was self-reported by the RACs, with no independent validation by CMS or the hospital community. Providers shared their stories on a case-by-case basis and, while this helped articulate some of the challenges facing providers under the demonstration, the lack of data made it difficult to demonstrate that the program's failures were widespread and a function of the program's inherent structure and incentives. In addition, the data provided by CMS contained little useful information on the distribution of recoveries among service types, what types of hospitals were impacted and to what extent.

One of the biggest challenges for hospitals participating in the demonstration program – and a challenge all hospitals are expected to face under the permanent program – was the administrative burden and unforeseen costs associated with RAC audits. A December 2007 AHA survey of hospitals in the demonstration states found:

- 80% of respondents experienced increased administrative costs;
- More than 50% of respondents added personnel to handle RAC activities;
- 20% of respondents added two or more full-time equivalent employees to handle RAC activities;
- One-third (1/3) of respondents hired RAC consultants, outside legal assistance and/or other consulting services to help them manage the RAC process;
- More then 25% of respondents had restricted patient admissions due to RAC denials; and
- 11% of respondents made staff or service cutbacks due to RAC audits.

The appeals process is complex, costly and time consuming, and the decision to appeal varies by hospital. However, filing an appeal is the only avenue by which a hospital can reverse a RAC recoupment."

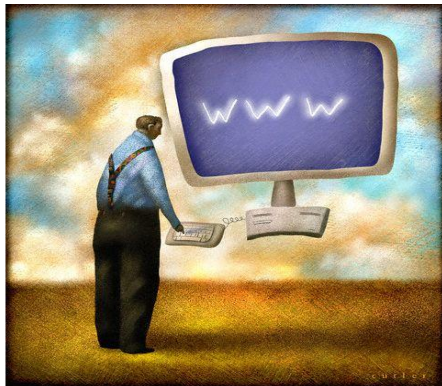
In a previous AIHC article I we saw appeals against RAC findings were 25% (assessments given to CMS had the rate at 22%), and actual overturn rate was 34%. The AHA picked up on this and stated "The AHA believes that the data released by CMS on the number of appeals filed by hospitals, and the rate at which the appeals have been found in favor of the provider, are underestimated. According to the January 2009 CMS update report on the status of pending RAC appeals, 22 percent of claims denied by the RACs were appealed. CMS notes that 34 percent of those appeals have been overturned in favor of the provider. However, the types of claims, total dollar value and appeals by provider type remain unknown."

What is the "RACTrac"?

RACTrac is a survey that to collect hospital-specific data on RAC audits from hospitals in all 50 states, in order to support the hospital field's RAC advocacy and educational activities.

RACTrac aims to supply timely, accurate data to support hospitals' advocacy efforts regarding the RAC program. Experience data collected through the survey will provide transparency to RAC trends and help the AHA address RAC program policy and/or practical implementation issues on a timely basis. It also will allow the AHA to better understand the program's impact on hospitals by monitoring data on an ongoing basis.

As we see, data collection will not begin until fall, as mentioned previously. To date there has been little in the way of fact-finding or clearer guidelines (something unsuccessfully attempted by several organizations), and as such there is no real baseline from which to build a strong monitoring system. However, as time goes on and the RACs cover more ground the RACTrac survey will have substantially more meat from which to accurately monitor RAC activities and impact.



However, the RACTrac is only a web-based survey - accumulating data will require a software program of the hospital's choosing.

The AHA does not recommend any particular program vendor. At the same time it seems prudent to research the RACTrac more closely; determine what questions the survey asks; then merge those with data requirements your own organization has come up with and query vendors on their system's compatibility with yours, and whether their programs can capture all of the data you need.

The AHA will need for any program chosen to be "RACTrac compatible". This, in the AHA's words, means "…a vendor providing a claim-level RAC audit tracking tool to providers has committed to creating a mechanism for the data entered into their tool to be aggregated and summarized so the user can easily respond to the RACTrac survey.

Vendors have two options for implementing this requirement:

- Option 1: is to create a simple summary report that can be created by the user.

- Option 2: is to create a CSV file export from their tool that the user can then use to upload their survey data directly into RACTrac.

Vendors do not have the ability to create a direct link between their product and the AHA RACTrac survey tool.

A vendor will be deemed "RACTrac-compatible" when the AHA has tested its application and verified that the data being exported or summarized are indeed correct. Testing will take place

this spring and summer. We anticipate that many, if not all applications will be RACTrac-compatible before data collection begins in October 2009.
Vendors that are working toward being RACTrac-compatible are listed on the AHA's Web site at www.aha.org/rac under RACTrac. The AHA does not endorse or support a specific product but does encourage those hospitals that wish to participate in RACTrac to ask their vendors to be RACTrac-compatible.

The AHA gives further guidance on the initiation of RACTrac: "*Hospitals should identify a mechanism that will allow them to organize and manage their RAC process internally.*"

Providers should identify a person within the organization to be responsible for responding to the RACTrac survey on a quarterly basis and begin to review the survey questions and data definitions an in anticipation of data collection this fall.

Later this summer, as we draw nearer to data collection, hospitals will receive their organizational ID and security codes, which will enable them to register at www.aharactrac.org as a RACTrac user.

Registration in RACTrac will likely occur this month and RACTrac data collection is projected to begin this fall.

The full text of the April 24th Member Advisory can be found at:
http://www.aha.org/aha/advisory/2009/090424-member-adv.pdf

Also, the AHA presented a webinar in May: the recording can be found on the AHA's web site, at: www.aha.org/rac under RACTrac.

If you have RAC specific inquiries you would like to put to the AHA you may contact them two ways:
1-888-RAC-TR1C (1-888-722-8712) or RACTracsupport@providercs.com.
For more information about the RAC program, e-mail RACinfo@aha.org.

Other links of interest which specifically address the RACs are:
www.RACMonitor.com
www.ModernHealthcare.com
www.linexlegal.com

Registration/membership is free and only takes a few minutes to join each. The AHA web site is always informative for those in the hospital arena: www.aha.org

1 CEU for CHA, CMC & MCMC Professionals