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RAC: A Program in Distress

Mary Squire

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RAC: A Program in Distress

I. INTRODUCTION

The Recovery Audit Program began in an effort to cut improper spending within Medicare. Medical providers, which could consist of, among other things, hospitals, nursing facilities, and individual medical practitioners, bill Medicare for services rendered from the provider to Medicare eligible patients. Sometimes the amounts billed to Medicare do not accurately reflect the true amount owed to the provider, either because the provider “billed & received” an amount too high (an overpayment), or an amount too low (an underpayment). The Recovery Audit Program was implemented to identify and correct any overpayments and underpayments, to ensure the actual amount owed and paid to the provider would be accurate. The program, administered by the Centers for Medicare and Medicaid Services (“CMS”), accepted bids from entities to service specific regions of the country. The recipients of those contracts, known as Recovery Audit Contractors, were given authorization to audit healthcare providers within the designated region for inaccurate Medicare payments.

An audit by a Recovery Audit Contractor (“RAC”)¹ has become a dreaded event in the business of a healthcare provider. RAC audits are notorious for their depth and breadth and the ensuing havoc they can cause in the business of caring for Medicare patients. One healthcare attorney even referred to the RAC audit as the “torture RAC.”² But beyond the business burden that these audits can create, there lies a distinct possibility of constitutional violations by the government. The current structure of the RAC audit system has already reached near-meltdown status, but so far, CMS has not made modifications that come close to solving the enormous problems the program is facing. By continuing with the present structure, CMS risks violating the due process rights of providers.

1. While it is standard for a three-letter acronym to be read letter by letter, in practice, RAC is read to sound like the word “rack.”

2. B. Scott McBride, *The Torture RAC*, ASS’N OF CORPORATE COUNSEL (Mar. 12, 2009), <http://www.lexology.com/library/detail.aspx?g=3ceb5ad7-9639-4181-bc30-4049ba343916>.

The purpose of this Comment is to explore, in depth, the possible constitutional violations and fatal flaws of the RAC program as it exists today. Part II. conveys the history, procedure, and implementation of the RAC audit program, from its demonstration period through the permanent rollout. Part III. details provider reactions to different aspects of the program, including examples of the action they have taken in response. Part IV. discusses the current condition of the audits and appeals process, and some of the small steps CMS has taken to remedy the present problems. Part V. explores the possible due process violations that have been created within the system as it stands today. Additionally, Part V. considers potential roadblocks within many of the steps that providers may take to try to mitigate due process concerns. Part VI. suggests a number of possible improvements CMS could make to the Recovery Audit Program to bring it out of the current stalemate. Part VII. concludes.

II. HISTORY AND IMPLEMENTATION OF RECOVERY AUDIT CONTRACTORS

A. RAC Demonstration

Recovery Audit Contractors were first employed during a three-year “demonstration,” or trial period, by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (“MMA”).³ RACs were to operate within the Medicare Integrity Program,⁴ which serves as Medicare’s “primary program for safeguarding the Medicare Trust Funds against fraud, waste and abuse.”⁵ Under section 306 of the MMA, Congress implemented the RAC program to detect and rectify underpayments and overpayments from Medicare to healthcare providers, thus furthering the program’s goal of combating waste of Medicare dollars.⁶ The demonstration was to discover whether the costs associated with paying a third party on a contingency basis would be an economical method of retrieving

3. Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, § 306, 117 Stat. 2065, 2256-7 (2003).

4. *Id.* § 306(a), (b); 42 U.S.C. § 1395.

5. *Medicare Integrity Program*, EXPECTMORE.GOV (2002), <http://georgewbush-whitehouse.archives.gov/omb/expectmore/summary/10000470.2002.html> (last visited Oct. 22, 2014).

6. Medicare Prescription Drug, Improvement, and Modernization Act § 306(a).

overpayments.⁷ The program originated in the states that had the highest Medicare utilization per capita,⁸ determined to be Florida, New York, and California, later expanding to South Carolina, Arizona, and Massachusetts.⁹

In the event of a discovered overpayment to a provider and absent an appeal, the default action by the Medicare Administrative Contractor, the entity charged with dispersing Medicare funds, was to initiate recoupment for recovery of the funds.¹⁰ Recoupment is the process by which Medicare payments to a provider are withheld on new claims to make up for an overpayment to that provider.¹¹ By withholding payments until the debt was satisfied, CMS could ensure return of funds that were determined to be improper.¹²

1. Audit methods

RAC audits were performed using two methods: automated review and complex review. Automated review was done through software analysis of claims submitted to Medicare.¹³ Automated review identified clearly erroneous inaccuracies in billing, like duplicate billings and coding errors.¹⁴ Once identified, a demand for repayment was sent to the provider without any further evaluation of the claim.¹⁵ Complex review required physical review of the medical record.¹⁶ After recognizing that there *could* be an overpayment issue,

7. *Id.* § 306(f).

8. *Id.* § 306(b)(1)(A).

9. Abby Pendleton & Jessica L. Gustafson, *The Future of the Recovery Audit Contractor Program*, ABA HEALTH ESOURCE (Aug. 2011), http://www.americanbar.org/newsletter/publications/aba_health_esource_home/aba_health_law_esource_1108_pendleton.html.

10. *The Medicare Overpayment Collection Process*, CMS.GOV, 2 (May, 2014), <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/OverpaymentBrochure508-09.pdf>.

11. *Id.* at 3.

12. *Id.*

13. *The Medicare Recovery Audit Contractor (RAC) Program: An Evaluation of the 3-Year Demonstration*, CMS.GOV, 12 (June 2008), <http://www.cms.gov/Recovery-Audit-Program/Downloads/RACEvaluationReport.pdf> [hereinafter *Evaluation of 3-Year Demonstration*].

14. *The Medicare Fee-For-Service Recovery Audit Program Process*, CMS.GOV, (JAN. 2013), www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Medicare-Fee-For-Service-Recovery-Audit-Program-Process-Educational-Tool-ICN908524.pdf; *Evaluation of 3-Year Demonstration*, *supra* note 10, at 12.

15. *The Medicare Fee-For-Service Recovery Audit Program Practice*, *supra* note 14, at 2.

16. *Id.*

the RAC would request the medical record from the provider.¹⁷ This request was called an Additional Document Request (“ADR”).¹⁸ If that physical review of the record revealed an overpayment, a demand letter was sent.¹⁹ Both automated and complex reviews could be conducted on claims as far back as four years from the date of the audit.²⁰

2. Discussion period

If a review found an overpayment, a letter requesting repayment was sent to the provider.²¹ The initial phase after a demand letter was sent by the RAC to a provider could also become a “discussion period.”²² If desired, the provider could contact the RAC outside of the formal appeal process to discuss the claim denials.²³ The provider could also offer documentation to the RAC that could have the potential to change the outcome of the denial.²⁴ The RAC had the option of reversing a determination during the discussion period.²⁵ Initiating a discussion did not begin the appeals process; the two were separate avenues.²⁶ This period could last up to forty days after receipt of the demand letter.²⁷

3. Appeals process

If the provider had a dispute over any of the funds flagged by the RAC as overpayments, she was entitled to utilize the established

17. *Id.*

18. *Medicare Program Integrity Manual*, CMS.GOV, ch. 3.2.3A, (2014), <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pim83c03.pdf>.

19. Joanne B. Erde, *Recovery Audit Contractors: Is the Honeymoon Over?*, DUANEMORRIS.COM (Feb. 2006), www.duanemorris.com/articles/static/modern_healthcare_feb06.pdf.

20. *Recovery Audit Contractors*, AMERICAN MEDICAL ASS'N, <http://www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/medicare/recovery-audit-contractors.page> (last visited Apr. 29, 2014).

21. *The Medicare Fee-For-Service Recovery Audit Program Process*, *supra* note 14.

22. *Frequently Asked Questions*, Centers for Medicare and Medicaid Services, <https://questions.cms.gov/faq.php?id=5005&faqId=2731> (last visited Apr. 29, 2014).

23. *Id.*

24. *Id.*

25. *Id.*

26. *Id.*

27. *Id.*

Medicare appeals process.²⁸ The first level of appeal involved a redetermination of the claim.²⁹ The provider had to file for a redetermination within 120 days of receiving the decision from the RAC.³⁰ This initial appeal was reviewed by staff of the RAC that had not been involved in the original determination of overpayment.³¹ If the appeal did not end in favor of the provider, she had the opportunity to continue the appeal. The second appeal level was a reconsideration of the claim by a Qualified Independent Contractor (“QIC”).³² A QIC was a contractor unaffiliated with the RAC and assigned by region.³³ The provider had 180 days after receipt of the redetermination to file for the reconsideration.³⁴ As a third party, the QIC would not have been involved with the redetermination, and would approach the claim with fresh eyes.³⁵

If the provider was still not happy with the outcome, she would continue to the third level of appeal—a hearing before an administrative law judge (“ALJ”).³⁶ The request for an ALJ hearing had to be made within sixty days of the QIC decision.³⁷ In addition to the escalated formality of a hearing, this level of appeal required a minimum amount to remain in controversy.³⁸ The fourth level of appeal within Medicare was the Medicare Appeals Council (“Appeals Council”); an appeal to the Appeals Council must be made within

28. *Medicare Appeals Process*, CMS.GOV (Aug. 2014), <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MedicareAppealsProcess.pdf>.

29. *Id.* at 2–3.

30. *Id.* at 3.

31. *Id.*

32. *Id.* at 4.

33. *Original Medicare Appeals - Level 2: Reconsideration by a Qualified Independent Contractor (QIC)*, MEDICARE.GOV, <http://www.medicare.gov/claims-and-appeals/file-an-appeal/original-medicare/original-medicare-appeals-level-2.html>; *Second Level of Appeal: Reconsideration by a Qualified Independent Contractor*, CMS.GOV (May 9, 2014) <http://www.cms.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals/ReconsiderationbyaQualifiedIndependentContractor.html>.

34. *Id.*

35. *Id.*

36. *Medicare Appeals Process*, *supra* note 28, at 5–6.

37. *Id.*

38. *Id.* In 2015, if the disputed amount is above \$150, an appeal can be heard by an ALJ. *Third Level of Appeal: Hearing by an Administrative Law Judge*, CMS.GOV (Feb. 25, 2015, 1:10 PM), <http://www.cms.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals/HearingsALJ.html>.

sixty days of the ALJ decision.³⁹ The Appeals Council was the final step within CMS, but not the final level of appeal.⁴⁰ If the provider was still dissatisfied with the result of the Appeals Council hearing, it may escalate the matter for judicial review in a federal district court.⁴¹ For a claim to progress to this point, it must meet the minimum amount in controversy and the appeal must be filed fewer than sixty days after the Appeals Council decision.⁴²

In addition to the timeline that dictated when providers must file, all stages of appeal had respective statutory timeliness requirements placed on each phase of review.⁴³ At any level, if the decision maker did not act within the prescribed timeframe, the provider could escalate the appeal to the next level.⁴⁴ The first and second levels must be decided by the RAC and the QIC, respectively, within sixty days of filing.⁴⁵ The ALJ and the Appeals Council both had ninety days to issue a decision before the provider could skip that level and move upward.⁴⁶

4. Fees to contractors

Under the MMA, Recovery Audit Contractors were paid a contingency fee for the payment errors they discovered during the demonstration.⁴⁷ Although initially applied only to overpayments to providers, the fee was eventually paid to the RAC whether it discovered an overpayment or an underpayment.⁴⁸ If an appeal was made, the RAC was allowed to

39. *Medicare Appeals Process*, *supra* note 28, at 7.

40. *Id.*

41. *Id.* at 7–8.

42. *Id.* at 8. This number can change yearly. For the year 2015, the amount is \$1,460.) *Fifth Level of Appeal: Judicial Review in Federal District Court*, CMS.GOV (Oct. 5, 2014, 1:29 PM), <http://www.cms.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals/Review-Federal-District-Court.html>; *see also Original Medicare (Fee-for-service) Appeals*, CMS.GOV (June 24, 2015, 1:25 PM), <http://www.cms.gov/Medicare/appeals-and-Grievances/OrgMedFFSAppeals/index.html>.

43. *Medicare Appeals Process*, *supra* note 28.

44. *Id.*

45. *Id.* at 2–3.

46. *Id.* at 4.

47. Medicare Prescription Drug, Improvement, and Modernization Act § 306(a)(1).

48. U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-10-143, MEDICARE RECOVERY AUDIT CONTRACTING: WEAKNESSES REMAIN IN ADDRESSING VULNERABILITIES TO IMPROPER PAYMENTS ALTHOUGH IMPROVEMENTS MADE TO CONTRACTOR OVERSIGHT, (2010) at 3, n.12 [hereinafter GAO REPORT].

keep the fee if the determination survived the first level of appeal.⁴⁹ However, if the RAC's decision was overturned at that stage, the fee was returned to CMS.⁵⁰ If the provider appealed beyond the first level and had the denial overturned at some later point, the RAC was allowed to keep the fee.⁵¹

5. Recoupment

Once an overpayment to a provider was identified by the RAC, CMS was quick to recover the funds. Initially, a demand letter would be sent to the provider, notifying it of the amount of the overpayment.⁵² If the funds were not repaid after forty days, Medicare would begin recoupment.⁵³ If funds were recouped, all future payments to the provider were halted until the amount owed back to Medicare was satisfied.⁵⁴

In order for a provider to delay recoupment pending an appeal, the provider had to file for redetermination within thirty days of receiving the demand letter.⁵⁵ This timetable was not consistent with the allowable time to file only for the redetermination, which was quite a bit longer at 120 days.⁵⁶ If the provider was later than thirty days in filing, and recoupment had commenced before the request was received, none of the funds recouped were returned to the provider, unless the claims were overturned later on appeal.⁵⁷

The recoupment process was similar at the second level of appeal. The provider was allowed 180 days to appeal a redetermination, but in order to again delay the recoupment process, the request for reconsideration by a QIC must be made within sixty days of the redetermination decision.⁵⁸ Once this second appeal level was exhausted, recoupment was inevitable if the decision was still

49. *Id.* at 31.

50. *Id.*

51. *Id.*

52. *The Medicare Overpayment Collection Process*, CMS.GOV, 2, (May 2014), <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/overpaymentbrochure508-09.pdf>.

53. *Id.* at 5.

54. *Id.* at 3.

55. *Id.* at 4.

56. *Id.* at 6.

57. *Id.* at 4.

58. *Id.* at 3-4.

adverse to the provider, regardless of the provider's decision to appeal further.⁵⁹

6. *Program evaluation*

The RAC demonstration lasted for a period of three years, and at the end of that time, the results were reviewed by CMS.⁶⁰ The program had collected over \$1 billion in improper payments⁶¹ and paid out over \$187 million in contingency fees.⁶² This meant that the cost of recovering overpayments was a mere twenty cents for every dollar recouped.⁶³ The demonstration period's goal was to examine whether it was financially beneficial to hire contractors to recover Medicare funds billed in error, and it would appear from the report that the answer was a resounding yes.⁶⁴ Although there were problems acknowledged in the report,⁶⁵ after such a glowing performance, the RAC audit was on its way to permanent application.⁶⁶

Additionally, a portion of the report was devoted to the reaction and impact of the RAC demonstration on providers.⁶⁷ The government results indicated that a large majority of providers felt the process was "fair and reasonable."⁶⁸ Furthermore, the analysis of the percentage of dollars recouped compared to providers' overall revenue from Medicare revealed that the financial burden for the providers was small.⁶⁹

7. *Initial provider response to the demonstration*

Despite the results of CMS' final report on the RAC demonstration to the contrary, providers were not happy with the

59. *Id.* at 4.

60. *Evaluation of 3-Year Demonstration*, *supra* note 13.

61. *Id.* at 15.

62. *Id.* at 14.

63. *Id.*

64. *Id.* at 29.

65. *Id.* at 24–27. Changes were made to the program based on the issues discovered in the demonstration. Those changes are discussed in the next section on permanent RAC implementation.

66. Tax Relief and Health Care Act of 2006, Pub. L. No. 109-432, § 120 Stat. 2922, 2991–92 (2006).

67. *Evaluation of 3-Year Demonstration*, *supra* note 13, at 20–21.

68. *Id.* at 2.

69. *Id.* at 20.

program.⁷⁰ Every dollar that was repaid to the government was taken away from a provider, and not all providers felt the process was sound or the results were valid.⁷¹ The proportion of overpayments as opposed to underpayments identified highlighted the RAC's focus on overpayments.⁷² When the program was implemented, detecting improper payments was identified as an objective of the program; improper payments included both overpayments *and* underpayments.⁷³ During the demonstration period, only about four percent of the errors identified were underpayments to providers.⁷⁴ A RAC was able to keep any fee it collected, so long as the claim determination survived the first level of appeal, which was performed by staff of the RAC itself.⁷⁵

B. Nationwide RAC Program Implementation

The national RAC program was permanently implemented with the passage of the Tax Relief and Health Care Act of 2006.⁷⁶ Section 302 of the Act specifically addressed implementation, requiring the RAC program to be rolled out in every state by 2010.⁷⁷

1. Initial updates to the RAC program

There were several notable differences, including the following, when CMS expanded the audits nationwide:⁷⁸

a. Three year "look-back" period. A look-back period is the amount of time in the past that the auditor may review a provider's claims.⁷⁹ The Act limited look-backs to three years, although no claims could be reviewed that were dated prior to October 2007, regardless of the date the program was implemented in the state

70. McBride, *supra* note 2.

71. *Id.*

72. *Evaluation of 3-Year Demonstration*, *supra* note 13, at 15.

73. *Id.*

74. *Id.*

75. *Id.* at 20.

76. Tax Relief and Healthcare Act of 2006, Pub. L. No. 109-432, § 302, 120 Stat. 2922, 2991-92 (2006).

77. *Id.*

78. McBride, *supra* note 2; CENTERS FOR MEDICARE AND MEDICAID SERVICES, STATEMENT OF WORK FOR THE RECOVERY AUDIT CONTRACTOR PROGRAM, (2007), available at <https://www.fbo.gov/utills/view?id=f8f1d845d960c3229301aeecc334c7eb4> [hereinafter CENTERS FOR MEDICARE AND MEDICAID SERVICES].

79. *Recovery Audit Contractors*, *supra* note 20.

where the provider was located.⁸⁰ The look-back period during the demonstration period had been four years.⁸¹

b. Status of RAC employees. During the demonstration period, RACs were not required to have either a physician medical director or a certified coder reviewing claims.⁸² The permanent program required both.⁸³

c. Limits on medical record requests. The new program limited the number of requests for medical records that a RAC could make on a provider within a forty-five-day period, varying by the size of provider.⁸⁴ There was not only a maximum number of ADRs that could be made, but also a minimum, meaning the audit had to uncover a threshold amount before the provider could be requested to provide the medical records.⁸⁵ There had been no statutory limits during the demonstration, although each RAC had the option to implement limits if it chose to.⁸⁶

d. Repayment of contingency fee. The RAC was only required to repay the contingency fee during the demonstration period if its determination was overturned at the first level of appeal.⁸⁷ In the nationwide program, the contractor must refund the fee if the determination is overturned, regardless of the appeal level.⁸⁸

2. Contingency fee rates

Since the program has rolled out nationwide, CMS has disclosed the contingency fees paid to the contractors.⁸⁹ There are now four RAC servicers, each assigned to a regional cluster of states.⁹⁰ Each

80. CENTERS FOR MEDICARE AND MEDICAID SERVICES, *supra* note 78, at 8.

81. *Recovery Audit Contractors*, *supra* note 20.

82. *Id.*

83. *Id.*

84. *Id.*

85. CENTERS FOR MEDICARE AND MEDICAID SERVICES, MEDICARE FEE-FOR-SERVICE RECOVERY AUDIT PROGRAM ADDITIONAL DOCUMENTATION LIMITS FOR MEDICARE PROVIDERS 2 (2013), *available at* <http://cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Recovery-Audit-Program/Downloads/April-2013-Provider-ADR-Limit-Update.pdf>.

86. *Id.*

87. *Id.*

88. *Id.*

89. GAO REPORT, *supra* note 48, at 13.

90. *Id.*

contractor negotiates its own fee, ranging from 9% to 12.5% of improper payments identified by the RAC.⁹¹

III. PROVIDER RESPONSE

A. Provider Issues

Medicare providers and provider advocacy groups have continued to be unhappy with the RAC program.⁹² Provider groups have advocated for reform on several fronts, and have lodged numerous complaints about the process of the audits, the burden on providers, and the costs associated with facilitating a RAC audit.⁹³

1. Contingency fee

Of the many complaints providers have had with the RAC program, none has been so unified and pronounced as their collective opposition to a contingency fee-based system for overpayment discovery. The contingency fees paid to RACs have been termed “bounty hunter-style” within the healthcare industry, and the term is freely used by reputable organizations like the American Medical Association⁹⁴ and the American Hospital Association (“AHA”),⁹⁵ as well as healthcare attorneys,⁹⁶ among

91. *Id.*

92. See Letter from Richard Umbdenstock, President and CEO of the American Hosp. Ass’n, to Kathleen Sebelius, Sec’y of the U.S. Dep’t of Health and Human Servs. (April 17, 2013), *available at* <http://www.aha.org/advocacy-issues/letter/2013/130417-let-hhs-umbdenstock.pdf> (noting recent changes to rectify unfair rebilling practices did not go far enough to adequately address the problem); Letter from Rick Pollack, Exec. Vice President of the American Hosp. Ass’n, to Marilyn Tavenner, Adm’r for Ctrs. for Medicare & Medicaid Servs. (January 14, 2014), *available at* <http://www.aha.org/advocacy-issues/letter/2014/140114-let-aljdelays.pdf> (stating that current delays for ALJ hearings are not consistent with statutory timelines, excessive denials by RACs are adding to the backlog problem).

93. See *Recovery Audit Contractors*, *supra*, note 20; *AHA RAC Trac Initiative*, AMERICAN HOSPITAL ASSOCIATION, <http://www.aha.org/advocacy-issues/rac/ractrac.shtml> (last visited Apr. 29, 2014).

94. AM. MED. ASS’N, AMERICAN MEDICAL ASSOCIATION FACT SHEET, MEDICARE RECOVERY AUDIT CONTRACTOR (RAC) PROGRAM APPEALS, *available at* https://resourcesforrisk.com/_default/download/download_free_doc.php?file=Recovery+Audit+Contractors+Fact+Sheet.pdf [hereinafter AMERICAN MEDICAL ASSOCIATION].

95. AMERICAN HOSPITAL ASSOCIATION, FACTS ABOUT THE MEDICARE AUDIT IMPROVEMENT ACT OF 2013 2 (2014), *available at* www.aha.org/content/13/fs-hr1250rac.pdf [hereinafter AMERICAN HOSPITAL ASSOCIATION].

96. McBride, *supra* note 2.

others.⁹⁷ It seems clear that if the entity responsible for the audit stands to profit directly from every claim it denies, there is a perverse incentive for it to reject claims that might otherwise be deemed legitimate.⁹⁸ This concern is furthered by the finding by CMS's Office of Inspector General that RACs deny half of the claims that they review upon redetermination.⁹⁹

2. *Status of auditors*

Providers were also critical of the medical expertise of the auditors.¹⁰⁰ Doctors interact with the patients and make decisions for treatments based on their knowledge of and experience with their diagnosis.¹⁰¹ The RAC was staffed with auditors who are usually either nurses or therapists.¹⁰² Providers strongly believed that a physician who was physically present with the patient when the treatments were chosen should not be second-guessed by less-qualified medical professionals months, and possibly years, after the fact.¹⁰³

3. *Look-back vs. rebilling*

After permanent implementation, a RAC could investigate payment claims made up to three years prior to the review.¹⁰⁴ Many of the RAC claim denials were made to hospitals regarding inpatient care, with the RAC deeming the treatment medically unnecessary.¹⁰⁵ In reality, the medical necessity often existed, but the treatment was provided in an inpatient setting instead of outpatient. These claims would have been allowable as outpatient care, because it was more cost effective than inpatient care.¹⁰⁶

97. A Google search for "Medicare RAC 'bounty hunters'" returns over 17,000 results.

98. AMERICAN MEDICAL ASSOCIATION, *supra* note 94.

99. DEPARTMENT OF HEALTH AND HUMAN SERVICES OFFICE OF INSPECTOR GENERAL MEDICARE RECOVERY AUDIT CONTRACTORS AND CMS'S ACTIONS TO ADDRESS IMPROPER PAYMENTS, REFERRALS OF POTENTIAL FRAUD, AND PERFORMANCE 17 (2013), *available at* <http://oig.hhs.gov/oei/reports/oei-04-11-00680.pdf> [hereinafter OIG REPORT].

100. AMERICAN HOSPITAL ASSOCIATION, *supra* note 95, at 3.

101. *Id.*

102. *Id.*

103. *Id.*

104. CENTERS FOR MEDICARE AND MEDICAID SERVICES *supra* note 78.

105. AMERICAN HOSPITAL ASSOCIATION, *supra* note 95, at 4.

106. *Id.*

Hospitals were only allowed to rebill these claims within one year, and were therefore often not able to recover any of the funds that would be due on an inpatient-turned-outpatient claim because of the time lapse.¹⁰⁷ The American Hospital Association advanced that this disparity between the time periods for look-back and allowable rebilling “violate[ed] CMS’s statutory requirement to pay for all reasonable and necessary care,” in addition to costing the providers millions of dollars.¹⁰⁸ The AHA advocated for a one-year look-back period, keeping the time frame for rebilling consistent with the audit window.¹⁰⁹

4. Rate of denials overturned

Providers who label the RACs “bounty hunters” were validated by two statistics: the percentage of cases “red-flagged” for complex review that actually contain error and the percentage of denials that are overturned on appeal.¹¹⁰ The AHA asserted that, of all claims audited by complex review, fifty-eight percent contained no billing errors.¹¹¹ These were the claims initially flagged by software as having some indicator for a billing error and then physically reviewed by an auditor.¹¹² Providers contended that the methods used by the RACs were not accurately indicating errors in well over half of the cases.¹¹³ Among the remaining claims denied by a RAC, nearly half of those are appealed.¹¹⁴ Once appealed, providers claimed that seventy-two percent of denied claims are overturned by the ALJ.¹¹⁵ Providers argued that the high rate of denials proved that RACs were motivated more by the possible contingency fee than the validity of the claim denial.¹¹⁶

The Office of Inspector General’s (“OIG”) numbers told a different story.¹¹⁷ In August 2013, the OIG released a report on

107. *Id.*

108. *Id.*

109. *Id.*

110. *Id.*

111. AMERICAN HOSPITAL ASSOCIATION, *Facts*, *supra* note 95, at 4.

112. *The Medicare Fee-For-Service Recovery Audit Program Process*, *supra* note 14, at 2.

113. AMERICAN HOSPITAL ASSOCIATION, *supra* note 95, at 3.

114. *Id.*

115. *Id.* at 2.

116. *Id.*

117. OIG REPORT, *supra* note 99.

RACs and included its own conclusion of their efficiency in determining payment errors within Medicare.¹¹⁸ In that report, the OIG found that only six percent of overpayment claims were appealed, and forty-four percent of those denials were overturned.¹¹⁹ No explanation has been given for the enormous disparity in data between the sources.

5. *Financial burden on providers*

The AHA continually surveys hospitals that are subject to RAC audits and monitors the costs associated with the process.¹²⁰ Of the hospitals responding, nearly half had spent at least \$100,000 in a year's time on costs related to RACs.¹²¹ Twelve percent of hospitals spent over \$400,000 each in the same amount of time.¹²² These costs could be justified in the interest of protection and preservation of the Medicare Trust Fund, but considering the rate at which providers claim their appeals are granted, the expenses seem burdensome to providers who find a high rate of success on appeal.

B. Provider Action

1. RACTrac

Healthcare providers felt they received a dearth of information from CMS regarding the RAC program.¹²³ Hospitals especially felt the pinch from the audits,¹²⁴ as RACs were able to target large numbers of high value claims at once through automated review. Denial of inpatient payments was especially common, and the fees the contractor would receive from denial of those claims would have added up quickly.¹²⁵

118. *Id.* at 11

119. *Id.*

120. AMERICAN HOSPITAL ASSOCIATION, *supra* note 95, at 4.

121. *Id.*

122. *Id.*

123. AMERICAN HOSPITAL ASSOCIATION, *supra* note 95, at 4.

124. OIG REPORT, *supra* note 99, at 11.

125. Jennifer Bresnick, *AHA Survey: Medicare RAC Audits Up 47% Since Last Year*, EHR INTELLIGENCE (Sept. 3, 2013), <http://ehrintelligence.com/2013/09/03/aha-survey-medicare-rac-audits-up-47-since-last-year/>.

Since hospitals were the biggest target of RACs,¹²⁶ the AHA sprang into action and created a program called RACTrac, which monitors RAC activity and appeals as well as the impact of the audits on providers.¹²⁷ RACTrac collects, compiles, and publishes information on RAC audits from hospitals.¹²⁸ The initial reports began in the first quarter of 2010 and have continued quarterly ever since.¹²⁹

The statistics reported by RACTrac often differ from information released by CMS regarding the RAC program.¹³⁰ There has not been an adequate explanation for the large discrepancies. RACTrac is a voluntary program provided by the AHA, although hospitals are incentivized to participate as a way to showcase the problems with the RAC system.¹³¹ Less than full participation could explain some discrepancy, but the differences are not insignificant. The real reason for the disparities remains to be found.

2. AHA lawsuits

In late 2012, the American Hospital Association and several hospitals filed suit against Kathleen Sebelius in her capacity as Secretary of the Department of Health & Human Services in the U.S. District Court for the District of Columbia over the inability of hospitals to rebill under the appropriate designation after initial inpatient claims were denied, discussed previously.¹³² The AHA claimed that CMS's stated policy to refuse rebilling was arbitrary and capricious, and violated federal law because it did not go through the necessary notice and comment procedure statutorily required for rulemaking.¹³³

In March of 2013 and presumably in response to this lawsuit, CMS issued a new order allowing for some rebilling to occur.¹³⁴ The AHA then amended its initial claim, claiming that the new remedies

126. OIG REPORT, *supra* note 99, at 11.

127. AMERICAN HOSPITAL ASSOCIATION, *supra* note 95.

128. *Id.*

129. *Id.*

130. Compare OIG REPORT, *supra* note 99, with AMERICAN HOSPITAL ASSOCIATION, *supra* note 95.

131. AMERICAN HOSPITAL ASSOCIATION, *supra* note 95.

132. Complaint, AHA v. Sebelius, No. 1:12-cv-1770 (D.D.C. 2012).

133. *Id.* at 4.

134. CMS Ruling No: CMS-1455-R, 78 Fed. Reg. 16632 (2013).

were inadequate and unlawful.¹³⁵ The lawsuit was dismissed in September, 2014 on jurisdictional grounds.¹³⁶

A mandamus complaint was filed by the AHA and three medical centers that have amounts ranging from about \$600,000 to \$7.6 million tied up in the Medicare appeals process.¹³⁷ The complaint indicates that the hospitals are being harmed by the immense amounts of cash unavailable to them because of the Medicare appeals backlog.¹³⁸

3. *Additional support for providers*

Providers are not alone in their disapproval of the RAC program. In February 2014, 111 members of Congress petitioned Secretary Sebelius to take immediate action to reform the RAC program and resolve the oppressing delays providers face.¹³⁹ The legislators took issue with many of the same problems that providers voiced concern over, including payment of contractors by contingency fee, the length of the look-back period, the administrative burden on providers, and the high rate of denials overturned on appeal.¹⁴⁰

IV. CURRENT STATE OF RAC APPEALS AND AUDITS

A. *Appeals*

The Office of Medicare Hearings and Appeals (“OMHA”) governs the ALJ hearings in the CMS appeals process.¹⁴¹ In December 2013, OMHA issued a memorandum to all Medicare appellants.¹⁴² Nancy Griswold, the Chief ALJ for OMHA, notified the appellants that in July 2013 OMHA had “temporarily

135. Second Amended Complaint, *AHA v. Sebelius*, No. 1:12-cv-1770, 5 (D.D.C. 2013).

136. *AHA v. Burwell*, No. 12-1770, (D.D.C. 2014).

137. Complaint, *AHA v. Sebelius*, No. 14-cv-851, 5–6 (D.D.C. 2014).

138. *Id.* at 16–19.

139. Letter from Members of Congress to Kathleen Sebelius, Sec’y of U.S. Dep’t of Health and Human Servs. (February 10, 2014), *available at* <http://www.aha.org/content/14/140210-let-congress-hhs.pdf>.

140. *Id.*

141. *Office of Medicare Hearings and Appeals (OMHA)*, U.S. DEP’T OF HEALTH AND HUM. SERVICES, <http://www.hhs.gov/omha/> (last visited Apr. 29, 2014).

142. Memorandum to OMHA Medicare Appellants, (Dec. 24, 2013) *available at* http://www.hhs.gov/omha/OMHA%20Medicare%20Appellant%20Forum/letter_to_medicare_appellants_from_the_calj.pdf.

suspended” assigning appeals to ALJs. OMHA employs sixty-five ALJs, who were at that time overloaded with appeals,¹⁴³ with over 350,000 claims pending.¹⁴⁴ While the number of appeals had grown shy of 200% from 2010 to 2013, the budget to adjudicate these claims remained the same.¹⁴⁵

In early 2014, OMHA added information about the backlog to its website.¹⁴⁶ It would now take five to six months for new hearing requests to be “doctored,” and up to twenty-eight months for the appeal to even be assigned to an ALJ.¹⁴⁷ OMHA also stated that appellants have a right to escalate their cases if cases are not adjudicated within the statutory timeframe of ninety days.¹⁴⁸ The website includes instructions on escalation, along with a reminder that the Appeals Council, the next level of review, has no hearing requirement, meaning the in-person appeal most providers were waiting for might not be provided. The Appeals Council, in accordance with 42 C.F.R. §405.1108(d),¹⁴⁹ may:

- 1) Issue a decision based on the record constructed at the QIC and any additional evidence, including oral testimony, entered in the record by the ALJ before the case was escalated.
- 2) Conduct any additional proceedings, including a hearing that the Appeals Council determines are necessary to issue a decision.
- 3) Remand the case to an ALJ for further proceedings, including a hearing.
- 4) Dismiss the request for Appeals Council review because the appellant does not have the right to escalate the appeal.
- 5) Dismiss the request for a hearing for any reason that the ALJ could have dismissed the request.¹⁵⁰

143. *Id.* at 1

144. *Id.*

145. *Id.*

146. *Adjudication Timeframes*, HHS.GOV, http://www.hhs.gov/omha/important_notice_regarding_adjudication_timeframes.html (last visited Apr. 29, 2014).

147. *Id.*

148. *Id.*

149. *Id.*

150. 42 C.F.R. § 405.1108 (2011).

In February 2014, OMHA held a forum for providers concerning the current backlog of appeals.¹⁵¹ According to the presentation, there are currently 480,000 appeals that are awaiting assignment to an ALJ.¹⁵² Although some minor advice was given to providers by OMHA representatives to speed up the appeals process, there were no major initiatives announced at the forum.¹⁵³

B. A Pause in Audits

Two days after the February 2014 OMHA provider forum, CMS announced a “pause” in RAC activity.¹⁵⁴ Current contracts with RACs would be expiring mid-year, and those contractors would need to wind down their cases to be finished by the June 1, 2014 deadline.¹⁵⁵ CMS instituted deadlines, after which RACs were not able to send out additional ADRs to providers or report improper payments to Medicare.¹⁵⁶ The pause would “allow CMS to continue to refine and improve the Medicare Recovery Audit Program. CMS [would] continue to review and refine the process as necessary.”¹⁵⁷

C. Recent Notable Updates and Improvements

In March of 2013, CMS issued a ruling concerning hospitals’ ability to rebill for outpatient services when the claim for inpatient services was denied during an audit.¹⁵⁸ CMS lifted the one-year rebilling limit so hospitals could re-submit claims under outpatient billing and get some payment for the services rendered to the patient.¹⁵⁹ The ruling, however, only covered claims that were still

151. *OMHA Medicare Appellant Forum*, HHS.GOV, http://www.hhs.gov/omha/omha_medicare_appellant_forum.html (last visited May 1, 2014).

152. Office of Medicare Hearings and Appeals, *Medicare Appellant Forum 57* (Feb. 12, 2014) http://www.hhs.gov/omha/OMHA%20Medicare%20Appellant%20Forum/omha_medicare_appellant_forum_presentations.pdf.

153. Donna K. Thiel, *OMHA Holds Medicare Appellant Forum*, AM. HEALTH LAWYERS ASS’N (February 17, 2014), <http://www.lexology.com/library/detail.aspx?g=aa6207aa-eb74-4ff6-93cc-df5c035944ff>.

154. *Recovery Audit Program Recent Updates*, CMS.GOV, http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Recent_Updates.html (last visited Apr. 29, 2014).

155. *Id.*

156. *Id.*

157. *Id.*

158. CMS Ruling No: CMS-1455-P, 78 Fed. Reg. 16632 (Mar. 13, 2013).

159. *Id.*

active, meaning those that were currently being appealed or those that were still in the statutory period of eligibility for appeal.¹⁶⁰

While this brought some relief going forward, there was some disappointment with the ruling.¹⁶¹ Providers claim they had been warned by CMS that appealing on the very basis of the inconsistency between lookback and rebilling was futile, and therefore a large majority of providers never appealed any inpatient denials.¹⁶² There was no reason for them to devote the time and money involved in an appeal that CMS had assured would fail.¹⁶³ Large numbers of claims that could have been rebilled were therefore lost because the hospitals did not have any way to predict this change in policy.¹⁶⁴

In early 2014, CMS announced that there would be some relevant changes to the RAC program when the new round of contracts began December 30, 2014.¹⁶⁵ RACs would only have a six-month look-back period when evaluating whether hospital inpatient status was appropriate.¹⁶⁶ This action should solve providers' concerns about their prior inability to rebill these denied claims under the correct status.

Changes included other areas of concern as well. First, the RAC was required to wait the duration of the discussion period before it sent the claim denial to Medicare.¹⁶⁷ Previously, the discussion period would discontinue if a provider filed an appeal.¹⁶⁸ The change would allow providers to engage in a conversation with the auditor before the clock started on the appeals process.¹⁶⁹ Second, CMS altered the timing of the award payment to the RAC.¹⁷⁰ The former rule required fees to be paid to contractors when the

160. *Id.*

161. Letter from Richard Umbdenstock, President and CEO of the Am. Hosp. Ass'n, to Kathleen Sebelius, Sec'y of the U.S. Dep't of Health and Human Serv. (Apr. 17, 2013), <http://www.aha.org/advocacy-issues/letter/2013/130417-let-hhs-umbdenstock.pdf>.

162. *Id.*

163. *Id.*

164. *Id.*

165. *Recovery Audit Program Improvements*, CMS.GOV, 1 (Feb. 18, 2014), <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Downloads/RAC-Program-Improvements.pdf>.

166. *Id.*

167. *Id.*

168. *Id.*

169. *Id.*

170. *Id.*

recoupment occurred, regardless of an appeal.¹⁷¹ The award to the RAC would now not be given until the claim, if appealed, finished the QIC level.¹⁷²

Third, CMS improved the way it calculated ADR limits. Although there were more complexities built into the computation, the basic analysis looked at the size of the provider and the amount of Medicare dollars it received, and based the cap on those factors.¹⁷³ The minimums were standard across the board.¹⁷⁴ CMS would now factor in the denial rate of the provider into the equation, allowing lower ADR limits for those providers who had a lower percentage of denials.¹⁷⁵

Fourth, RACs would now face penalties for high rates of overturned claim denials and low accuracy on automated reviews.¹⁷⁶ If a contractor met or exceeded a ten percent overturn rate at the first level of appeal, it would be subject to corrective action, followed by the possibility of exclusion from review of certain types of claims or the increase of ADR limits.¹⁷⁷ Automated reviews needed to meet or exceed ninety-five percent accuracy.¹⁷⁸ If they fail, CMS will employ a third party to aid the RAC in lowering the error rate.¹⁷⁹

Finally, CMS instituted a Provider Relations Coordinator to act as an intermediary between providers and RACs when a concern could not be resolved.¹⁸⁰ Providers will now have a specific person within CMS to contact with RAC issues.¹⁸¹

171. *Id.*

172. *Id.*

173. *Medicare Fee-for-Service Recovery Audit Program Additional Documentation Limits for Medicare Providers*, CMS.GOV (Mar. 15, 2012), http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/recovery-audit-program/downloads/Providers_ADRLimit_Update-03-12.pdf.

174. *Medicare Fee-for-Service Recovery Audit Program Additional Documentation Limits for Medicare Providers*, CMS.GOV, 2 (Apr. 15, 2013), <http://cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Recovery-Audit-Program/Downloads/April-2013-Provider-ADR-Limit-Update.pdf>.

175. *Id.*

176. *Id.* at 3.

177. *Id.*

178. *Id.*

179. *Id.*

180. *Id.* at 4.

181. *Id.*

In spite of these changes, not all provider concerns were addressed.¹⁸² Most notably, there was no mention of alleviating the massive delays at the ALJ appeal level.

In March 2014, the Protecting Access to Medicare Act was passed.¹⁸³ Section 111(b) of the Act contains, among other things, a provision that freezes the RAC's ability to review a certain types of Medicare claims absent indication of fraud or abuse.¹⁸⁴ Review of short-stay inpatient claims examined for compliance with the "two-midnight rule" is prohibited.¹⁸⁵ Although this Act inhibits the ability of RACs to review this one type of claim, they are still free to evaluate any others.

In July 2014, Nancy Griswold, the Chief ALJ for OMHA, made a statement before the House Committee on Oversight and Government Reform Subcommittee on Energy Policy, Health Care, and Entitlements.¹⁸⁶ In that statement she revealed some new statistics and additional measures recently employed to begin to ease the appeal backlog. Ms. Griswold stated that the supplemental funding allowed OMHA to hire additional staff, but still did not come close to addressing the over 800,000 pending appeals.¹⁸⁷

Just days before the statement was made, OMHA revealed on its website two new methods for appellants to exercise in an effort to speed up their appeals at the ALJ level.¹⁸⁸ The first was through a "statistical sampling initiative."¹⁸⁹ Statistical sampling requires large numbers of claims to be submitted, then a random sample taken.¹⁹⁰

182. Letter from Rick Pollack, Executive Vice President of the American Hospital Association, to Marilyn Tavenner, Administrator for Centers for Medicare & Medicaid Services (Jan. 14, 2014), <http://www.aha.org/advocacy-issues/letter/2014/140114-let-aljdelays.pdf>.

183. Protecting Access to Medicare Act of 2014, Pub. L. No. 113-93 § 111(b) (Mar. 31, 2014).

184. *Id.*

185. *Id.*

186. Statement of Nancy J. Griswold, Chief Administrative Law Judge, Office of Medicare Hearings and Appeals, on "Office of Medicare Hearings and Appeals Workloads," before the United States House Committee on Oversight & Government Reform, Subcommittee on Energy Policy (July 10, 2014), <http://oversight.house.gov/wp-content/uploads/2014/07/CMS-Griswold-OMHA-Final.pdf>.

187. *Id.* at 4.

188. *Id.* at 5.

189.

Statistical Sampling Initiative, HHS.GOV, http://www.hhs.gov/omha/omha%20statistical%20sampling/statistical_sampling_initiative.html.

190. *Id.*

The results from the sample (claim denials overturned vs. affirmed) are then projected onto the entire group. The results are reviewed by an ALJ to formulate her decision.¹⁹¹

The second new option available to appellants is a mediation-based process, called “settlement conference facilitation.”¹⁹² A facilitator, an OMHA employee, would attempt to find a solution that would appeal to both parties.¹⁹³ The facilitator would not participate in any fact-finding, but focus on a solution.¹⁹⁴ If a solution is reached, both parties sign an agreement and the appellant’s appeal concerning the agreed-upon claims is to be dismissed.¹⁹⁵

V. VIOLATION OF PROVIDERS’ PROCEDURAL DUE PROCESS

A. *Procedural Due Process*

In practice, the current RAC program has the potential to violate a provider’s procedural due process during the appeal proceedings. The Fifth and Fourteenth Amendments grant due process to all citizens.¹⁹⁶ The Fifth Amendment states, in part, “No person shall . . . be deprived of life, liberty, or property, without due process of law.”¹⁹⁷ By withholding funds necessary to sustain the provider’s business, the government is violating the due process provision of the Constitution.

Medical providers are entitled to be engaged in their profession without the government limiting that freedom unnecessarily. The United State Supreme Court has established that the abilities to be employed and earn a living are legitimate liberty interests protected by the Fifth and Fourteenth Amendments.¹⁹⁸ In *Meyer v. Nebraska*, the Court stated:

While this court has not attempted to define with exactness the liberty thus guaranteed, the term has received much consideration

191. *Id.*

192. *Settlement Conference Facilitation Pilot*, HHS.GOV, http://www.hhs.gov/omha/settlement_conference_facilitation_pilot.html

193. *Id.*

194. *Id.*

195. *Id.*

196. U.S. CONST. amend. V and XIV, § 1.

197. U.S. CONST. amend. V.

198. *Meyer v. Nebraska*, 262 U.S. 390, 399 (1923).

and some of the included things have been definitely stated. Without doubt, it denotes not merely freedom from bodily restraint but also the right of the individual to contract, to engage in any of the common occupations of life.¹⁹⁹

Since *Meyer* was decided, these words have become so firmly part of American jurisprudence that this concept has been cited or quoted well over a thousand times in subsequent cases.²⁰⁰

Once a liberty interest has been established, it is important to determine that the proceeding necessarily affords the provider due process. Although due process is not applicable to agency rulemaking, it is applicable to agency adjudications, so long as the proceeding has the potential to deprive the provider of liberty or property.²⁰¹ The occupational interest of the provider is at risk in the appeals process and Medicare recoupment, and therefore due process must be afforded.

For some providers, recoupment of funds still under appeal from a RAC audit could deprive providers of their occupations. In these cases, the government is not fulfilling its statutory duty to hear appeals in a timely manner. When one level of appeal drags on in excess of two years, CMS has adequate time to recover all monies in dispute in the appeal without ever holding a hearing.

The RAC auditors, utilizing computer software,²⁰² have the ability to review a large number of Medicare claims in small amounts of time. They also have the grant of authority from CMS to look as far back as three years into a provider's Medicare claims.²⁰³ These two factors enable the auditor to potentially call into question claims worth a substantial amount of money. When CMS initiates recoupment during the prolonged appeals process, the lack of incoming funds can devastate a medical provider.

If providers serve a large number of Medicare patients, they may also receive a significant percentage of their incomes from those patients. In the event of a large-scale audit that resulted in recoupment of substantial funds under appeal, the provider's remaining income may not be sufficient to compensate for the lost

199. *Id.*

200. *Id.* Westlaw Headnote 1, Constitutional Law, has over 1200 references.

201. *Londoner v. City of Denver*, 210 U.S. 373 (1908); *Bi-Metallic Inv. v. State B. of Equalization*, 239 U.S. 441 (1915).

202. McBride, *supra* note 2.

203. *Recovery Audit Contractors*, *supra* note 20.

Medicare funds, and as a result, those providers would have no choice but to close their doors. Had the appeals process occurred in the statutorily designated timeframe of ninety days, the burden on the provider would be much lighter, as the appeal would be decided within a reasonable amount of time. Even if Medicare recoups all of the money in dispute by the end of the ALJ ruling, as long as the process occurs within the limited timeframe, it is less likely to have such a harsh effect in the event the appeals are overturned.

1. Timeliness as a Due Process requirement

Even absent recognition that a provider's opportunity to practice within his occupation constitutes a liberty right for due process purposes, agency adjudicatory timeliness has been presented as a due process requirement.²⁰⁴ In the Supreme Court case *Barry v. Barchi*, a horse trainer's license was revoked without a hearing after his horse tested positive for drugs.²⁰⁵ The applicable state law allowed this practice, but also required a post-suspension hearing to determine the trainer's culpability, if any.²⁰⁶ The Court conceded that the initial suspension was allowable.²⁰⁷ Although the statute called for an eventual hearing, the Court took issue with the absence of a timeframe for the hearing to be held.²⁰⁸ The suspension must be followed by a "prompt judicial or administrative hearing that would definitely determine the issues"²⁰⁹ Additionally, language used in previous cases called for the trainer to be heard "at a meaningful time and in a meaningful manner."²¹⁰ Because of the lack of any timeframe in *Barry*, a trainer's suspension could be over before a hearing was even held, causing the trainer to suffer the full penalty before having a chance to be heard and present his evidence.²¹¹ The Court concluded that the lack of a timely hearing requirement in the statute, on its face and as applied in this case, resulted in a denial of the trainer's due process.²¹²

204. *Barry v. Barchi*, 443 U.S. 55, 64 (1979).

205. *Id.* at 59.

206. *Id.* at 59–60.

207. *Id.* at 63.

208. *Id.* at 64.

209. *Id.*

210. *Id.* at 66 (quoting *Armstrong v. Manzo*, 380 U.S. 545, 552 (1965)).

211. *Id.*

212. *Id.*

Several other cases involving agency timeliness followed *Barry*, with parallel results.²¹³ In one such case, *Martell v. Mauzy*, a landfill owner was denied a continuing permit without any hearing on the allegations that constituted the denial.²¹⁴ The owner had an opportunity to have the decision reviewed, but the review could extend as long as 120 days.²¹⁵ The court determined that the time allotted for review coupled with the deprivation of the permit could damage the livelihood of the owner.²¹⁶ The court stated, “The post-denial review procedures set out . . . are constitutionally inadequate in this case in that they fail to provide for a prompt post-denial hearing and disposition.”²¹⁷ The landfill would likely be bankrupt and out of business by the time the agency was required to issue a decision.²¹⁸

As the concepts in these cases are applied to the current state of RAC appeals that are backlogged for years, it suggests that CMS’s lack of timeliness is a due process violation. Any provider who has experienced recoupment of funds before the ALJ hearing is comparable to the trainer in *Barry*, whose license was revoked prior to a hearing. But the Court did not take issue, per se, with the imposition of a penalty before a hearing. The problem with the procedure in *Barry* is identical to the problem with the procedure in RAC appeals—there is no method by which to compel the hearing within a reasonable time. In *Barry*, this was the situation because the statute did not call for any time period by which the hearing should be held. But that was not the only problem. The Court was not solely concerned with the lack of a timetable. The Court also found the lack of a timely hearing significant, as applied in that particular instance, indicating that the procedure actually in use is just as important as the words in the statute.

In the case of RAC appeals, there is a clear timetable set forth within the statute, eliminating the need for a facial analysis. But courts consider how the regulation is applied as well. The full stop

213. See *Martell v. Mauzy*, 511 F. Supp. 729, 742 (N.D. Ill. 1981); *Gleichman v. U.S. Dep’t of Agric.*, 896 F. Supp. 42 (D. Me. 1995); *Gershenfeld v. Justices of the Supreme Court of Pa.*, 641 F. Supp. 1419 (E.D. Pa. 1986); *Lasmer Indus., Inc. v. Def. Supply Ctr. Columbus*, 2:08-CV-0286, 2008 WL 2457704 (S.D. Ohio 2008).

214. *Martell*, 511 F. Supp. at 731.

215. *Id.* at 740–1.

216. *Id.* at 740.

217. *Id.* at 742.

218. *Id.*

that has been implemented within the appeals process violates the portion of the statute that calls for timeliness, thereby creating the same situation that the Court addressed in *Barry*.

Barry also conveyed the importance of a hearing “at a meaningful time and in a meaningful manner.”²¹⁹ Were a hearing to take place within the statutorily designated time, a court would likely find that “meaningful.” When the statutory limit is being exceeded by nearly ten times, any court would be hard pressed to make the determination that the timing was even reasonable, let alone meaningful.

The liberty right in *Martell* mirrors that of providers facing recoupment within RAC appeals. When the court analyzed the review process, it found that the business owner could well be out of business before the agency issued its determination.²²⁰ In this instance, 120 days was too long for the business to be losing its source of income before review.²²¹ Considering RAC appeals are currently at twenty-eight months²²²—approximately 840 days— it would be difficult for CMS to argue that such a long delay does not deprive providers of their due process rights.

2. *What process is due?*

The test put forth in *Mathews v. Eldridge* has become the standard for determining what process is due within an agency.²²³ The strength of each of these factors must be balanced against the others to conclude the proper process.

First, the private interest that will be affected by the official action; second, the risk of an erroneous deprivation of such interest through the procedures used, and the probable value, if any, of additional or substitute procedural safeguards; and finally, the Government’s interest, including the function involved and the fiscal and administrative burdens that the additional or substitute procedural requirement would entail.²²⁴

219. *Barry*, 443 U.S. at 66.

220. *Martell*, 511 F. Supp. at 740.

221. *Id.* at 740–41.

222. *Adjudication Timeframes*, *supra* note 146.

223. *Mathews v. Eldridge*, 424 U.S. 319, 335 (1976).

224. *Id.*

The court in *Martell* spent considerable time analyzing the three factors set forth in *Mathews*.²²⁵ The private interest was the landfill, and the official action was the permit denial.²²⁶ Without review, the owner had no opportunity for a reversal of the denial, and the business would quickly have had to close its doors.²²⁷ The weight of this factor was abundant in the eyes of the court, considering significant damage to the business had already been done.²²⁸ The second factor was the assessment of the risk of erroneous deprivation of the stated interest.²²⁹ The *Martell* court pointed to the lack of credibility of the information used as a basis for the denial, and concluded that the risk was “great.”²³⁰ The state’s interest in the proceedings, the third factor, was also important.²³¹ The government had a responsibility to protect the public health, a major factor in the licensure of landfills.²³² The court also weighed the burden that would be placed on the agency if the matter were to be resolved differently.²³³ The court did not find any appreciable, additional burden, either financial or administrative, if the agency were to provide a hearing prior to the denial of the permit.²³⁴ Although the state’s interests in this case bore some weight, the procedures employed “poorly served” those interests.²³⁵ The procedures left open the risk that a private interest could be erroneously deprived, and the court found a “minimal” burden on the agency to accommodate further proceedings.²³⁶ The agency was required to hold a hearing to satisfy the business owner’s due process.²³⁷

When determining what process is due in a RAC appeal, the first factor requires recognizing the private interest involved and determining its relative weight. In this analysis, the private interest is the occupation and sustainment of the provider’s business. The risk

225. *Martell*, 511 F. Supp. at 740–42.

226. *Id.* at 740.

227. *Id.*

228. *Id.*

229. *Id.* at 741.

230. *Id.*

231. *Id.*

232. *Id.*

233. *Id.* at 742.

234. *Id.*

235. *Id.*

236. *Id.*

237. *Id.* at 744.

that a business could be required to close its doors because of premature recoupment is a substantial interest. The Supreme Court has found this interest to weigh heavily in the analysis towards requiring more process before agency action is taken.²³⁸ The current substantial delays within OMHA show that although more process is essential, the agency has no ability to provide it.

The risk of erroneous deprivation of the identified liberty also bears consideration. A high percentage of Medicare denials are overturned at the ALJ level, suggesting a great risk that dollars in dispute are wrongly recouped from providers. Because the damage has the potential to be devastating, this erroneous deprivation has the potential to cause irreparable harm to the provider.

The final consideration analyzes the agency's interest in limiting the procedures to those already in place. CMS has an obvious financial interest in keeping the status quo. Not only is the agency recouping dollars, some of which it may or may not actually have a claim to, but CMS is additionally not putting forth more money to either speed up the proceedings or offer alternatives to providers. There would be little harm, if any, to CMS if the recoupment began later in the process, for example, after the ALJ determination. The providers that were billing before an ALJ hearing, enabling recoupment, would presumably still be billing after the hearing, still allowing CMS to recover the funds at a later date.

The factors within RAC appeals appear to be weighted similarly to the factors in *Martell*. In *Martell*, the court found that the agency would not be burdened by affording the business owner additional process, especially when the agency's burden was weighed against the liberty right of the owner and the chance for the right to be deprived in error. The occupational right of a RAC provider is indistinguishable from the same right in *Martell*. The result from deprivation of that right is identical in the two instances—a business risks closing its doors. The burden to CMS is light in comparison to the rights of the business, which should bring any court to the same conclusion as *Martell*. Therefore, CMS should be implementing additional procedures to ensure due process to every provider. In this case, CMS would likely need to, at the very least, delay recoupment until providers are given an adequate hearing.

238. *Id.* at 740.

*B. Additional Factors that Weigh on Due Process**1. Time as a weapon*

A further theory on timeliness has been raised by Joe Sims and Michael McFalls: “[Agencies] are more than willing to extract additional relief by leveraging the fact that time is the enemy of all transactions, thus obtaining relief in many cases that would never have been awarded in a litigated decree.”²³⁹

The theory posited here is not unfathomable. CMS is fully aware of the financial predicament that providers confront when a large portion of their revenue faces the possibility of termination. The agency has nothing to lose by dragging the proceedings on for years. Many providers may be willing to settle claims for a smaller amount than initially demanded out of a fear of losing their entire business as an alternative, even when they believe the denials were made in error. But that alternative is only recognizable because of the enormous delays within the agency, making any settlement proceedings biased against the provider from their inception.

Although there is no evidence that CMS is intentionally prolonging the appeals process, there seems to be little effort to mitigate the immense time a provider must wait for its appeal to be adjudicated. Since timeliness is a requirement of due process, it would be reasonable to require the agency to at least attempt to alleviate the delays providers face.

2. Escalation as a solution

It could be argued that a provider has the option of avoiding the lengthy wait for an ALJ hearing. Since the statutory timeliness requirement for the appeal is not being met, the provider may proceed to the next level of appeal, thereby alleviating the due process violation. Unfortunately, problems remain with that option as well.

As of February, 2014, backlog of appeals was numbered at 480,000.²⁴⁰ If even a small percentage of affected providers exercised the option to move on to the Appeals Council, the appeal level after the ALJ, the problem plaguing the ALJ would merely shift to the

239. Joe Sims & Michael McFalls, *Negotiated Merger Remedies: How Well Do They Solve Competition Problems?*, 69 GEO. WASH. L. REV. 932, 944 (2001).

240. *Medicare Appellant Forum*, *supra* note 152.

Appeals Council. The Appeals Council is not a large entity, adjudicating just under 2,600 appeals during 2013 with 76 employees.²⁴¹ A greater number of reviews before the Appeals Council would delay the process at that level as well. Furthermore, the Appeals Council is not required, although it is allowed by statute, to hold an actual hearing on appeal.²⁴² This may serve as a deterrent to providers looking for a hearing. If there is a chance that the Appeals Council will rule without a hearing, which would just be a repetition of the earlier process, a provider might not want to risk skipping the only step where it will have the opportunity to present, question, and cross-examine witnesses.

Additionally, there are three important reasons for not bypassing the ALJ hearing. First, the hearing is the only step in the process that produces a record and affords the provider the opportunity to present and cross-examine witnesses.²⁴³ It is also the only formal proceeding in the process in which the ALJ issues a written decision.²⁴⁴ The hearing creates a record that decision-makers in the subsequent stages of appeal can reference when reviewing the case; the ALJ hearing is the only step to do so before an appeal reaches the federal district court.²⁴⁵

Secondly, the ALJ presiding over the hearing is the first uninterested party to do so in the process, since the ALJ is part of OMHA, a separate entity from CMS.²⁴⁶ The QIC in the appeal step below and the Appeals Council in the step above are part of CMS and HHS, respectively, and the initial redetermination is made by an employee of the RAC.

Finally, the bulk of Medicare appeals that come before an ALJ are overturned.²⁴⁷ Providers are able to collect the funds that have

241. Rich Marotti, *A Report and Analysis on the OMHA Medicare Appellant Forum and the Suspension of ALJ Hearings for Medicare Providers*, AMERICAN BAR ASSOCIATION (April 2014), www.americanbar.org/publications/aba_health_esource/2013-14/april/omha_medicare.html.

242. 42 C.F.R. § 405.1108 (2011).

243. *Your ALJ Hearing*, HHS.GOV, <http://www.hhs.gov/omha/Coverage%20and%20Claims%20Appeals/Your%20ALJ%20Hearing/hearing.html>; Mariotti, *supra* note 241.

244. *Medicare Appeals Process*, MEDICARE CMS.GOV, 9 (Aug. 2014), <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MedicareAppealsProcess.pdf>.

245. Marotti, *supra* note 241.

246. *Id.*

247. AMERICAN HOSPITAL ASSOCIATION, *supra* note 95, at 3.

been recouped once the ALJ determines the denial was in error, presumably making many providers willing to wait a little longer to ensure the availability of this step.

3. Burdens of judicial review

If the Appeals Council appeal is not performed in a timely manner, providers have the chance to bypass this step.²⁴⁸ Providers may escalate the dispute to the courts, starting in the federal district court.²⁴⁹ Although this action may satisfy due process, it imposes additional burdens on the providers.

Time is a fairly obvious burden on the provider during the appeals process. Clearly, time is not a friend to a provider who is being forced to fight with CMS over money he earned during the treatment of a Medicare patient. Once the money has been recouped by CMS, the provider must make do without those funds. In certain cases, a provider may have to close his doors. On the other side, CMS is not burdened at all by the delays. CMS is in possession of the money, and there are no penalties imposed for its failure to act. Even absent any nefarious intent on CMS's part, the process is still unfairly tilted in favor of CMS.

Financial hardship is another genuine burden on providers waiting for their day to be heard. Each step in the appeals process requires the provider to submit additional forms and information, provide notice to all parties to the proceeding, and prepare for any witnesses, cross-examinations, or testimony to be provided. Most providers retain counsel, especially at the ALJ level, and this, of course, costs money. By the time the claim enters federal court, there will inevitably be attorneys involved, and court preparation usually comes at financial expense. Also, any monies in dispute have been or are in the process of being recouped by this point, denying the provider access to that money as well. Although CMS also requires the preparation for a court proceeding as the provider, those costs are small in comparison to its budget, whereas a provider's costs are greater in proportion. Again, the bulk of the burden is solely on the provider.

248. *The Medicare Appeals Process*, *supra* note 28, at 7.

249. *Id.* at 7–8.

4. *Exhaustion and finality*

The Administrative Procedure Act (“APA”)²⁵⁰ is the default governing statute for agencies. Although the APA grants judicial review of agency decisions, it does impose some restrictions on what matters may reach a courtroom,²⁵¹ which could also hinder due process during escalation.

Section 704 of the APA calls for judicial review of “final agency action for which there is no other adequate remedy in a court”²⁵² The concept of exhaustion is a product of common law, and the Supreme Court explained the requirement in *Williamson County Regional Planning Commission v. Hamilton Bank of Johnson City*.²⁵³ The two doctrines of finality and exhaustion are often intertwined, yet the Court clarifies that they are separate and discrete requirements.²⁵⁴

The question whether administrative remedies must be exhausted is conceptually distinct, however, from the question whether an administrative action must be final before it is judicially reviewable. While the policies underlying the two concepts often overlap, the finality requirement is concerned with whether the initial decisionmaker has arrived at a definitive position on the issue that inflicts an actual, concrete injury; the exhaustion requirement generally refers to administrative and judicial procedures by which an injured party may seek review of an adverse decision and obtain a remedy if the decision is found to be unlawful or otherwise inappropriate.²⁵⁵

The absence of either of these requirements may be fatal flaws in cases that are escalated to federal court.

In *McCarthy v. Madigan*, the Court discusses important policy reasons for these doctrines.²⁵⁶ First, it acknowledges that Congress has granted the agency authority to administer its own programs.²⁵⁷ The agency should provide the primary body to right any wrong

250. Administrative Procedure Act, Pub. L. 79-404, 60 Stat. 237 (1946).

251. *Id.* at § 704.

252. *Id.*

253. *Williamson County Regional Planning Comm’n v. Hamilton Bank of Johnson City*, 473 U.S. 172, 192-93 (1985).

254. *Id.*

255. *Id.* (citations omitted).

256. *McCarthy v. Madigan*, 503 U.S. 140, 145 (1992).

257. *Id.*

within the program before being “haled into federal court.”²⁵⁸ Judicial efficiency is also served when an agency can solve its own problems because problems are worked out more cohesively, not in a “piecemeal” manner.²⁵⁹ Lastly, the court found exhausting that the administrative avenues created a record that a judge could refer to in rendering his decision, notably in matters where the agency has significant expertise;²⁶⁰ conversely, the absence of a record from prior proceedings provides nothing for a court to review.

Exhaustion of a RAC audit appeal requires the provider to work his way through the entire appeals process that CMS provides before escalating the matter to federal district court. If the provider has escalated the claim as a result of agency inaction, it would appear that he has technically exhausted all channels of agency review. The possibility remains that a federal judge could see the matter differently. She could disallow this type of appeal altogether, sending it back to the agency and further prolonging the process. One reason a judge may make that type of decision is that without the two-skipped appeals in the record, most notably the ALJ hearing and decision, the judge has little to draw from when analyzing the appeal.

There are three exceptions to the exhaustion requirement: undue prejudice, futility, and lack of effective relief.²⁶¹ The undue prejudice exception could apply to this type of case. A court may waive the exhaustion requirement if it determines that requiring the provider to continue the process with CMS would unduly prejudice the provider’s rights. One example of undue prejudice that the Court has specifically mentioned is “unreasonable or indefinite timeframe for administrative action.”²⁶² That exception may well apply, since CMS has written adjudication timelines, but they are routinely not being met at the ALJ level. Those delays are in essence voiding the timeframes, leaving the providers without adequate remedy.

Even if a court were to exempt exhaustion, finality could also prove fatal to a provider’s case in court. Finality in this instance would entail an ultimate conclusion from CMS that the provider had, in error, received the Medicare funds. If a provider were to

258. *Id.*

259. *Id.*

260. *Id.*

261. *Id.* at 146–48.

262. *Id.* at 147.

escalate from the QIC all the way to the federal district court, he would bypass the final level of agency review, which seems to be the entity that would issue a final order. Without an order from the Appeals Council, a judge reviewing the case may kick it back to the agency for a final conclusion in order to satisfy the doctrine of finality.

VI. SUGGESTED IMPROVEMENTS TO THE RAC PROGRAM

Bills were introduced in Congress in 2012 and 2013 that would have imposed fines on RACs for overturned denials, further limited ADR requests, required CMS to publish RAC statistics, and addressed hospital rebilling issues.²⁶³ Although they contained provisions that would have been a good step in improving the RAC program, neither bill made any headway, never making it out of committee.²⁶⁴

In order to reduce the backlog of cases, CMS will need to devise some new strategies for expeditiously processing RAC appeals and making the process fairer to providers who are in limbo awaiting a final adjudication. CMS could alter the audit process, thereby reducing the number of claims that would be denied. Another set of options arises in the appeals phase. By facilitating an appeals process that finalizes more claims earlier, both the government and the provider will benefit through reduced adjudicatory costs and more satisfaction with the procedure.

A. Proposed Audit Changes

1. Increase ADR minimums

Increasing minimum ADRs forces the RAC to uncover more possible errors before it burdens the provider with a request for production. This will delay the requests until there is a more substantial basis for assuming error. It could also eliminate the requests for some providers altogether, if the audit does not uncover the threshold amount. The new rules issued and enacted in December 2014 improve the state of ADRs, as the maximums

²⁶³ Medicare Audit Improvement Act of 2012, H.R. 6575, 112th Cong. (2012); Medicare Audit Improvement Act of 2013, H.R. 1250, 113th Cong. (2013).

²⁶⁴ *Id.*

were addressed,²⁶⁵ but problems still remain with a lower threshold minimum.

2. Shorten the look-back period for all types of claims

A shortened look-back period would immediately reduce the number of claims denied by the RACs because it would shrink the number of claims they had the ability to review. CMS has already addressed the unfair look-back period for hospital patient status claims, but a further reduction in the overall look-back allowance for RACs would relieve some of the pressure on the appeals process and allow the current appeals to begin to filter through without adding more at the same or higher rate.

B. Proposed Appeals Changes

1. Delay recoupment

Recoupment begins upon the issuance of an affirming opinion at the QIC.²⁶⁶ During the current backlog of twenty-eight months that a provider must wait for its appeal to be heard by an ALJ,²⁶⁷ the next appeal level, Medicare begins recoupment of funds.²⁶⁸ Since the ALJs are not fulfilling their statutory obligation of hearing the cases within 60 days of filing, and a high number of appeals are overturned at this point, CMS should postpone the initiation of recoupment until completion of the ALJ determination.²⁶⁹ This delay would allow for providers' businesses to continue operating in a healthy financial manner, while the delayed appeals process continues.

2. Delay RAC fee payment

Under the current system, RACs have an incentive to not only deny as many claims as possible at the audit stage, but they have an increased incentive to deny any and all redeterminations. No evidence exists that RACs have put this theory into practice; but there is, nonetheless, a concerning percentage of claims that are overturned at higher appeal levels outside of the RAC itself.

265. *Recovery Audit Program Improvements*, *supra* note 165.

266. *The Medicare Overpayment Collection Process*, *supra* note 10, at 3.

267. *Adjudication Timeframes*, *supra* note 146.

268. *Id.*

269. Letter from Rick Pollack, *supra* note 92, at 2–3.

Currently, as long as a denial survives that second level of appeal, the RAC collects the fee upon recoupment.²⁷⁰ Delaying payment until after the QIC is a small step in the right direction, but the RACs may take the penalty more seriously if they have to wait the same length of time as the providers.

Despite possible repayment, it is still in the interest of the RAC to collect as much money as it can as soon as possible. Not only can the RAC collect interest from its collected fees, including those in dispute, but the longer the appeals process goes on, the more likely it is that the provider will give up on the appeal or miss a deadline, thereby invalidating the appeal and guaranteeing the RAC its fee. Since a majority of appeals that reach the ALJ are overturned, the RAC should not be paid its fee on a claim until the appeal survives a hearing at the third level.

3. Auditor penalties²⁷¹

The current penalty structure continues to create perverse incentives for the RACs. Not only are RACs incentivized to review and deny as many claims as possible, but they are also incentivized to deny redeterminations. The recent CMS improvements punish a RAC with ten percent or higher overturns at the first level of appeal, which is conducted by employees of the RAC. It would seem the incentive is now greater to ensure claims are not overturned at this level to avoid the financial penalty. The solution to this continued problem lies in penalties levied against the RAC for high percentages of overturn at appeal levels out of the RAC's control. This incentivizes the RAC to "get it right" at the redetermination.

4. Pre-Appeal Mediation

Mediation is not a component of the present RAC program until the appeals process. Allowing for mediation prior to an appeal could alleviate a lot of the stress on the current appeals system. If the parties are comfortable compromising, it would be wise to allow them to take this step prior to an appeal.

270. See *Recovery Audit Program Improvements*, *supra* note 165.

271. Medicare Audit Improvement Act of 2012, H.R. 6575, 112th Cong. (2012); Medicare Audit Improvement Act of 2013, H.R. 1250, 113th Cong. (2013).

VII. CONCLUSION

It seems clear that the RAC program is broken in the largest of ways. Not only are the processes used questioned by those targeted as well as by public officials, but the procedure to handle adjudication is also not efficiently disposing of the cases. As the backlog grew, the auditors continued to send more and more denials. Now CMS is in a precarious position that it seems nearly impossible to remedy absent a complete halt to the program while the appeals system has a chance to catch up.

That is not to say that the RAC program does not have supporters. Taxpayer groups recognize the amount of money that RAC audits have returned to Medicare, and seem to oppose any limitation placed on the auditors.²⁷² This view holds some validity, as the program does recover legitimate funds. But the cost at which those funds come is too high. A program that so heavily burdens those entrusted to provide medical care to the elderly, especially when facing due process violations, cannot be allowed to continue.

Looking at the situation in its totality, it seems clear on several fronts that providers' due process rights stand a considerable chance of being violated. If the harms were isolated, they would be easier to justify. But when there are possible violations regarding occupational rights and timeliness rights, as well as questionable methods and incentives for denial of claims, topped off with CMS's inability to handle its own adjudication process, it appears that the best solution could range from instituting a major overhaul to cancelling the whole program and starting from scratch.

Because of the complexity and severity of the state of RAC audits and appeals today, none of the suggested improvements will solve the current problems. Permanent solutions will require overhauls not only of the audit procedure, but of the appeals process as well. The

272. .See Alexandra Booze & Leslie Paige, *CCAGW Opposes Rep. Graves' Medicare Oversight Bill, Urges Members Not to Co-Sponsor*, BUSINESS WIRE (February 24, 2014), <http://www.businesswire.com/news/home/20140224006993/en/CCAGW-Opposes-Rep.-Graves%E2%80%99-Medicare-Oversight-Bill#.VExqNIexswc>; Tom Shatz & Pete Sepp, *Prevent the Delay of Recovery Audit Savings in Doc Fix Bill*, COUNCIL FOR CITIZENS AGAINST GOVERNMENT WASTE, (March 26, 2014), <http://ccagw.org/legislative-affairs/letters-officials/prevent-delay-recovery-audit-savings-doc-fix-bill>; Alexandra Booze & Leslie Paige, *CMS Gives Recovery Auditing Program High Marks, Saves Medicare Billions*, BUSINESS WIRE (March 26, 2014), <http://www.businesswire.com/news/home/20140326006563/en/CMS-Recovery-Auditing-Program-High-Marks-Saves#.VExrb4exswc>.

circumstances that lead to the possible violation of provider due process must end, regardless of whether the program is eliminated or is revamped to remove and remedy the circumstances that have undermined the program.

CMS has created a situation where its own actions could lead to a constitutional intrusion on the rights of the providers who care for its beneficiaries. Unfortunately, this situation is dire and in need of immediate attention. Coupled with the desperation of providers for more fair and timely resolutions to appeals, CMS must acknowledge and fix the imperfections in the system that brought it to a standstill.

Mary Squire