



# Medicare's Recovery Audit Contractor (RAC) Program: Background and Issues

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## Summary

Recovery Audit Contractors, or RACs, are private organizations that contract with the Centers for Medicare and Medicaid Services (CMS) to identify and collect improper payments made in Medicare's fee-for-service (FFS) program. CMS projects improper FFS payments to amount to approximately \$10.4 billion or 3.6% of all paid Medicare claims in 2008. Congress originally required the Secretary of the Department of Health and Human Services to conduct a three-year demonstration program using RACs in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, P.L. 108-173). In December 2006, Congress passed the Tax Relief and Health Care Act of 2006 (TRHCA, P.L. 109-432), which made the program permanent and mandated the expansion of RACs nationwide by 2010. CMS began the national rollout of the permanent program in 19 states in March 2009.

CMS initiated the RAC demonstration in March 2005 in three states—California, Florida, and New York. After a preliminary status report revealed that the three participating RACs had returned \$54.1 million to the Medicare Trust Funds during its first year of operation, CMS expanded the demonstration to two additional states—Massachusetts and South Carolina. The agency concluded the pilot in March 2008. According to the final evaluation of the demonstration, the RACs returned \$693.6 million in overpayments to the Medicare Trust Funds over the course of three years.

Throughout the demonstration, CMS continuously highlighted the success of the RAC initiative in protecting the fiscal integrity of Medicare. However, the demonstration and subsequent permanent program have raised concerns among policymakers and industry groups because Medicare pays RACs differently than it pays other administrative contractors. Historically, Medicare's administrative contractors have been paid a fixed annual budget for a defined scope of work. In contrast, Congress mandated that CMS pay RACs using contingency fees. A contingency fee is a negotiated payment, typically a percentage, for every overpayment recovered. Under a contingency fee payment system, contractors receive no additional administrative funding. This type of compensation has been criticized for incentivizing RACs to aggressively audit and deny provider claims.

This report provides an overview of the RAC program along with a brief history of improper payments in Medicare. A description of the medical review processes used by RACs and how it compares with other Medicare administrative contractors is also presented. The report concludes with a discussion of current issues. This report will be updated as needed.

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## Background on Medicare

Medicare, authorized under Title XVIII of the Social Security Act, is the nation's health insurance program for persons aged 65 and older and certain disabled persons.<sup>1</sup> In 2008, Medicare expenditures totaled approximately \$468 billion for 45 million beneficiaries.<sup>2</sup>

Medicare consists of four distinct parts: Parts A, B, C, and D. Medicare Part A (Hospital Insurance) covers inpatient hospital services, skilled nursing facility services, home health, and hospice services. Medicare Part B (Supplementary Medical Insurance) covers a variety of other medical services, such as physician visits, outpatient hospital care, laboratory services, and durable medical equipment. Parts A and B constitute the fee-for-service (FFS) portion of the program, otherwise known as "original" or "traditional" Medicare. Beneficiaries also have the option to enroll in a private Part C or Medicare Advantage (MA) plan to receive Part A and B benefits, and a private Part D or Prescription Drug Plan (PDP) for drug coverage.

The agency responsible for administering Medicare is the Centers for Medicare and Medicaid Services (CMS) at the Department of Health and Human Services (HHS). CMS contracts with a variety of private entities to carry out the day-to-day operations of the program, such as paying provider claims, detecting alleged fraud and abuse, and overseeing the quality of care delivered to beneficiaries.<sup>3</sup> As opposed to specializing in one particular function, these entities are often responsible for performing multiple administrative activities under one contract. For example, in addition to processing claims, Medicare's administrative contractors may enroll providers in the Medicare program, educate physicians on appropriate billing practices, adjudicate appeals, and identify and recover improper payments.

## Brief Introduction to Improper Payments

An improper payment is any payment that should not have been made or that was made in an incorrect amount. This includes duplicate payments, payments to ineligible recipients, payments for ineligible services, or payments for services not received. In Medicare, improper payments include both underpayments and overpayments to providers and largely result from provider billing mistakes and inadvertent claims processing errors.<sup>4</sup>

Since 1990, the Government Accountability Office (GAO) has declared Medicare at high risk for improper payments and fraud due to its size, scope, and decentralized administrative structure.<sup>5</sup> In

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<sup>1</sup> Of the program's 44 million enrollees, approximately 85% are aged and the remaining 15% are disabled. For an overview of the Medicare program, see CRS Report RL33712, *Medicare: A Primer*, by (name redacted).

<sup>2</sup> Centers for Medicare and Medicaid Services (CMS) Office of the Actuary, *2009 Medicare Trustees Report*. Available at <http://www.cms.hhs.gov/ReportsTrustFunds/downloads/tr2009.pdf>.

<sup>3</sup> For additional information on Medicare contractors' and their varied responsibilities see CRS Report RL34217, *Medicare Program Integrity: Activities to Protect Medicare from Payment Errors, Fraud, and Abuse*, by (name redacted).

<sup>4</sup> Although improper payments may be fraudulent, they are not meant to be a measure of fraud. Generally, fraud involves intentional acts of deception or representation to deceive with knowledge that the action or representation could result in gain.

<sup>5</sup> U.S. Government Accountability Office, *High-Risk Series: An Update*, GAO-09-271, January 2009, p. 5, <http://www.gao.gov/new.items/d09271.pdf>.

2002, Congress enacted the Improper Payments Information Act (IPIA, P.L. 107-300), which requires federal agencies to estimate and report an annual amount of improper payments for all programs and activities.<sup>6</sup> HHS began estimating an error rate for its Medicare FFS program in 1996. At that time, improper payments totaled an estimated \$23.2 billion dollars, or 14.2% of total paid claims. That same year, Congress passed the Health Insurance Portability and Accountability Act (HIPAA, P.L. 104-191), which included provisions designed to increase and stabilize funding for activities directed at reducing health care fraud and improper payments in federal health programs. In addition to creating a Health Care Fraud and Abuse Control (HCFAC) program, HIPAA established the Medicare Integrity Program, or MIP, to decrease improper payments in Medicare.<sup>7</sup> Since 1996, the improper payment rate has progressively declined, reaching \$10.8 billion, or 3.9% of total paid claims in 2007.<sup>8</sup>

## Recovery Audit Contractors (RACs) in Medicare

In the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, P.L. 108-173) Congress authorized a demonstration project for recovery audit contractors (RACs) in Parts A and B of the Medicare program. Recovery auditing is the term used to describe activities directed at identifying and recovering overpayments.<sup>9</sup> The legislation required that the Secretary enter into contracts with RACs for the purpose of identifying Medicare overpayments and underpayments, and recouping overpayments for services for which payment is made under Parts A and B.<sup>10</sup> The legislation also granted CMS the authority to reimburse RACs using contingency fees. A contingency fee is a negotiated payment, typically a percentage, of every overpayment recovered. CMS conducted the demonstration in five states (California, Florida, Massachusetts, New York, and South Carolina) between March 2005 and March 2008. Over the course of three

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<sup>6</sup> The law requires agencies to annually identify programs and activities vulnerable to significant improper payments, estimate the amount of overpayments or underpayments, and report to Congress on steps being taken to reduce such payments. For additional information on the Improper Payment Act see CRS Report RS22587, *Improper Payments Information Act of 2002: A Brief Introduction*, by (name redacted) and (name redacted).

<sup>7</sup> For additional information on Medicare's anti-fraud activities, including HCFAC and MIP, see CRS Report RL34217, *Medicare Program Integrity: Activities to Protect Medicare from Payment Errors, Fraud, and Abuse*, by (name redacted).

<sup>8</sup> Between 1996 and 2002, the HHS Office of the Inspector General (OIG) was responsible for calculating Medicare's improper payment rate. In 2003, CMS took over this responsibility. Over the years the adequacy and accuracy of CMS's calculation of Medicare's improper payment rate has been questioned by the GAO and OIG. In 2006, the GAO reported that reductions in the improper payment rate could not be attributed to improved payment controls, but instead were the result of changes CMS had made to its methodology for calculating the improper payment rate. See GAO Report, GAO-07-92, *Agencies' Fiscal Year 2005 Reporting under the Improper Payments Information Act Remains Incomplete*, November 2006, <http://www.gao.gov/new.items/d0792.pdf>. Most recently, the OIG reported problems with the agency's calculation of the FY2006 and FY2008 improper payment rates for Durable Medical Equipment (DME). In a report released on May 12, 2009, an independent OIG audit of CMS's DME error rate revealed a significantly higher error rate than the rate calculated by CMS. See HHS OIG Report, A-01-09-00500, *Independent Contractor's Review of DME Claims from the FY 2008 Comprehensive Error Rate Testing Program*, May 2009, <http://www.oig.hhs.gov/oas/reports/region1/10900500.pdf>.

<sup>9</sup> In 2003, in a memorandum to the heads of executive departments and agencies, the Office of Management and Budget (OMB) defined a recovery audit as a review and analysis of an agency's books, supporting documents, and other available information that is designed to identify overpayments to contractors due to payment errors. See OMB Memo, *Programs to Identify and Recover Erroneous Payments to Contractors*, M-03-07, January 16, 2003, <http://georgewbush-whitehouse.archives.gov/omb/memoranda/m03-07.html>.

<sup>10</sup> Recoupment is recovering a Medicare overpayment by reducing present or future Medicare payments and applying the amount withheld against the debt.

years, the RACs returned \$693.6 million in overpayments to the Medicare Trust Funds and corrected a total of \$1 billion in improper payments (overpayments and underpayments) at a cost of only 20 cents for every dollar collected, a return of 5 to 1.<sup>11</sup>

Prior to the conclusion of the demonstration, Congress passed the Tax Relief and Health Care Act of 2006 (TRHCA, P.L. 109-432), which made RACs permanent and mandated their expansion nationwide by January 1, 2010. The legislation was passed in December 2006; one month after a preliminary status report on the demonstration was released.<sup>12</sup> The statutory language expanding the RAC program required rather than authorized the Secretary to reimburse RACs using contingency fees. The legislation also granted the Secretary permission to pay RACs for identifying underpayments. Additional requirements include stipulations related to deposits of overpayments, audit and recovery periods, contractor qualifications, and a mandate for an annual performance report.<sup>13</sup> As in the demonstration, RACs are not authorized to look for improper payments in the MA or PDP programs.

On October 6, 2008, CMS announced the national rollout of the permanent program and released the names of the four RAC contractors: Diversified Collection Services (DCS), CGI Technologies, Connolly Consulting Associates, and Health DataInsights (HDI).<sup>14</sup> Beginning in March 2009, the four RACs began reviewing claims for select states in approximately one-fourth of the country. More states will be added to each RAC's jurisdiction as the program expands over the next two years.<sup>15</sup> All providers who receive payment under Medicare Parts A and B are subject to a RAC audit, including inpatient hospitals, physicians, skilled nursing facilities, inpatient rehabilitation facilities, DME suppliers, home health agencies, and other Part A or B providers.

The RACs were to begin conducting outreach for the permanent program in November 2008. However, shortly after announcing the names of the four new RACs, CMS imposed an automatic stay on the implementation of the nationwide program after two unsuccessful bidders for a RAC contract—Viant Payment Systems and PRG Schultz—filed a protest with the GAO. Viant and PRG, which served as RACs in the demonstration program, have subsequently settled their protest with the agency and are now acting as subcontractors for the permanent RACs. **Table 1** lists the regions and initial 19 states served by each of the four RAC contractors.

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<sup>11</sup> U.S. Congress, House Committee on Small Business, Subcommittee on Regulations, Health Care, and Trade, *The Impact of CMS Regulations and Programs on Small Healthcare Providers*, Testimony of Tim Hill, Director of Office of Financial Management, CMS, 111<sup>th</sup> Cong., 2<sup>nd</sup> sess., May 14, 2008.

<sup>12</sup> The first report released in November 2006 indicated that RACs operating in California, Florida, and New York returned \$54.1 million to the Medicare Trust Funds in year one (FY2006). Subsequent status reports indicated returning \$247.4M in year two of the demonstration (FY2007) and \$693.6 million over the course of the three-year demonstration (March 2005-March 2008). All status reports can be accessed on the CMS website at [http://www.cms.hhs.gov/RAC/02\\_ExpansionStrategy.asp](http://www.cms.hhs.gov/RAC/02_ExpansionStrategy.asp).

<sup>13</sup> The statute requires that the Secretary retain a portion of amounts recovered in its program management account to support the activities of the recovery audit contractor program. Remaining recoveries are to be applied to reduce expenditures under parts A and B.

<sup>14</sup> CMS, "CMS Announces New Recovery Audit Contractors to Help Identify Improper Medicare Payments," press release, October 6, 2008, [http://www.cms.hhs.gov/apps/media/fact\\_sheets.asp](http://www.cms.hhs.gov/apps/media/fact_sheets.asp).

<sup>15</sup> For a map of the states included in each region visit the CMS website at <http://www.cms.hhs.gov/RAC/Downloads/Four%20RAC%20Jurisdictions.pdf>.

**Table I. States Covered by Each RAC Contractor**

Region	Contractor	States
A	Diversified Collection Services (DCS) with subcontractor PRG Shultz	Maine, Massachusetts, New Hampshire, New York, Rhode Island, Vermont
B	CGI Technologies and Solutions with subcontractor PRG Shultz	Michigan, Indiana, Minnesota
C	Connolly Consulting Associates with subcontractor Viant Payment Systems	Colorado, Florida, New Mexico, and South Carolina
D	Health Data Insights with subcontractor PRG Shultz	Arizona, Montana, North Dakota, South Dakota, Wyoming, Utah

**Source:** CMS Website on RACs. Available at <http://www.cms.hhs.gov/RAC/>.

## Claims Review Process Used by RACs

To identify improper payments, RACs are instructed to use a combination of both automated and complex review processes.<sup>16</sup> Under automated review, there is no human review of the claim or medical record. Computer edits within the claims processing system automatically check claims for evidence of improper coding or mistakes. RACs may use automated review only when the following two conditions are met: (1) there is certainty that the service is not covered by Medicare, and (2) there exists a written Medicare policy, such as a Medicare statutory provision, regulation, national or local coverage determination,<sup>17</sup> or manual instruction that specifies the circumstances under which a service will not be covered by Medicare. RACs may also use Medicare articles or coding guidelines approved by CMS to serve as the basis for an automated review.

In the absence of written Medicare policy, RACs are required to perform complex review. Complex review involves human review of the medical record and other documentation supporting the claim. RACs must use complex review in situations where there is a high probability that the claim contains an overpayment. They are also instructed to refer to appropriate medical literature and clinical judgment when making complex claim determinations. Although there is no specific requirement that RACs consult with physicians when conducting complex review, CMS does mandate that RACs use nurses and certified coders to review all medical records. All Medicare administrative contractors, including RACs, are required to employ one full-time medical director to oversee the claims review process. Although this was

<sup>16</sup> The following types of claim determinations may be considered improper by a RAC: (1) claims that were incorrectly coded, (2) claims resulting from incorrect payment amounts, (3) claims for services that do not meet Medicare's coverage criteria (i.e., services that are considered medically unnecessary), and (4) claims for services that were already provided (duplicate claims). Final Request for Proposal (RFP) or Statement of Work (SOW) for Recovery Audit Contractors. RFP-CMS-2007-0022. Amended version dated November 7, 2007. Available on CMS website at [http://www.cms.hhs.gov/RAC/01\\_Overview.asp#TopOfPage](http://www.cms.hhs.gov/RAC/01_Overview.asp#TopOfPage).

<sup>17</sup> Medicare makes coverage decisions at the national and local level. National Coverage Determinations or NCDs are national policy statements issued by the central office which grant, limit, or exclude Medicare coverage for a specific medical service, procedure, or device. Local Coverage Determinations or LCDs are coverage decisions made at the local level by Medicare's claims administration contractors. LCDs are only binding on a contractor's local service area. The majority of Medicare's coverage determinations are made at the local level.

not a requirement for the RACs during the demonstration program, it has been mandated for the permanent program.

To select claims for review, RACs utilize data analysis. Although the actual data analysis techniques used by the contractors is proprietary, the process typically involves examining billing histories of providers to identify unusual or suspicious claims and comparing billing patterns to peers in a provider group to identify aberrancies. RAC contractors are also encouraged to review reports prepared by the HHS Office of Inspector General (OIG) and the GAO to identify claims likely to contain improper payments.

## **Comparison of Claims Review Processes Between RACs and Other Medicare Administrative Contractors**

There are other contractors that review Medicare claims for improper payments as part of their administrative responsibilities. These include Medicare Administrative Contractors (MACs), Fiscal Intermediaries (FIs), and Carriers;<sup>18</sup> Medicare's Comprehensive Error Rate Testing, or CERT, contractor; Program Safeguard and Zone Program Integrity Contractors (PSCs and ZPICs); and Quality Improvement Organizations or QIOs.<sup>19</sup> All of these contractors have the authority to review any claim they suspect may be improper, subject to certain limitations. An improper payment determination may be made for claims that were incorrectly coded, claims for services that were not medically necessary, claims resulting from incorrect payment amounts, and claims for services that were already provided (duplicate claims).

Although the claims review processes followed by RACs is relatively similar to that of other Medicare contractors, there are some differences. For example, MACs, FIs, Carriers, PSCs, and ZPICs can review claims prior to payment, otherwise known as pre-payment review. RACs, the CERT contractor, and QIOs can only review claims post-payment.

Additionally, the statute and CMS have set restrictions on how many years contractors can "look-back" and select claims for review. These time periods are called "look-back" periods. Unless there is evidence of fraud, Medicare regulations prohibit contractors from reviewing claims more than four years past the date the claim was initially paid. During the demonstration program, the

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<sup>18</sup> MACs process claims for Part A and B providers, FIs process claims for Part A providers, and Carriers process claims for Part B providers. In the Medicare Prescription Drug, Improvement, and Modernization Act (MMA, P.L. 108-173), Congress required the Secretary to reform its administrative contracting procedures. CMS refers to these legislatively mandated changes as contracting reform. Under contracting reform, the agency is gradually replacing the 40+ FIs and Carriers with 19 MACs. As of January 2009, CMS had awarded all 19 MAC contracts for participation in the Medicare program.

<sup>19</sup> MACs, FIs, and Carriers process and pay provider claims. Medicare's CERT contractor is responsible for measuring and reporting Medicare's improper payment rate. PSCs and ZPICs are Medicare's anti-fraud contractors, and QIOs monitor the quality of care delivered to beneficiaries. As of August 1, 2008, QIOs are no longer responsible for reviewing inpatient hospital claims. This responsibility has now been transferred to MACs and FIs. However, the QIOs will remain responsible for performing quality of care reviews, hospital-requested higher-weighted DRG reviews, reviewing beneficiary appeals, and EMTALA (anti-dumping) reviews. For additional information on Medicare contractors' and their varied responsibilities see CRS Report RL34217, *Medicare Program Integrity: Activities to Protect Medicare from Payment Errors, Fraud, and Abuse*, by (name redacted).



RACs were authorized to review claims in accordance with this four-year look-back period. However, in response to concerns from providers that RAC requests for medical records were becoming too burdensome, CMS reduced the claim look-back period from four to three years in the permanent program. Medicare's other administrative contractors will still be allowed to look-back four years. In the permanent program, RACs will also be prohibited from reviewing any claim paid prior to October 1, 2007.

Finally, CMS manual instructions direct certain administrative contractors to use physician consultants and other health professionals in the various specialties as necessary to perform complex review of medical documentation. This is not a requirement for RACs. **Table 2** highlights the similarities and differences among the various contractor claims review processes.

**Table 2. Comparison of Medicare Contractors' Claims Review Processes**

	<b>RAC</b>	<b>MAC, FI, Carrier</b>	<b>CERT</b>	<b>PSC, ZPIC</b>	<b>QIO</b>
When claims can be selected for review	Post-payment	Pre-payment and post-payment	Post-payment	Pre-payment and post-payment	Post-payment
Claim look-back period	Up to three years; not before October 1, 2007	Up to four years	Up to four years	Up to four years	Up to four years
Medical Director	Required	Required	Required	Required	Required
Staffing requirements for claims review	Nurses, therapists, and certified coders	Nurses and therapists; physician consultants and other health professionals in the various specialties as needed	Nurses and therapists; physician consultants and other health professionals in the various specialties as needed	Nurses and therapists; physician consultants and other health professionals in the various specialties as needed	Nurses and therapists; physician consultants and other health professionals in the various specialties as needed

**Source:** CRS Analysis of CMS Manual Instructions, RAC SOW, and CMS documentation related to Medicare's claims review programs.

## Concerns Related to the RAC Program

### Payment

The RAC legislation provided CMS with the authority to pay RACs differently than it pays other administrative contractors. Historically, Medicare has paid its contractors using cost-based contracts. Under a cost-based contract, Medicare reimburses organizations for all necessary and proper costs incurred during the year. In contrast, the MMA legislation required that the Secretary pay RACs on a contingency basis. Under a contingency-based contract, contractors are paid a

percentage of every overpayment they identify and collect from the provider.<sup>20</sup> They receive no additional funding as part of the contract.

This is the first time a contingency fee reimbursement mechanism has been used in the Medicare program to pay a contractor. CMS would not release data on the fees paid to each RAC during the demonstration program, asserting that the information was proprietary and therefore not disclosable. However, the agency did decide to make public the contingency percentages for each of the four permanent RACs, which range from 9.0% to 12.5% for each contractor.<sup>21</sup> According to CMS, RAC contracts were competitively awarded to the organization that met the agency's technical standards, such as knowledge of Medicare billing and coverage policies, and bid the lowest contingency percentage for a particular region.<sup>22</sup>

Opponents of the program charge that paying contractors on a contingent basis creates an incentive for RACs to aggressively audit and deny claims. Provider groups such as the American Hospital Association (AHA) and the American Medical Association (AMA) have requested that CMS remove the contingency fee payment structure and compensate RACs as they do other Medicare contractors—by paying them a fixed annual amount for a defined scope of work.<sup>23</sup> This concern was magnified during the demonstration program because participating RACs were allowed to retain their contingency fees even if their overpayment determinations were overturned on appeal. CMS subsequently changed this in the permanent program. RACs are now required to return contingency fees for all overpayment determinations overturned on appeal.

Opponents also assert that a contingency fee compensation mechanism encourages RACs to inaccurately or inappropriately deny claims. In May 2007, a California House Delegation led by Representative Lois Capps and Deven Nunes wrote to CMS indicating that Inpatient Rehabilitation Facilities (IRFs) in California were reporting nearly universal denial rates associated with admissions for joint replacement procedures during the RAC demonstration.<sup>24</sup> In response, CMS hired an independent validation contractor to re-review a sample of the RAC's determinations. After the independent validation contractor disagreed with the RAC's denials in 40% of the cases, CMS directed the RAC to stop its review of IRF claims in California.<sup>25</sup> On November 7, 2007, Representative Lois Capps introduced the Medicare Recovery Audit Contractor Program Moratorium of 2007 legislation (H.R. 4105), which would have placed a one-year moratorium on the implementation of the RAC program. The bill was referred to the House

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<sup>20</sup> RACs are also paid a fee for every underpayment they identify and return to providers.

<sup>21</sup> See CMS Website on Recent Updates on the RAC program for the agency's announcement on the RAC contingency fees: [http://www.cms.hhs.gov/RAC/03\\_RecentUpdates.asp](http://www.cms.hhs.gov/RAC/03_RecentUpdates.asp).

<sup>22</sup> Individual communication with Division of Recovery Audit Operations at CMS, and RAC Request for Proposals (RFP). Amendment #3. RFP-CMS-2007-0022. November 28, 2007. Accessible at FedBizOpps.Gov website: [https://www.fbo.gov/index?s=opportunity&mode=form&id=5c8c7d4b00249ba579d4d77d64bd0aea&tab=core&\\_cview=1](https://www.fbo.gov/index?s=opportunity&mode=form&id=5c8c7d4b00249ba579d4d77d64bd0aea&tab=core&_cview=1).

<sup>23</sup> Letter to Chairman Rangel, Chairman Stark, Representative Capps, and Representative Nunes from the American Hospital Association (AHA), California Hospital Association, and Healthcare Association of New York State. December 10, 2007; and testimony of the American Medical Association (AMA). May 14, 2008. House Small Business Committee Subcommittee on Regulations, Healthcare, and Trade. Hearing. The Impact of CMS Regulations and Programs on Small Healthcare Providers.

<sup>24</sup> A copy of the letter and press release can be accessed on Congresswoman Lois Capps's website at [http://www.house.gov/list/speech/ca23\\_capps/morenews/pr\\_070605medicareaudits.shtml](http://www.house.gov/list/speech/ca23_capps/morenews/pr_070605medicareaudits.shtml).

<sup>25</sup> PRG-Shultz, the subcontractor to three of the four RACs selected to participate in the demonstration program, was the RAC for California in the demonstration program.

Committee on Energy and Commerce and the Committee on Ways and Means but did not become law.

In response to provider concerns, CMS will be requiring all RACs to request permission before beginning an audit related to a particular payment issue. The agency has also hired a RAC validation contractor to perform accuracy reviews on a sample of randomly selected overpayments identified by each RAC.<sup>26</sup> At a minimum, this audit would be performed annually. The results of the accuracy audit would not directly affect the RAC contingency fees but would be one of the performance metrics used to evaluate the RAC's effectiveness.

## **Trust Fund Recoveries**

Throughout the three-year demonstration, RACs returned \$693.6 million to the Medicare Trust Funds and corrected more than \$1.03 billion in improper payments.<sup>27</sup> Provider groups claim that this overstates the actual net savings to the Trust Funds. At the time the final RAC evaluation was released there were still appeals pending, which were not accounted for in the final numbers. The appeals process can take months to years, depending on the provider's willingness to appeal to higher levels, meaning that funds initially recouped and returned to the Trust Funds may then have to be paid back to the provider. Further, provider groups assert that providers that do appeal an overpayment determination are often successful.

The final evaluation of the RAC demonstration indicates that providers appealed 14% of the total number of overpayment determinations made by the RACs (525,133 out of 1,167.9 million reviewed claims). Out of the overpayments that were appealed, 33% were overturned in the provider's favor. CMS has since updated the evaluation report with more recent appeals statistics.<sup>28</sup> As of August 31, 2008, providers chose to appeal 22.5% of the total number of overpayment determinations made by the RACs, up from 14% at the conclusion of the demonstration. The percentage of appealed claims decided in the provider's favor rose slightly from 33% to 34%. Additionally, out of the total number of appeals, the percentage overturned and decided in the provider's favor increased from 4.6% to 7.6%. The agency plans to release a final report with updated numbers on the total dollar value returned to the Trust Funds in the coming months.

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<sup>26</sup> See CMS Website on Recent Updates on the RAC program: [http://www.cms.hhs.gov/RAC/03\\_RecentUpdates.asp](http://www.cms.hhs.gov/RAC/03_RecentUpdates.asp).

<sup>27</sup> CMS, *The Medicare Recovery Audit Contractor (RAC) Program: An Evaluation of the 3-Year Demonstration*, June 2008, <http://www.cms.hhs.gov/RAC/Downloads/RAC%20Evaluation%20Report.pdf>. This is the final net savings after accounting for approximately \$40 million paid in underpayments, the total costs to operate the RAC program (\$201.3M), and \$46 million returned to providers on appeal, and \$14 million in re-review of IRF claims.

<sup>28</sup> See Updates to the Evaluation of the 3-Year RAC Demonstration. September 2008 and January 2009. Available at [http://www.cms.hhs.gov/RAC/02\\_ExpansionStrategy.asp#TopOfPage](http://www.cms.hhs.gov/RAC/02_ExpansionStrategy.asp#TopOfPage).

**Table 3. Provider Appeals of RAC Overpayments**

	<b>Total # of Overpayments</b>	<b># of Overpayments Appealed at any Level</b>	<b>% of Overpayments Appealed at any Level</b>	<b># of Appeals Decided in Provider's Favor</b>	<b>% of Appeals Decided in Provider's Favor</b>	<b>Total % of Overpayments Decided in Provider's Favor</b>
3-Year Evaluation (as of 3/27/08)	525,133	73,266	14%	24,376	33.3%	4.6%
September 2008 Appeals Update (as of 6/30/08)	525,133	102,705	19.6%	35,819	34.9%	6.8%
January 2009 Appeals Update (as of 8/31/08)	525,133	118,051	22.5%	40,155	34.0%	7.6%

**Source:** The Medicare Recovery Audit Contractor (RAC) Program: An Evaluation of the 3-Year Demonstration released in June 2008 and Updates to the Evaluation of the RAC Program released in September 2008 and January 2009.

## Recoupment

Medicare regulations grant the Secretary the authority to recoup overpayments made to Medicare providers.<sup>29</sup> In 2003, Congress set limitations on the Secretary's authority to recoup overpayments with Section 935 of the MMA. Prior to the MMA, Medicare had the authority to recoup an overpayment regardless of whether or not the provider had elected to appeal the overpayment determination. Medicare would then repay the overpayment if the provider was successful in his or her appeal. Section 935 of the MMA restricts the Secretary from recouping overpayments, if an appeal has been initiated, until a decision has been made at the second level of the appeals process. CMS manual instructions, however, require that providers wishing to delay or prevent recoupment of an overpayment file a valid appeal within 30 days from the date they receive an overpayment demand letter.<sup>30</sup> If they do not file an appeal within 30 days, CMS reserves the right to initiate recoupment on day 41 after the demand letter is sent. CMS contends that while Medicare providers still have the statutorily mandated 120 days to file a first level appeal, the Secretary maintains the authority to begin recouping those funds prior to the 120 days.<sup>31</sup> However, at any time during those 120 days if a provider files an appeal, the Secretary must stop recoupment proceedings.

Certain providers assert that CMS's requirement that providers file an appeal within 30 days of the initial overpayment determination to delay recoupment is in conflict with Section 935 of the MMA. In July 2008, over 30 hospitals in South Carolina filed a complaint against the Secretary alleging that CMS had unlawfully recouped \$30 million in alleged overpayments identified during a RAC audit. The hospitals claim that CMS recouped these overpayments prior to their receiving a decision at the second level of the appeals process. According to the complaint, the

<sup>29</sup> 42 CFR 405.371

<sup>30</sup> CMS. Medicare Financial Management Manual. Chapter 3 - Overpayments. <http://www.cms.hhs.gov/manuals/downloads/fin106c03.pdf>.

<sup>31</sup> In accordance with Section 1869 of the SSA, providers wishing to contest an overpayment determination have 120 days from the date of the initial determination on a claim to file an appeal.

hospitals did not receive an overpayment demand letter from the RAC in time to issue a valid appeal and stay recoupment proceedings. The hospitals also contend that Section 935 of the MMA precludes recoupment entirely until a provider has an opportunity to appeal at both the first and second levels of the appeals process. In September 2006, CMS published a proposed rule implementing the limitation on recoupment. Two years later, in September 2008, CMS issued a change request detailing instructions for the rule's final implementation.<sup>32</sup>

## **Provider Burden**

After identifying claims likely to contain improper payments, RACs may request medical records from the provider to substantiate a claim. During the demonstration, provider groups maintained that RAC audits were onerous to providers, sometimes requiring they respond to multiple medical record requests over the course of several weeks. In addition to copying and sending medical records to the RAC, providers must also complete the paperwork to initiate an appeal if they disagreed with the RAC's determination. Providers assert that RAC audits are time-consuming and take providers away from patient care. They are particularly burdensome for single practitioners or small group practices that sometimes have to close their offices to respond to an audit request.

CMS has made certain changes to the permanent program that may alleviate some of these concerns. For example, during the demonstration, RACs were allowed to set their own limits on medical record requests. In October 2008, CMS released the maximum number of records RACs can request in 2009. The limits range from 10-50 medical records in a 45-day time period for certain physician types to 10% of the average claims paid per month for inpatient hospitals, skilled nursing facilities, inpatient rehabilitation facilities, and hospices (up to a maximum of 200) per 45 days.<sup>33</sup> Although the limits are smaller for smaller provider types, certain practitioners remain concerned because the limits apply to each provider's National Provider Identifier (NPI). The NPI is a unique provider billing number that applies to all health care providers. Because some providers, particularly facilities such as hospitals, have multiple NPIs the medical record requests could continue to be administratively burdensome. CMS intends to further clarify its medical record policy related to facilities with multiple NPIs in the coming months.

## **Upcoming Evaluations**

On July 11, 2008, John Dingell, Chairman of the House Energy and Commerce Committee; Charles Rangel, Chairman of the House Ways and Means Committee; Pete Stark, Chairman of the House Ways and Means Subcommittee on Health; Frank Pallone, Chairman of the House Energy and Commerce Subcommittee on Health; and Representative Lois Capps wrote a letter to the GAO requesting that the agency undertake a study of the RAC program. As part of its study, the GAO will be examining any actions CMS is taking to prevent future improper payments in high-

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<sup>32</sup> See CMS Proposed Rule, 71 FR 55404, and September 22, 2006. Limitation on Recoupment of Provider and Supplier Overpayments. The change request can be accessed at <http://www.cms.hhs.gov/Transmittals/downloads/R141FM.pdf>.

<sup>33</sup> For more detailed information on the Medical Record Limits for RACs see the following CMS Fact Sheet: <http://www.cms.hhs.gov/RAC/Downloads/RAC%20Medical%20Record%20Request%20Limits.pdf>.

risk areas identified during the demonstration as well as the agency's plans for the ongoing monitoring and oversight of its RAC contractors. The OIG is also conducting a study of the RAC initiative, which is expected to be completed in March 2010.

## Concluding Observations

Improper payments pose a significant risk to Medicare. In FY2010, Medicare spending is expected to exceed \$500 billion for approximately 47 million elderly and disabled beneficiaries.<sup>34</sup> Excluding improper payments in the Part C and D programs, overpayments in Medicare FFS amount to over \$10 billion annually.

Historically, CMS has relied on its claims administration contractors to reduce improper payments in the Medicare program. However, shortly after HHS began reporting the first Medicare improper payment rate in 1996, concerns surrounding the contractors' effectiveness at safeguarding the program began to emerge. As noted by various experts, at least one contributing factor to the perceived weakness in this area was budget constraints and the lack of incentives for contractors to direct specific efforts at reducing payment errors.<sup>35</sup> Prior to the MMA, which mandated contracting reform, Medicare statute precluded CMS from offering financial incentives to its contractors to improve performance. Contractors were paid under cost-based contracts, which prohibited them from making a profit. Additionally, these entities were evaluated based on their ability to pay claims quickly and efficiently and not necessarily accurately. Therefore the RAC program, which authorizes the use of payment incentives to reimburse contractors, could be viewed as an opportunity for CMS to enhance its program integrity efforts.

On the other hand, paying contractors a fee for every improper payment they identify and recover has many policymakers and provider groups concerned. Results from the demonstration showed that while the RACs were successful in returning millions of dollars to the Medicare Trust Funds, some of their audits were inaccurate and overly burdensome for providers, raising questions about CMS's oversight of the program. The agency has since made a number of changes to the permanent program to mitigate some of these concerns, such as requiring RACs to return all contingency fees for overpayments overturned on appeal, hiring a validation contractor to review RAC audits, and setting limits on the number of medical records RACs can request from providers at one time. However, anxiety among providers remains. As the roll-out of the permanent program unfolds, results of the upcoming GAO and OIG evaluations will likely be critical to helping policymakers assess the pros and cons of using recovery audit contractors in Medicare.

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<sup>34</sup> DHHS, Fiscal Year 2010, Budget in Brief, May 7, 2009. Available at <http://www.hhs.gov/asrt/ob/docbudget/2010budgetinbrief.pdf>.

<sup>35</sup> David A. Hyman, "HIPAA and Health Care Fraud: An Empirical Perspective," *CATO Journal*, Spring/Summer 2002, pp. 151-178. Thomas H. Stanton, "Fraud-And-Abuse Enforcement in Medicare: Finding Middle Ground," *Health Affairs*, July/August 2001, pp. 28-42. GAO-01-817, Medicare Management: CMS Faces Challenges to Sustain Progress and Address Weaknesses, p. 21. Available at <http://www.gao.gov/new.items/d01817.pdf>.

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