The Medicare Recovery Audit Contractor (RAC) Program:

Update

to the Evaluation of the

3-Year Demonstration

January 2009

Purpose

The purpose of this report is to evaluate the RAC demonstration and to share with all interested parties information about the demonstration. This January revision serves to update information reported in the Evaluation report released in July 2008, which included information through March 27, 2008. This report includes updated appeals statistics through August 31, 2008. This report includes information primarily on Claim RACs only; however some tables include data on both Claim and MSP RACs. CMS will continue to update this information on a regular basis until all appeals have completed the appeals system. At that time CMS will release a full update to the Demonstration Evaluation Report, including updated cost and collection information.

Background

In Section 306 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), Congress directed DHHS to conduct a 3-year demonstration using RACs to detect and correct improper payments in the Medicare FFS program. Congress gave CMS the authority to pay each RAC on a contingency fee basis, which is a percentage of the improper payments corrected by the RACs.

CMS designed the RAC Program to:

1) Detect and correct *past* improper payments in the Medicare FFS program; and

2) Provide information to CMS and Medicare contractors that could help protect the Medicare Trust Funds by preventing *future* improper payments thereby lowering the Medicare FFS claims payment error rate.

CMS held a full and open competition to competitively select three RACs for the demonstration. Initially each RAC was given a single State jurisdiction. California, Florida, and New York were selected for the demonstration because they are the largest States in terms of Medicare utilization. PRG-Schultz (PRG) was awarded the contract for California, HealthDataInsights (HDI) was awarded the contract for Florida, and Connolly Consulting was awarded the contract for New York. Each jurisdiction was expanded by one State in the summer of 2007 to include Arizona, South Carolina, and Massachusetts.

Results of the RAC Demonstration

RACs succeeded in correcting more than $1.03 billion of Medicare improper payments (see Table JU4). Approximately 96 percent of these improper payments were overpayments collected from providers, while the remaining 4 percent were underpayments repaid to providers.

Table JU4: Improper Payments Corrected by the RAC Demonstration: Cumulative through 3/27/08, Both Claim RACs and MSP RACs (Million Dollars)

RAC	Overpayments Collected	Underpayments Repaid	Total Improper Payments Corrected
Connolly	$266.1	$4.3	$270.4
HDI	$396.1	$20.8	$416.9
PRG	$317.8	$12.7	$330.5
Claim RAC Subtotal	***$980.0***	***$37.8***	***$1,017.8***
HMS	$1.3	$0.0	$1.3
DCS	$11.4	$0.0	$11.4
MSP RAC Subtotal	***$12.7***	***$0.0***	***$12.7***
Grand Total	**$992.7**	**$37.8**	**$1,030.5**

Source: For Claim RACs, RAC invoice files and RAC Data Warehouse. For MSP RACs, Treasury Deposit Slips.

Updated Appeals of RAC Determinations

From the inception of the RAC demonstration through August 31, 2008, providers chose to appeal 22.5 percent (118,051) of the RAC determinations. Overall, the data indicate that of all the RAC overpayments determinations (525,133), only 7.6 percent (40,115) were overturned on appeal (see Table JU7). Appendix JUL includes more detailed data on appeals.

Table JU7: Provider Appeals of RAC-Initiated Overpayments: Cumulative through 8/31/08, Claim RACs Only

Number of claims with overpayment determinations	525,133
Number of claims where provider appealed (any level)	118,051
Number of claims with appeal decisions in provider's favor	40,115
Percentage of appealed claims with a decision in provider's favor	34.0%
Percentage of claims overturned on appeal	7.6%

Source: RAC invoice files, RAC Data Warehouse, and data reported by the Administrative Qualified Independent Contractor (AdQIC) and Medicare claims processing contractors.

The table above includes 1,219 Part A appeals and 7,398 Part B appeals reported by the AdQIC that cannot be attributed to a specific RAC. Because the QIC appeals system does not track the affiliated RAC who reviewed the initial claim, appeals staff must match the RAC jurisdiction with the location of the provider listed on the appeal. Discrepancies in billing provider vs. rendering provider, chain providers, and/or poor data entry can contribute to these unknown cases. System changes in appeals reporting are being implemented for appeals tracking in the RAC permanent program. Also, CMS is not able to determine the number of appeals pending at the first level. CMS believes that the majority of first-level appeals of RAC determinations should have been filed by July 1, 2008. For this reason, the tables in this report will continue to be updated until all appeals have completed the appeals system.

Preventing Future Improper Payments

Future improper payments can be avoided by analyzing the RACs' service-specific findings. CMS can use this information to implement more provider education and outreach activities or establishing new system edits, with the goal of preventing future improper payments. Hospitals and other health care providers can use this information to help ensure that they are submitting correctly coded claims for services that meet Medicare's coding and medical necessity policies.

Conclusion

The RAC demonstration was an important tool in helping CMS prepare for and shape the RAC permanent program. This preparation led to the incorporation of several important components of the RAC permanent program, including building cooperative relationships with Medicare claims processing contractors, fraud fighters, the Department of Justice, and appeals entities; contracting with a RAC validation contractor to conduct independent third-party reviews of RAC claim determinations; limiting the claim review look-back period to three years; requiring each RAC to hire a medical director; and conducting significant outreach to providers. CMS will expand the RAC program gradually.

Appendix L

Provider Appeals

Table JUL1: Provider Appeals of RAC-Initiated Overpayments: Cumulative through 8/31/08, Claim RACs only, Part A claims only

Claim RAC	Claims with Overpayment Determinations	# appealed to FI	# appealed to QIC	# appealed to ALJ	# appealed to DAB	# appealed (all levels)	% appealed (all levels)	# favorable to provider (all levels)	% favorable to provider (all levels)	% of all claims overturned on appeal
Connolly	78,698	6,608	1,067	73	18	7,766	9.9%	4,007	51.6%	5.1%
HDI	104,394	24,318	6,053	556	7	30,934	29.6%	11,658	37.7%	11.2%
PRG	91,860	11,868	3,410	1,380	172	16,830	18.3%	2,478	14.7%	2.7%
RAC not known[1]	n/a	0	1,018	201	0	1,219	n/a	443	36.3%	n/a
All RACs	274,952	42,794	11,548	2,210	197	56,749	20.6%	18,586	32.8%	6.8%

Source: RAC invoice files, RAC Data Warehouse, and data reported by the AdQIC and Medicare claims processing contractors. Includes all completed appeals and some pending appeals. This is because some Medicare claims processing contractors cannot distinguish between pending appeals of RAC determinations and pending appeals of other contractor determinations. These statistics are based on appeals that were known to the AdQIC and Medicare claims processing contractors on or before 8/31/08. Any QIC or ALJ appeals processed by the appeal entities or reported to the Medicare claims processing contractors after that date are not included in these statistics.

[1] This table includes 1,219 Part A appeals that cannot be attributed to a specific RAC. See page four for more details.

Table JUL2: Provider Appeals of RAC-Initiated Overpayments: Cumulative through 8/31/08, Claim RACs only, Part B claims only

Claim RAC	Claims with Overpayment Determinations	# appealed to FI	# appealed to QIC	# appealed to ALJ	# appealed to DAB	# appealed (all levels)	% appealed (all levels)	# favorable to provider (all levels)	% favorable to provider (all levels)	% of all claims overturned on appeal
Connolly	31,937	2,244	56	40	0	2,340	7.3%	1,455	62.2%	4.6%
HDI	134,811	31,113	4,332	2,441	1	37,887[2]	28.1%	16,578	43.8%	12.3%
PRG	83,433	12,570	961	146	0	13,677	16.4%	2,642	19.3%	3.2%
RAC not known[3]	n/a	0	6,878	520	0	7,398	n/a	854	11.5%	n/a
All RACs	250,181	45,927	12,228	3,147	1	61,303	24.5%	21,529	35.1%	8.6%

Source: RAC invoice files, RAC Data Warehouse, and data reported by the AdQIC and Medicare claims processing contractors. Includes all completed appeals and some pending appeals. This is because some Medicare claims processing contractors cannot distinguish between pending appeals of RAC determinations and pending appeals of other contractor determinations. These statistics are based on appeals that were known to the AdQIC and Medicare claims processing contractors on or before 8/31/08. Any QIC or ALJ appeals processed by the appeal entities or reported to the Medicare claims processing contractors after that date are not included in these statistics.

[2] In previous reports, HDI Part B appeals statistics were reported by claim line. In this and all future reports, HDI Part B appeals statistics will be reported by claim. This accounts for the decrease in the total number of appeals of HDI claim determinations.

[3] This table includes 7,398 Part B appeals that cannot be attributed to a specific RAC. See page four for more details.

Table JUL3: Provider Appeals of RAC-Initiated Overpayments: Cumulative through 8/31/08, Claim RACs only, Parts A and B claims combined

Claim RAC	Claims with Overpayment Determinations	# appealed to FI	# appealed to QIC	# appealed to ALJ	# appealed to DAB	# appealed (all levels)	% appealed (all levels)	# favorable to provider	% favorable to provider	% of all claims overturned on appeal
Connolly	110,635	8,852	1,123	113	18	10,106	9.1%	5,462	54.1%	4.9%
HDI	239,205	55,431	10,385	2,997	8	68,821	28.8%	28,236	41.0%	11.8%
PRG	175,293	24,438	4,371	1,526	172	30,507	17.4%	5,120	16.8%	2.9%
RAC not known[4]	n/a	0	7,896	721	0	8,617	n/a	1,297	15.1%	n/a
All RACs	525,133	88,721	23,775	5,357	198	118,051	22.5%	40,115	34.0%	7.6%

Source: RAC invoice files, RAC Data Warehouse, and data reported by the AdQIC and Medicare claims processing contractors. Includes all completed appeals and some pending appeals. This is because some Medicare claims processing contractors cannot distinguish between pending appeals of RAC determinations and pending appeals of other contractor determinations. These statistics are based on appeals that were known to the AdQIC and Medicare claims processing contractors on or before 8/31/08. Any QIC or ALJ appeals processed by the appeal entities or reported to the Medicare claims processing contractors after that date are not included in these statistics.

[4] This table includes 1,219 Part A appeals and 7,398 Part B appeals that cannot be attributed to a specific RAC. See page four for more details.