The Medicare Recovery Audit Contractor (RAC) Program:

Update

to the Evaluation of the

3-Year Demonstration

September 2008

Purpose

The purpose of this report is to evaluate the RAC demonstration and to share with all interested parties information about the demonstration. This September 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 June 30, 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 through the fall of 2008. A full update to the Demonstration Evaluation Report, including updated cost and collection information, will be released in late 2008 or early 2009.

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 SU4). Approximately 96 percent of these improper payments were overpayments collected from providers, while the remaining 4 percent were underpayments repaid to providers.

Table SU4: 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 June 30, 2008, providers chose to appeal only 19.6 percent (102,705) of the RAC determinations. Overall, the data indicate that of all the RAC overpayments determinations (525,133), only 6.8 percent (35,819) were overturned on appeal (see Table SU7). Appendix SUL includes more detailed data on appeals.

Table SU7: Provider Appeals of RAC-Initiated Overpayments: Cumulative through 6/30/08, Claim RACs Only

Number of claims with overpayment determinations	525,133
Number of claims where provider appealed (any level)	102,705
Number of claims with appeal decisions in provider's favor	35,819
Percentage of appealed claims with a decision in provider's favor	34.9%
Percentage of claims overturned on appeal	6.8%

Source: RAC invoice files, RAC Data Warehouse, and data reported by Medicare claims processing contractors.

In addition to the data in Table SU7, as of June 30, 2008, there are an additional 1,607 claims (valued at $12.0 million) pending at the ALJ – the third level of appeals (see Table SU9). At this time, 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 be updated on a regular basis through the fall of 2008.

Table SU9: Pending Appeals as of 6/30/08

Level of Pending Appeal	Number of Claims	Value of Claims (Million Dollars)
Pending at ALJ	1,607	$12.0

Source: Administrative Qualified Independent Contractor (AdQIC)

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 SUL1: Provider Appeals of RAC-Initiated Overpayments: Cumulative through 6/30/08, 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	5,207	654	29	0	5,890	7.5%	3,214	54.6%	4.1%
HDI	104,394	16,582	2,098	47	0	18,727	17.9%	6,325	33.8%	6.1%
PRG	91,860	11,849	2,298	339	18	14,504	15.8%	1,091[1]	7.5%	1.2%
All RACs	274,952	33,638	5,050	415	18	39,121	14.2%	10,630	27.2%	3.9%

Source: RAC invoice files, RAC Data Warehouse, and data reported by 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 Medicare claims processing contractors on or before 6/30/08. Any QIC or ALJ appeals reported to the Medicare claims processing contractors after that date are not included in these statistics.

Table SUL2: Provider Appeals of RAC-Initiated Overpayments: Cumulative through 6/30/08, 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	2,226	9	0	0	2,235	7.0%	1,447	64.7%	4.5%
HDI	134,811	47,216	20	0	0	47,236	35.0%	21,232	45.0%	15.8%
PRG	83,433	12,566	1,353	194	0	14,113	16.9%	2,510[2]	17.8%	3.0%
All RACs	250,181	62,008	1,382	194	0	63,584	25.4%	25,189	39.6%	10.1%

Source: RAC invoice files, RAC Data Warehouse, and data reported by Medicare claims processing contractors. Includes all completed appeals and some pending appeals. This is because some Medicare claims processing

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Table SUL3: Provider Appeals of RAC-Initiated Overpayments: Cumulative through 6/30/08, 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	7,433	663	29	0	8,125	7.3%	4,661	57.4%	4.2%
HDI	239,205	63,798	2,118	47	0	65,963	27.6%	27,557	41.8%	11.5%
PRG	175,293	24,415	3,651	533	18	28,617	16.3%	3,601[3]	12.6%	2.1%
All RACs	525,133	95,646	6,432	609	18	102,705	19.6%	35,819	34.9%	6.8%

Source: RAC invoice files, RAC Data Warehouse, and data reported by 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 Medicare claims processing contractors on or before 6/30/08. Any QIC or ALJ appeals reported to the Medicare claims processing contractors after that date are not included in these statistics.

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