STATEMENT OF

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ON

PREVENTING AND RECOVERING MEDICARE PAYMENT ERRORS

BEFORE THE

U.S. SENATE COMMITTEE ON
HOMELAND SECURITY AND GOVERNMENTAL AFFAIRS, SUBCOMMITTEE ON
FEDERAL FINANCIAL MANAGEMENT, GOVERNMENT INFORMATION,
FEDERAL SERVICES, AND INTERNATIONAL SECURITY

JULY 15, 2010

U.S. Senate Committee on Homeland Security and Governmental Affairs,
Subcommittee on Federal Financial Management, Government Information,
Federal Services, and International Security
Hearing on Preventing and Recovering Medicare Payment Errors
July 15, 2010

Chairman Carper, Ranking Member McCain, and distinguished members of the Subcommittee, I thank you for the opportunity to discuss the Recovery Audit Contractor (RAC) program with you today. RACs provide the Centers for Medicare & Medicaid Services (CMS) with an important tool for identifying and correcting improper payments, a goal that we all share.

Background on CMS Programs

Before proceeding, it is helpful to consider the context in which the RAC program operates. As you know, CMS is the Federal agency responsible for oversight of Medicare, Medicaid, and the Children's Health Insurance Program (CHIP). Through these three programs, CMS is responsible for providing health care to more than 100 million beneficiaries and expends more than $700 billion per year.[1] Medicare and Medicaid alone account for 35 cents of each health care dollar spent in the United States.[2]

While CMS administers and has general oversight over these health insurance programs, they each operate differently through a combination of direct federal administration, contracts with private insurers, and partnerships with the States. These statutory design differences require CMS to contract or work with very different entities. For instance, Medicare is a multifaceted program, with four distinct parts to provide benefits to Medicare beneficiaries. The traditional, Medicare fee-for-service (FFS) program, Parts A and B, provides hospital and medical insurance and uses a number of different payment systems to directly reimburse more than one million health care providers and suppliers such as hospitals, physicians, skilled nursing facilities, labs, ambulance companies, and durable medical equipment (DME) suppliers. Meanwhile, CMS also contracts with hundreds of different private insurance plans to provide full Medicare Part A and B benefits and additional benefits under a managed care benefit, referred to as Medicare

[1] Budget in Brief, Fiscal Year 2011, U.S. Department of Health & Human Services, page 51.
[2] National Health Expenditures data 2009.

Advantage or Part C. In addition, CMS administers hundreds of different contracts with insurance plans that provide outpatient prescription drug coverage under the Part D benefit.

While CMS administers "the Medicaid Program" and "CHIP," it is important to remember that Medicaid and CHIP are essentially more than 50 individualized programs, in which CMS works with each State and Territory to administer a program that meets the particular health care needs and level of benefits established by that jurisdiction, within Federal guidelines.

Improper Payments and the Medicare Program

Like other large Federal programs, Medicare and Medicaid are susceptible to errors—typically called "improper payments." These improper payments represent a fraction of total program spending; however, given the staggering size of overall program expenditures, even a small percentage of improper payment is significant for both Federal and State treasuries and taxpayers. Any level of improper payment is unacceptable and CMS is aggressively working to reduce these errors.

Due to the volume of claims processed by Medicare and the significant cost associated with conducting medical review of an individual claim, claims processing contractors rely heavily on automated edits to flag problematic claims and pay most claims without requesting or individually reviewing the medical records associated with the services listed in the claim. In addition, due to requirements to promptly pay claims in Medicare, our claims processing systems were built to quickly process and pay the 4.8 million claims that we receive each day, totaling approximately 1.2 billion claims in fiscal year 2011.

Improper payments can result from a variety of assorted circumstances, such as a claim paid based on an outdated fee schedule or double payment for a duplicate claim. Improper payments are not necessarily fraudulent; rather, they are an indication of errors made by either the provider or our systems that need to be corrected. Most improper payments by providers are classified as such because they refer to claims that do not have all accompanying documentation. For example, providers may fail to submit documentation when requested, or fail to submit sufficient documentation to support the claim.

Examples of common payment errors made by providers include services that were medically unnecessary, performed in a medically unnecessary setting, or were incorrectly coded.[3] Additionally, Medicare Secondary Payer (MSP) improper payments can occur when Medicare pays a claim that should have been paid by a different group health plan or other liable party.

The Administration is committed to reducing waste and improper payments across the government. On November 20, 2009, President Obama issued Executive Order 13520 calling on all Federal agencies to reduce waste and improper payments across Federal programs. Further, President Obama recently announced that CMS will cut the Medicare FFS improper payment rate in half by 2012. For its part, in the last year, CMS has applied a stricter and improved methodology for calculating the Medicare FFS error rate to ensure accuracy in the error rate measurement. These changes will provide CMS with more complete information that can be used to focus on corrective actions that may need to be made. CMS is also taking action to ensure that providers submit all required documentation to support a claim and that beneficiary claim histories are no longer being used to fill in missing treatment documentation at a later date.

In addition to these efforts, CMS has taken a variety of actions to prevent and reduce the number of improper payments, and recoup improper payments that have occurred. A core goal of CMS program integrity efforts is to strengthen prevention of fraudulent and improper payments, getting away from the historic "pay and chase" framework for program integrity. Bolstered by new authorities in the Affordable Care Act (ACA), we are steadily working to apply stricter scrutiny to providers and suppliers relating to program enrollment.

As our nation begins to adopt electronic health records (EHRs), the Department and CMS are working to encourage providers to use EHRs and develop standards that will make it possible for providers to electronically submit medical documentation to Medicare upon request. We anticipate that this will result in a reduced error rate for Medicare FFS because there will be fewer errors for illegible or missing signatures, and medical documentation will be easier to

[3] Incorrect coding: Claims are placed into this category when providers submit medical documentation that support a lower or higher code than the code submitted. (CMS Improper Medicare Fee-For-Service Payments Report, November 2009).

retrieve and submit. In today's paper-intensive process, most providers and suppliers maintain and store hard-copy medical documentation. When requested by a Medicare review contractor, these records must be manually located, retrieved, photocopied and mailed to the requesting contractor, which can lead to omissions, causing missing documentation errors.

Legislative History of Medicare Recovery Audit Contractors (RACs)

In recent years, RACs have been an important tool in CMS' ongoing efforts to ensure that Medicare payments are accurate and appropriate. The RAC demonstration project was required by section 306 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), which directed CMS to establish a RAC demonstration in at least two States from among States with the highest per-capita Medicare utilization rates, and to use at least three RACs. CMS began this demonstration in Florida, California and New York in 2005, and later expanded to Massachusetts, South Carolina, and Arizona.

Congress expanded the RAC program in section 302 of the Tax Relief and Health Care Act of 2006 (TRHCA), directing CMS to implement a permanent national recovery audit contractor program by January 1, 2010. Just this year, Congress further expanded the RAC program in ACA to Medicare Parts C and D and to State Medicaid programs.

RAC Demonstration

The RAC demonstration provided valuable lessons to CMS, providers, and the RACs that have led to improvements in the national program. As part of the RAC demonstration project, Congress authorized CMS to pay each RAC a contingency fee instead of a standard contract fee award. This demonstration was the first time the Medicare program paid a contractor on a contingency fee basis; however, this type of payment methodology has been an accepted standard practice among private healthcare payers for more than 20 years. CMS found that it was possible to administratively pay the contractors a contingency fee and that contractors were willing to be paid on a contingency fee basis.

The RACs were chosen and awarded through a competitive process. CMS held a full and open competition to select the three Claim RACs and two additional Medicare Secondary Payer

(MSP) RACs for the demonstration. CMS provided each Claim RAC with claims data from 2001 to 2007 for its assigned jurisdiction and each RAC had the flexibility to identify the claims most likely to contain improper payments. RACs reviewed all claims using their proprietary algorithms to identify improper payments that could be detected without medical review, and conducted post-pay medical record reviews of claims identified as likely to contain improper payments. Based on these results, RACs notified providers and directed Medicare claims processing contractors to make necessary adjustments to collect the overpayments or underpayments. MSP RACs were charged with obtaining and reviewing health plan information to determine whether Medicare should have been the primary payer of a claim, or whether a beneficiary had other coverage (e.g. employer-sponsored coverage or worker's compensation insurance) that should have made the primary payment.

The RAC demonstration was a success, resulting in the correction of $1.03 billion in improper Medicare payments. Ninety-six percent of these improper payment corrections – or approximately $990 million – were overpayments collected by CMS, resulting primarily from medically unnecessary care or claims that were incorrectly coded. MSP RACs accounted for only $12.7 million of the total overpayments collected, suggesting that CMS' current efforts to identify and address MSP improper payments are relatively robust. As a result, MSP RACs were not included as part of CMS' permanent national RAC program. The costs of operating the RAC demonstration program totaled $201.3 million, meaning that the program cost approximately 20 cents for each dollar collected.

Lessons Learned

CMS learned a variety of valuable administrative and programmatic lessons from the demonstration project that have informed future program efforts. First, RACs proved successful in identifying and correcting improper payments in the Medicare program. CMS also learned that the administrative cost of the RAC demonstration was significantly less than the amount of money returned to the Medicare trust funds. The structure of the RAC demonstration proved viable, with companies willing to be paid on a contingency fee basis. These contingency fee contractors did not interfere with other ongoing Medicare anti-fraud efforts, and were also willing to spend time on RAC program provider outreach activities. CMS also learned that it is

possible to gradually expand the RAC program, which became especially important after Congress established a January 1, 2010 deadline for a nationwide implementation of the permanent program.

One of the major lessons learned was the importance of communication with providers, and that a gradual rollout provides time to develop strong communication channels with providers in advance of RAC operations. CMS also realized the importance of involving the provider community in making changes to the national program. CMS worked very closely with the provider community and associations to get feedback prior to instituting large-scale changes and continues to value their ongoing participation and feedback.

From a programmatic perspective, the RACs shed light on areas where policy changes, systems changes and education and outreach were needed by CMS. For example, the demonstration RACs identified a number of improper payments related to inpatient rehabilitation facilities (IRFs). CMS recognized that the IRF policy was outdated, and recently published a regulation to update and clarify the policy. Additionally, CMS conducted extensive provider education to ensure providers understood the updated policies and knew how to bill IRF claims correctly. The demonstration RACs also identified cases in which the billing code for a certain drug had been updated. Providers were unaware of the change and were incorrectly billing. In response, CMS implemented a national edit in the claims processing system to deny the claim. In addition, CMS conducted provider education on this vulnerability at more than 25 National conferences in FY 2007 and 2008.

National Rollout of RAC Program

While the demonstration affirmed the feasibility of the RAC model to identify and correct improper Medicare payments, it also identified a number of problems and programmatic challenges that CMS was able to address before further expanding the program. CMS acknowledged that several of the concerns raised by providers in the demonstration were valid, and addressing them prior to national rollout has resulted in positive changes that will enable the national RAC program to maximize transparency, ensure accuracy, and minimize provider burden.

The full list of changes made in the permanent RAC program appears as an addendum to this testimony,[4] but I would like to highlight a few of these changes. Every RAC is required to hire a physician medical director, which gives providers additional assurance that the reviews of their medical decisions are accurate and handled appropriately. Providers expressed concerns that filling multiple requests for medical records for review created a burden. As a result, CMS created sliding scale limits, based on provider size, for the number of medical records that can be requested by RACs from a provider. In order to ensure accurate determinations of payments made in error, RACs must now also secure pre-approval from CMS of issues they wish to pursue for review, meaning that before a RAC can proceed with large numbers of reviews, CMS staff, and if necessary, a third party independent reviewer, must examine and approve the proposed provider type, error type, policy violated and potential improper payment amount per claim to ensure that the review is appropriate. In addition, to address the concern that RACs might have a perverse incentive to over-identify improper payments, CMS now requires RACs to refund contingency fees for any decision overturned on appeal.

With these changes in place, CMS awarded four RAC contracts in 2008. States have been brought into the national program in phases, allowing sufficient time for CMS and the RACs to conduct extensive RAC program outreach. CMS began with 19 States in October 2008, added 5 additional States in March 2009, and added the remainder of the States in August 2009. In addition to the gradual rollout of States, CMS also employed a gradual rollout of review types. RACs first began conducting automated reviews or reviews using data analysis. In these situations, data analysis indicates an improper payment has occurred and no review of the medical record is necessary. Late in 2009, the RACs began requesting additional documentation, including medical records, to conduct coding reviews and Diagnosis Related Group (DRG) validations. In coding reviews, additional documentation is necessary to support the payment of the claim. Many times these situations appear improper; however, documentation is necessary to support the finding. An example would include the billing of too much of a drug based on FDA dosage guidelines. A review of the medical record and/or additional documentation is necessary to determine the dosage given. DRG validations involve reviewing the supporting medical

[4] See Addendum 1 on page 10 of the testimony.

documentation to ensure the correct DRG was billed and the correct principal and secondary diagnoses were used to determine the billed DRG. CMS gave the RACs authority to begin to request reviews for medical necessity. As of today, the RACs can review any claim type for any reason as long as the issue has been approved in advance by CMS.

To date, a significant portion of the review in the national program has focused on durable medical equipment and DRG validation. RACs are identifying other issues such as claims paid while a beneficiary is being treated in an inpatient setting and situations where a claim is submitted with an incorrect principal diagnosis, which results in a higher DRG being billed. As trends become apparent, CMS is reviewing and monitoring the improper payments identified by the RACs to determine if corrective actions need to occur. For example, CMS is exploring the creation of a national edit in the system to identify these issues before the claim is paid. We are also discussing the improper payment determinations with the claim processing contractors so that they can determine if local actions should take place.

Affordable Care Act Expansion of RACs

As mentioned above, Congress expanded the role of recovery audit contracting in ACA to Medicaid and Medicare Advantage (Part C) and the prescription drug program (Part D). This change requires all States to establish individual Medicaid RAC programs under their State plan or waiver. In addition, the ACA provision requires RACs to also serve in a program integrity capacity, reviewing each MA and Part D plan's anti-fraud plan.

Both expansions will take the RAC program beyond Medicare FFS for the first time. The lessons and experience that CMS has with fee-for-service Medicare RACs will certainly inform our efforts to pursue recovery auditing in Medicaid, Medicare Advantage and the Medicare prescription drug program. Each of these programs is administered and reimbursed differently and presents its own unique challenges. Although RACs proved effective and relevant to FFS Medicare, it remains to be seen how this effort will translate into the other programs. CMS looks forward to working with Congress as we move forward with implementing the ACA provision,

and with the overarching goal of ensuring payments are made correctly in the Medicare and Medicaid programs.

Conclusion

Our past experience shows that RACs can have a positive role in identifying and correcting improper payments and returning money to the Medicare trust funds. In addition to recoveries, RACs give CMS a window into areas where additional provider education, pre-payment or post payment edits, data mining, or medical record review are needed.

As we work to implement the new requirement in ACA and expand the role of RACs to Medicare Parts C and D and Medicaid, CMS will continue to examine the lessons learned for improvements that can be made in the RAC program in the future, as well as pursuing other efforts to reduce and eliminate improper payments.

Addendum 1: Differences between Demonstration RACs and Permanent RACs

	Demonstration RACs	Permanent RACs
RAC medical director	Not Required	Mandatory
Coding experts	Optional	Mandatory
Credentials of reviewers provided upon request	Not Required	Mandatory
Discussion with CMD regarding claim denials if requested	Not Required	Mandatory
Minimum claim amount	$10.00 aggregate claims	$10.00 minimal claims
AC validation process	Optional	Limited
External validation process	Not Required	Mandatory
RAC must payback the contingency fee if the claim overturned at any level of appeal	Only required to pay back if claim is overturned on the first level of appeals	All levels of Appeal
Vulnerability reporting	Limited	Mandatory
Standardized base notification of overpayment letters to providers	Not Required	Mandatory
Look back period (from claim pmt date – date of medical record request)	4 years	3 years
Maximum look back date	None	10/1/2007
Allowed to review claims in current fiscal year?	No	Yes
Limits on # of medical records requested	Optional. Each RAC set own limit	Mandatory. CMS will establish uniform limits
Timeframe for paying hospital medical record photocopying vouchers	None	Within 45 days of receipt of medical record
Quality assurance/ Internal control audit	No	Mandatory
Remote call monitoring	Yes	Yes
Reason for review listed on request for records letters and overpayment letters	Not Required	Mandatory
General RAC webpage	Not Required	By Jan 2010
RAC claim status webpage	Not Required	By Jan 2010