



Testimony

Before the Subcommittee on Federal Financial Management, Government Information, Federal Services, and International Security, Homeland Security and Governmental Affairs Committee, U.S. Senate

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MEDICARE RECOVERY AUDIT CONTRACTING

Lessons Learned to Address Improper Payments and Improve Contractor Coordination and Oversight

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Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today to discuss preventing and addressing government payment errors in the Medicare program.¹ Medicare, which provides health insurance for those aged 65 and older and certain disabled persons, is susceptible to improper payments due to its size and complexity.² Because the Medicare program has paid billions of dollars in error each year,³ the Centers for Medicare & Medicaid Services (CMS)—the agency that administers Medicare—conducts a number of activities to reduce improper payments. CMS administers the Medicare program with the help of Medicare claims administration contractors,⁴ which are not only responsible for processing and paying approximately 4.5 million claims per day, but for also conducting pre-payment reviews of claims to prevent improper payments before claims are paid, as well as post-

¹Medicare consists of four parts. Medicare Fee for Service (FFS) includes two parts—Medicare Parts A and B whereby providers are paid for each service, unit or bundle of services provided. Medicare Part A covers inpatient hospital services, skilled nursing facility services, some home health, and hospice services. Medicare Part B covers hospital outpatient, physician services, some home health services and preventive services, among other things. Medicare beneficiaries have the option of obtaining coverage for Medicare Part A and B services from private health plans that participate in Medicare Advantage—Medicare's managed care program, also known as Medicare Part C. All Medicare beneficiaries may purchase coverage for outpatient prescription drugs under Medicare Part D.

²Improper payments may be due to errors, such as the inadvertent submission of duplicate claims for the same service, or misconduct, such as fraud and abuse. Fraud is an intentional act or representation to deceive with knowledge that the action or representation could result in an inappropriate gain. Abuse typically involves actions that are inconsistent with acceptable business or medical practices and result in unnecessary costs.

³For example, in 2009 the Department of Health and Human Services (HHS) estimated that approximately \$24.1 billion or 7.8 percent of Medicare FFS payments for claims from April 2008 through March 2009 were improper. (November 2009 "Improper Medicare FFS Payments Report" in HHS's *Fiscal Year 2009 Agency Financial Report*.) Since 1990, Medicare has been included in our reporting of "high risk" areas, those government operations involving substantial resources and that provide critical services to the public that we find to contain serious weaknesses. See GAO, *High-Risk Series: An Update*, GAO-09-271 (Washington, D.C.: January 2009) and www.gao.gov/highrisk/risks/insurance/medicare_program.php.

⁴CMS has historically used contractors, known as fiscal intermediaries and carriers, to process Medicare claims. CMS is in the process of transitioning to new contracting entities called Medicare Administrative Contractors. Because the transition is ongoing, we use the term Medicare claims administration contractors to refer to the contractors that historically have processed Medicare claims as well as the new Medicare Administrative Contractors.

payment reviews of claims potentially paid in error. To supplement these and other program integrity efforts, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 directed CMS to conduct a 3-year demonstration project on the use of a new type of contractors—recovery audit contractors⁵ (RAC)—in identifying underpayments and overpayments, and recouping overpayments in the Medicare program.⁶ The RAC demonstration program began in 2005. Subsequently, the Tax Relief and Health Care Act of 2006 required CMS to implement a national recovery audit contractor program by January 1, 2010.⁷

Since the conclusion of the demonstration project, CMS and we have reported on improvements needed for the RAC national program. For example, in a June 2008 report evaluating the demonstration project, CMS reported its intent to make a number of changes to the RAC national program to better address RAC-identified vulnerabilities,⁸ respond to provider concerns, and streamline operations.⁹ In March 2010, we reported on weaknesses in the agency's actions to address improper payments and CMS concurred with our recommendations.¹⁰ The findings in both reports are important in light of the administration's recent commitment to reducing payment errors in federal programs.¹¹ In addition, the Patient Protection and Affordable Care Act mandates the use of RACs to identify overpayments and underpayments and to recoup overpayments made in

⁵Recovery auditing has been used in various industries, including health care, to identify and collect overpayments for about 40 years.

⁶Pub. L. No. 108-173, § 306, 117 Stat. 2066, 2256-57.

⁷Pub. L. No. 109-432, div B., title III, § 302, 120 Stat. 2922, 2991-92 (codified at 42 U.S.C. § 1395 ddd(h)).

⁸A vulnerability is an issue likely to lead to an improper payment such as billing the incorrect number of units for a particular drug or service or inpatient hospital claims not meeting CMS's criteria for inpatient admission.

⁹See Department of Health and Human Services, Centers for Medicare and Medicaid Services, *The Medicare Recovery Audit Contractor (RAC) Program: An Evaluation of the 3-Year Demonstration* (Baltimore, Md.: June 2008).

¹⁰See GAO, *Medicare Recovery Audit Contracting: Weaknesses Remain in Addressing Vulnerabilities to Improper Payments, Although Improvements Made to Contractor Oversight*, GAO-10-143 (Washington, D.C.: March 31, 2010).

¹¹Finding and Recapturing Improper Payments, 75 Fed. Reg. 12,119 (March 15, 2010); *See also* Exec. Order No. 13,520, 74 Fed. Reg. 62,201 (Nov. 25, 2009); & OMB Circular No. A-123, Appx. C, Requirements for Effective Measurement and Remediation of Improper Payments (Revised March 22, 2010).

Medicare Parts C and D and the Medicaid program.¹² Not only can CMS's experience with RAC contractors benefit its other programs, but lessons learned from the RAC program may also assist other agencies' payment recapture audits, increase the funds recovered, and help prevent such improper payments from being made in the future.

Our testimony today is based on our March 2010 report¹³ and will focus on the lessons that can be learned from the RAC demonstration about (1) developing an adequate process and taking corrective action to address RAC-identified vulnerabilities leading to improper payments, (2) resolving coordination issues between the RACs and the Medicare claims administration contractors, and (3) establishing methods to oversee RAC claim review accuracy and provider service during the national program.

For our March 2010 report, we reviewed CMS documents and interviewed officials from CMS, as well as contractors and provider groups affected by the demonstration project. We conducted our work for this performance audit from March 2009 through March 2010. Our work was performed in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

The RAC demonstration project was designed to supplement existing claims review processes and required the RACs to review claims previously paid by existing Medicare claims administration contractors. RACs were charged with identifying payment errors, such as whether a provider billed the correct number of units for a particular drug or service. Once a RAC identified a payment error, it informed the provider of the error and its amount. The Medicare claims administration contractor then

¹²Pub. L. No. 111-148, § 6411, 124 Stat. 119, codified at 42 U.S.C. §§ 1396a(a)(42)(B) and 1395ddd(h).

¹³See GAO-10-143.

adjusted the claim to the proper amount¹⁴ and collected the overpayment from, or reimbursed the underpayment to, the provider. CMS paid RACs contingency fees on overpayments collected and underpayments refunded.¹⁵ CMS and its Medicare claims administration contractors were responsible for taking corrective actions¹⁶ for vulnerabilities identified by the RACs, including identifying the causes of each type of vulnerability and addressing them, in order to reduce future improper payments.

In a 2006 status report, CMS noted that the demonstration RACs identified \$303.5 million in improper payments. However, this amount did not include the final results of any provider appeals filed afterwards or pending at that time.¹⁷ CMS concluded that “preliminary results indicate that the use of recovery auditors is a viable and useful tool for ensuring accurate payments” and that RACs would be a “value-added adjunct” to the agency’s programs. Throughout the RAC demonstration, CMS stated its intention to use information on the vulnerabilities found by the RACs to help prevent future improper payments. In addition, the agency wanted to address concerns expressed by providers prior to the implementation of a national program, such as holding the RACs accountable for the accuracy of their decisions.

¹⁴During the demonstration project, the Medicare claims administration contractors processed hundreds of thousands of RAC claim adjustments—some manually—which created significant additional workload.

¹⁵During the demonstration, CMS paid the RACs a total of \$187.2 million in contingency fees. Initially, the RAC demonstration project did not include contingency fee payment to the RACs for identifying underpayments and refunding providers. Beginning on March 1, 2006, the RACs were paid an equivalent percentage contingency fee for the identification of underpayments.

¹⁶Corrective actions that could be taken by CMS or its Medicare claims administration contractors include: conducting provider outreach and education; developing guidance or new regulations; reissuing instructions for coding a claim or initiating additional service-specific local or national prepayment computer edits to deny improper claims or flag them for additional review.

¹⁷Providers could appeal unfavorable RAC determinations through the standard Medicare appeals process, which includes five levels of review. The Medicare claims administration contractors conduct the first level of appeal.

Lessons Learned Highlight the Need to Develop Processes to Take Corrective Actions and to Improve Coordination and Oversight

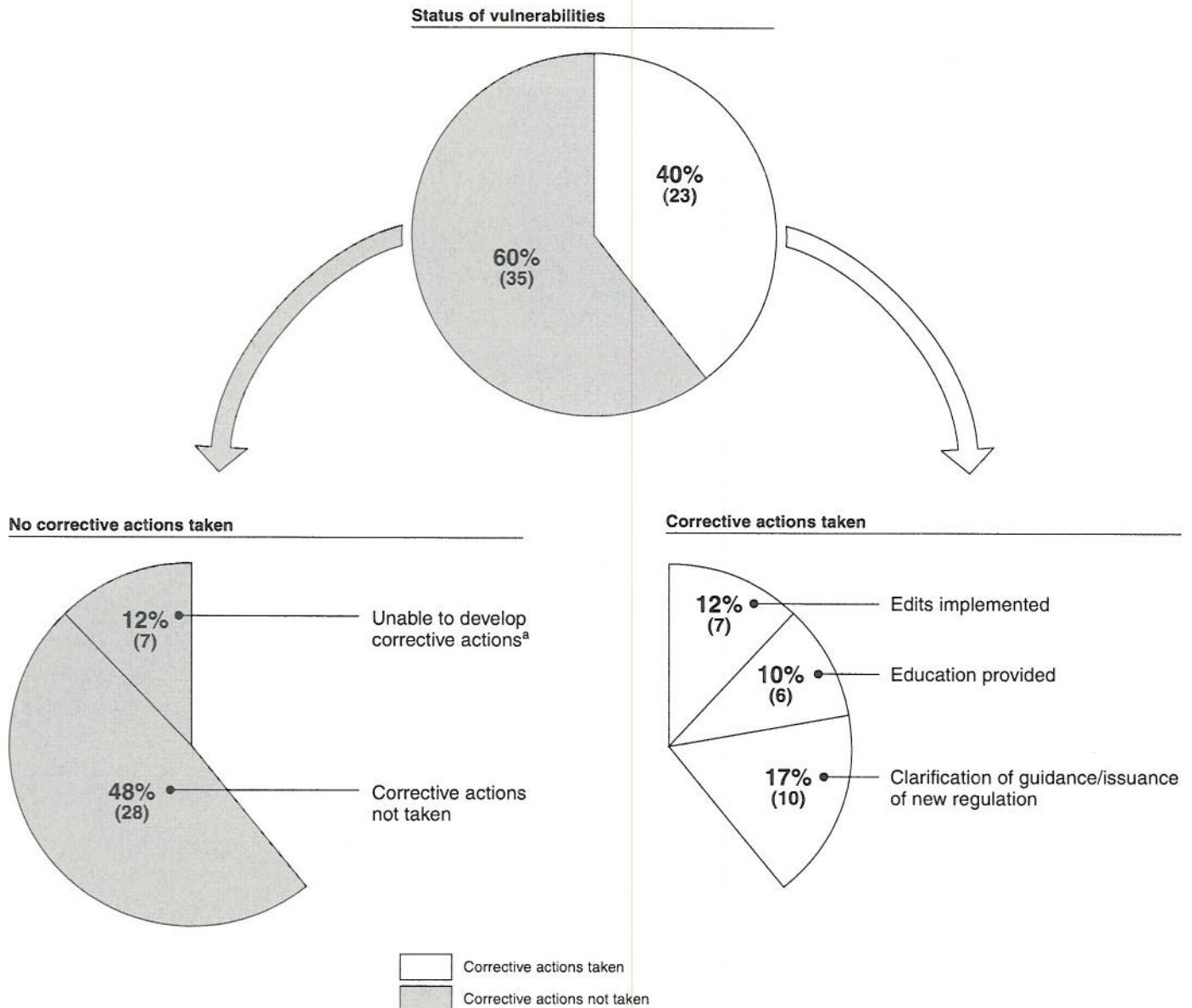
Our March 2010 report pointed to three areas for lessons to be learned from the RAC demonstration that could be applicable as CMS expands recovery audits to Medicare Parts C and D and Medicaid and to other agencies' payment recapture efforts. Establishing an effective recovery audit program involves developing processes to take corrective action on underlying vulnerabilities that lead to improper payments; coordinating the activities of various parties that have responsibilities related to the payment process; and assuring recovery audit contractor accuracy and service through oversight. Specifically, agencies should

- *Establish an adequate process to address RAC-identified vulnerabilities leading to improper payments.* During the demonstration, we found that CMS did not develop a process to take corrective actions or implement sufficient monitoring, oversight, and control activities to ensure the "most significant" RAC-identified vulnerabilities were addressed.¹⁸ In addition, providers informed us that CMS did not take corrective actions on RAC-identified vulnerabilities such as conducting provider education or implementing computer system edits to help prevent future improper payments. We found that CMS and the Medicare claims administration contractors did not implement corrective actions for 35 of 58 (60 percent) of the most significant vulnerabilities that led to improper payments during the demonstration as shown in figure 1. We also found that the unaddressed corrective actions represented \$231 million.¹⁹

¹⁸According to CMS, the most significant vulnerabilities were those for which RACs identified more than \$1 million in improper payments for medical services or \$500,000 for durable medical equipment.

¹⁹These unaddressed vulnerabilities are a portion of 18 specific medical services CMS valued at \$378 million.

Figure 1: Status of Corrective Actions for 58 Vulnerabilities with Improper Payments of Greater Than \$1 Million, as of the End of the Recovery Audit Contractor Demonstration Project—March 2008



Source: GAO analysis of CMS data.

^aAccording to CMS officials the agency was unable to develop corrective actions because it either lacked adequate information on the specific services involved or decided it was not cost effective to do so.

Note: Potential corrective actions include implementing computer edits that deny improper claims or flag claims for further review, educating providers about Medicare rules and proper billing procedures and issuing clarification of guidance or a new regulation.

Percentages in figure may not add to 100 due to rounding.

For the four RAC contractors implementing the national program, CMS developed a process to compile identified vulnerabilities and recommend actions to prevent improper payments. However, we found that this new corrective action process lacked essential procedures, such as evaluating the effectiveness of corrective actions taken, and staff with the authority to ensure that these vulnerabilities are resolved promptly and adequately to prevent further improper payments. Our report recommended that the Administrator of CMS develop and implement a process that includes policies and procedures to ensure that the agency promptly evaluates findings of RAC audits, decides on the appropriate response and a time frame for taking action based on established criteria, and acts to correct the vulnerabilities identified. As part of this process, we recommended that the Administrator of CMS designate key personnel with appropriate authority to be responsible for ensuring that corrective actions are implemented and that the actions taken are effective. In commenting on a draft of the report, CMS concurred with our recommendations and stated that the Administrator of CMS is the official responsible for assuring that vulnerabilities that cut across all agency components are addressed.

- *Take steps to address coordination issues between contractors.* The agency continued activities that worked well during the demonstration project, initiated a number of new actions, and is taking steps to address coordination challenges. According to CMS, once the RACs identify errors, Medicare claims administration contractors are responsible for re-processing the claims to repay underpayments or recoup overpayments, conducting the first level review for RAC-related appeals, and informing and training providers about lessons learned through the RAC reviews. During the demonstration project, providers noted that RAC determinations resulted in thousands of provider appeals to Medicare claims administration contractors. These appeals and re-processing of claims produced additional workload for the Medicare claims administration contractors, who are also responsible for adjudicating the first level of appeals. The appeals and adjustments workload led to coordination challenges for the Medicare claims administration contractors and RACs. As a result, CMS learned that regular communication between the RACs and the Medicare claims administration contractors regarding RAC-identified payment vulnerabilities was important due to their interdependence. In addition, CMS created a data warehouse for the demonstration that contained information on which

claims were unavailable for RAC review to prevent the RACs from auditing claims previously reviewed by a claims administration contractor or other contractor investigating potential Medicare fraud. For the national program, CMS modified the data warehouse to include more capacity and utility. The agency also automated the manual claims adjustment process used by the Medicare claims administration contractors to recoup improper payments in order to reduce their administrative burden. Further, the volume of provider appeals made it difficult to manage all of the paper medical records that needed to be exchanged between the RACs and claims administration contractors in order to assess the RAC determinations. Provider association and hospital representatives noted the RACs sometimes requested duplicate medical records to evaluate the medical necessity or appropriateness claims as part of their reviews, thus increasing providers' administrative burden. As a result, CMS developed an electronic documentation sharing system to improve storage and transfer of medical records.

- *Oversee the accuracy of RACs' claims reviews and the quality of their service to providers.* During the demonstration project, providers stated that the contingency fee payment structure CMS employed created an incentive for RACs to be aggressive in determining that paid claims were improper. RACs were paid contingency fees during the demonstration even if their findings were later overturned on appeal. For the national program, CMS changed its payment of contingency fees so that RACs will have to refund contingency fees received on a determination overturned at any level of the appeal process. CMS also established performance metrics that the agency will use to monitor RAC accuracy and service to providers. In addition, CMS added processes to review the accuracy of RAC determinations including independent reviews by a validation contractor. Prior to pursuing a wide-scale review of any vulnerability in the national program, the RAC must submit information and a small sample of reviewed claims and related findings to CMS to check for accuracy and to ensure the RAC's compliance with the rule, policy, or regulation against which the claims will be evaluated. CMS has also established a process for ongoing oversight of RAC accuracy through a regular independent assessment of a sample of RAC-reviewed claims and determinations by the validation contractor. This will lead to an annual accuracy score for each RAC, scores which CMS intends to publish. Further, CMS established requirements to address provider concerns about service. Specifically, CMS required RACs to establish Web sites that will allow providers to track the status of a claim being reviewed and include information on each vulnerability being audited by that RAC. However, because the agency does not have a standard system to track appeals through the entire five

levels of the appeals process, CMS does not require RACs to provide information on the status of claims' appeals on their Web sites.

In conclusion, the ultimate success of the government-wide effort to reduce improper payments hinges on each federal agency's diligence and commitment to identify, estimate, determine the causes of, take corrective actions on, and measure progress in reducing improper payments. CMS's experience provides useful lessons for the management of the Medicare and Medicaid programs, as well as other recovery auditing programs on the importance of addressing the root causes of vulnerabilities to improper payments and effectively coordinating and overseeing the accuracy of contractors. Such lessons may be useful as recovery auditing is incorporated more broadly in the federal government.

Mr. Chairman, this concludes our prepared statement. We would be happy to answer any questions you or other members of the subcommittee may have.

GAO Contacts and Staff Acknowledgments

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