



**To:** Council for Medicare Integrity

**From:** Avalere Health

**Date:** September 25, 2015

**Re:** Estimated Federal Impact of the Medicare Fee-For-Service (FFS) Recovery Audit Program

**Summary**

The Council for Medicare Integrity asked Avalere Health to estimate the cost or savings to the Federal budget from discontinuing the Medicare fee-for-service (FFS) Recovery Audit Program. Since early 2014, the Centers for Medicare & Medicaid Services (CMS) began a pause in operations for Recovery Audit Contractors (RAC) by not allowing them to conduct new reviews of Medicare claims. Although recoveries have declined during the past 18 months, no official budget scores have been produced by the Congressional Budget Office (CBO) to estimate the effect on Federal spending.

Improper payments in Medicare encompass billions of dollars each year. The lack of a budget impact analysis for the break in RAC operations does not reflect a position by CBO that the RACs do or do not reduce Federal spending. Rather, the need for CBO to fully measure the potential longer-term Federal budget implications has been limited due to the uncertain nature of the recent changes to the RAC program, and the fact that they are administrative changes by CMS rather than legislative changes.

Avalere estimates that if CMS continues to pause the RAC program over the next decade as it has done for the past 18 months, federal spending will be \$47 billion higher over the 2016-2025 budget window. It remains unclear how much of this increase in spending could be addressed via legislation due to Federal budgetary scoring rules.

*Estimated change in federal spending, \$ billions*

	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY2025	<b>FY2016-2025</b>
Estimated effect of permanent pause in RAC operations	\$2	\$3	\$3	\$4	\$5	\$5	\$6	\$6	\$6	\$7	<b>\$47</b>

## Background

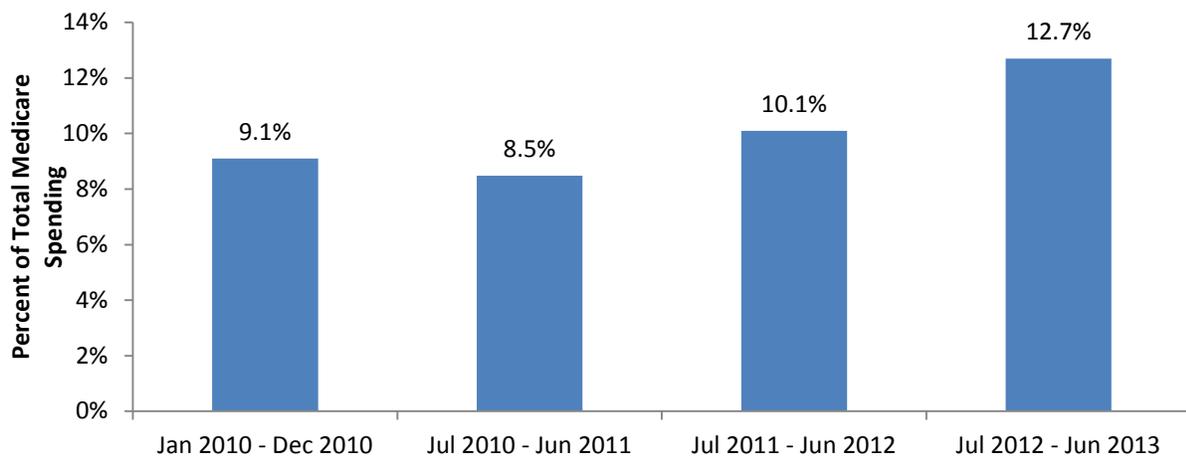
### *Improper Payments in Medicare*

The Office of Management and Budget has designated fee-for-service (FFS) Medicare as the highest source of improper payments across the entire government for each of the past six years.<sup>1</sup> FFS Medicare paid an estimated \$45.8 billion (12.7 percent of payments) incorrectly from June 2012 through July 2013, the most recent year of available results. Almost all improper payments, \$44.3 billion, were overpayments to providers.<sup>2</sup>

Improper payments occur when submitted claims do not meet Medicare policy requirements. The intent of Medicare policy requirements typically is to prevent fraud and waste, but improper payments are not a measure of fraud and waste. In some cases, providers have billed for services inconsistent with Medicare policy. In other cases, a specific documentation element required for payment is missing. Sometimes, improper payments are simply the result of duplicate billing or incorrect coding.

The most recent CMS report shows that the rate of improper payments has increased 4.2 percentage points during the last two years, and that about 85 percent of improper payments are due to medical necessity and insufficient documentation errors.<sup>3</sup> CMS's most recent report estimates that the error rate was 12.7 percent for July 2012 through June 2013, a period which precedes the current pause in RAC operations.

**Figure 1: Medicare FFS Improper Payment Rates**



Note: Improper payment rates are adjusted for appeal adjudication and for allowing full Part A to B rebilling  
Source: Medicare FFS Improper Payments Reports, FY2011 – FY2014

<sup>1</sup> Official government website required by Executive Order 13520 (Sec 2b), "Reducing Improper Payments and Eliminating Waste in Federal Program" URL: <https://paymentaccuracy.gov/improper-payment-amounts>

<sup>2</sup> Centers for Medicare and Medicaid, U.S. Department of Health and Human Services. "Medicare Fee-For-Service 2014 Improper Payments Report. Note: CMS estimates that, after allowing for pending appeals to complete final adjudication, the overall FY 2014 improper payments rate would be lowered by 0.2 percentage points to 12.5 percent.

<sup>3</sup>ibid.

### ***Purpose of Recovery Audit Program***

The FFS Medicare Recovery Audit Program started with the Medicare Prescription Drug, Improvement and Modernization Act of 2003, which required a demonstration to determine whether Recovery Audit Contractors (RACs) could efficiently and effectively identify and recover improper payments in Medicare FFS. The demonstration was conducted from March 2005 to March 2008 across six states. Congress authorized the expansion of the program nationwide in the Tax Relief Act of 2006.

The national FFS Recovery Audit Program was established in 2009, and four competitively-awarded RACs began in fiscal year (FY) 2010 to actively identify improper payments for all types of claims paid under Medicare Parts A and B. Each of the four FFS RACs are responsible for auditing and identifying Medicare improper payments in their geographic region through post-payment review and recoveries. RACs also help CMS prevent improper payments by identifying common billing errors, trends, and payment issues. RACs are paid a contingency fee for all improper payments recovered from, or reimbursed to, providers. RACs negotiate their contingency fees when contracts are awarded. The base contingency fees range from 9.0 to 12.5 percent for all claims except DME. For DME, fees range from 14.0 to 17.5 percent.

RACs are one of several types of entities and programs used by CMS to help ensure that claims are paid based on Medicare policy. Due to the high volume of Medicare claims, CMS is only able to review a small portion of submitted claims each year via a handful of programs. The FFS RAC program conducts a subset of those reviews, identifying improper payments worth roughly 1 percent of FFS Medicare payments during their peak performance period in FY 2013.<sup>4</sup> The Medicare Administrative Contractors (MACs), which process all claims submitted under FFS Parts A and B and process RAC recoveries, also review claims pre- and post-payment. The Comprehensive Error Rate Testing (CERT) Program reviews a statistically valid random sample covering roughly 50 thousand claims in order to estimate the overall improper payment rates across Medicare FFS.

Although RACs are unique in that they are paid contingency fees, they follow the same Medicare policies and regulations as MACs and only review payment issues already approved by CMS and MACs. The types of reviews and types of errors identified are also the same for RACs, MACs, and the CERT. There are three types of reviews: automated, semi-automated, and complex. Automated reviews are done solely using data analysis to identify improper payments. Complex reviews require a qualified health care coder or clinician to review the supporting medical records. The third type, semi-automated reviews, are initiated using data analysis but also require review of documentation submitted by the provider to substantiate the claim.

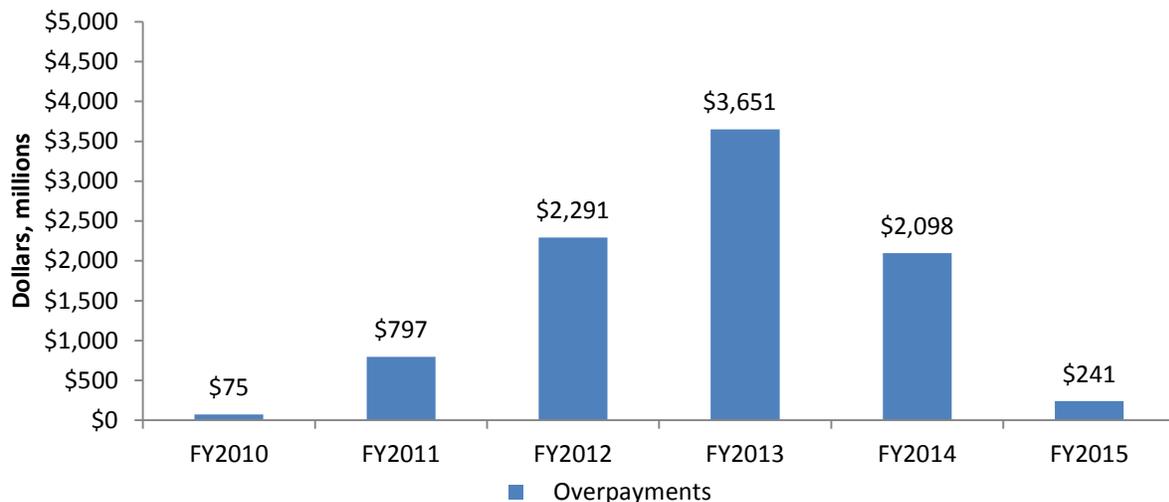
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<sup>4</sup> Centers for Medicare & Medicaid, U.S. Department of Health and Human Services. "Recovery Auditing in Medicare for Fiscal Year 2013."

The types of errors identified include medical necessity criteria, insufficient documentation, and incorrect coding. Insufficient documentation and medical necessity determinations have been the biggest drivers of improper payments over the past five years.<sup>5</sup> In addition to incorrect billing by providers, changes in Medicare policy requirements, or unclear Medicare policies, often can be the reasons for changes in rates for these types of errors.

RAC determinations grew from \$75 million in FY 2010 to \$3.7 billion in FY 2013 as the RACs ramped up their capabilities. By FY 2013, RAC recoveries amounted to about 1.0 percent of Medicare FFS payments. The dramatic increase in recoveries during this time primarily reflects a ramp-up in RAC review capabilities, both in terms of learning as well as employing more staff and resources to review claims. Because RACs are paid contingency fees when determinations are upheld, they tend to hire additional staff and resources after making recoveries.

**Figure 2: FFS RAC Recoveries**



Source: CMS annual and quarterly reports on the Recovery Audit Program, FY2010 – FY2015

The historical performance of the RAC program is heavily skewed by medical necessity determinations for hospital inpatient claims, in terms of both overpayment determinations and appeals. Roughly 95 percent of the growth in RAC recoveries between FY 2010 and FY 2013 was due to overpayment determinations for inpatient hospital admissions. In FY 2013, RAC recoveries for hospital inpatient claims amounted to a third of estimated overpayments, but were much less for other Part A claims (<1 percent), Part B claims (<1 percent), and DME (1.3 percent).<sup>6</sup>

<sup>5</sup> Centers for Medicare and Medicaid, U.S. Department of Health and Human Services. "Medicare Fee-For-Service 2014 Improper Payments Report.

<sup>6</sup> Avalere calculation based on data from two sources: 1) Centers for Medicare and Medicaid, U.S. Department of Health and Human Services. "Recovery Auditing in Medicare for Fiscal Year 2013."; 2) Centers for Medicare and Medicaid, U.S. Department of Health and Human Services. "Medicare Fee-For-Service 2014 Improper Payments Report.

A tendency for RAC recoveries to be more weighted toward hospital inpatient claims was noted by CMS in its evaluation of the 2005-2008 RAC demonstration—hospital inpatient claims accounted for about 85 percent of FFS RAC recoveries during the demonstration. CMS speculated that higher contingency fees during the demonstration likely influenced contractors to strategically focus first on hospital inpatient claims.<sup>7</sup>

At the end of the first contract period in February 2014, CMS issued a pause in operations—which has so far continued through August 2015—to allow, as described by CMS, further refinement and improvement of the Medicare Recovery Audit Program.<sup>8</sup> In particular, CMS noted it was reviewing limits on the number of documents that RACs could request from providers, the timeframe for reviews, and communication between RACs and providers. During the pause in operations, RACs stopped issuing new reviews. New complex reviews stopped after February 2014 and new automated reviews stopped in June 2014. The amount of improper payments recovered fell dramatically in FY 2014 and FY 2015 as RAC activities were limited to completing already-initiated reviews.

In August 2015, CMS announced that Quality Improvement Organizations (QIOs), instead of RACs, will assume initial responsibility for determining the appropriateness of Part A payment for short stay inpatient hospital claims.<sup>9</sup> Beginning in January 2016, RACs may conduct short-stay reviews only for those providers referred by QIOs as repeat offenders. RAC determinations that short stay inpatient admissions were medically unnecessary became a substantial portion of identified overpayments and provider appeals in FY 2012 and FY 2013.

### **Appeals**

Provider appeals for RAC determinations follow the same multi-level process as MAC or CERT determinations. The initial levels of appeal start with CMS—first the MAC performs a redetermination, followed by a reconsideration performed by a Qualified Independent Contractor (QIC). The third and fourth level appeals occur outside of CMS, but within the Department of Health and Human Services (HHS)—first the Office of Medicare Hearings and Appeals (OMHA), and then the Departmental Appeals Board (DAB). The final level of appeal occurs outside of HHS, with the Federal District Court.

Many appeals, especially at the first and second level, are overturned when the provider corrects the claim during the appeals process by modifying the claim so that it follows Medicare policy. For example, many Part B claims can be resubmitted simply by adding a missing modifier code to the claim. Appeals at the Federal District Court level are very rare. The overall

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<sup>7</sup> Centers for Medicare and Medicaid, U.S. Department of Health and Human Services. “The Medicare Recovery Audit Contractor (RAC) Program: An Evaluation of the 3-Year Demonstration.” June 2008.

<sup>8</sup>Centers for Medicare and Medicaid, U.S. Department of Health and Human Services. Web-posted Updates on Recovery Audit Program, February 18, 2014. URL: [https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Recent\\_Updates.html](https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Recent_Updates.html)

<sup>9</sup> Centers for Medicare and Medicaid, U.S. Department of Health and Human Services. Web-posted Inpatient Hospital Reviews, August 12, 2015. URL: <https://www.cms.gov/research-statistics-data-and-systems/monitoring-programs/medicare-ffs-compliance-programs/medical-review/inpatienthospitalreviews.html>

share of RAC overpayment determinations overturned on appeal, at any level, grew from 2.9 percent in FY 2011 to 9.3 percent in FY 2013.<sup>10</sup>

Beginning in 2010, OMHA experienced an increase in the number of third-level appeals being filed, due to both the establishment of the Recovery Audit Program and growth in its traditional workload.<sup>11</sup> During 2013, 10.6 percent of recovery audits were appealed to the OMHA level, and those appeals made up 42.3 percent of all appeals at the OMHA.<sup>12</sup> The majority of RAC determination appeals in FY 2012 and FY 2013 were for inpatient admissions that were identified as medically unnecessary.

Many of the OMHA rulings in favor of the provider during this time involved allowing the provider expanded Part A to B rebilling, which contradicted Medicare policy until CMS Interim Ruling 1455-R (78 FR 16614) in March 2013. As the backlog grew, CMS offered settlements to many hospitals at 68 cents on the dollar.<sup>13</sup> OMHA's appeal overturn rate declined from 63 percent in 2010 to 43 percent in 2014, due not only to provider withdrawals and settlements, but also to collaborative training and participation among OMHA and CMS adjudicators.<sup>14</sup>

### ***Congressional Budget Office Scoring of RACs***

Historical estimates from CBO's Medicare baselines show Medicare's recovery rate increasing 1.7 percentage points, from about 2.6 percent to 4.3 percent of Part A and Part B FFS payments, between FY 2010 and FY2013—the FFS RAC recovery rate grew 1.0 percentage point during this time, potentially accounting for about 59 percent of the increase in overall recoveries. For FY 2014, CBO estimated a 0.6 percentage point decline in recoveries as a share of Part A and B FFS payments, slightly more than the 0.5 percentage point decrease shown in CMS Reports (the pause in operations took effect mostly in the latter half of FY 2014).<sup>15</sup>

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<sup>10</sup>CMS annual reports on the Recovery Audit Program, FY2010 – FY2013

<sup>11</sup> United States Senate Finance Committee. "Statement of Nancy J. Griswold, Chief Administrative Law Judge, Office of Medicare Hearings and Appeals, on "Creating a More Efficient and Level Playing Field: Audit and Appeals Issues in Medicare". April 28, 2015.

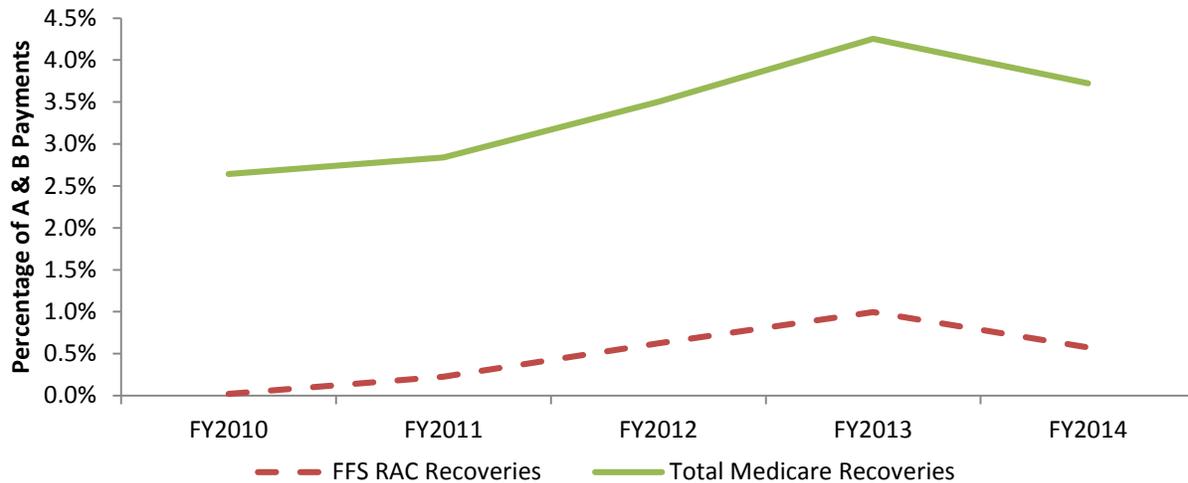
<sup>12</sup> Moore, CF. "Update from OMHA". Presentation at the National RAC (and MAC) Summit. November 14, 2014.

<sup>13</sup> Centers for Medicare and Medicaid, U.S. Department of Health and Human Services. Web-posted Hospital Participant Settlement Instructions: [https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/Downloads/HospitalParticipantSettlementInstructions\\_updated09092014.pdf](https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/Downloads/HospitalParticipantSettlementInstructions_updated09092014.pdf)

<sup>14</sup> United States Senate Finance Committee. "Statement of Nancy J. Griswold, Chief Administrative Law Judge, Office of Medicare Hearings and Appeals, on "Creating a More Efficient and Level Playing Field: Audit and Appeals Issues in Medicare". April 28, 2015.

<sup>15</sup> CBO does not break down recoveries by type of provider. CMS RAC reports show RAC recoveries as a share of Medicare Part A and B FFS payments. For purposes of comparing historical trends, we are showing CBO recoveries as a share of Part A and B FFS payments.

**Figure 3 Recoveries as a Share of FFS Part A and B Payments**



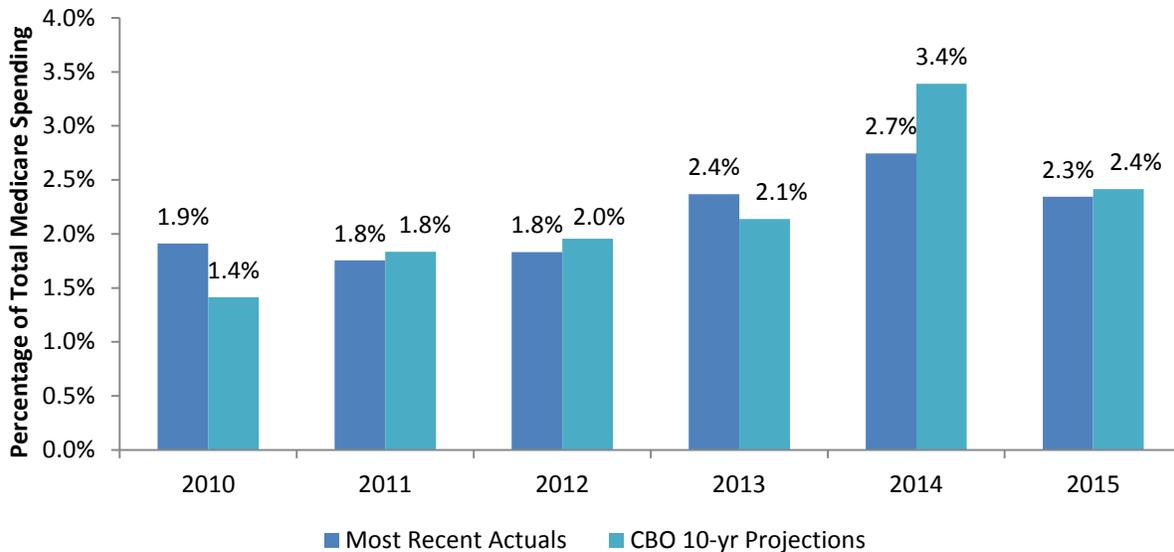
Source: Total Medicare Recoveries from CBO Medicare Baselines for 2011 – 2015; FFS RAC Recoveries from CMS Annual and Quarterly Reports on the RAC Program for FY2010 – FY2014

Although CBO has not scored the effect of the break in RAC operations, it has continually made changes to its baseline estimates for Medicare spending and recoveries that coincide with the RAC program’s launch, ramp-up, and current pause in operations. And, though CBO has not officially deliberated on the longer-term budget implications of RACs, it continually updates its projected recoveries over the budget window based on both CMS’s most recent overall track record of reviewing claims and CBO expectations.

For example, in 2011-2013 CBO projected a Medicare baseline recovery rate that matched CMS’s most recent actual recovery rate for the prior fiscal year. However, for its 2014 baseline CBO projected an increasing recovery rate over time—most likely due to both actual FY 2013 growth in FFS RAC recoveries and expected future growth in recoveries across other CMS programs (e.g., Part D and Medicare Advantage (MA) RACs authorized by the Affordable Care Act (ACA) but not yet fully implemented).

CBO’s 2014 baseline showed recoveries increasing from 2.7 to 3.7 percent of all Medicare payments (including Part D and MA). This change in projected recovery rates decreased 2014 baseline Medicare spending by about \$110 billion. More recently, CBO modified its Medicare baseline in 2015 by again projecting a roughly constant recovery rate similar to CMS’s actual performance in the most recent fiscal year. In 2015, CBO lowered the projected recovery rate over the 10 year budget window, as a share of all Medicare payments, by 1.0 percentage point and no longer assumed an increasing recovery rate over time. This change in projected recovery rates, likely due to both the pause in FFS RAC operations and changes in other CMS programs, increased 2015 Medicare baseline spending by \$97 billion.

**Figure 4: CBO Projected Recovery Rate vs. Most Recent Year Actual Recovery Rate**



Note: Most recent actual year is the preceding fiscal year. So, for 2010 CBO baseline, the most recent actual year is FY2009. The CBO 10-yr projection is the average recovery rate over the 10-yr budget window. So, for 2010 CBO baseline, the average recovery rate over the then projected window is 1.4 percent

Source: CBO Medicare baselines, 2010-2015

CBO’s updated assumptions of Medicare recoveries are designed to improve the accuracy of its baseline estimates. If the pause in the FFS RAC program becomes permanent, then future CBO baseline estimates will reflect CMS’s adjusted level of effectiveness in recovering improper payments. Rather than evaluate the effect of administrative changes in program management (e.g., between RACs or MACs reviewing claims), CBO assesses the agency’s overall past performance and efficiency when projecting future spending, and then also estimates, when possible, the impact of any legislation changing CMS authority (e.g. ACA expansion of the RACs into Part D and MA).

Budget scoring rules are annually agreed upon by House and Senate Budget Committees, CBO, and the Office of Management and Budget (OMB) to establish consistent scoring practices. Budget Rule 14 forbids “scoring of receipt increases or direct spending reductions for additional administrative program management expenses” unless agency authorities or policies are changed by the legislation.<sup>16</sup>

The impact of Budget Rule 14 is twofold. The rule prevents CBO from having to forecast results of agency management decisions, but it also limits the context in which it can measure the budgetary value of the RACs or similar programs.

<sup>16</sup> Congressional Budget Office. “How Initiatives to Reduce Fraud in Federal Health Care Programs Affect the Budget”. October 2014.

## **Data Sources**

All of the data used for this analysis are made publicly available by the Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services, and the Congressional Budget Office (CBO).

- Medicare Fee-For-Service Improper Payment Report for Fiscal Years 2003-2014 ([link](#))
- CMS Annual Reports to Congress on the Recovery Audit Program for Fiscal Years 2010-2013 ([link](#))
- Congressional Budget Office (CBO) Medicare Baselines for 2010 – 2015 ([link](#))

## **Methodology and Assumptions**

Avalere frequently conducts budget scores for various legislative proposals in a manner intentionally similar to CBO, so that its clients can accurately understand and predict budget implications of legislative proposals. However, for this analysis, since there is no specific legislative proposal under consideration, we used two key assumptions that would likely not be made by CBO at this time:

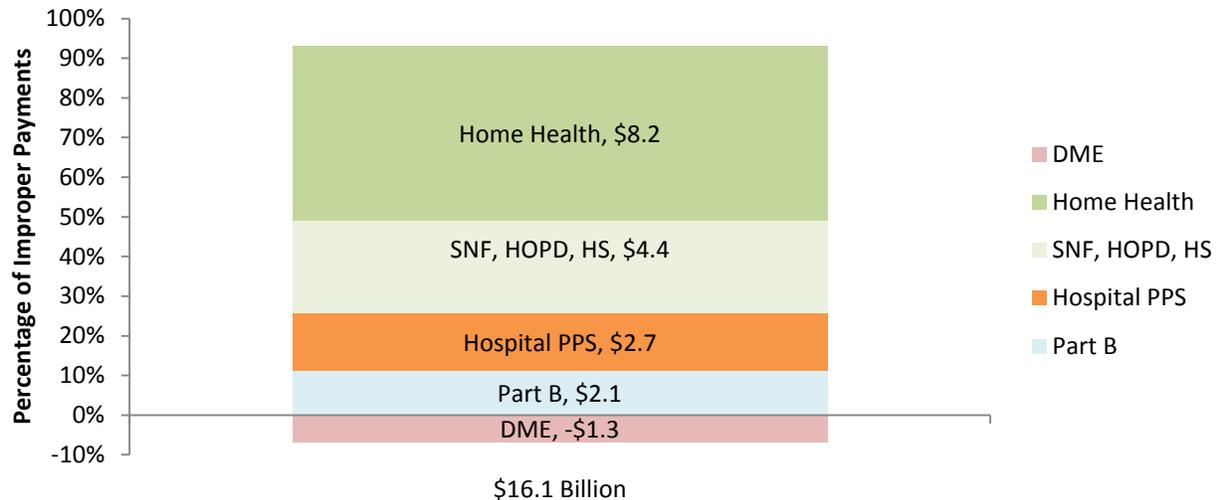
- 1) We assume that the current pause in operations for the FFS RAC program continues throughout the 2016-2025 budget window even though CMS has stated that the pause is temporary.
- 2) We assume that CMS makes only minimal administrative changes to its Medicare claims review process throughout the budget window to compensate for the loss of the FFS RAC program.

To estimate the budgetary effect of the FFS Recovery Audit Program over the next ten years, we assessed both the magnitude of improper payments in Medicare FFS and the historical performance of the RACs. We relied on CMS CERT reports to assess trends for improper payments across the Medicare FFS program. To evaluate the performance of RACs, we used the CMS reports to Congress on the Recovery Audit Program and CBO estimates of total Medicare spending and recoveries.

### ***Overall Estimated Payment Error Rate***

Improper payments grew by \$16.1 billion between July 2010 and June 2013, a period of time when RAC determinations were also growing. Improper payment rates for Part A hospital inpatient claims, which became a primary focus of the RACs, remained relatively stable during this time. However, improper payment rates for other types of claims, especially Part A claims other than hospital inpatient, increased much faster and explain most of the overall growth in improper payments. Home health claims, in particular, account for about 50 percent of the increase in improper payments during this time, due primarily to insufficient face-to-face encounter documentation.

**Figure 5: Change in Improper Payments: from July 2010 to June 2013**



Note: Improper payment amounts are adjusted for appeal adjudication, but not for allowing full Part A to B rebilling  
 Source: Medicare FFS Improper Payments Reports, FY2011 – FY2014

Over the past four years, the Medicare FFS improper payment rate has averaged about 10 percent.<sup>17</sup> Insufficient documentation and medical necessity determinations have been the biggest drivers of improper payments over the past four years, and we expect that trend to continue. Over the past four years, the combined improper payment rate for insufficient documentation and medical necessity errors has averaged about 8 percentage points, fluctuating between 7 percent and 10 percent of Medicare FFS payments.<sup>18</sup> All other types of errors, such as incorrect coding and duplicate billing, averaged about 1.7 percentage points and fluctuated within a narrower range of 1.5 to 1.9 percent of Medicare FFS payments.<sup>19</sup>

To forecast the error rate going forward, we used the five-year average rate for these combined error types, but adjusted downward the rate for home health claims. We anticipate that the recent surge in home health improper payments will dissipate as it partly reflects providers adapting to new Medicare requirements. Overall, we forecast that the combined improper payment rate for all types of errors to average 8.0 percent over the next ten years.

**Estimated RAC Performance**

During the first four years of the RAC program, improper payment determinations grew from \$75 million in FY 2010 to \$3.7 billion in FY 2013. Avalere views FY 2013 as the best available time period for assessing the future performance capabilities of the RAC program. More recent

<sup>17</sup> Adjusted for full Part A to Part B billing and appeals adjudication.

<sup>18</sup>Centers for Medicare and Medicaid, U.S. Department of Health and Human Services. "Medicare Fee-For-Service 2014 Improper Payments Report

<sup>19</sup> Centers for Medicare and Medicaid, U.S. Department of Health and Human Services. "Medicare Fee-For-Service 2014 Improper Payments Report

years are affected by the current pause in operations, and prior years reflect a program wherein RACs were still developing their capabilities.

In FY 2013, RAC recoveries amounted to a recovery rate of 1.0 percent on FFS Medicare payments. However, RAC recoveries stemmed primarily from reviews of hospital inpatient claims, and recent policy changes will transfer much of the RAC review authority in this area to QIOs starting in 2016. Additionally, RAC performance in FY 2013 occurred with review limits in place. For example, in FY 2013 RACs could review up to 75 percent of each type of claim and no more than two percent of a single provider's claims in a given year.<sup>20</sup> More restrictive limits could reduce potential federal savings from the RAC program.

Absent the continued pause in operations, we expect that future RAC recovery amounts will encompass a more diversified portfolio of claim types and providers. Specifically, the newly-defined role of QIOs in reviewing hospital inpatient claims will reduce RAC recoveries from hospital inpatient claims, and RAC capacity will steer toward other types of FFS claims. Based on this expected shift in focus, and assuming no change in RAC review limits, we project that RACs eventually would recover, on average, 1.3 percent of payments if the pause on operations were lifted. Due to the shift in focus, however, we anticipate that it will take the RAC program five years to return to this rate of overall recovery.

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<sup>20</sup> CMS Update on Provider additional development request (ADR) limits <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Recovery-Audit-Program/Downloads/April-2013-Provider-ADR-Limit-Update.pdf>