FLIP FOR THE RAC TIMELINE

A History of the RAC Program

To reduce widespread waste, Congress mandated the creation of the Recovery Audit Contractor (RAC) program to review Medicare claims, identify billing errors and return improper payments back to the Medicare Trust Funds. Since the program began in 2009, **RACs have returned more than $10 billion in improper payments to these Trust Funds and more than $800 million in underpayments to providers.** Recovery auditing has been credited by Senator Claire McCaskill (D-MO) with extending the life of the Medicare program by **two full years*.**

Even with this success, the program has faced consistent opposition from the hospital industry, which spends millions of dollars each year to lobby Congress to end Medicare integrity programs that safeguard taxpayer dollars from waste and abuse.

Fiscal Year	CERT Error Rate	RAC Recoveries
2010	10.5%	$75.4 Million
2011	8.6%	$797.4 Million
2012	8.5%	$2.3 Billion
2013	10.1%	$3.7 Billion
2014	12.7%	$2 Billion
2015	12.1%	$385.9 Million

New Policies Slash Claim Reviews

Despite consistent increases in the Medicare billing error rate (CERT), policy changes have significantly scaled back the Recovery Audit Contractor (RAC) program causing a consistent decrease in the recovery of improper payments.

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A Timeline of the RAC Program

2003:

PILOT PROGRAM CREATED

The Medicare Prescription Drug Improvement and Modernization Act of 2003 created a pilot program to determine if RACs could efficiently and effectively identify and recover improper payments for the Medicare Fee-For-Service (FFS) program.

2005-2008:

CONGRESS EXPANDS PROGRAM

RAC Program operated in six states as a demonstration project. Based on the great success of the pilot, in 2006 Congress passed the Tax Relief and Health Care Act which called for the program to expand nationwide.

2009:

REGIONAL CONTRACTS AWARDED

The RAC Program was created with the mandate to expand to all states by January 2010. Four contracts were awarded for four regions, with each contractor responsible for identifying both overpayments and underpayments in roughly one-quarter of the United States.

FEBRUARY 2014:

AUDITS PAUSED

Due to continued intense pressure from provider groups, who oppose the auditing of their Medicare billing, RAC audit capabilities were first significantly limited and then paused completely while the Medicare billing error rate remained at an all time high.

2014:

SKYROCKETING WASTE

The Government Accountability Office (GAO) found that waste in the Medicare Fee for Service (FFS) program was skyrocketing. Providers were overpaid by $46 billion in FY2014 – a CERT billing error rate of 12.7%.*

FALL 2013:

"AUDIT HOLIDAY"

Provider complaints about audit "burden" caused the Centers for Medicare & Medicaid Services (CMS) to scale back Medicare integrity programs. RACs were prohibited from reviewing short-stay hospital claims, an area with the highest rates of improper billing within Medicare. This two-year "audit holiday" caused the Medicare Trust Funds to lose more than $8 billion.

NOVEMBER 2012:

HHS IDENTIFIES "FREQUENT FILERS"

The Department of Health and Human Services (HHS) Office of the Inspector General (OIG) issued a report identifying "frequent filers" – providers that had filed more than 50 appeals – as the reason for the flood of new Medicare appeals entering the system from FY2010 claims.*

AUGUST 2014:

PROGRAM RESTART

The RAC program restarted on a limited basis but the number of issues auditors were able to review drastically decreased from 800 claim issues to less than 400.

2015:

HISTORIC OVERBILLING

CMS reported that improper payments within the Medicare FFS program remained at historic levels with $43.3 billion in improper payment paid to providers in FY2015 – A CERT error rate of 12.1%*.

JULY 2015:

TRUST FUND THREATENED

The Medicare Trustees projected that, at current spending levels, the Medicare Hospital Insurance Trust Fund would be bankrupt by 2030.

APRIL 2015:

HOSPITALS CITED FOR ALJ BACKLOG

CMS stated that their decision to limit RAC activities was due in part to the appeals backlog. However, Chief ALJ Nancy Griswold testified before the U.S. Senate Committee on Finance that frequent filers were the cause of the Medicare appeals backlog, with 51% of all appeals filed in FY2015 filed by the same five appellants.*

JUNE 2016:

INSOLVENCY APPROACHES

Medicare Trustees report that at current spending levels the Medicare Hospital Insurance Trust Fund will be insolvent in 2028, two years earlier than their 2015 prediction.*

MAY 2016:

AUDITS SCALED BACK

CMS reduced the RAC Additional Document Request (ADR) limit, scaling back review of inpatient hospital claims by 75%. A new risk-based adjusted ADR limit was also added. The new policy allows auditors to review a maximum of 5% of a providers claims, even if the provider makes errors in 90% of their claim submissions.

MAY 2016:

OVERBILLING LIMIT EXCEEDED

A new OIG report finds that Medicare has exceeded the legal threshold for improper payments of 10% for three consecutive years, resulting in a need for the program to submit re-authorization plans to Congress in order to return to compliance.

JANUARY 2016:

QIO'S TAKE OVER SHORT STAYS

CMS moved the review of short inpatient hospital stay claims to the Quality Improvement Organizations (QIOs). Shortly after making this change, the QIOs were halted in their work due to a need for more training, beginning a second "audit holiday" for inpatient hospital providers.

JULY 29, 2016:

RAC CONTRACTS EXPIRE

The current RAC contracts expired. Medicare auditing will be on hiatus until CMS issues new RAC contracts.

*Click text to see original report.

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