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## Press Releases

### Details for: **NEW REPORT SHOWS CMS PILOT PROGRAM SAVING NEARLY \$700 MILLION IN IMPROPER MEDICARE PAYMENTS**

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### **NEW REPORT SHOWS CMS PILOT PROGRAM SAVING NEARLY \$700 MILLION IN IMPROPER MEDICARE PAYMENTS**

The Centers for Medicare & Medicaid Services (CMS) today released a new report offering fresh evidence that the recovery audit contractors (RACs) pilot program is successfully identifying improper payments. The findings will also help the agency improve the program as it is expanded nationwide within two years, officials say.

The evaluation report shows that \$693.6 million in improper Medicare payments was returned to the Medicare Trust Funds between 2005 and March 2008. The funds returned to the Medicare Trust Funds occurred after taking into account the dollars repaid to health care providers, the money overturned on appeal and the costs of operating the RAC demonstration program.

Of the overpayments, 85 percent were collected from inpatient hospital providers, and the other principal collections were 6 percent from inpatient rehabilitation facilities, and 4 percent from outpatient hospital providers.

The program, designed to protect the Medicare Trust Funds and beneficiaries from improper payments, began in California , Florida and New York in 2005 and in July 2007 expanded to Arizona , Massachusetts and South Carolina .

CMS has begun the expansion process by initiating a competition for four permanent RACs after the pilot program ended in March 2008. CMS also has developed a strategy to ensure that the RAC program does not interfere with the transition from the existing Medicare claims processing contractors to the new claims processors, called Medicare Administrative Contractors (MACs). This will

allow the new MACs to focus on claims processing activities before working with the RACs, according to a report evaluating the RAC pilot program issued today by CMS.

When a new RAC begins to issue its first overpayment notification letters, it will be limited to "black-and-white" billing issues, such as duplicate claims and wrong fee schedule amounts.

"Because of the success of the recovery audit contractor pilot, Congress has made the program permanent and required its expansion throughout the country," Acting CMS Administrator Kerry Weems said. "The RAC pilot helped us refine and plan the implementation of the future, permanent national program."

The results described in the evaluation report demonstrate that the RAC program is a needed and useful resource for detecting and correcting past improper payments. CMS continues to evaluate the extent to which the program protects the Medicare Trust Funds from improper payments.

"We need to ensure accurate payments for services to Medicare beneficiaries," Weems said. "With a permanent recovery audit contractor program, people with Medicare can be assured they are being charged correctly for their share of their health care services."

The RACs corrected over \$1 billion of Medicare improper payments from 2005 through March 27, 2008. Roughly 96 percent of the improper payments (\$992.7 million) were overpayments collected from providers, while the remaining 4 percent (\$37.8 million) were underpayments repaid to providers.

Of the \$1 billion in improper payment determinations by the RACs, providers chose to appeal only 14 percent of the RAC decisions. Of all the RAC overpayment determinations, only 4.6 percent were overturned on appeal. Throughout the demonstration, the RAC program has cost only 20 cents for each dollar collected.

The evaluation report found that the RAC program has had a limited financial impact on most providers. For example, in fiscal years 2006-2008, over 84 percent of hospitals in California, Florida and South Carolina had their Medicare revenue impacted by less than 2.5 percent, while in New York and Massachusetts over 94 percent of hospitals had their Medicare revenue impacted by less than 2.5 percent.

"A key part of the future recovery audit contractor program will be to contract with a RAC validation contractor to conduct independent third-party reviews of RAC claim determinations," Weems said. "Other changes will include limiting the claim review look-back period to three years, requiring each RAC to hire a medical director, and conducting significant outreach to providers. These and other program improvements are a direct result of lessons learned from the pilot program."

The RAC program was created by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) to find and correct improper Medicare

payments paid to health care providers participating in fee-for-service Medicare.

Medicare processes more than 1.2 billion Medicare claims annually, submitted by more than one million health care providers, including hospitals, skilled nursing facilities, physicians and medical equipment suppliers. Errors in claims submitted by these health care providers for services provided to Medicare beneficiaries can account for billions of dollars in improper payments each year.

Most of the improper payments that the RACs identified occurred when health care providers submitted claims that did not comply with Medicare's coverage or coding rules. The types of inadvertent errors leading to improper payments, found by the RACs include billing for a procedure multiple times (for example, when a health care provider charged Medicare for conducting three colonoscopies on the same patient on the same day), incorrectly coded procedures, and submission of duplicate claims resulting in two payments to a provider.

The permanent RAC demonstration is a key tool that CMS will use to ensure that payments to health care providers are accurate and proper and that the number of errors in Medicare claims continues to decline. Medicare calculates the error rate – the amount of incorrect claims submitted by health care providers – as part of the Comprehensive Error Rate Testing (CERT) program.

Since CMS began the program, the error rate dropped from 14.2 percent in 1996 to 3.9 percent in 2007. This decline in improper payments reflects CMS' efforts to target erroneous claims processing, inaccurate billing and errors by health care providers.

Implementation of the RAC program has been guided by reports from the Department of Health and Human Services' Office of Inspector General and the Government Accountability Office. The RACs in the demonstration returned funds to the Medicare Trust Funds based on the recommendations included in these reports and experience gained from their work conducting audits of Medicaid and the private sector health care claims.

The RAC demonstration, authorized in the MMA, was required by Congress to be a permanent part of Medicare in the Tax Relief and Healthcare Act of 2006. The law states the national program must be implemented by Jan. 1, 2010.

For more information on the RAC program and to view the evaluation report, visit: <http://www.cms.hhs.gov/RAC>

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