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First Annual RAC Report: Mo is the "Big Winner"

Recently, the Centers for Medicare and Medicaid Services (CMS) issued the first annual report to Congress detailing the findings of the Recovery Audit Contractor (RAC) program. Established in 2003, the RAC program identifies Medicare billing errors with the aim of improving accuracy through efficient and effective operation and increased program transparency. Through a post-payment review of the 2010 Fiscal Year (October 1, 2009 – September 20, 2010), the RAC report presents and analyzes data regarding Medicare reimbursement errors to hospitals, physician offices, medical suppliers, ambulance services, nursing homes, and other providers. The report published the cumulative quality of overpayments and underpayments by each state and found that Missouri providers were owed more than $3 million in underpayments – the most of any state.[1]

The RAC program identifies improper Medicare payments based on three categories: (1) payment for medically unnecessary services; (2) payment for incorrectly coded services; and, (3) payment for services not supported by sufficient documentation. Medicare payments that require a correction include both overpayments and underpayments to providers.[2] An overpayment occurs when the provider is reimbursed an excess amount for a given claim and results in a provider owing Medicare the overpayment back. Conversely, an underpayment occurs when the Medicare reimbursement received by providers is less than the costs of providing care and results in Medicare owing providers extra reimbursement funds.[3]

Within the 2010 Fiscal Year, the RAC program corrected 191,878 claims, adjusting $92.34 million in reimbursement errors. This included 185,065 claims classified as underpayments, totaling $75.44 million, with an average claim amount of $408, and 6,813 overpayment claims, totaling $16.90 million, with a $2,481 average claim amount.[4] After both overpayments and underpayments were accounted for, nationally, CMS was owed approximately $58,535,556.[5]

Though the report did not include information regarding specific reasons for Medicare reimbursement underpayment errors, it did indicate that Missouri had more errors than any of its Region D counterparts.[6] In Missouri, 9,347 claims included Medicare reimbursement errors, involving a total of $5.35 million. Of these claims, 8,309 claims were classified as underpayments with an average claim amount of $280 summing a total of approximately $2.33 million. Missouri underpayments summed a total of $3.02 million, which included 1,038 claims with an average claim amount of $2,912.[7]

Overall, only six states received payments from CMS for greater underpayments (i.e., the amount owed to providers in a state) then overpayments (i.e., the amount providers within a state owed CMS). When total corrections were taken into account, Missouri providers were owed the greatest amount by CMS (approximately $693,373) followed by providers in the states of Iowa (approximately $240,997); Nebraska (approximately $118,807); Nevada (approximately $39,527); Vermont (approximately $39,371); and, Maine (approximately $14,708). Over the one year period, most states' providers owed funds to the Medicare program. California owed the most, approximately $6,687,702, followed by Florida (nearly $6,537,578), and Texas (approximately $5,579,543).[8]

The RAC program aims to make Medicare more accurate. Accurate payment to healthcare workers provides incentives for high quality care and may ease frictions between providers and CMS regarding incorrect payments. Regardless of the overall success of the RAC program, providers express concerns surrounding increased monitoring and expansion of the RAC program.[9] While this is likely because majority of states' providers were required to return substantial overpayments to CMS, the Medicare system as a whole is expected to become more efficient and effective as a result of the RAC Program.

1 "Implementation of Recovery Auditing at the Centers for Medicare and Medicaid Services: FY 2010 Report to Congress As Required By Section 6411 of Affordable Care Act" Centers for Medicare and Medicaid Services, (2011); "Medicare Shortchanges Missouri the Most, Audit Finds" By David Twiddy, Kansas City Business Journal, October 3, 2011, http://www.bizjournals.com/kansascity/news/2011/10/03/medicare-shortchanges-missouri-most.html?s=print (Accessed 10/11/2011).

2 CMS "Implementation of Recovery Auditing at the Centers for Medicare and Medicaid Services: FY 2010 Report to Congress," 2011, p. 2.

3 Ibid; "Underpayment by Medicare and Medicaid Factsheet" American Hospital Association, December, 2010,

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http://www.aha.org/content/00-10/10medunderpayment.pdf (Accessed 12/1/11).

4 CMS "Implementation of Recovery Auditing at the Centers for Medicare and Medicaid Services: FY 2010 Report to Congress," 2011, p. A6-A7.

5 Calculations conducted from data included in CMS "Implementation of Recovery Auditing at the Centers for Medicare and Medicaid Services: FY 2010 Report to Congress," 2011, p. A6-A7.

6 David Twiddy "Medicare Shortchanges Missouri the Most, Audit Finds," October 3, 2011.

7 CMS "Implementation of Recovery Auditing at the Centers for Medicare and Medicaid Services: FY 2010 Report to Congress," 2011, p. A6-A7.

8 Calculations conducted from data included in "Implementation of Recovery Auditing at the Centers for Medicare and Medicaid Services: FY 2010 Report to Congress," 2011, p. A6-A7.

9 "Letter to CMS from MGMA RE: Medicaid RAC" By William F. Jessee President and CEO-Medical Group Management Association, To Donald Berwick Administrator-Centers for Medicare and Medicaid Services, January 10, 2011.

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Robert James Cimasi, MHA, ASA, FRICS, MCBA, AVA, CM&AA, serves as President of **HEALTH CAPITAL CONSULTANTS** (HCC), a nationally recognized healthcare financial and economic consulting firm headquartered in St. Louis, MO, serving clients in 49 states since 1993. Mr. Cimasi has over thirty years of experience in serving clients, with a professional focus on the financial and economic aspects of healthcare service sector entities including: valuation consulting and capital formation services; healthcare industry transactions including joint ventures, mergers, acquisitions, and divestitures; litigation support & expert testimony; and, certificate-of-need and other regulatory and policy planning consulting.

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