



STATEMENT OF
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ON

**THE IMPACT OF CMS REGULATIONS AND PROGRAMS ON SMALL
HEALTH CARE PROVIDERS**

BEFORE THE

HOUSE SMALL BUSINESS COMMITTEE
SUBCOMMITTEE ON REGULATIONS, HEALTH CARE, AND TRADE

May 14, 2008



**Testimony of
Timothy B. Hill
Director, Office of Financial Management
Centers for Medicare & Medicaid Services
Before the
House Small Business Committee
Subcommittee on Regulations, Healthcare and Trade
Hearing on
“The Impact of CMS Regulations and Programs on
Small Health Care Providers”**

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Chairman Gonzalez, Mr. Westmoreland, and distinguished members of the Subcommittee, thank you for inviting me here today to discuss the Recovery Audit Contractor (RAC) program and how it affects Medicare providers that are small businesses.

The Centers for Medicare & Medicaid Services (CMS) is committed to being effective and accountable stewards of the public resources entrusted to us. CMS is dedicated to managing our programs in a fiscally responsible manner to ensure our resources are used wisely and efficiently. As part of that effort, we are actively engaged with the Congress and the provider community to ensure accurate and appropriate reimbursement payments to all Medicare providers. Given the size and scope of the Medicare program, now and in the future, it is critical that CMS maintain a commitment to fiscal integrity as the Agency moves from a passive payer to an active purchaser of high-quality, efficient, and cost-effective care.

Identifying Improper Payments

The Department of Health & Human Services (HHS) has been measuring improper payments in the Medicare program since 1996 and was a model for the Improper Payment Information Act (IPIA), enacted in 2002, which requires all Federal agencies to annually review their programs and activities to identify those susceptible to significant improper payments. In January of 2008, the Office of Management and Budget reported

that Medicare is one of the top three Federal programs making improper payments, with an estimated \$10.8 billion in improper payments made in Fiscal Year (FY) 2007.

To fulfill IPIA's statutory requirement and safeguard the fiscal integrity of the Medicare program, CMS has developed a variety of tools to reduce payment errors in the Medicare program and to ensure the proper use of taxpayer dollars. These tools include policy development, provider education, claims review processes, and recovery processes when improper payments are identified. RACs are not tasked with identifying civil or criminal fraudulent payments.

CMS' efforts to reduce improper payments have been successful, even though we know that more work remains. Since 1996, CMS has reduced the Medicare fee-for-service error rate from 13.8 percent to 3.9 percent.

RAC Demonstration Summary

It is in the context of significant Medicare payments errors that Congress passed Section 306 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), directing HHS to conduct a three-year demonstration program using RACs to detect and correct improper payments, primarily from coding errors, in Parts A and B of the Medicare program.

The Act required the demonstration to be conducted in at least two of the states with the highest Medicare utilization rates. California, New York, and Florida were chosen for the initial demonstration program, as they represent three of the largest Medicare utilization states, and contracts for RACs were selected using a competitive bid process. It is worth noting that one of the three claim review RACs that CMS selected to conduct the demonstration is a small business.

The demonstration program was conducted from March of 2005 through March of 2008, expanding beyond the three initial States of California, New York, and Florida to include Arizona, Massachusetts, and South Carolina in July of 2007, although no claims were

ultimately reviewed in Arizona. During the demonstration, the contractors were tasked with detecting underpayments and overpayments in the Medicare program and correcting those improper payments, by either collecting the overpayments or paying back providers who were underpaid.

The demonstration corrected a total of more than \$1 billion in improper payments during its three-year run. This amount includes both overpayments collected from providers and underpayments refunded to providers. The RAC demonstration program has cost only 20 cents for every dollar collected. In addition to uncovering substantial savings, the RAC program has also provided information to CMS and the Medicare claims processing contractors that can be used to further protect the Medicare Trust Funds by preventing future improper payments.

While this \$1 billion in improper payments are significant, it is worth noting that they were identified from a universe of \$317 billion in Medicare payments that were available for review by the RACs during the demonstration. This amounts to a 0.3 percent error rate, significantly lower than the national Medicare fee-for-service error rate of 3.9 percent.

Of the \$980 million collected by the RACs, only \$12.8 million, or 1 percent, were overpayments that had been made to physicians. In fact, the vast majority of overpayments (more than 84 percent) were collected from inpatient hospitals. The remaining 15 percent were collected from outpatient hospitals, skilled nursing facilities, durable medical equipment (DME) suppliers, ambulance suppliers, clinical laboratories, and other providers. Over half of the overpayments to physicians were due to billing for an incorrect number of units. (For example, billing for six vials of a drug when the physician only administered one vial of the medication to the patient.)

It is important to note that if a provider disagrees with a RAC's overpayment determination, he or she can appeal the decision through the normal Medicare appeals process.

Transition to Permanent RACs

Because the demonstration program has been successful in identifying and correcting improper payments, Congress, in Section 302 of the Tax Relief and Health Care Act of 2006 (TRHCA), required HHS to make the RAC program permanent and expand it nationwide by no later than January 1, 2010. The results of the demonstration program are currently under review, and a comprehensive report will be issued to inform on optimal approaches for expanding the RAC program consistent with Section 302 of TRHCA. The evaluation of the demonstration has focused on some valuable lessons that were learned throughout the course of the demonstration project, and as a result of the feedback and experience of the demonstration, CMS has already made some important improvements and protections that will be in place when the permanent RAC program begins.

For example, both a Medical Director and certified coding experts will be required to be employed by all permanent RACs. In the demonstration project, no Medical Director was required, and coding experts were optional. Additionally, during the demonstration, RACs were only required to pay back their contingency fees if they lost a first-level appeal, but not at subsequent levels. Permanent RACs must pay back their fees if they lose at any level of appeal. Permanent RACs will also be able to review claims in the current fiscal year, whereas, the demonstration program RACs were not able to review current claims. In the demonstration, there was no maximum look-back date. In the permanent program, RACs will be able to look back for improper payments for up to three years, though no earlier than claims paid before October 1, 2007. CMS will require the permanent RACs to operate web-based systems so that providers who are involved in an audit will have secure online access to information that explains the status of their claims in the RAC audit process. None of the RACs in the demonstration had this capability. In the demonstration CMS did not set a limit on the number of medical records that could be requested by a RAC. In the national RAC program, CMS will establish a record limit that will vary by a biller's size to protect small providers from undue administrative burden.

Most importantly, under the permanent and nationwide RAC program, CMS will place a much greater emphasis on provider education and training as part of the RAC program. For example, CMS will require RACs to seek CMS approval before beginning medical necessity reviews of provider claims. These reviews sometimes involve “grey” areas of Medicare policy and CMS oversight will ensure that providers are not unduly burdened or second-guessed by the RACs. Additionally, CMS will require the permanent RACs to identify and publish vulnerability analyses so that the provider community can better understand where mistakes are being made so they can correct those errors before an audit would begin.

CMS hopes to have selections of the national RAC contractors made later this spring so that claim review can begin this calendar year.

Provider Outreach

As CMS moves towards a phased-in, nationwide implementation of the RAC program, CMS is committed to ensuring that Medicare physicians and other providers have sufficient information on how the program will work and what changes, if any, providers can expect.

Under the demonstration program, CMS worked very hard to take into account the concerns of individual physicians. CMS specifically excluded from review physician claims for evaluation and management services precisely because of the considerable confusion that can be associated with review of these physician services.

CMS also worked very closely with physician and other provider groups to ensure that they understood how the demonstration program was progressing. This included monthly meetings with the American Medical Association (AMA) and members of the affected State medical associations to discuss specific issues that arose during the course of the demonstration. Many of these discussions were helpful for making improvements to the demonstration as it was happening. For example, the AMA helped draft a physician-friendly medical record demand letter which was piloted in one state during the

demonstration. CMS representatives also attended on-site meetings with local medical societies in New York and Florida.

When specialty-specific issues arose, CMS held meetings with representatives from the affected specialty societies to address their concerns. In addition, an e-mail account was set up specifically for RAC inquiries, and CMS was thus able to answer questions from physicians, which generally consisted of individualized concerns. Similarly, CMS met regularly with the Practicing Physicians Advisory Council to update this HHS advisory group on the status of the demonstration and to seek their input and suggestions for program improvement.

In addition to the information found on the Physician Regulatory Issues Team (PRIT) website and e-mail address, which aim to eliminate unnecessary regulatory burdens on physicians, 26 PRIT outreach events in the last year have featured RAC provider education presentations, and the director of PRIT authored a RAC article that was distributed to physician trade associations to be used for their own publications.

The RAC-specific e-mail account previously mentioned will continue to operate during the program expansion as a method for addressing individual physician questions. The CMS staff who oversee the RAC contracts have worked diligently to resolve physician concerns and the discussions with the AMA and State medical associations helped CMS draft a Request For Proposal (RFP) for the permanent RACs which ensures that these new RACs will be more physician friendly. The RFP for the new RACs, for instance, requires that the RAC employ an M.D. or D.O. as a Contractor Medical Director (CMD). Providers rely heavily on their local carrier medical directors, so having a doctor in this role at the RAC will be helpful and reinforce the importance of the RAC program.

CMS staff and physicians running the RAC program continue to lead the communication efforts with the AMA and State medical associations as CMS prepares to launch the permanent RAC program. After the companies that will be the permanent RACs are

selected, CMS and the new RACs will conduct extensive provider outreach, including visits with local medical provider organizations and representatives in each State.

Even now, CMS continues to hold monthly conference calls with the AMA and State medical associations to address areas of future concern. The State medical associations are also currently partnering with CMS to prepare a bulletin that will inform physicians about the expansion of the RAC program, which will be sent to the entire membership of each State's association.

CMS is also utilizing its standard methods of provider outreach and education, including listserv e-mail messages that are distributed widely among national and regional provider trade associations, Open Door Forums, *Medicare Learning Network (MLN) Matters* articles, press releases, Provider Partnership Programs, Regional Office outreach activities, and publication of the RAC website address, which includes links to Frequently Asked Questions and contact information for each RAC. These multifaceted initiatives demonstrate the Agency's ongoing commitment to educate providers about upcoming changes in the Medicare program.

Conclusion

The RAC demonstration program has proven to be successful in identifying past improper Medicare payments and recognizing ways to prevent them in the future. Moreover, the demonstration program has provided helpful feedback for CMS as the Agency prepares to implement the expansion of the RAC program, as authorized by Congress. CMS views the RAC program as a complement to its existing program integrity activities and a valuable new tool for ensuring the integrity of Medicare provider payments. We believe that the implementation of the permanent RAC program will support ongoing beneficiary access to care by ensuring the appropriate expenditure of taxpayer resources and supporting the financial integrity of the Medicare program. Thank you for your time and I would be happy to answer your questions.