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additional resources available at [www.wha.org](http://www.wha.org)

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## CMS Recovery Audit Contractors (RACs)

### Resources

Preparing for RAC Audits in Wisconsin – Are You Ready? (July 2008)

<http://www.wha.org/financeAndData/pdf/RACwhitepaper7-08.pdf>

### WHA Web site information:

<http://www.wha.org/governmentRelations/rac.aspx>

### Background

*The Medicare Modernization Act of 2003* established the Medicare Recovery Audit Contractor (RAC) three-year demonstration program to identify improper Medicare payments – both overpayments and underpayments. In the *Tax Relief and Health Care Act of 2006*, the RAC program became permanent and the Centers for Medicare & Medicaid Services (CMS) was authorized to expand the program to all 50 states by 2010. The RAC program was initially scheduled to roll out in phases across the nation through 2009; however, on October 18, 2007, an RFP issued by CMS indicated the intention to have RACs review inpatient and outpatient hospital claims for coding errors in all 50 states by March 2008. Several weeks later CMS again reversed course and returned to a phase-in approach for the RAC program through 2009. The current roll-out schedule has RAC review coming to Wisconsin in January 2009.

### RAC Program Overview

Under the program, RACs are able to review the last three years of provider claims (but only back to Oct. 1, 2007) for the following types of services: hospital inpatient and outpatient, skilled nursing facility, physician, ambulance and laboratory, as well as durable medical equipment. RACs are paid on a contingency fee basis, receiving a percentage of the improper overpayments and underpayments they collect from providers. They are authorized to perform “automated reviews” (ie: no human review of claims data) and “complex reviews” (human review of claims data) to identify potential payment errors in such areas as duplicate payments, fiscal intermediaries’ mistakes, medical necessity and coding. During fiscal year 2006, the RACs collected \$69 million in overpayments and found \$3 million in underpayments.

### RAC Program Problems

The RAC demonstration has been operating in California, Florida and New York and each state has experienced a variety of problems. Some of WHA’s concerns include:



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- Hospitals strive for payment accuracy and are committed to continuing to work with CMS and its contractors to ensure the validity of hospital payments. However, WHA has serious concerns about whether the RAC program is necessary. CMS already employs Fiscal Intermediaries, carriers, Medicare Administrative Contractors (MACs), the CERT program, Program Safeguard Contractors (PSCs) and Quality Improvement Organizations (QIOs) to administer Medicare payment, coverage and medical necessity determinations. Additional oversight is provided by the Office of the Inspector General. Rather than add yet another layer to this convoluted process, issues should be addressed within the current contractors already overseeing Medicare payment compliance.
- RAC contractors are paid on a contingency fee basis, giving RACs the incentive to aggressively deny any claims that appear at all questionable. This “bounty hunter” payment system forces providers into an appeals process in order to receive appropriate payment. A flat fee unrelated to claims collections would be a far fairer approach.
- Medical necessity determinations should be removed from the RACs’ purview. These are too complex and patient-specific for untrained professionals to assess and make payment determinations on.
- The four year “look-back” period for RAC review, which CMS has recently reduced to 3 years, is still too lengthy. At best, a 12-month window should be in place.
- CMS should play a more diligent role in overseeing the RACs and their activities.
- While the law states that RACs are to look for underpayments, the experiences of the demonstration states show this receives far less attention (69 million in overpayments to \$3 million in underpayments).

### WHA Next Steps

After learning from other states that have gone through the transition to RAC audits, it is clear that this initiative will be burdensome and potentially costly for hospitals. Representatives from the California, New York and Florida hospital associations have shared their RAC implementation experiences and it is also clear that there is an important member education role for hospital associations to play. There is also a public policy role for WHA as we work with American Hospital Association to make sure that the RAC follows the approved scope of work and has rules and protocols for their reviews. California, in particular, has had significant issues with their RAC denying claims that hospitals ultimately recovered during the appeals process. **With these experiences in mind, the following are some activities WHA will undertake to help Wisconsin hospitals deal with this new initiative:**

- Create a RAC Task Force to help guide WHA activities. This will be multidisciplinary, reflecting the need to draw in financial, legal and clinical expertise.
- Establish an ongoing relationship with Wisconsin’s selected RAC.
- Help facilitate and promote training and education opportunities in cooperation with the RAC and CMS.
- Identify other educational opportunities in this area.
- Establish and maintain a database of RAC liaisons at each Wisconsin hospital.
- Develop a list serve tool so hospitals can share their experiences as they move through these claims reviews.

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