RACs rock, so stop gutting the program

By Tom Schatz, November 3, 2014

On Sept. 29, the Centers for Medicare and Medicaid Services (CMS) released its annual report to Congress on the Recovery Auditing Contractor Program (RACs). The RACs scour Medicare fee-for-service claims for improper payments, examining about 2 percent of the more than 1 billion annual Medicare claims since the RAC program went nationwide in 2009. RACs have identified a total of $9.7 billion in billing errors, overpayments and underpayments, and returned $8.9 billion to the Medicare Trust Fund. In fiscal year FY 2013, RACs recovered $3.65 billion, compared to $1.35 billion in 2012.

There wasn't much new about the Medicare program in the report; it continues to be plagued by improper payments, 94 percent of which are related to hospital inpatient stays. RACs have been focused on those payments.

Yet, perhaps because they been atypically successful, RACs have been under attack and are in danger of being crippled permanently. Not surprisingly, the complaints emanate from providers, particularly hospitals, whose error-ridden claims have been under the fiscal microscope. The American Hospital Association (AHA) believes that the RACs' demands for claims documentation are onerous and costly, bristles at what it views as a bunch of green eyeshade pencil pushers second-guessing the judgment of medical personnel after the fact, and argues that hospitals should be compensated for care at some level, even when claims submissions are incorrect.

More surprising is criticism from members of Congress, especially fiscal conservatives who otherwise are enthusiastic about fighting waste. Indeed, there have been two improper payments improvement bills signed into law since 2010, demonstrating strong bipartisan support to get them under control.

Providers also complain about the Medicare post-payment review system, and here they do have a point. It is outmoded and sclerotic, and providers must comply with the demands made by multiple auditors, all operating under conflicting rules and deadlines. The Government Accountability Office has issued multiple reports on the post-payment review regime and concluded that the CMS's claims database that was created to untangle that process "was not designed to provide information on all possible duplication, and its data are not reliable because other post-payment contractors did not consistently enter information about their reviews. CMS has not provided sufficient oversight of these data or issued complete guidance to contractors on avoiding duplicative claims reviews."

Streamlining the post-payment review process makes eminent good sense. But providers have instead focused their ire on decimating the RACs because they don't like the paperwork or paying back the erroneous overpayments. Contrary to the AHA's overheated rhetoric, RACs are not permitted to randomly chase any claims they see fit; CMS prepares an annual Comprehensive Error Rate Testing program, which identifies the types of claims most vulnerable to errors and abuse. RACs can only audit claims that are pre-authorized by CMS.

The effort to undermine the RAC program now includes a scheme by hospitals to appeal all RAC decisions, even though only 9.3 percent of all decisions get overturned, and, according to the October CMS report, RACs have an average accuracy rate of 96 percent. As a result, the appeals process has a two-year backlog and new appeals have been temporarily suspended.

On Aug. 29, CMS announced that it would offer to refund 68 cents for every dollar in dispute for claims in the appeals pipeline; in exchange, hospitals would drop the appeals. This arbitrary and questionable offer attracted the attention of House Ways and Means Subcommittee on Health Chairman Kevin Brady (R-Texas), who sent a letter on Sept. 15 to Health and Human Services Secretary Sylvia Burwell, requesting information on CMS's authority to craft such a deal, the empirical data for the formula and the costs to taxpayers, Medicare beneficiaries and the trust fund.

Regardless of the secretary's response, CMS's proposal is an atrocious deal that will cost billions for taxpayers and the Medicare Trust Fund. Furthermore, it sets a terrible precedent, essentially rewarding providers for submitting improper claims for medically unnecessary procedures and then abusing the appeals process to force a financial settlement. That will damage the trust fund and do nothing to clear up the inefficient thicket of Medicare claims auditing procedures. It will also encourage entities that have been overpaid by other federal agencies to creatively attempt to hold on to their ill-gotten gains.

Congress can help fix the Medicare auditing process, but that will be a Pyrrhic victory if members continue to bow to pressure and assist in gutting the RAC program, the most successful tool for Medicare program integrity that taxpayers have ever had.