

CMS-RAC Initiative and Private Contracting with Beneficiaries Key Topics at National Medicare Conference

Two topics that were of significant interest to the participants at ICA's National Medicare Conferences in Washington, DC and were discussed at length were the CMS-RAC initiative and the potential for private contracting with Medicare beneficiaries.

CMS-RAC Initiative

Given the experience of the chiropractic profession with Medicare post-payment reviews and demands for repayment, also of considerable concern to conference participants, was the Centers for Medicare and Medicaid Services (CMS) Recovery Audit Contractor (RAC) program.

Through the RAC initiative, which covers all providers filing Medicare claims including doctors of chiropractic, private contractors are credentialed by CMS to review Medicare Part A and B claims to determine whether overpayments or underpayments have been made. This effort is in addition to the regional carrier's on-going claims review processes. According to the authorizing statute:

Review of activities of providers of services or other individuals and entities furnishing items and services for which payment may be made under this title (including skilled nursing facilities and home health agencies), including medical and utilization review and fraud review (employing similar standards, processes, and technologies used by private health plans, including equipment and software technologies which surpass the capability of the equipment and technologies used in the review of claims (by existing procedures).

In a break with existing procedures, RACs are paid a contingency fee of 20 to 35 percent on every alleged overpayment they identify, and keep their fees even if the denials are overturned after the first level of review. The law stipulates that RAC contractors can only be paid out of amounts recovered, raising concerns throughout the health care community about the potential for overly aggressive collections efforts. In addition, the reach of such contractors can go back as far as five years.

RAC authority was first authorized by Congress in 2003 as a means to help address inappropriate payments in Medicare. Medicare has been continually identified by the Government Accountability Office (GAO) as one of the top three federal programs with the largest improper payments, finishing third behind Medicaid, with \$12.9 billion, the IRS earned income tax credit benefit at \$11.4 billion and Medicare posting an estimated \$10.8 billion.

What began as a demonstration project in 2005 in just three states will now become a permanent, standard part of the CMS claims review process. In February 2008, CMS published documents making it official that the pilot "Recovery Audit Contractor (RAC) program would gradually be expanded nationwide, covering all states by 2010. The purpose of the RAC initiative is to recover the large amounts of overpayments annually es-

timated for the Medicare program. From 1996 through 2002, the Office of Inspector General published annual Medicare fee-for-service error rates. These showed net projected overpayments (overpayments minus underpayments) of \$23.2 billion in 1996 and a general trend down to \$13.3 billion in 2002.

The Recovery Audit Contractor (RAC) demonstration program was designed to determine whether the use of RACs would be a cost-effective means of adding resources to ensure correct payments are being made to providers and suppliers and, therefore, protect the Medicare Trust Fund. The demonstration was conducted in New York, Florida and California. CMS officially reported to Congress that, "The RAC demonstration program has proven to be successful in returning overpayments to the Medicare Trust Funds and identifying underpayments for providers. The program returned a significant amount of improper payments to the Medicare Trust Funds while limiting, to the extent possible, the burden on the provider community and the Medicare claims processing contractors."

While the CMS report that came out in February of 2008 spoke about the utility of extending the program nationwide as a permanent Medicare activity, Congress had already acted to make its permanent status official through the Tax Relief and Health Care Act of 2006, apparently anticipating a positive outcome to the "demonstration" phase of the program.

ICA had made repeated requests to CMS to provide an official representative from the agency to address the RAC program at the April 24th Medicare Conference, but the agency declined, even after Members of Congress joined the call for the participation of a CMS spokesperson. Calling the program an "emergent" activity, in a very rare decision CMS declined to discuss the matter in a public chiropractic forum. This refusal in itself does not bode well for the provider community.

The RAC initiative has not been without its critics. Claims reviews that resulted in nearly all post-surgical knee or hip replacement rehabilitation claims being rejected, along with a number of heavy-handed actions on the part of a few contractor's employees, motivated Rep. Lois Capps, (D-CA) and Rep. Devin Nunes, (R-CA) to introduce HR 4105, The Medicare Recovery Audit Contractor Program Moratorium Act of 2007. This bill would substantially put the brakes on the RAC program until Congress agrees that all of the program's flaws have been corrected. This legislation currently has 77 co-sponsors from both sides of the aisle.

Congress is currently more attuned to possible concerns with federal outsourcing programs such as Medicare's RAC contractors, following the recent findings that the Internal Revenue Service (IRS) efforts at outsourcing the collection of back taxes cost millions more than the effort brought in. In that program, private collection agents were not bound by the same procedures and behavior protocols that govern

federal employees and it has been demonstrated that in many instances, contractors did not adequately safeguard individual tax payer information, such as Social Security numbers.

Potential for Private Contracting with Medicare Beneficiaries

Another issue that was discussed in-depth was the growing demand by many in the chiropractic profession for the option to privately contract with Medicare patients, with no government role. This is because of their frustration with Medicare's fee structures, documentation demands and what is perceived by many as anti-chiropractic attitudes on the part of Medicare administrators.

At present, some health care professionals can, after meeting stringent conditions, enter into private contract arrangements with Medicare eligible individuals. Doctors of chiropractic cannot. Many chiropractors believe the law should be changed to include DCs in this pool of eligible private contract providers. This change would require legislation. In addition, the terms under which a provider can "opt out," as private contracting has come to be known, are stringent to the point of being excessive. Under the current law, a provider must refrain from accepting any federal payment for a period of two full calendar years before becoming eligible to enter into private contract agreements.

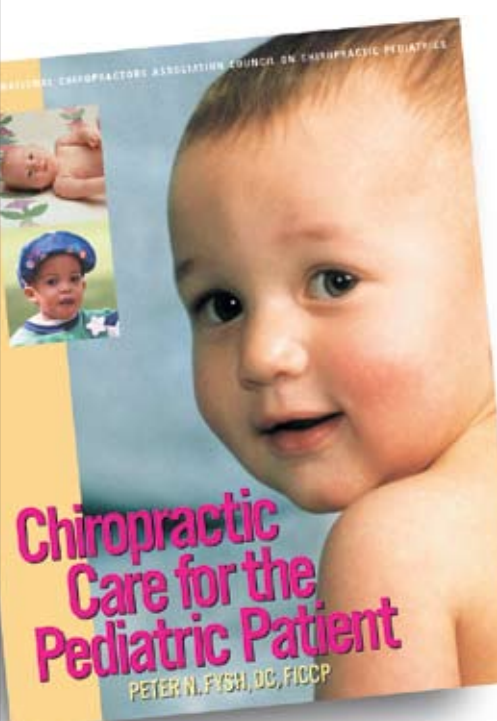
Representatives of all participating national associations present at this con-

ference were in agreement that doctors of chiropractic should be added to the list of providers eligible to enter into private contracts with Medicare patients. They also agreed that the terms of private contracting for any professional were harsh and not at all attractive, and that to make such an option meaningful, changes in the private contracting rules would need to be made. This would also require a change in the statute by Congressional action. The prospects for such a change, however, do not appear very favorable.

In the years following the passage of the 1997 Balanced Budget Act that included the initial "opt-out" provisions, Senator John Kyl (R-AZ) introduced the Medicare Beneficiary Freedom to Contract Act to amend Section 4507 by eliminating the two-year dis-enrollment period. The measure stalled in Congress, and no comparable measure is presently being seriously considered. This was, in part, because HHS reported that fewer than 500 physicians have sought to exercise the "opt-out" authority, and more than half of those were psychiatrists. In recent years, however, as Medicare fees have been reduced and with still pending cuts of an additional 15 percent in 2008 and 2009, new life is being breathed into these revision efforts.

For those so authorized, private contracting decisions may not be made on a case-by-case or patient-by-patient basis, however. Once physicians have opted out

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