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CMS Publishes Solicitation for Industry Comment on RAC Program Expansion to Medicare Part C and Part D: Plans and Their Contracted Providers Should Consider Submitting Comments by February 25, 2011, Deadline

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On Monday, December 27, 2010, the Centers for Medicare & Medicaid Services ("CMS") published a solicitation for public comments ("Solicitation for Comments") regarding the expected implementation of the Recovery Audit Contractor ("RAC") program to the Medicare Part C and Part D programs. 75 Fed. Reg. 81278 (Dec. 27, 2010). RAC auditing has been underway in the Medicare fee-for-service ("Medicare FFS") program. CMS is now expanding RAC audits beyond Medicare Parts A and B to include Parts C and D as well, as authorized by the Affordable Care Act ("ACA" a/k/a "Health Reform").[1] The Solicitation for Comments requests industry feedback on several key issues arising under the pending RAC program expansion. Comments are due by February 25, 2011. Managed care organizations ("MCOs") that contract with CMS to operate Medicare Advantage ("MA") and Medicare Part D Prescription Drug program lines of business – as well as their contracted providers and Part D pharmacies – are well-advised to submit comments to CMS to help inform the government as to the issues surrounding the expansion of the RAC audit program to the MA and Part D programs.

"Given the fundamental differences between Medicare FFS and the Medicare Parts C and D programs and since this is the first time we have attempted to expand RACs to other parts of the Medicare program, we are soliciting the views of industry stakeholders on how to best implement the RAC program requirements established in section 6411(b) of ACA for the Medicare Part C and Part D programs," CMS says in the Solicitation for Comments (75 Fed. Reg. at 81279). Filing these public comments now

[1] ACA consists of H.R. 3590 (the Patient Protection and Affordable Care Act) and H.R. 4872 (the Health Care and Education Reconciliation Act of 2010).

is one of the best ways to shape this new initiative to accommodate the realities of the Medicare Part C and Part D programs.

This EpsteinBeckerGreen Client Alert gives a brief history of the RAC program as it has applied to the original Medicare FFS program, and then identifies the potential issues for consideration regarding expansion of the RAC program to Medicare managed care and Part D.

A Brief History of the RAC Program

MCOs may not realize that the RAC program was originally authorized by Congress at the same time that Medicare Part D became effective. Specifically, on December 8, 2003, Congress enacted the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 ("MMA") (Pub. L. 108–173). Title I of the MMA added new sections 1860D–1 through 1860D–42 to the Social Security Act to create the Medicare Prescription Drug Benefit (Part D) program. At the same time, Section 306 of the MMA gave the Department of Health and Human Services (HHS") authority to pilot a new contracting program designed to detect improper payments and directed the Secretary of HHS to demonstrate the use of RACs in identifying Medicare FFS underpayments and overpayments and collecting Medicare overpayments. On the fee-for-service side, Medicare program overpayments and underpayments were identified through a review of individual Medicare claims to determine if the claims were medically necessary, correctly coded, and conformed to Medicare payment policy. RACs are outside contractors hired by CMS to carry out these specific functions. An important aspect of the RAC program is that RACs are paid contingency fees based on the amount of overpayments collected from providers and for underpayments identified.[2]

After an initial demonstration project involving RAC auditors in select states from 2005 to 2008 proved to be successful, the Medicare FFS RAC program was expanded to become fully implemented on a nationwide Medicare FFS basis. Section 302 of the Tax Relief and Health Care Act of 2006 made the RAC program permanent and required the Secretary of HHS to expand the program to all 50 states by no later than 2010. RACs are currently reviewing claims from all Medicare FFS billers – both Part A and Part B. The four RACs also contract with subcontractors to supplement their efforts. Each subcontractor has negotiated different responsibilities in each region, including some claim review. Each RAC is responsible for identifying overpayments and underpayments in approximately one-quarter of the United States.[3]

ACA-Mandated RAC Program Expansion

ACA requires the expansion of the RAC program to the Medicare Part C and Part D programs. ACA specifically requires that RAC contractors for Medicare Part C and Part D be engaged by the Secretary of HHS to:

[2] 75 Fed. Reg. at 81279.

[3] For more information about the RAC program, see http://www.cms.gov/rac/.

- Ensure that each MA plan and Part D plan has an anti-fraud plan in place and to review the effectiveness of such anti-fraud plan;

- Examine claims for reinsurance payments to determine whether prescription drug plans submitting such claims incurred costs in excess of the allowable reinsurance costs permitted under the ACA; and

- Review estimates submitted by prescription drug plans by private plans with respect to the enrollment of high cost beneficiaries (as defined by the Secretary) and to compare such estimates with the numbers of such beneficiaries actually enrolled by such plans.[4]

In its Solicitation for Comments, CMS specifically states that "we are interested in knowing how the RAC findings could be used to more accurately inform Medicare's reimbursement to Part C and Part D plans."[5]

ACA also mandates expansion of RAC audits to Medicaid plans by requiring states to establish programs by no later than December 31, 2010, under which they contract with recovery audit contractors for purposes of identifying underpayments and overpayments and recouping overpayments.[6] While states are required to establish their Medicaid RAC programs by December 31, 2010, such programs need not be implemented by this date. Instead, absent an exception, states must fully implement their Medicaid RAC programs by April 1, 2011.[7]

Potential Issues for RAC Expansion to MA and Part D

CMS acknowledges in the Solicitation for Comments that the payment structure in the Medicare Part C and Part D programs is different than in the Medicare FFS program. CMS identifies the following nine areas as those for which it is most interested in receiving comments:

1) Methods for RACs to identify underpayments and overpayments in the Medicare Part C and Part D programs.

2) Utilizing a phased-in approach for RACs in the Medicare Part C and Part D programs, similar to the development of RACs in the Medicare FFS program.

[4] ACA Section 6411(b)(5).

[5] 75 Fed. Reg. at 81279.

[6] See ACA Section 6411(a).

[7] 75 Fed. Reg. at 69038.

3) The criteria or qualifications necessary to enable a RAC to knowledgeably and appropriately review the payments in Medicare Part C and Part D plans.[8]

4) Specific conflict-of-interest rules that should apply to RACs for the Medicare Part C and Part D programs.

5) Establishing an oversight entity for Medicare Part C and Part D RAC Issue Approval (CMS is considering establishing a review board for the Part C and Part D RACs).[9]

6) Methods for resolving underpayments and how payments related to underpayments identified by the RAC would be implemented in the Part C and Part D programs.

7) Potential for allowing Part C and Part D plans to use RACs within their own plans to identify overpayments in its operations.

According to CMS, this initiative could involve RAC contractors entering into agreements with interested MA organizations ("MAO") to conduct Medicare claims reviews. Under this approach, the claims reviews would be conducted on claims submitted to the MAO for payment to health care providers serving the MAO enrollees. The RAC would be paid by the MAO on a contingency fee basis. The overpayments recouped for the MAO as a result of the RAC's activities would be retained by the MAO.

8) Approaches to implementing the following special rules provisions of section 6411(b) of ACA:

    a) Using RACs to ensure that each Part C and Part D plan has anti-fraud plans in place and to review the effectiveness of those anti-fraud plans.

In accordance with section 1893(h) of the ACA, payments to RACs for the Part C and Part D programs would be made to a RAC contractor, as in the Medicare FFS program, only from amounts recovered. RAC contractor payments would be made on a contingency basis for collecting overpayments and may be made in such amounts as the Secretary may specify for identifying underpayments.[10] CMS is interested in the industry's views on how to pay RACs on a contingency basis for reviewing anti-fraud plans in the Part C and Part D programs given there are no recoveries or overpayments resulting from a review of such plans. Specific questions posed by CMS include:

[8] In order to meet the qualifications under the Medicare FFS RAC program, RACs must obtain the services of certified coders, nurses, or therapists, and a Contractor Medical Director.

[9] Medicare FFS RACs have the authority to pursue clear-cut vulnerabilities that can lead to improper payments. However, for more complex vulnerabilities, a review board is utilized. This board decides whether Medicare FFS RACs can proceed with the proposed review. 75 Fed. Reg. at 81279.

[10] 75 Fed. Reg. at 81280.

"Should this contingency basis differ from how RACs are paid for reviewing Medicare FFS claims? If so, how?"

b) Using RACs to examine claims for reinsurance payments to determine whether Part D plans submitting such claims incurred costs in excess of the allowable reinsurance costs permitted under the statute.

Under the Part D statute, Part D plans legitimately incur costs in excess of allowable reinsurance costs during the catastrophic phase of the benefit. In the catastrophic phase of the defined standard benefit, 80 percent of the negotiated price is paid by federal reinsurance, 15 percent is the responsibility of the sponsor (and is incorporated into its bid for the direct subsidy), and 5 percent is the responsibility of the beneficiary. Prospective reinsurance payments to plans are based on the plans' estimates of reinsurance costs and, as required by statute, CMS reconciles these prospective reinsurance payments for sponsors with actual reinsurance costs. Given this annual reconciliation process, requiring RACs to review the accuracy of the prospective reinsurance payments is less likely to result in recovery of overpayments. However, CMS is considering having RACs examine the accuracy and completeness of sponsors' reporting of Direct and Indirect Remuneration ("DIR"). The DIR information reported by plans includes rebates paid by pharmaceutical manufacturers, as well as other remuneration received by the plans that has the effect of reducing their drug costs, and is used as a factor in CMS's payment calculations to Part D plans. Underreporting of DIR by plans would overstate their drug costs, including in the catastrophic phase of the benefit, and would result in an overpayment to a plan. CMS is interested in receiving comments on how RACs could be used to review the accuracy and completeness of DIR information provided to CMS by plans.

c) Using RACs to review estimates submitted by Part D plans with respect to enrollment of high-cost beneficiaries.

A Part D sponsor's estimates for the enrollment of high-cost beneficiaries may impact the reinsurance estimates in the sponsor's Part D bids and, thus, the prospective reinsurance subsidy payments it receives from CMS. However, given the structure of the Part D program that requires CMS to reconcile reinsurance subsidy payments against a Part D sponsor's actual costs, requiring RACs to undertake this activity is less likely to result in recovery of any reinsurance overpayments. CMS is interested in receiving comments on how RACs might be used to identify overpayments and underpayments associated with DIR reporting.

9) Successful overpayment recoupment models in managed care that may already exist in the commercial sector and to what extent these models are applicable to Part C.

Successfully integrating RACs into Part C presents a particular challenge because of how Part C payments are paid. Under the statutory payment formula, plans are paid on a capitated basis. Therefore, the plan, not the government, is at direct risk for any overpayments and underpayments made to its providers. CMS is interested in learning

whether and how other purchasers have identified overpayments and underpayments made by capitated plans and to what extent savings were shared between the plan and the purchaser.

a) Any additional information concerning the development of a RAC program in Medicare Part C and Part D and how CMS can establish the required program elements to protect the Medicare Part C and Part D programs from fraud, waste, and abuse.

Conclusion

CMS may do further rulemaking on the development and implementation of requirements for RACs in the Part C and Part D programs, based on the comments received from the Solicitation for Comments. Consequently, it is important for the public to file comments by the deadline.

In addition to submitting comments on the areas identified by CMS, another critically important activity for MCOs is to ensure that they have an effective compliance program already in place that addresses the various payment risk areas under the Medicare Part C and Part D programs. Not only is an effective "anti-fraud" program an area specifically identified for RAC audit review, but having an effective compliance program is the overall key step required to ensure that an MCO's payments and performance under the Medicare Part C and Part D programs are compliant in the first place.

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This Client Alert was authored by ***Marci Handler***, ***Mark S. Armstrong***, *and* ***Lynn Shapiro Snyder****. For additional information about the issues discussed in this Client Alert, please contact one of the authors or the EpsteinBeckerGreen attorney who regularly handles your legal matters.*

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