March 15, 2012

RAC Roundup: What's on the Horizon for Medicare Part C and D RACs? Medicaid RAC Implementation Is Underway

RESOURCE LINKS

For information about the Medicare RAC program:
http://www.cms.gov/rac

For information about the Medicaid RAC program:
http://www.cms.gov/medicaidracs
http://www.medicaid-rac.com

IMPORTANT DATES

Implementation of state Medicaid RAC programs:
January 1, 2012

Implementation of Medicare Part C and Part D RAC programs:
To be determined

From its inception as a three-state pilot, the Recovery Audit Contractor ("**RAC**") program has grown to a permanent national program accounting for the collection of $398 million in Medicare overpayments in the first quarter of fiscal year ("**FY**") 2012 alone.[1] Over the next year, the RAC program will expand its reach beyond the current focus on fee-for-service ("**FFS**") payments under Medicare Parts A and B to include Medicare Part C (Medicare Advantage) and Part D (Prescription Drug Benefit) as well as state Medicaid programs. As Medicaid RAC programs get underway in the states, and private insurers offering coverage under Medicare Part C and D prepare for new, yet still undefined, RAC efforts, it is more important than ever for providers to make sure that their processes for documentation, billing, and coding are accurate and comprehensive.

Background

The RAC program was originally implemented as a pilot in three states (California, Florida, and New York) under Section 306 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.[2] The pilot allowed the Centers for Medicare & Medicaid Services ("**CMS**") to engage outside contractors to identify Medicare program overpayments and underpayments through a review of individual Medicare claims. These contractors are paid contingency fees based on the amount of

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[1] CMS recently reported that the Medicare RACs recovered $398 million in Medicare overpayments, representing a 44 percent increase from the $277 million recovered in the fourth quarter of FY 2011. CMS, First Quarter Fiscal 2012 RAC Results (Feb. 7, 2012), *available at* https://www.cms.gov/Recovery-Audit-Program/Downloads/FY2012NationalProgramCorrections_vj.pdf.

[2] Pub. L. 108-173 (2003).

overpayments collected from providers and for underpayments identified. The pilot was expanded to a permanent national program through Section 302 of the Tax Relief and Health Care Act of 2006.[3]

Since national implementation of the Medicare RAC program began in October 2009, the program has recovered a total of $1.27 billion in overpayments and has returned $184 million in underpayments to providers.[4] Although RAC audits have primarily focused on inpatient hospital claims, the list of issues focused on different provider types, including outpatient hospitals, physicians, and durable medical equipment ("**DME**") suppliers, is growing.[5] For example, Diversified Collection Services ("**DCS**"), the Region A contractor, has posted several issues targeted at DME suppliers. DCS is examining claims for DME items, such as air-fluidized beds, pneumatic compression devices, and power wheelchairs (Group 2), to determine whether provision of these items to beneficiaries is reasonable and medically necessary.[6] Recently, Connolly, Inc., the Region C contractor, posted its first issue targeted at home health providers. The issue focuses on whether billing of home health partial episode payment claims identified with a discharge status 06 and another home health claim were billed within 60 days of the "claim from" date.[7]

Given the success of the RAC program in detecting and correcting improper payments in the Medicare FFS program, and the ongoing need to reduce fraud, waste, and abuse in the financially strapped federal health care programs, the Patient Protection and Affordable Care Act of 2010 ("**ACA**")[8] requires the expansion of the RAC program to effectively cover all providers and programs under CMS's jurisdiction.

Further expansion of the RAC program has also been considered by CMS through the implementation of a prepayment claims review demonstration. The demonstration project, announced in November 2011, would allow RACs to conduct prepayment reviews on certain types of Medicare claims that historically result in high rates of improper payments. The reviews would focus on a group of seven states with higher than average numbers of fraud- and error-prone providers—California, Florida, Illinois, Louisiana, Michigan, New York, and Texas—and an additional four states with high claims volumes of short inpatient hospital stays—Missouri, North Carolina, Ohio, and Pennsylvania. The intent behind the demonstration project is to help lower fraud and error rates by preventing improper payments, rather than relying on the traditional "pay and chase" methods of looking for improper payments after they have occurred. CMS delayed implementation of this demonstration project in late December 2011, and on February 3, 2012, CMS announced that the demonstration is expected to begin on or after June 1, 2012.[9]

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[3] Pub. L. 109-432 (2006).

[4] CMS, First Quarter Fiscal 2012 RAC Results, *supra* note 1.

[5] The RAC auditor websites contain lists of issues currently under review. *See, e.g.*, Region A: Diversified Collection Services, http://www.dcsrac.com/IssuesUnderReview.aspx; Region B: CGI, http://racb.cgi.com/Issues.aspx; Region C: Connolly, Inc., http://www.connolly.com/healthcare/pages/ApprovedIssues.aspx; and Region D: HealthDataInsights, http://racinfo.healthdatainsights.com/Public1/NewIssues.aspx.

[6] *See* Diversified Collection Services, http://www.dcsrac.com/IssuesUnderReview.aspx.

[7] *See* Connolly, Inc., http://www.connolly.com/healthcare/pages/ApprovedIssues.aspx.

[8] Pub. L. 111-148 (2010), as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. 111-152 (2010), hereinafter collectively referred to as the Affordable Care Act ("ACA").

[9] CMS, Comprehensive Error Rate Testing (CERT) Demonstrations, *available at* https://www.cms.gov/CERT/02_Demonstrations.asp.

Medicaid RACs

Section 6411 of ACA requires states and territories to establish Medicaid RAC programs by December 31, 2010. In October 2010, CMS issued a State Medicaid Director Letter to provide initial guidance on the implementation of these RAC programs. Each state and territory was required to submit a State Plan Amendment ("**SPA**") to CMS, in order to establish a state Medicaid RAC program subject to the exceptions and requirements provided by the Secretary. Currently, seven states are awaiting approval of newly submitted SPAs.[10] States may seek exceptions from implementing the entire Medicaid RAC program or any of the requirements of the RAC program.[11] To date, a total of 23 states and territories have requested exceptions from CMS.[12] The two largest subcategories of exceptions were requests from states for either a delay of implementation of a RAC program or a complete exemption from implementing a RAC program on the basis of Medicaid claims system infrastructure challenges. CMS granted the latter of these types of requests to each of the five U.S. territories.[13]

CMS published a Notice of Proposed Rule Making in November 2010 and subsequently issued a final rule implementing the Medicaid RAC program in September 2011.[14] The originally proposed implementation date of April 1, 2011, was delayed in order to give states sufficient time to develop their RAC programs.[15] In a recently issued Frequently Asked Questions document, CMS clarified that "[s]tates are required to implement their respective RAC programs by January 1, 2012," which means that states must "have a signed contract in place with its selected RAC vendor by January 1, 2012."[16] If states cannot meet that deadline, they "must request an exception from the implementation date from CMS by submitting a State Plan amendment (SPA) through the normal SPA process."[17]

States have been working to implement their Medicaid RAC programs, and CMS continues to provide support to the states during the implementation process. Although Medicaid RAC program requirements are generally consistent with the Medicare RAC program, states have been given flexibility in the design of their RAC programs in a number of areas. For example, each state is required to set its own limits on the number and frequency of records to be reviewed by the RACs, as well as the types of claims that will be excluded from review. Each state will establish its own audit areas, but the states are not required to provide advanced notice of those issues to providers. Each state will also establish its own appeals process and its own educational outreach programs for providers. Further, CMS has encouraged, but is not requiring, alignment with the Medicare RAC program in a number of areas, including medical necessity reviews, extrapolation of audit findings,

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[10] CMS, State Medicaid RACs At-A-Glance (last updated Feb. 7, 2012), *available at* https://www.cms.gov/medicaidracs/home.aspx.

[11] *See* CMS, State Medicaid Director Letter Re: Recovery Audit Contractors (RACs) for Medicaid (Oct. 1, 2010), *available at* https://www.cms.gov/smdl/downloads/SMD10021.pdf.

[12] CMS, State Medicaid RACs At-A-Glance, *supra* note 10.

[13] CMS, Implementation of Recovery Auditing at the Centers for Medicare & Medicaid Services: FY 2010 Report to Congress as Required by Section 6411 of Affordable Care Act (Oct. 2011), *available at* https://www.cms.gov/Recovery-Audit.../FY2010ReportCongress.pdf.

[14] *See* 75 Fed. Reg. 69037 (Nov. 10, 2010); 76 Fed. Reg. 57808 (Sept. 16, 2011).

[15] CMS, Informational Bulletin CPI-B 11-03, Clarification of CMS expectations for State implementation of Medicaid Recovery Audit Contractor (RAC) programs (Feb. 1, 2011), *available at* http://www.cms.gov/MedicaidIntegrityProgram/Downloads/6411racdelay.pdf.

[16] CMS, Frequently Asked Questions: Section 6411(a) of the Affordable Care Act (Dec. 2011), *available at* https://www.cms.gov/MedicaidIntegrityProgram/downloads/Scanned_document_29-12-2011_13-20-42.pdf.

[17] *Id.*

external validation of the accuracy of RAC findings, and types of claims audited.[18] It is important for providers to be mindful of the meaningful differences that will arise between each state's Medicaid RAC program and the Medicare RAC program.

Medicare Part C and D RACs

Section 6411 of ACA also expanded the reach of the RAC program to cover Medicare Part C and Part D in 2012. ACA specifically requires RAC contractors for Medicare Part C and Part D to do the following:

- Ensure that each Medicare Advantage plan and Part D plan has an anti-fraud plan in place, and 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 ACA; and

- Review estimates submitted by prescription drug plans by private plans with regard to the enrollment of high cost beneficiaries, and compare such estimates with the numbers of such beneficiaries actually enrolled by such plans.[19]

CMS has taken several steps towards implementation of Part C and Part D RACs, although it is much farther along on Part D. In December 2010, CMS published a solicitation for public comments, acknowledging challenges in implementing the program for Medicare Advantage plans and requesting industry feedback on several key issues arising under the pending RAC program expansion.[20]

In January 2011, CMS awarded a contract for Part D recovery auditing to ACLR Strategic Business Solutions. Although CMS indicated that the Part D recovery audits would start in the third quarter of 2011, a specific date for initiation has not yet been established.[21] However, prior to launching the expansion of the RAC program, the Part D RAC has been working to fulfill CMS systems access requirements, developing outreach plans to Part D sponsors, and working with CMS to establish priorities for recovery auditing.

What Can Providers Do to Be Prepared?

To avoid the reach of RACs or, at least, minimize the impact of responding to RAC audit requests, providers must take certain steps to analyze and evaluate their compliance programs. Following such a review, providers must adopt any updates to their compliance programs, such as policy revisions,

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[18] 76 Fed. Reg. 57817 (Sept. 16, 2011).

[19] *See* ACA §6411(b)(5).

[20] *See* 75 Fed. Reg. 81278 (Dec. 27, 2010). For more background information on this solicitation, see EBG Client Alert, "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 2/25/11 Deadline," *available at* http://www.ebglaw.com/showclientalert.aspx?Show=13882.

[21] CMS, Center for Program Integrity Letter Re: Implementation of the Medicare Parts C and D Recovery Audit Contractor Program (May 31, 2011), *available at* http://aishealth.com/sites/all/files/recovery_auditing_memo_5_31_11_final.pdf.

staff training, and regular audits, to ensure that appropriate and comprehensive policies and processes are thoroughly implemented. Efforts made by providers to assess and prepare for the reach of the RACs will be time well spent.

As both federal and state enforcement efforts increase, providers need to be vigilant about tracking where audit requests are coming from and understanding the rules of each audit program, including the types of claims audited, the number and frequency of medical record reviews, response timeframes for additional documentation requests, external validation of RAC finding accuracy, and appeal rights. Further, with the introduction of Medicaid RACs, providers must do the diligence to understand any state-specific requirements in states where they have entities.

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