

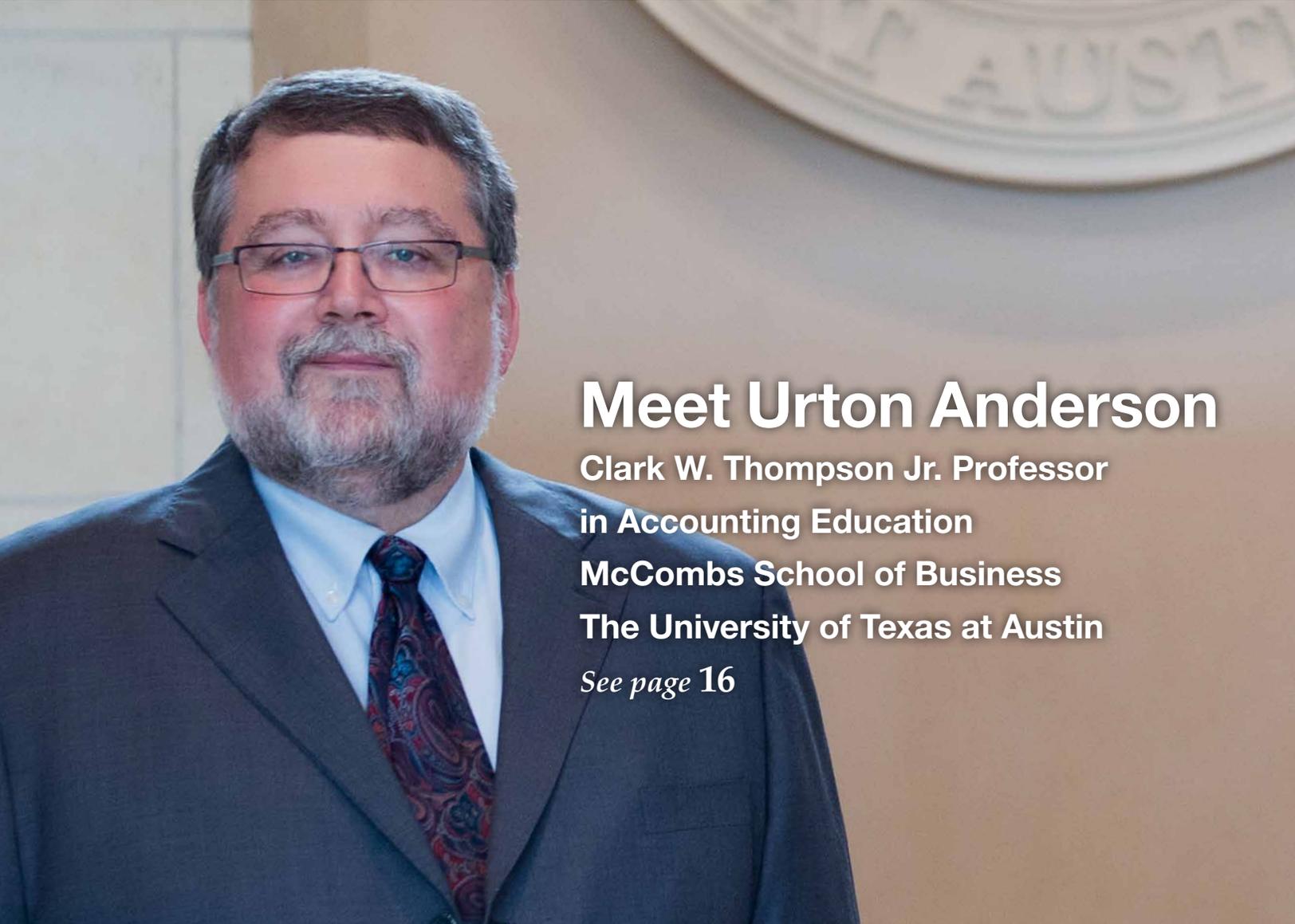


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Recovery Audit Contractor (RAC) audits: Are plan sponsors ready?

- » Medicare fee-for-service RACs are recovering considerable amounts of money from providers and suppliers.
- » The Affordable Care Act (ACA) expanded the RAC program to Medicare Parts C and D.
- » CMS has taken various actions to implement the Part D RAC program following enactment of the ACA.
- » CMS established three phases to the Part D RAC audits, and Plan sponsors and their contractors must understand what they are.
- » Plan sponsors should follow best practices to limit future overpayment recoveries resulting from Part D RAC audits.

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Given the scale and complexity of the Medicare program, payments made to providers, suppliers, and health plans are not always made accurately, even with the best of intentions. In an effort to recoup improper reimbursements, the Centers for Medicare & Medicaid Services (CMS) contracts with Recovery Audit Contractors (RACs) to audit payments from CMS for items and services provided to Medicare beneficiaries. Many providers and suppliers participating in Medicare Parts A and B are familiar with RAC audits. Until recently, however, Medicare Advantage (Part C) and Medicare Prescription Drug Plan sponsors (Part D) were spared from these audits.

One of the many revenue generating provisions of the Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010 (collectively, the Affordable Care Act, or ACA)¹ expanded the RAC program to Medicare Parts C and D. The ACA mandated that CMS use

RAC audits for payments made to Medicare Advantage and Prescription Drug Plan sponsors. Given the differences from original Medicare, CMS has spent the past two years analyzing how to implement the RAC program for Parts C and D. As described in more detail below, after thorough review, CMS decided to implement the RAC program to apply to plan sponsors that have Medicare prescription drug plan components (Medicare Advantage Prescription Drug Plans [MA-PDs] and Prescription Drug Plans). Medicare Advantage plans that do not provide Part D services will be unaffected by the RAC audits at this time. CMS recently reported that “Part D RAC activity is now underway” and that plan sponsors began receiving Notification of Improper Payment Letters in June 2012 for payments made in fiscal year 2008 for transactions that occurred during calendar year 2007.



Berson



Albert

RAC program in fee-for-service Medicare
Since 2005, CMS has contracted with RACs to identify and collect improper Medicare

payments made throughout the country. Unlike other Medicare contractors, RACs are paid a contingency fee based on the amount of money CMS recovers from the providers and suppliers subject to the RAC audits. Although this fee structure is mandated by statute, it has been the source of criticism by those who allege that RACs are too aggressive and are financially motivated to collect overpayments for items and services that may not have been improperly reimbursed by Medicare.

Medicare fee-for-service RACs collected \$397.8 million in overpayments and returned \$24.9 million in underpayments during the last quarter of 2011.² The top billing issues recently identified by RACs relate to the medical necessity of care for neurological disorders, cardiovascular procedures, minor treatments, and other treatment billed as hospital inpatient procedures.

The country is divided into four geographic regions for purposes of fee-for-service RAC audits, each of which is covered by a different contractor. RACs utilize information technology analytics and conduct medical record review to assess whether CMS has made an improper payment.³ When an overpayment or underpayment is identified, contractors notify the provider or supplier. In the case of an overpayment, the contractor issues a demand letter that sets forth the amount and reason for the overpayment. Providers and suppliers have the right to appeal demand letters using the same process governing Medicare claims denials:

- ▶ Level 1: Redetermination
- ▶ Level 2: Reconsideration by Qualified Independent Contractor
- ▶ Level 3: Administrative Law Judge hearing
- ▶ Level 4: Medicare Appeals Council review
- ▶ Level 5: Federal District Court review.

The ACA

The ACA expanded the RAC program to Medicare Parts C and D.⁴ The statute

enumerates “special rules” applicable to Parts C and D that require RACs to:

- ▶ Ensure that each Medicare Advantage plan under Part C has an anti-fraud plan in effect and to review the effectiveness of each such anti-fraud plan;
- ▶ Ensure that each Prescription Drug Plan under Part D has an anti-fraud plan in effect and to review the effectiveness of each such anti-fraud plan;
- ▶ Examine claims for reinsurance payments to determine whether Prescription Drug Plans submitting such claims incurred costs in excess of allowable reinsurance costs; and
- ▶ Review estimates submitted by Prescription Drug Plans with respect to the enrollment of high cost beneficiaries and to compare these estimates with the numbers of beneficiaries actually enrolled by such plans.

CMS implementation and description of Part D RAC audits

In a Request for Information published in *The Federal Register* on December 27, 2010, CMS solicited comments from stakeholders on the best way to implement the RAC program for Medicare Parts C and D.⁵ In addition to reviewing these comments, CMS had the benefit of building upon its experience in implementing the Medicare fee-for-service RAC program. However, CMS faced considerable challenges in developing the Part D RAC program, because fee-for-service payments differ significantly from the Medicare Advantage and Prescription Drug Plan payment models, and the program design and authorizing legislation for original Medicare are different from those for Medicare Parts C and D.

Interestingly, CMS awarded the Part D RAC contract to ACLR Strategic Business Solutions (ACLR or the Part D RAC) for all

regions, even though the fee-for-service RAC program utilizes four different RACs. CMS has also contracted with Livanta LLC, a data validation contractor (the DVC), to be responsible for validating or rejecting the Part D RAC's overpayment findings. The DVC is responsible for confirming the Part D RAC's improper payment findings and measuring its accuracy rate. If the DVC validates the Part D RAC's findings, CMS will issue a Notification of Improper

Payment Letter.

If the DVC rejects the Part D RAC's findings, then the DVC and the Part D RAC will attempt to resolve the discrepancies, with CMS being the final decision-

maker for any disputes that cannot be resolved between the two contractors. The Part D RAC will refer cases of suspected fraud directly to the Medicare Drug Integrity Contractor.

As stated above, although the implementation of the Part D RAC program focuses on the Prescription Drug Program under Medicare Part D, it also impacts Medicare Advantage Organizations that offer prescription drug coverage through MA-PDs. The Part D RAC audits apply to MA-PDs as they would for plan sponsors that only offer a prescription drug benefit. Accordingly, the RAC will only focus on prescriptions drugs and not on other medical items and services provided by MA-PDs and, for the most part, will not take into account a beneficiary's utilization of prescription drugs.

The Part D RAC has not been engaged to address payment errors made for inaccuracies in coding tied to risk adjustment payments that CMS makes to Medicare Advantage Organizations, which are unique to Medicare

Part C. CMS may have decided not to apply the RAC audits to those Medicare Advantage plans that do not offer a Part D benefit (also called "stand alone MA plans") because a separate and distinct audit process already focuses on plan sponsors' accuracy of health care condition coding of members for risk adjustment purposes. Specifically, CMS conducts risk adjustment data validation (RADV) audits to assess whether Medicare Advantage

Organizations are adequately coding the health care conditions of their members.⁶

The three phases of Part D RAC audits

Pre-analysis

CMS determines the audit criteria and scope of the audit.

If the DVC rejects the Part D RAC's findings, then the DVC and the Part D RAC will attempt to resolve the discrepancies.

The Part D RAC conducts its analysis based on this criteria and scope, and on prescription drug event (PDE) data received from CMS, although it may request additional information from the plan sponsor. CMS also identifies the areas that the Part D RAC should focus on; these issues may change over time, but CMS will inform plan sponsors of modifications.⁷ Initial focus areas include: (1) reviewing PDE records associated with providers excluded from Medicare, Medicaid, or other federal health care programs; (2) direct and indirect remuneration (DIR); and (3) duplicate PDEs. CMS limits the number of audit issues to a maximum of five per year, which are the same for all plan sponsors, and are determined by CMS's New Issues Review Board (the NIRB). Future audit issues may change based on the results of studies from the Department of Health and Human Services (HHS), the HHS Office of Inspector General, and the Government Accountability Office (GAO). CMS encourages the Part D

RAC, plan sponsors, and other stakeholders to submit potential audit issues to the NIRB for consideration.

Analysis

The Part D RAC conducts improper payment and impact calculations based on the PDE data CMS provides, although it may request additional information from the plan sponsor. The impact calculation assesses the effect that the overpayment could have on reinsurance and low-income cost sharing amounts. A reconciliation, based on the corrected payment amounts (after improper payments have been accounted for), is performed and then compared to the initial amount reimbursed to the plan sponsor. The result of this reconciliation is the overpayment that the plan sponsor owes, which will be reflected in the Notification of Improper Payment Letter. The Part D RAC's findings must be validated by the DVC before plan sponsors are notified of alleged overpayments.

Post analysis

If the Part D RAC's findings are validated by the DVC, CMS issues a Notification of Improper Payment Letter. This letter specifies the amount of improper payments identified by the Part D RAC and the recoupment process. Findings set forth in the Notification of Improper Payment Letter may be appealed, if certain conditions are met. Although the Part D RAC is tasked with identifying both overpayments and underpayments that have been made, the vast majority of CMS guidance addresses those instances when plan sponsors have potentially been overpaid.

Appeals process

Plan sponsors may seek two levels of administrative review following CMS's issuance of the Notification of Improper Payment Letter: (1) request for redetermination, which must be filed no later than 30 calendar days from the date of the Notification of Improper Payment Letter; and (2) request for reconsideration, which must be filed no later than 15 days following the issuance of the redetermination.⁸

Appeals are limited to the amount of the overpayment, and narrow issues, such as whether an overpayment was made as a result of either an excluded provider ordering or an excluded pharmacy filling a prescription.

Plan sponsors are precluded from appealing the methodology/standards used to calculate overpayments and issues that are not identified in the Notification of Improper Payment Letter. Further, plan sponsors may not use payment informa-

tion that was not considered by the RAC in its review. This relatively narrow appeals process differs substantially from the Medicare fee-for-service RAC appeals process, which offers up to five levels of review. It is unclear why CMS opted for such a streamlined administrative review process for Medicare Advantage and Prescription Drug Plan sponsors, when providers and suppliers participating in Medicare Parts A and B are offered considerably more opportunities to challenge the RAC's findings.

Practical takeaways

Uncertainties remain regarding how Part D RAC audits will be administered given the program's infancy. CMS has announced it will issue additional guidance in the near future. CMS has

The impact calculation assesses the effect that the overpayment could have on reinsurance and low-income cost sharing amounts.

also stated that plan sponsors will not need to undertake significant activities to prepare for Part D RAC audits. However, plan sponsors and their first tier, downstream, and related entities should consider taking the following actions, so they understand the Part D RAC program and can seek to limit Medicare payments that may be recovered by the RAC in the future:

- ▶ Regularly review the Health Plan Management System (HPMS) for guidance from CMS addressing the Part D RAC program.
- ▶ Establish uniform and coordinated processes to respond to Part D RAC requests in a targeted, organized fashion. Ensure that the plan sponsor communicates effectively with first tier, downstream, and related entities (e.g., pharmacy benefit managers) so all parties are aware of Part D RAC audits and requests for additional information.
- ▶ Require first tier, downstream, and related entities to regularly report data associated with potential issues that may be subject to RAC audits. Plan sponsors should also consider conducting regular and ongoing audits of their contractors. These actions will provide plan sponsors with information and data in advance of the Part D RAC audits that may be difficult to obtain in real time after an audit has been initiated.
- ▶ Have policies and procedures that meet all CMS standards governing the Part D program. Plan sponsors and their first tier, downstream, and related entities should be

aware that the initial focus of Part D RAC audits will relate to PDEs either scripted by excluded prescribers or filled by excluded pharmacies, duplicate PDE records, and direct and indirect remuneration.

- ▶ Review all Part D RAC findings in the Notification of Improper Payments Letter for accuracy. If the Part D RAC may have made an error that is reviewable, consider requesting an appeal.
- ▶ If an appeal is filed, raise all relevant issues at the initial (redetermination) level of appeal. Issues that are not raised at the redetermination level will be dismissed.
- ▶ Consult the website CMS created exclusively for the Part D RAC program, because this initiative will likely evolve over time.⁹ 

1. Patient Protection and Affordable Care Act of 2010, Pub. L. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. 111-152.
2. See CMS, Medicare Fee for Service National Recovery Audit Program, Quarterly Newsletter (Oct. 1, 2011 through Dec. 31, 2011).
3. CMS, Implementation of Recovery Auditing at the Centers for Medicare & Medicaid Services, FY 2010 Report to Congress As Required by Section 6411 of the Affordable Care Act, p. 9.
4. ACA, § 6411(b) (amending section 1893 and creating section 1893(h) (9) of the Social Security Act).
5. 75 Fed. Reg. 81278 (Dec. 27, 2010).
6. See CMS, Notice of Final Payment Error Calculation Methodology for Part C Medicare Advantage Risk Adjustment Data Validation Contract-Level Audits (Feb. 24, 2012).
7. See Memorandum to All Medicare Advantage Organizations and Part D Sponsors from John Spiegel, Director, Medicare Program Integrity Group, *Industry Update Regarding Implementation of the Medicare Part D Recovery Audit Contractor (RAC) Program* (Apr. 12, 2012).
8. See CMS, Appeals Process for Identified Overpayments by the Medicare Part D Recovery Audit Contractor (RAC) (Rev. July 3, 2012). Available at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/recovery-audit-program-parts-c-and-d/Downloads/Part-D-RAC-Appeals-Process.pdf>.
9. CMS Website, Parts C and D Recovery Audit Program, available at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/recovery-audit-program-parts-c-and-d/Part-D-Recovery-Audit-Contractor.html>. Among other resources, CMS has posted a document on its website titled "Q&A for Medicare Part D RAC Program," published in June 2012.

Thank you!

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