



The Future of the Recovery Audit Contractor Program

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In fiscal year 2010 alone, the Government Accountability Office estimates that \$70 billion in improper Medicare and Medicaid payments were made.¹ In March 2010, President Obama issued a Memorandum directing federal agencies to expand their use of recovery audits in an effort to reduce such improper payments.² Days later, the Patient Protection and Affordable Care Act (“PPACA”) was signed into law, expanding the Recovery Audit Contractor (“RAC”) program to include claims submitted under

Medicare Part C (*i.e.*, Medicare Advantage), Medicare Part D (*i.e.*, prescription drug benefit), and Medicaid. Although implementation of the statutory mandate to expand the RAC program has been slower than expected, the Centers for Medicare & Medicaid Services (“CMS”) is now actively moving forward with RAC program expansion. Legal counsel representing healthcare providers and suppliers ought to be mindful of this forthcoming claims scrutiny.

History of the Medicare Fee for Service RAC Program

The Medicare Fee for Service (“FFS”) RAC program initially began as a “demonstration program,” authorized by Section 306 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (“MMA”). The RAC demonstration program began in 2005 and was limited to the states with the highest Medicare expenditures: California, Florida and New York, later expanding to include Arizona, Massachusetts, and South Carolina. One purpose of the demonstration program was to determine whether it would be “cost-effective” for CMS to use private entities paid on a contingency fee basis to identify and correct improper payments. The demonstration program was more than cost-effective from the point of view of CMS. In fact, during the three-year span of the demonstration program, the RACs collected nearly \$1 billion.³ Importantly for healthcare providers and suppliers and their legal counsel considering this staggering figure, it should be noted that just 12.7 percent of RAC overpayment determinations were appealed during the demonstration program; however, of these appeals, available data reflects that at least 64 percent were decided in favor of the provider.⁴

Section 302 of the Tax Relief and Health Care Act of 2006 made the Medicare FFS RAC program permanent and required its expansion nationwide by 2010. FFS RACs are tasked to identify and correct improper payments (*i.e.*, identify underpayments and overpayments and recoup overpayments). There are four RAC contractors, each assigned particular states to audit.⁵ The RACs are compensated on a contingency fee basis ranging from 9 to 12.5 percent, depending on the RAC.⁶

The Medicare FFS RAC program is presently operational in all 50 states. Pursuant to the CMS National Recovery Audit Program 3rd Quarter FY 2011 Quarterly Newsletter, the FFS RAC program has been very successful correcting alleged improper payments. For example, the RACs have identified and corrected \$233.4 million in overpayments and identified and returned \$55.9 million in underpayments in the third quarter of FY 2011 alone. Since the beginning of fiscal year 2011, the FFS RACs have identified and corrected \$592.5 million in improper payments.⁷ As evidenced by the “approved issues” lists for RAC audits, hospitals continue to experience the majority of RAC audit activity. However, the FFS RACs are now auditing different types of providers and suppliers in addition to hospitals, including physicians and durable medical equipment (“DME”) suppliers.⁸

In the third quarter of this year, the most audited issue for Region A (covering the northeastern states) and Region D (covering the western states) is the medical necessity for inpatient hospital admissions (that is, the RACs have been auditing to determine whether hospital services could have been provided on an outpatient basis).⁹ As was the case during the RAC demonstration program, this issue is a favorite for the RACs¹⁰ and is one of contention for hospitals. When the RACs review claims for this issue and allege an overpayment, the RACs will deny the claim outright and will not provide appropriate credit/reimbursement for the services provided. At least one Medicare Appeals Council decision supports the conclusion that this issue can be addressed through the Medicare appeals process.¹¹

Medicare Part C and Part D RAC Program

As noted above, Section 6411 (b) of PPACA expands the RAC program to include Medicare Part C and Part D. Like the Medicare FFS RACs, the Medicare Part C and Part D RACs will be compensated on a contingency fee basis. Medicare Part C and Part D RACs are tasked to identify underpayments and overpayments and recoup overpayments. In addition, Section 6411 (b) (5) of PPACA sets forth “Special Rules Relating to Parts C and D” (“Special Rules”). In particular, this portion of PPACA requires Part C and Part D RACs to perform the following functions in addition to identifying and correcting improper payments:

- Ensure that each Medicare Advantage Plan under Part C and each prescription drug plan under Part D has an effective anti-fraud plan in place;
- Examine claims for reinsurance payments to determine whether prescription drug plans submitting such claims incurred costs in excess of the costs allowed; 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 compare such estimates with the numbers of such beneficiaries actually enrolled by such plans.

There are complexities inherent to the implementation of the RAC program in Medicare Part C and Part D, which have created challenges for CMS in determining the best way to implement the requirements of PPACA. Principally, there are fundamental differences in the payment structure of Medicare Part C, Medicare Part D and traditional Medicare FFS. In contrast to payments made under Medicare FFS, with respect to payments to Medicare Advantage organizations (Part C), “CMS makes advance monthly payments to an MA organization for each enrollee in an MA plan for coverage of original Medicare benefits in an MA payment area for a month.”¹² With respect to payments made to Part D plan

sponsors, “CMS makes a direct subsidy payment for each Part D eligible beneficiary enrolled in a Part D plan for a month equal to the amount of the plan’s approved standardized bid,” as adjusted.¹³ Noting the “fundamental differences” between Medicare FFS and Medicare Parts C and D, by way of a Request for Information issued on December 27, 2010, CMS solicited comments from industry stakeholders regarding the best way to implement the RAC program in Part C and Part D.¹⁴

Each of the Special Rules also raises challenges with respect to RAC implementation, which CMS recognized in its Request for Information.¹⁵ CMS specifically acknowledged that it is not clear that performing the functions outlined in the Special Rules will result in monetary overpayments, which creates a challenge to structure RAC compensation for performing these functions. For example, as noted above, the statute requires Part C and Part D RACs to ensure that each Medicare Advantage Plan and prescription drug plan has in place an effective anti-fraud plan. There are not “overpayments” or monetary recoveries associated with this function. Because the Part C and Part D RACs also will be compensated on a contingency fee basis, it is unclear how the RACs will be compensated for performing this function.

Despite these challenges, a May 31, 2011 memorandum from the CMS Center for Program Integrity¹⁶ to all Medicare Advantage Organizations and Prescription Drug Plan Sponsors indicates that CMS is planning to implement the Part D RAC program in the coming months. As noted by the memorandum, “CMS is working to implement the Part D RAC program component during the third quarter of 2011. To that end, ACLR Strategic Business Solutions has been contracted to perform Part D recovery auditing. CMS is working on the business planning, technology requirements, staffing and communications initiatives required for achieving the program’s goals.”¹⁷

Part C RAC program implementation may prove more difficult. As noted by the “Request for Information” issued on December 27, 2010, CMS stated, “Successfully integrating RACs into Part C presents a particular challenge because of how Part C payments are made. 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.”¹⁸ The May 31, 2011 Center for Program Integrity memorandum indicates that additional information related to the Part C (as well as Part D) RAC programs soon will be placed on a website dedicated to these programs.¹⁹

Medicaid RAC Program

Section 6411 (a) of PPACA requires each state to enter into contracts with one or more Medicaid RACs to identify underpayments and overpayments and recoup overpayments. States will be granted discretion to determine the way to coordinate with the Medicaid RACs to recoup overpayments. PPACA stipulates that Medicaid RACs, like Medicare RACs, will be compensated on a contingency fee basis. In an effort to apply the lessons learned from the RAC demonstration program, Medicaid RACs must employ a trained medical professional to review claims. In addition, each state is required to have an “adequate appeals process” in place to handle provider appeals.²⁰ To satisfy this requirement, “States may utilize the existing appeals infrastructure to adjudicate Medicaid RAC appeals... Alternatively, a State may elect to establish a separate appeals process for RAC determinations, which must also ensure providers adequate due process in pursuing an appeal.”²¹ One result of this flexibility is that the Medicaid RAC appeals process may differ from state-to-state.

While PPACA required each state to enter into a contract with a RAC to perform the requisite auditing functions prior to December 31, 2010, Medicaid RAC programs were not required to be fully implemented by this date. By way of a letter dated October 1, 2010 to state Medicaid Directors²², and subsequently by way of Proposed Rule related to the Medicaid RAC Program,²³ CMS announced its expectation that states implement their RAC programs by April 1, 2011. However, in response to the multitude of comments received in response to the Proposed Rule, on February 1, 2011, CMS issued an Informational Bulletin delaying the proposed April 1, 2011 implementation deadline.²⁴ According to the Informational Bulletin, “States will not be required to implement their RAC programs by the proposed implementation date of April 1, 2011. Instead, when the Final Rule is published it will indicate the new implementation deadline. We anticipate the final rule will be issued later this year.”²⁵

To date, the Final Rule related to the Medicaid RAC program has not been published. Despite this fact, each state has taken steps towards implementation. All states and territories have submitted state plans for review, and CMS has approved nearly all.²⁶ CMS has created a RAC website specifically designated for Medicaid RACs, which is available as a link from the Medicare FFS RAC website (*i.e.*, <http://www.cms.gov/RAC>) and at <http://www.cms.gov/medicaidracs/home.aspx>.

Conclusion

Protecting the Trust Fund is a high priority for CMS. As described herein, the expansion of the RAC program into Medicare Part C, Medicare Part D and Medicaid is moving forward. Of note, Medicare and Medicaid providers and suppliers already are subject to significant claims scrutiny (*e.g.*, Medicare Administrative Contractor (“MAC”) medical reviews, Zone Program Integrity Contractor (“ZPIC”) audits, routine state program integrity audits, Medicaid Integrity Contractor (“MIC”) audits, and audits conducted by other state and federal agencies). The expanded RAC program creates an additional layer of auditing activity, creating increased administrative burdens for providers and suppliers in tracking and responding to records requests and appealing claim denials. In fact, in the Medicaid RAC program Proposed Rule, CMS expressly acknowledged that, “overlapping or multiple provider audits may be necessary.”²⁷ However, CMS hopes “to minimize the likelihood of overlapping audits” by requiring Medicaid RACs to coordinate their auditing efforts with other contractors.²⁸ Legal counsel representing healthcare providers and suppliers must be mindful of this increased claims scrutiny when advising their clients.

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U.S. Government Accountability Office, “Fraud Detection Systems: Centers for Medicare and Medicaid Services Need to Ensure More Widespread Use” (Publication No. GAO-11-475) (June 2011), available at <http://www.gao.gov/new.items/d11475.pdf> (last accessed July 22, 2011). See also U.S. Government Accountability Office, “Improper Payments: Reported Medicare Estimates and Key Remediation Strategies,” available at http://oversight.house.gov/images/stories/Testimony/7-28-11_Joint_Daly_and_King_GovOrg_Testimony.pdf (last accessed July 29, 2011).

2 75 Fed. Reg. 12119-12120 (March 15, 2010).

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“The Medicare Recovery Audit Contractor Program: An Evaluation of the 3-Year Demonstration,” (June 2008), *available at* <http://www.cms.gov/Recovery-Audit-Program/Downloads/RACEvaluationReport.pdf> (last accessed July 22, 2011).

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See “The Medicare Recovery Audit Contractor Program: Update to the Evaluation of the 3-Year Demonstration,” (June 2010), *available at* <http://www.cms.gov/Recovery-Audit-Program/Downloads/DemoAppealsUpdate61410.pdf> (last accessed July 22, 2011).

While this is the most-recent update published on the CMS RAC website, it should be noted that this report was published prior to all claims making their way through the Medicare appeals process. The vast majority of the claim denials made in the demonstration program were made in second quarter 2008, the final quarter of the demonstration program (*see* The Medicare Recovery Audit Contractor Program: An Evaluation of the 3-Year Demonstration,” (June 2008), *available at* <http://www.cms.gov/Recovery-Audit-Program/Downloads/RACEvaluationReport.pdf> (last accessed July 22, 2011); all of these claims were not yet through the appeals process at the time the update was published.

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See generally <http://www.cms.gov/RAC> (last accessed July 22, 2011).

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[Link here](#) (last accessed July 22, 2011).

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CMS National Recovery Audit Program 3 rd Quarter FY 2011 Quarterly Newsletter, *available at* <https://www.cms.gov/Recovery-Audit-Program/Downloads/FFSUpdate.pdf> (last accessed July 29, 2011).

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See <https://www.cms.gov/Recovery-Audit-Program/Downloads/RACAbbr.pdf> (linking to each RAC’s website containing approved issues) (last accessed July 29, 2011).

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CMS National Recovery Audit Program 3 rd Quarter FY 2011 Quarterly Newsletter, *available at* <https://www.cms.gov/Recovery-Audit-Program/Downloads/FFSUpdate.pdf> (last accessed July 29, 2011).

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See The Medicare Recovery Audit Contractor Program: An Evaluation of the 3-Year Demonstration,” (June 2008), *available at* <http://www.cms.gov/Recovery-Audit-Program/Downloads/RACEvaluationReport.pdf> (last accessed July 22, 2011)

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See *In the Case of O'Connor Hospital*, decided February 1, 2010, available at <http://www.hhs.gov/dab/divisions/medicareoperations/macdecisions/oconnorhospital.pdf> (last accessed July 29, 2011).

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Medicare Managed Care Manual (CMS Pub. 100-16), Chapter 8, Section 10 (General Payment Rules). See also 42 C.F.R. § 422.304.

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42 C.F.R. § 423.329.

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75 Fed. Reg. 81278 (December 27, 2010). Specifically, CMS requested comments regarding the following: (1) The methods for RACs to identify improper payments in the Medicare Part C and Part D programs; (2) whether implementation should be phased-in; (3) the criteria for RACs to use in reviewing claims; (4) conflict of interest rules; (5) establishing an oversight entity for issue approval; (5) the methods for RACs to use in resolving underpayments; (6) allowing Part C and Part D plans to use RACs within their own plans to identify overpayments; (7) implementing the Special Rules.

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Id.

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On April 11, 2010, CMS realigned its internal organizational structure, consolidating its Medicare and Medicaid program integrity activities. The CMS Center for Program Integrity oversees and facilitates the strategic and coordinated approach between Medicare and Medicaid benefit integrity activities (e.g., fraud and abuse investigations). See <http://www.hhs.gov/asl/testify/2010/06/t20100615a.html> (last accessed July 29, 2011).

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Available at http://aishealth.com/sites/all/files/recovery_auditing_memo_5_31_11_final.pdf (last accessed July 22, 2011).

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75 Fed. Reg. at 81280. See also 42 C.F.R. § 422.304.

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Available at http://aishealth.com/sites/all/files/recovery_auditing_memo_5_31_11_final.pdf (last accessed July 22, 2011).

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See also 75 Fed. Reg. 69037 *et seq.* (November 10, 2010).

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75 Fed. Reg. at 69041.

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Available at <http://www.cms.gov/smdl/downloads/SMD10021.pdf> (last accessed July 22, 2011).

23

75 Fed. Reg. 69037 (November 10, 2010).

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Available at <http://www.cms.gov/MedicaidIntegrityProgram/Downloads/6411racdelay.pdf> (last accessed July 22, 2011).

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Id.

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<http://www.cms.gov/medicaidracs/home.aspx> (last accessed July 22, 2011). As of the date of publication of this article, just three states are awaiting CMS approval of their state plans (*i.e.*, Louisiana, North Dakota and Wyoming). Of these state plans pending approval, two (*i.e.*, Louisiana and North Dakota) very recently submitted their state plans for approval in May 2011.

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75 Fed Reg. at 69042.

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Id.

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