

HERE COME THE MEDICARE RACS AND OTHER FUN AND GAMES FROM MEDICAID AND THE OIG



Presented By:
Carla J. Cox
Jackson Walker, LLP
October 28, 2008





What is a RAC and what does it do?



- A RAC is a Medicare Recovery Audit Contractor
- The RAC program's mission is to reduce Medicare improper payments through the efficient detection and collection of overpayments, the identification of underpayments and the implementation of actions that will prevent future improper payments



RAC Background



- In the Medicare and Prescription Drug Act of 2003, Congress directed DHHS to conduct a 3-year demonstration using RACs to detect and correct improper Medicare payments through an audit process
- The Tax Relief and Health Care Act of 2006 made the RAC Program permanent and required expansion to all fifty states by 2010



RAC Demonstration Project



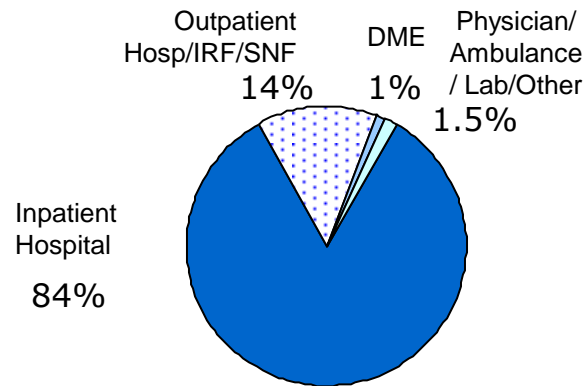
- Three states in 3 year demonstration: New York, Florida and California
- Arizona, South Carolina and Massachusetts added to demo project in 2007
- MSP RACs audited group health plans for Medicare as Secondary Payor issues
- Non-MSP RACs audited providers

Demonstration Results

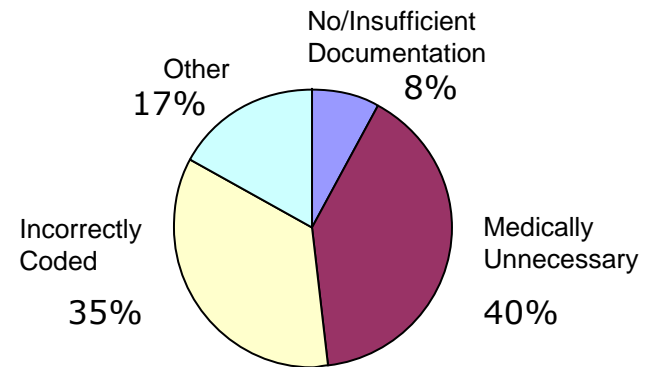


RACs collected \$980 million dollars, March 2005 – March 2008

Overpayments Collected by Provider Type



Overpayments Collected by Error Type



SOURCE: RAC Data Warehouse

CMS has not updated the figure of \$980 million to reflect successful appeals through 6/30/08



Source of Majority of Overpayments in the Project



- Inpatient Hospitals—84% of overpayments collected
- Why?
 - Certain claims such as physician visits excluded from demonstration project
 - RACs target high dollar improper payments to maximize contingency fees



Top SNF Services with RAC Initiated Overpayment Collections



- Physical and occupational therapy—
 - Amount collected--\$1.9 million on 1591 claims (net of appeals)
- Speech and language therapy—
 - Amount collected--\$1.5 million of 2690 claims (net of appeals)
- Location of problem claims—California

*Note this data is for FY 2007 only

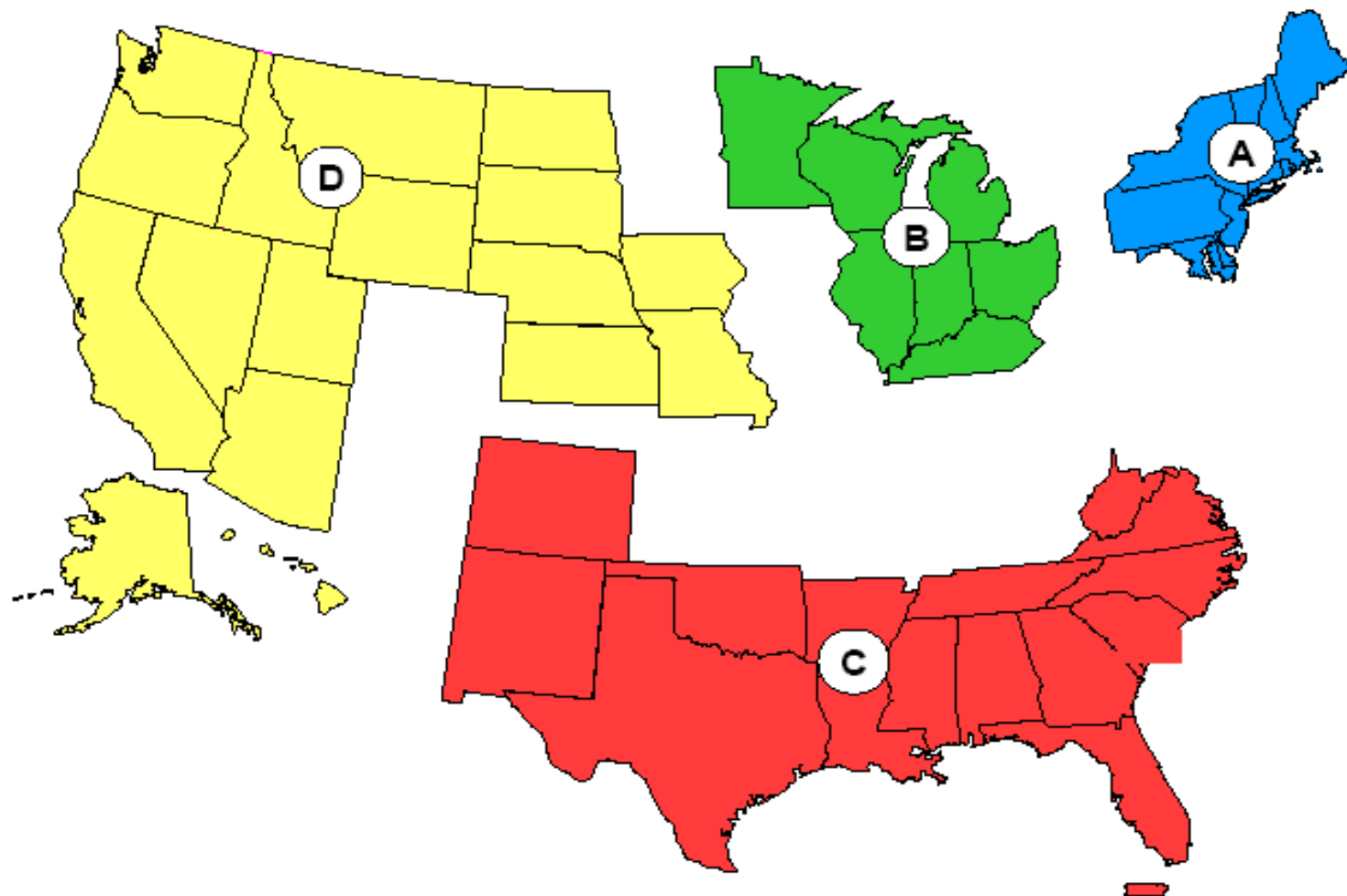


Coming soon to Texas

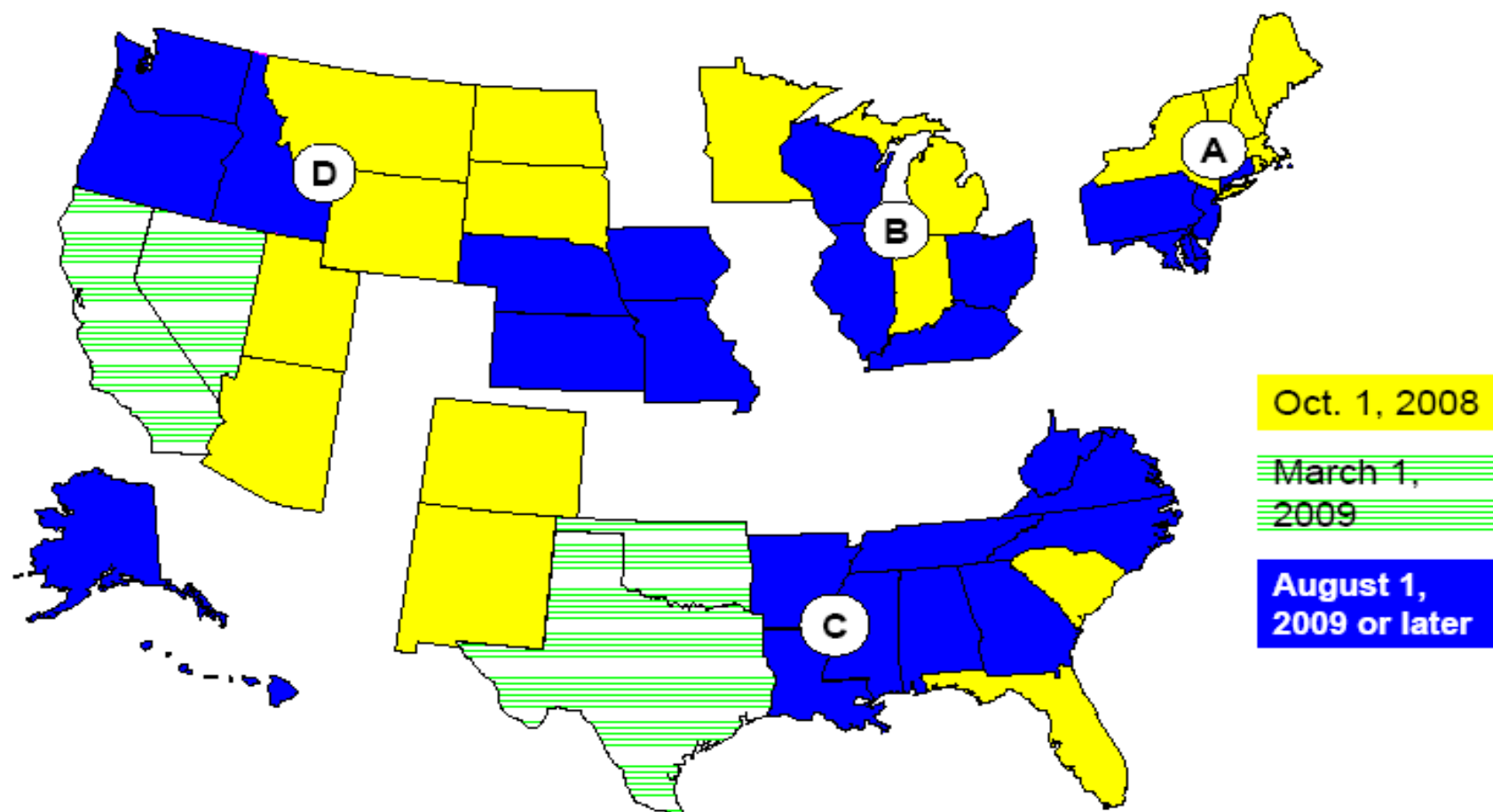


- Texas is scheduled to be added to the RAC Program in March 2009
- Texas will be in Region C
- October 6, 2008, CMS announced the four new national RACs
- The RAC for Region C is:
 - Connolly Consulting Associates, Inc. of Wilton, Connecticut

Proposed 2008 RAC Jurisdictions



RAC Expansion Schedule



Differences Between Demonstration and Permanent RACs



Strategy	Demonstration RACs	Permanent RACs
RAC Medical Director	Not Required	Mandatory
Coding Experts	Optional	Mandatory
Validation Process	Optional	Mandatory
RAC must payback the contingency fee if the claim overturned at any level of Appeal	RAC must pay back contingency fee if the claim is overturned on the first level of appeal	RAC must pay back if the claim is overturned on any level of appeal
Claims Reviewed	Records from three prior fiscal years	Claims with initial determination on or after October 1, 2007
Number of Records Requested	No limit per SOW	To be set by CMS



Know your enemy (oops, I meant RAC)



- From Connolly's website:
 - "Connolly is now the healthcare industry's largest data mining recovery audit firm, reviewing over \$120 billion in paid medical claims annually."
- All RACs are paid on a contingency basis
- In FY 2007, payments for contingency fees and other administrative expenses totaled \$77.7 million
- Good news: Connolly's contingency only 9% (lowest of all national RACs)



What will RACs be looking for?



- Over (and under) payments that result from:
 - Non-covered services
 - Incorrectly coded services
 - Services that are not reasonably necessary
 - Duplicate services
 - Information in medical record did not support claim



Be Prepared for RAC



- Select a RAC coordinator to manage all RAC inquiries, coordinate evaluation of all medical records sent out for RAC review
- RAC coordinator to log and track in all notices of overpayment from RAC
- Log should specify deadline for filing request for redetermination (and should be updated for each appeal level)
- Log should document deadline for repayment of overpayments contained in RAC demand letter
- Set up RAC management team to decide whether to appeal notices of overpayment



Be Prepared for RAC



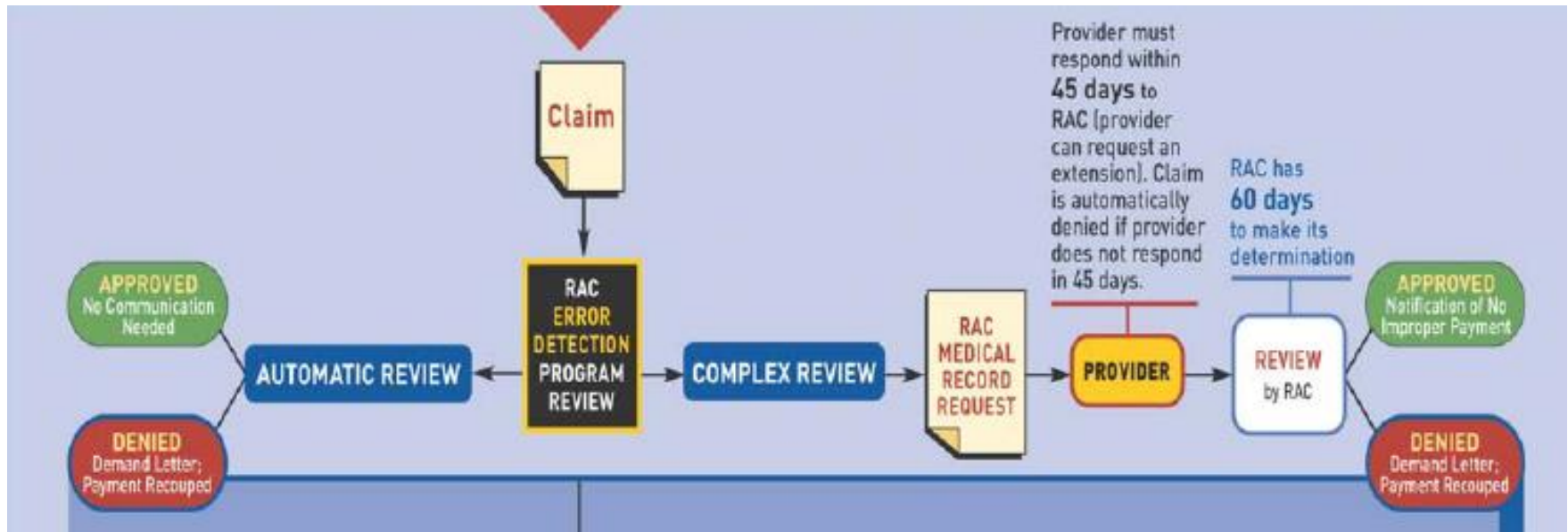
- Appeal all inappropriate denials
- Know the rules that apply
 - To you
 - To the RAC
- Medical record must be pulled and documentation that rebuts basis for overpayment identified
- Connect the dots for reviewer



Types of Reviews

- Automated review
 - Occurs when a RAC makes a claim determination without a human review of the medical record
 - Only where there is certainty that service is not covered, incorrectly coded, a duplicate payment or other claims related overpayment
- Complex medical review
 - Must be used if there is probability, but not certainty, of overpayment, and medical records are needed to make that determination
 - RAC must complete complex review within 60 days of receipt of the medical record documents unless waiver granted by CMS

RAC Claims Review Process



Source: America Hospital Assn.

Possible Results of RAC Review



- Full denial—no service provided, duplicate payments rec'd, no service reasonably and necessarily required—overpayment=full amount
- Partial denial—level of service not reasonable an necessary but lower level justified—overpayment=difference between full payment and payment at lower level
- No improper payment found

Communication of Review Results



- Notification letters must include
 - Provider ID and reason for conducting review
 - Description of facts that created each overpayment
 - Recommended corrective action
 - Findings for each claim in sample with specific explanation of why service determined to be non-covered
 - list of all individual claims and amount determined to be non-covered

Communication of Review Results



- Notification letters must include (cont.)
 - instructions to providers to forward refund checks
 - explanation of right to submit rebuttal statement prior to recoupment
 - explanation of procedures for recovery of overpayments
 - Medicare's right to recover overpayments (and interest) not repaid within 30 days
 - provider's right to request extended repayment schedule (ERS)
 - provider appeal rights



FAQs about RACs



- How many years of claims is a RAC permitted to review?
 - Claims paid after October 1, 2007 (FY 2008)
 - Cannot review claims paid more than 3 years before date of review



FAQs about RACs

- What claims are excluded from RAC review?
- Permanent exclusions:
 - Claims already reviewed by another Medicare contractor (FI, quality improvement organization, or carrier)
 - Includes claims originally denied and then paid on appeal
- Temporary Exclusions
 - Claims being reviewed as a potential for fraud by CMS, OIG, DoJ, or other law enforcement entity



FAQs about RACs

- How will RACs obtain copies of medical records for review?
 - On site review and copying
 - Provider may refuse on-site review
 - Written request by mail or fax
 - Request must contain good cause for re-opening claim
 - RAC does not have to pay SNF for copies
 - CMS may limit # of copies per month (see Late Breaking News)



FAQs about RACs



- How are overpayments recouped?
 - Demand made by RAC for repayment in notice of review results to provider
 - Medicare carrier, FI, or MAC notified of overpayment
 - If payment not made within 30 days, overpayment recouped unless ERS is arranged
 - Payments applied to interest first, then principal
 - Interest accrue from date of demand



Late Breaking News...



- Top CMS RAC officials say RAC's not permitted to conduct complex audits unless rationale for audit screened by newly created "new issues review board"
- CMS will nix audits and overpayment recoveries unless RAC spells out detailed reasons for the audit/overpayment recovery
- CMS has hired auditor to audit RACs and accuracy will play a role in contract renewal
- RACs will be required to return contingency fees if they lose at any level of appeal

Source: Report on Medicare Compliance, Oct. 13, 2008

Provider Appeals of RAC-Initiated Overpayments: Cumulative through 6/30/08



Provider Appeals of RAC-Initiated Overpayments Cumulative through 6/30/08 – Claim RACs Only

	Number of Claims with Overpayment Collections	Claims Appealed By Provider to Any Level		Appealed Claims with Decision in Provider's Favor		Percentage of Overpayment Determinations Overturned on Appeal
		Number	Percent	Number	Percent	
All Claim RACs	525,133	102,705	19.6%	35,819	34.9%	6.8%

Why appeal? Numbers Tell the Story



- CMS declares demonstration project a success because only 6.8% of all RAC overpayment determinations overturned on appeal
- But only 19% were appealed and 35% of all RAC overpayment determinations that have been appealed decided in provider's favor
- Connolly only had 7.3% of overpayment determinations appealed but a whopping 57.4% decided for provider (stats through 6/30/08) (highest of all RACs in demo)



Pending Appeals as of 5/1/08



- Pending at QIC (Qualified Independent Contractors):
 - 181 (\$ 2.8 million)
- Pending at ALJ:
 - 828 (\$ 22.5 million)
- Timeframe for appeal still open
 - \$255.1 million

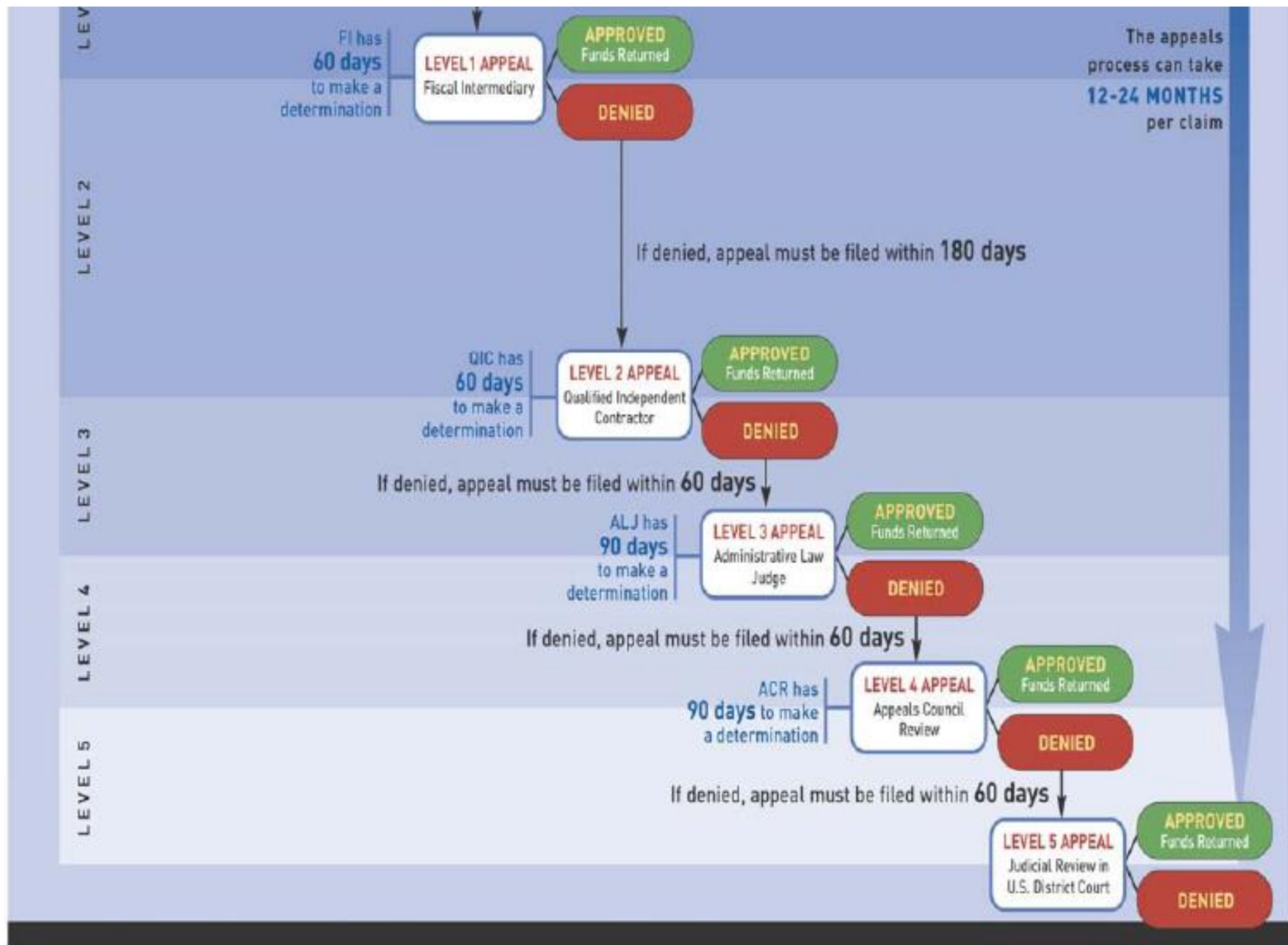
Source: Ad-QIC and RAC Data Warehouse



Appeals Process (Nothing is Ever Easy with Medicare)



- First Level of Appeal
 - Request redetermination from Medicare Carrier (or FI) within **120** days of initial determination
 - Medicare Carrier must respond within **60** days
 - If redetermination is in provider's favor, Carrier must refund any funds recouped with the notice of results
- Levels 2-5, see chart on next slide (Source: American Hospital Assn.)





Appeals Process



- Second Level of Appeal
(Reconsideration by QIC)
 - No minimum dollar amount
 - Request must be filed within 180 days of denial of redetermination
 - CMS has forms for requests for reconsideration



Appeals Process



- Third Level—Administrative Law Judge
 - Minimum amount in controversy=\$110 (\$120 '09)
 - Appeals are to the Office of Medicare Hearing and Appeals (OMHA)
 - Must be received by OMHA within 60 days of provider's receipt of denial of reconsideration by QIC
 - OMHA issues written notice of hearing (in person, or video-conference or telephone) 20 days prior to hearing
 - ALJ must issue written ruling within 90 days from date OMHA receives request for hearing request



Appeals Process



- Fourth Level—Appeals Council
 - Appeals must be filed within 60 days of receipt of ALJ's decision
 - Appeals Council may modify or reverse or remand ALJ's decision
 - Appeals Council must issue determination within 90 days of request for review



Appeals Process



- Fifth Level—Federal District Court
 - Minimum amount in controversy must be \$1090 (\$1,220 in '09)
 - Suit in federal district court must be filed within 60 days of Appeals Council decision
 - Last level of appeal available to providers



Compliance Implications



- Provider should review any RAC findings that indicate a systemic problem resulting in overpayments and correct prospectively
- Provider should review claims for periods not reviewed by RAC and may make voluntary repayments if they agree with RAC findings
- Failure to investigate and correct systemic problems may have False Claims Act implications



Compliance Implications



- Appeals of incorrect findings indicate existence of a legal dispute
- A legal dispute as to validity of overpayment determination may effect issue of knowledge of falsity under FCA
- Providers in multiple states under different RACs should consider implications of RAC findings as to claims in state under different RAC jurisdiction

Have You Been RAC'ed Enough?



My apologies to Delbert McClinton,
singer of "Have you never been rocked
enough?"



Medicaid Integrity Program



Deficit Reduction Act 2005



- Created Medicaid Integrity Program (MIP)
- Dramatically increased resources of CMS and HHS-OIG to fight Medicaid Fraud
- Funding \$560M over 5 years
- Required CMS to add 100 FTEs
 - GAO report—For FY 2005 CMS had only 8.1 FTEs to support states in anti-fraud and abuse operations



MIP Field Offices and Regions



New York

Region 1 and 2

Includes:

ME, MA, RI, VT, CT, NH, NY, NJ, PR, VI

Atlanta

Region 3 and 4

Includes:

MD, VA, WV, PA, DE, DC, NC, SC, TN, KY,
GA, AL, MS, FL

Chicago

Regions 5 and 7

Includes:

IL, IN, OH, MO, MN, WI, IA, NE, MI, KS

Dallas

Regions 6 and 8

Includes:

TX, LA, OK, AR, NM, CO, UT, MT, WY, ND, SD

San Francisco

Regions 9 and 10

Includes:

NV, AZ, OR, AK, ID, CA, WA, HI, CNMI,
Guam, American Samoa



MIP Statutory Requirements

- CMS tasked with
 - Developing 5-year Comprehensive Medicaid Integrity Plan
 - Making annual reports to Congress
 - Entering into Medicaid Integrity Contracts
 - Providing effective support and assistance to States to combat Medicaid fraud and abuse.



Medicaid Integrity Group



- Responsibilities:
 - Directing data analysis and contractor activities
 - Reviewing MIC reports
 - Liaison with State Medicaid agencies and state Medicaid Program Integrity Units
 - Coordination with CMS Regional Medicaid Financial Management staff



Medicaid Integrity Contractors

- MICs will carry out the following activities:
 - Review actions of individuals or entities furnishing Medicaid services to determine if fraud, waste or abuse has occurred or is likely to occur (the Review MIC)
 - Audit claims for services including cost reports (the Audit MIC)
 - Identify Overpayments
 - Education of providers regarding program integrity and quality of care



Final MIP Rule Effective 10/27/08

- CMS to release individual task orders for five jurisdictions, which are comprised of two CMS Regions
- Auditing is scheduled to begin in mid-June 2008 with the Atlanta jurisdiction which is comprised of CMS Regions II and IV
- The Review MIC will initially concentrate on CMS' Region IV, the Atlanta Region
- The Audit MIC will concentrate on CMS' Region III and IV, the Atlanta and Philadelphia Region.



RFP for Review MIC Provides Clues to Coming Activities



- Data mining, data analysis using State database systems
- Develop models using data to predict aberrant provider patterns
- Identify and rank by risk providers to be audited
- Risk assessment tool will identify high risk/problem areas by provider groups



MIC Review

- What are the criteria for review?
 - CMS is in the process of developing protocols for reviewing providers
- If Review MIC finds fraud, waste or abuse has occurred or is likely to occur
 - Will report provider to Audit MIC for audit
 - Will also share info with state and federal OIGs, DOJ, FBI, MFCUs, QIOs and private managed care and health insurers



Provider Review MICs

- Umbrella Contracts Awarded 12/07:
 - ACS Healthcare Analytics
 - AdvanceMed
 - IMS Gov't Solutions
 - Thompson Healthcare
 - Safeguard Services
 - Thomson Healthcare awarded Task Order for Regional Office IV 4/14/08



Audit MICs Selected

- Umbrella contracts awarded 12/07
 - Booz Allen Hamilton
 - Fox Systems
 - Health Integrity
 - Health Management Systems (HMS Holdings)
 - Island Peer Review Organization



What Happens If

- The MIC Audit contractor finds Medicaid overpayments to a provider?
 - CMS recovers federal % of overpayment from the state
 - State is responsible for recovering entire overpayment from provider
 - Providers to use Texas reimbursement appeals procedures to challenge overpayment findings and proposed recoupment



Recoupment of Overpayments

- Will state wait on outcome of appeal to recoup?
 - Probably not
 - CMS says that depends on state law
 - State does not have rules specifically addressing MIC audits
 - Generally state takes position that they can recoup pending appeal



Money Talks



- “For 2008 we’re projecting and actually are continuing to project that HMS revenues will grow to \$170 million, that’s about 16% growth rate, and that adjusted EBITDA will grow 21% to \$49 million.”

Robert Holster, HMS Holdings Corp 8-K filed with
SEC 2/28/08 (Audit MIC)



FAQs About MICs

- MICs will not be paid on a contingency basis
- Maximum award under any MIC contract=\$100,000M
- CMS certified in final rule on MICs
 - No substantial impact on small entities (revenues of \$6.5--\$31.5M per year)



Any Limits to Review/Audit?

- Not yet addressed in rules
- Hopefully will adopt similar limitations to RAC audits



What to Expect

- MIC reviews and audits in Texas will likely gear up in 2009
- Medicaid constitutes about 70% of all nursing home revenues in Texas
- No contingency incentive to go after higher dollar overpayments
- Nursing homes are likely to be a bigger target of MICs than of RACs



Being Prepared

- Develop internal monitoring techniques
 - Review TILE and RUG changes to determine if there are patterns
 - This will be complicated by switch from TILES to RUGs
- Perform annual risk assessments
- Correct any problem areas identified immediately





2009 OIG Work Plan

- Provides roadmap for Medicare and Medicaid risk assessment

SNF consolidated billing claims

- Medicare Part B made a total of \$106.9M in overpayments to suppliers of outpatient services on behalf of beneficiaries in Part A-covered SNFs in 2001 and 2002
- CMS implemented edits to correct but OIG continues to review effectiveness of edits



OIG SNF Focus Areas

- Accuracy of coding for Medicare Part-A SNF RUGs claims
 - For FY 2002 OIG found 22% of claims upcoded=\$542M in potential overpayments
- Part B claims for mental health and psychotherapy services
 - OIG found 31% of outpatient mental health claims did not meet coverage requirements



Additional SNF Focus Areas



- Calculation of Medicare benefit days
 - Will review whether failure to submit no-pay bills results in inappropriate calculation of eligibility periods
- Review of accuracy of MDS data
- Review necessity of anti-psychotic drugs for SNF Residents over 65



OIG Hospice Concerns

- Will review appropriateness of hospice services for SNF beneficiaries
 - Medicare hospice payments increased from \$3.5B to \$7B between 2001-2004
 - OIG found hospice patients in SNFs received 46% fewer nursing and aid services than hospice patients at home
 - Will review medical records to determine if services are consistent with plans of care and payments appropriate



OIG Medicaid Focus Areas



- Will review Medicaid payments to dual-eligible beneficiaries in Part-A stays
- Transparency of nursing facility ownership
 - Will review complex ownership structures that leave operators of NF with no assets
- Appropriateness of payments for bed holds



Medicaid Fraud Control Units

- State Attorney General's Office
 - Investigates criminal fraud and patient abuse
 - In FY 2007, MFCUs nationally recovered more than \$1.1B in restitution, fines, settlements and penalties
 - Criminal convictions—in FY 2007, 50 MFCUs obtained 1205 convictions



Texas MFCU Actions

Action	3 rd & 4 th Quarters FY2007
Cases Opened	387
Cases Closed	330
Cases Presented	244
Criminal Charges Obtained	79
Convictions	66
Potential Overpayments Identified	28829
Misappropriations Identified	\$190,663
Settlements	\$35,398,575
Cases Pending	1296



Texas AG's Civil Medicaid Fraud Section



- Authority to investigate and civilly prosecute any person who commits an "unlawful act"

CMF Docket		3rd & 4th Quarters FY2007	
Pending Cases/Investigations		191	
Cases Closed		8	
Cases Opened		27	



Texas OIG

- Objectives
 - Coordinate investigations to “aggressively” recover Medicaid overpayments
 - Allocate resources to cases with strongest supporting evidence and greatest potential for monetary recovery
 - Maximize opportunities for referrals to MFCU

Medicaid Fraud, Abuse, and Waste Workload Statistics and Recoupments – FY 2007

Action	1 st Quarter FY2007	2 nd Quarter FY2007	3 rd Quarter FY2007	4 th Quarter FY2007	Total FY2007
Medicaid Provider Integrity					
• Cases Opened	166	182	129	117	594
• Cases Closed	62 ¹	48	67	131	308
• Referrals to MFCU	58	44	77	88	267
• Referrals to Other Entities	57	109	40	61	267
• MPI Cases Referred to Sanctions	8	19	24	7	58
• On-site Provider Verifications	50	51	74	73	248
• Criminal History (CH) Checks Conducted	4,284	4,638	6,097	5,081	20,100
Medicaid Fraud & Abuse Detection System ²					
• Cases Opened	328	973	177	490	1,968
• Cases Closed	766	595	152	557	2,070
Sanctions Recoupments ³	\$6,593,747	\$1,463,849	\$1,764,638	\$2,792,050	\$12,614,283
Providers Excluded	143	98	145	102	488



What, Me Worry?

