On December 22, 2015, the Centers for Medicare & Medicaid Services (CMS) released a request for information (RFI) and a proposed statement of work (SOW) seeking industry feedback on the expansion of the recovery audit contractor (RAC) program to Medicare Part C through the proposed incorporation of RACs into CMS' Risk Adjustment Data Validation (RADV) audit process. CMS currently contracts with RACs to identify and correct overpayments and underpayments in Medicare Parts A, B, and D and Section 6411(b) of the Patient Protection and Affordable Care Act of 2010 (PPACA) required expansion of the RAC program to Medicare Part C. The RFI seeks comment on expanding the Recovery Audit Program to include the identification and correction of overpayments and underpayments associated with diagnosis data submitted to CMS by Medicare Advantage Organizations (MAOs) for Part C payment.

CMS’ proposal would integrate three levels of RACs into the RADV process, using the RACs to select Medicare Advantage (MA) plan enrollees for review, identify underpayments and overpayments associated with diagnosis data submitted to CMS, and calculate the final overpayment/underpayment amount. By using independent RACs to assist with the RADV audits, CMS intends “to have all MA contracts subject to either a comprehensive or condition-specific RADV audit for each payment year.” The comment period on the Medicare Advantage RAC program closes at 10:00 a.m. EST on Feb. 1, 2016. CMS noted that it will determine the next steps for procurement of the Part C RACs after reviewing the comments received in response to the RFI.
Given that every MA plan will likely be subject to a RADV audit—and potentially every year—MAOs are cautioned to take heed of this latest development and prepare for a more complicated, and likely more aggressive, audit environment.

Pillsbury attorneys previously reported in 2012 and 2015 on the government and the public’s growing attention to MA risk score inflation and the likelihood that MAO payments would become the next big target for fraud and abuse scrutiny, including a very likely target for the Department of Justice and qui tam relators under the False Claims Act (FCA). Once RACs become engaged in the RADV process, the risk of overpayment liability will only intensify.

**Overview of Risk Adjusted Payment**

Under the MAOs’ contracts with CMS, the MAO is paid on a capitated per enrollee, per month basis based on the health status of the MA plan’s enrollees. To discourage cherry-picking of healthy patients by the MA plans, CMS pays the MAO a higher capitated payment for a sicker enrollee than a healthier one. Specifically, CMS groups diagnosis codes into separate disease categories known as Hierarchical Condition Categories (HCCs) and calculates a risk score for each enrollee based on his or her HCCs. The risk score in turn determines the risk adjustment payment to be paid to the MAO on behalf of each enrollee. Generally speaking, the more diagnoses or conditions reported by a MAO, the higher CMS’ payment to the plan. RADV audits verify, through medical record review, the accuracy of enrollee diagnoses submitted by MAOs to CMS for the calculation of this risk adjusted payment.

Currently, CMS performs approximately 30 RADV audits each year, or roughly 5% of all MA contracts, which has resulted in a 9.5% improper payment rate in Medicare Part C. Under the proposed RAC expansion, CMS intends to audit every MAO, every year.

**Proposed Incorporation of RACs into the RADV Process**

RACs would be incorporated into the RADV audit process in two ways, performing both comprehensive audits and condition-specific audits. For the comprehensive audits, CMS will select a sample of MA contracts for review each year. From that sample, CMS will then select a statistically valid sample of plan enrollees for medical record audit. The MA plans would submit the medical record documentation along with each of the diagnoses reported to CMS for each enrollee in the sample. The RACs would then review enrollee medical records to determine whether the criteria for establishing the risk score were satisfied. To the extent that the assigned risk score is found to not meet the criteria, the RAC will identify the underpayment or overpayment and will initiate recoupment of all overpayments. Extrapolation would be applied to the identified overpayments. See Pillsbury’s 2012 alert for a discussion of the sampling methodology and payment error calculation methodology to be used in the comprehensive RADV audits.

Condition-specific audits would also be performed for a sample of MA contracts that were not subject to a
A comprehensive audit in that same year. The condition-specific audits will focus on specific health conditions (e.g., diabetes) or codes that have high rates of payment errors. The RAC would identify and submit to CMS for approval the HCCs deemed to be at a high risk for error. Once the HCCs are approved, the RAC would select a statistically valid sample of enrollees and review those records. Just as with the comprehensive audit, any identified overpayments would be extrapolated.

Importantly, under CMS’ proposal, the RACs would also be involved in developing the Coder Guidance document used to evaluate medical records for the presence of diagnosis codes. To guard against improper determinations that are financially motivated, CMS proposes that each payment error identified by the RACs will be independently reviewed and verified by a Secondary Review RADV contractor. In the event that the Secondary Review RAC disagrees with the determination by the first-level RADV RAC, the Second Review RAC’s decision will prevail. Coding consistency for RAC auditors must be at least 95%, meaning that the RAC auditors must agree at least 95% of the time; however, it is unclear how failures to achieve the 95% rate will be handled.

Download: CMS Proposes Expansion of RAC Program to Medicare Part C – All Medicare Advantage Contracts to Become Target of RADV Audits

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