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

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*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.*

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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 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.

### Financial Incentive to Find Overpayments

Medicare Part A and B RACs are paid an amount (approximately 10%) that is contingent on how much money they recover on behalf of the government. The Medicare Part C RAC program also proposes a contingency fee payment, similarly incentivizing RACs to find improper overpayments despite their mandate to identify both overpayments and underpayments. While CMS has proposed a complex process of secondary review to offset such concerns for impropriety, the risk for financially motivated determinations remains, especially when the RACs are playing a role in determining the Coder Guidance used to evaluate the sufficiency of the medical record documentation. It is also notable that the RAC RADV process, as proposed, will move very quickly; specifically, the first level RAC must complete its medical record review within 14 calendar days of its receipt of the documentation. The speed and anticipated volume of audits combined with the contingency fee payment, creates an environment where overpayments are more likely to be identified. In such case, MAOs should prepare to appeal RAC determinations, especially where extrapolation is applied.

### Administrative Appeals Process

MAOs may appeal the medical record review determinations and/or the payment error calculation. Under Section 422.311, the MAO may elect Reconsideration, where CMS reviews the medical record and payment error calculation again. If unfavorable, the Reconsideration decision may be appealed to the Office of Hearings and then to the CMS Administrator, whose decision is final.

Under CMS' proposal, the RACs will prepare Audit Reports for each MA plan contract per CMS instruction. For MAOs that elect not to appeal, the Part C RAC will issue demand letters approved by CMS. Interestingly, the proposal states that RACs shall have an "appeal overturn rate" of less than 10% at the first level of administrative appeal. However, it is unclear whether the RACs will be financially penalized for inappropriate overpayment determinations that are later overturned in the appeals process.

### What Does All of This Mean?

CMS' latest proposal to incorporate RACs into the RADV audit process has confirmed that MA plan risk score inflation is a target on the government's radar and under this new audit plan, no MAO will escape scrutiny. RAC determinations in Medicare Parts A and B have historically been unfavorable to health care entities and according to 2012 data released by the Department of Health and Human Services Office of the Inspector General (OIG), 72 percent of hospital RAC appeals that go to the third level of the Medicare appeals system are overturned in favor of the hospital. (See, HHS OIG, OEI-02-10-00340 - *Improvements are Needed at the Administrative Law Judge Level of Medicare Appeals* (Nov. 2012), available at: <http://oig.hhs.gov/oei/reports/oei-02-10-00340.pdf>.)

Because the RACs have a financial stake in finding overpayments owed to the government, MAOs should aggressively challenge determinations where appropriate, especially in cases where the government uses extrapolation. MAOs should be proactive in this process and prepare for RAC audits by (i) reviewing their

high risk diagnoses and ensuring accurate coding (including ICD-10), (ii) developing internal coding guidance based on published CMS RADV criteria, and (iii) conducting internal reviews to identify areas of risk. These proactive actions may help to deter potential whistleblowers as well as provide a solid defense to a RAC overpayment determination.

Pillsbury attorneys have a wealth of experience with respect to administrative appeals as well as the representation of MA plans, including the successful settlement of one of the few—if not the only—FCA actions to-date pursued by the DOJ against a MA plan as a result of an extrapolated RADV audit.

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If you have any questions about the content of this alert, please contact the Pillsbury attorney with whom you regularly work, or one of the attorneys listed below.

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