RECOVERY AUDIT CONTRACTORS

RAC SUBSCRIPTION SERVICE

"Being Proactive"

July 12, 2011

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Faculty

- Brian Annulis, JD
  - Partner, Meade & Roach, LLP
  - 773.907.8343
  - bannulis@meaderoach.com

- Ryan Meade, JD
  - Partner, Meade & Roach, LLP
  - 773.472.3975
  - rmeade@meaderoach.com

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RAC Subscription Service: Webinar Overview

- "RACs: Being Proactive"
  - Second Tuesday of each month
  - Discuss one or two high-risk areas for RAC review
  - Review ideas on how to proactively audit
  - Propose operational safeguards

- "RACs: What are We Learning"
  - Fourth Tuesday of each month
  - Keep subscribers up-to-date on RAC developments
    - Discuss RAC updates
    - Analyze publicly available decisions involving RACs
  - Pool questions from subscribers

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RAC Subscription Service: Webinar Overview

- Regularly scheduled Webinars will be supplemented, as necessary, with special “emergency” sessions

- Administrative Matters
  - Each session will be 60-75 minutes in duration, including a question and answer session
  - Each session will begin at 12:00 PM CT
  - If you are unable to participate in the live discussion, each session will be recorded and made available in MP3 format

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Goals

- The goals of the RAC Webinars:
  - Teaching/knowledge transfer
  - Practical points
  - Assist organizations to develop in-house methods of managing
  - Please share your thoughts, suggestions (and criticisms)

- Our Perspective—
  - *Defend your claims*: Appeals process is critical
  - *Manage your compliance risks*: Compliance implications to a RAC review must be addressed – the RAC process is not just about RAC recovery
  - *Be proactive*…and preemptive

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Today's Topics and Agenda

- FY 2010 Top Management and Performance Challenges Identified by the OIG
- HHS Semiannual Regulatory Agenda, 76 Fed. Reg. 40052 (July 7, 2011)
- Proposed 2012 Physician Fee Schedule
- Proposed 2012 HOPD Payment Policies and Rates

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FY 2010 Top Management and Performance Challenges Identified by the OIG

FY 2010 Top Management and Performance Challenges Identified by the OIG

- Pursuant to the Reports Consolidation Act of 2000 (P.L. No. 106-531), each year the Office of Inspector General (OIG) summarizes what OIG considers to be the most significant management and performance challenges facing the Department of Health & Human Services (the Department or HHS) and the Department's progress in addressing those challenges.

- The OIG report is divided into four parts:
  (1) health care reform;
  (2) integrity of the Medicare, Medicaid and the Children's Health Insurance Program (CHIP);
  (3) integrity of the HHS's public health and human services programs; and
  (4) cross-cutting issues that span multiple agencies within HHS.

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Identified Management Issues/Challenges

- Management Issue I: Incorporating Integrity into Health Care Reform Implementation
- Management Issue 2: Integrity of Provider and Supplier Enrollment
- Management Issue 3: Integrity of Federal Health Care Program Payment Methodologies
- Management Issue 4: Promoting Compliance With Federal Health Care Program Requirements
- Management Issue 5: Oversight and Monitoring of Federal Health Care Programs
- Management Issue 6: Response to Fraud and Vulnerabilities in Federal Health Care Programs
- Management Issue 7: Quality of Care
- Management Issue 8: Oversight of Food, Drugs, and Medical Devices
- Management Issue 9: Public Health Emergency Preparedness and Response
- Management Issue 10: Grants and Contracts Management

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Management Challenges

- Management Issue 11: American Recovery and Reinvestment Act Accountability and Transparency
- Management Issue 12: Health Information Technology and Integrity of Information Systems
- Management Issue 13: Ethics Program Oversight and Enforcement

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Issue 1: Health Care Reform

Implementation of the law merits thoroughness, scrutiny, and oversight. A significant challenge for HHS will be identifying key vulnerabilities and prioritizing oversight resources. Based on OIG's experience in auditing, evaluating, and investigating fraud, waste, and abuse, areas that warrant vigilant HHS oversight include:

- Programs implemented under expedited timeframes. The Department can draw upon experience gained in two recent programs that were implemented with short timeframes – the Medicare Prescription Drug Benefit and the American Recovery and Reinvestment Act (Recovery Act) of 2009 (P.L. No. 111-5).
- Programs involving data collection to ensure accuracy and completeness of data.
- Grant programs.

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Medicare, Medicaid, CHIP Programs

For Federal health care programs to best serve beneficiaries and remain solvent for future generations, the Government must pursue a comprehensive strategy to prevent, detect, and correct fraud, waste, and abuse.

Based on its experience in combating health care fraud, waste, and abuse, OIG has identified five principles that it believes should guide the Department's integrity strategy for Medicare, Medicaid, and CHIP. These principles offer a framework for implementing programs, as well as designing integrity safeguards and putting them into practice.

- Enrollment – Scrutinize individuals and entities that seek to participate as providers and suppliers before they enroll in health care programs.
- Payment – Establish payment methodologies that are reasonable and responsive to changes in the marketplace.
- Compliance – Assist health care providers and suppliers in adopting practices that promote compliance with program requirements, including quality and safety standards.
- Oversight – Vigilantly monitor programs for evidence of fraud, waste, and abuse.
- Response – Respond swiftly to fraud, impose appropriate punishment to deter others, and promptly eliminate program vulnerabilities

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Issue 2: Enrollment

- The Affordable Care Act requires the Secretary to implement screening procedures for different categories of providers and suppliers based on the risk of fraud, waste, and abuse. The screening must be applied to all new enrollments starting March 23, 2011, and all providers and suppliers must be subject to the same process by March 23, 2013.

- The Affordable Care Act has several additional provisions aimed at reducing vulnerabilities in provider and supplier enrollment, including subjecting new providers and suppliers to enhanced oversight, such as prepayment review for 30 days to 1 year after enrollment.

- Providers or suppliers applying for enrollment on or after March 23, 2011, must disclose any direct or indirect, current, or previous affiliation with a provider or supplier that has uncollected debt or that has been subject to a payment suspension, program exclusion, or revocation or denial of its billing privileges under a Federal health care program.

- The Secretary may also impose a temporary moratorium on enrollment of providers and suppliers or on enrollment of certain categories of providers and suppliers, if necessary, to prevent or combat fraud, waste, and abuse.

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Issue 3: Payment Methodologies

- Initial payment methodologies must be set to reimburse providers and suppliers fairly for appropriate care. Payment methodologies must also be responsive to ensure that they remain reasonable and appropriate as the health care marketplace and medical practice evolve. Finally, CMS must be nimble enough to safeguard against the financial incentives and fraud and abuse risks associated with each payment methodology that is established.

- Certain types of services may be vulnerable to abuses such as upcoding, or billing a higher complexity code than the one appropriate for the service performed. OIG has observed that Medicare payments for E&M services increased by over $9 billion between 2000 and 2009, in part because of a trend of increased billing for high-complexity E&M codes. E&M services may be particularly vulnerable to abuse because the differences among complexity levels are less distinct than the differences in other services and because monitoring by CMS and contractors is lacking.

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Issue 4: Compliance

- The risks associated with failing to create a culture of compliance and the costs of noncompliance are significant.
- CMS estimated that in FY 2009, improper FFS payments cost Medicare $24.1 billion (7.8% error rate). Changes were implemented during FY 2009 review year, and as a result, the 7.8% was a combined error rate using two different methodologies. The revised methodology is more stringent.
- The national paid claims error rate for those claims reviewed under the strictest criteria, when applied to the entire year, is **12.4%** or $35.4 billion.
- CMS estimated that in FY 2008, improper Medicaid State and Federal payments cost $28.7 billion (**8.71%** error rate).

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Issue 4: Compliance

- OIG recently found that certain DME claims did not meet Medicare program requirements, resulting in potentially more than $200 million in improper payments.
- OIG found that New York's Medicaid program paid more than $414.5 million ($207.6 million Federal share) to providers in New York City for rehabilitation services claims that did not meet program requirements.
- Error rates and improper payment estimates include paid claims that do not meet program rules, whether because of error, fraud, or other factors.
- OIG has also identified fraud and abuse that have resulted in substantial costs to Federal health care programs: **expected OIG recoveries for the 6 months that ended March 2010 include about $667 million in audit receivables and $2.5 billion in investigative receivables**.

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Issue 4: Compliance—Education

- Provider education and guidance are important tools for fostering compliance.
- **However, several factors create challenges in promoting industry compliance with program rules through education. Federal health care programs are governed by complex statutes, regulations, and subregulatory guidance. There are national rules, such as statutes, regulations, and national coverage determinations, and local rules, including local medical review policies. These rules and regulations are frequently updated or changed by law or by administrative action. In a complex programmatic environment, it is a challenge to ensure that guidance is clear, informed, complete, and audience appropriate.**

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Issue 4: Compliance—Compliance Programs

- Implementation of effective compliance programs is another method of fostering an industry culture of compliance and a continuing commitment to delivering quality health care.

- One challenge, historically, is that the implementation of compliance programs has been largely voluntary. Before enactment of the Affordable Care Act, most Medicare and Medicaid providers were not required to adopt compliance programs. Compliance programs have been required only among certain categories of providers and suppliers, including Medicare Part D drug plan sponsors and MA organizations, which are required by statute to implement compliance plans and individuals and entities that have entered into CIAs with OIG.

- OIG has recommended that all Medicare and Medicaid providers and suppliers be required to adopt compliance programs as a condition of participating in the Medicare and Medicaid programs. Passage of the Affordable Care Act entails major changes in the role of provider and supplier compliance plans in Federal health care programs. Section 6102 of the Act requires, among other things, that nursing homes develop effective compliance and ethics programs to be in place by March 2013.

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Issue 5—Oversight and Monitoring

- **The Department often fails to use these data effectively for oversight and monitoring, resulting in the loss of Federal health care dollars**.

- Claims-processing and payment systems have traditionally relied on claim-by-claim review. However, in many cases, fraud or abuse can be detected only by reviewing aggregated claims and billing patterns because each claim may appear on its face to be legitimate.

- OIG has identified opportunities for the Department to improve its collection, analysis, and monitoring of data to better fight fraud, waste, and abuse.

- CMS plans to enhance the data available to monitor payment accuracy and integrity across the Medicare and Medicaid programs.

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Issue 5: Oversight—Data Analysis

- Measuring error rates is key to monitoring program integrity and the scope of inappropriate payments. In its reviews of CMS's annual Comprehensive Error Rate Testing (CERT) program, OIG has raised concerns that the Medicare error rates for certain provider types may be understated.

- Measuring payment errors and their causes in the Medicaid and CHIP programs is particularly challenging because of the diversity of State programs and the variation in their administrative and control systems. CMS's Payment Error Rate Measurement (PERM) program was designed to measure error rates for three components of Medicaid and CHIP: FFS, managed care, and eligibility.

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Issue 5: Oversight—Data Analysis

- The health care system compiles an enormous amount of data on patients, providers, and the delivery of health care items and services. However, OIG has found numerous examples in which Federal health care programs have failed to use claims-processing edits and other information technology effectively to prevent improper claims.

- Claims analysis can reveal instances in which providers bill for medically unnecessary services to defraud programs.

- Claims analysis can also reveal instances in which providers bill for more services than are physically possible.

- Claims analysis can also identify service areas in which providers submit questionable claims.

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Issue 5: Oversight—Data Analysis

- The Department is making progress in improving the oversight and monitoring of Federal health care programs. CMS is augmenting its oversight capabilities by **contracting with outside entities** to perform many oversight and monitoring functions for Medicare and Medicaid. CMS is also acting to enhance data systems available for use by these contractors.

- For Medicare, CMS is transitioning program safeguard functions from PSCs and MEDICs to Zone Program Integrity Contractors (ZPIC). These new contractors will be responsible for ensuring the integrity of all Medicare-related claims under Parts A and B (e.g., hospital, skilled nursing, home health, physician, and DME claims); Part C (MA health plans); and Part D (prescription drug data) and for coordinating Medicare-Medicaid data matches.

- As of November 2010, CMS had awarded four ZPIC contracts, with three more contracts planned. With the transition to ZPICs, determining whether the change in contractors has brought about improvement in the use of proactive methods in analyzing claims data will be important. OIG is examining ZPICs' efforts to identify program vulnerabilities and detect and investigate fraud and abuse.

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Issue 5: Oversight—Data Analysis

- In 2003, Congress authorized the Department to establish a demonstration program for Recovery Audit Contractors (RAC) to identify underpayments and overpayments and to recoup overpayments under Part A or B of the Medicare program. Under this authority, Congress provided for payments to RACs on a contingent basis for detecting and correcting overpayments and underpayments.

- In 2006, Congress mandated that the Department implement RACs on a nationwide and permanent basis.

- As of October 2009, CMS completed implementation of the national RAC program in all 50 States.

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Issue 5: Oversight—Data Analysis

- CMS reported that the RAC demonstration project successfully returned almost a **billion dollars** to Medicare, which represented a new mechanism for detecting improper payments, and provided CMS with a tool for preventing and reducing future improper payments.

- CMS will require RACs to help develop plans designed to address vulnerabilities found during their reviews.

- RACs are also responsible for referring to CMS any cases of potential fraud that are found during their reviews. However, OIG noted that over the 3-year demonstration period, RACs referred only two cases of potential fraud to CMS. OIG and CMS are working together to ensure appropriate referrals of suspected fraud under the national RAC program. CMS has agreed to implement a system to track fraud referrals and to require RACs to receive mandatory training on the identification and referral of fraud.

- Section 6411 of the Affordable Care Act expands the RAC program, giving it additional responsibilities to address improper payments in Medicaid and Medicare Parts D and C.

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Issue 6: Response to Fraud & Abuse

- Responding to fraud and program vulnerabilities requires a high degree of coordination and collaboration between multiple Federal and State agencies and contractors.

- Federal health care programs are built on a range of regulations, program requirements, and payment methodologies that are often the result of detailed rulemaking and programmatic balancing of competing stakeholder interests. The size and complexity of Federal health care programs also make implementing a comprehensive and swift response to fraud and vulnerabilities difficult.

- Adding to this complexity, the Medicare administration and program integrity responsibilities are divided among a variety of contractors, and Medicaid and CHIP have their own systems and contractors. The programs compile an enormous amount of data on patients, providers, and the delivery of health care items and services, which are often housed in many locations with different data infrastructures. Operating within this complex framework, it is often difficult for the programs to respond nimbly in the face of a vulnerability, which can result in a significant monetary loss before a remedy or sanction is applied.

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Issue 6: Response to Fraud & Abuse

- HHS and DOJ took strong and decisive enforcement action through the creation of Medicare Fraud Strike Forces as part of the HEAT initiative to combat health care waste, fraud, and abuse.

- HEAT built on the successful Medicare Fraud Strike Force (Strike Force) initiated in south Florida by expanding Strike Forces to other metropolitan areas across the country.

- These Strike Forces use advanced data analysis techniques (see Management Issue 5) to identify criminals operating as health care providers and detect emerging or migrating fraud schemes. Strike Force teams operate in Miami, Los Angeles, Detroit, Houston, Brooklyn, Baton Rouge, and Tampa, and 13 more teams are to be established in other cities as resources permit.

- As of September 30, 2010, Strike Force efforts have resulted in charges against approximately 625 individuals or entities, more than 300 convictions, and approximately $315 million in investigative receivables. Strike Forces have been successful, but the teams require sufficient staffing and resources to respond effectively to health care fraud schemes.

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Issue 6: Response to Fraud & Abuse

- The Affordable Care Act strengthens the Government's ability to detect fraud and abuse and to respond rapidly to health care fraud. The law also requires the Department to expand CMS's integrated data repository to include claims and payment data from Medicaid, VA, DOD, SSA and IHS and fosters data-matching agreements among Federal agencies.

- These agreements will make it easier for the Federal Government to identify fraud, waste, and abuse. It will then be a challenge for the Department to integrate all of this data into its systems for analysis and response.

- The challenge remains to obtain real-time information across all areas of the programs, which will enable the Government to respond to fraud more quickly, bring criminals to justice, and recoup stolen funds.

- Timely data are also essential to responding with agility as criminals shift their schemes and locations to avoid detection.

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Issues 7: Quality of Care

- Ensuring quality of care for beneficiaries of Federal health care programs continues to be a significant challenge for the Department.

- This challenge has many facets, such as ensuring that the Department adequately oversees health care providers' compliance with quality-of-care standards and ensuring that beneficiaries do not receive substandard care and are not abused or neglected.

- The Department also faces challenges in adopting tenets of the patient-safety movement, which focuses on improving care through quality improvement initiatives, measurement, and reporting.

- Medicare's primary program for addressing substandard care is the Quality Improvement Organization (QIO) program, which was established to promote the effective, efficient, and economical delivery of Medicare health care services and ensure the quality of those services. However, in 2007, OIG found that only 11 percent of cases reviewed by QIOs were for quality-of-care concerns and that sanction referrals were rare.

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Issues 7: Quality of Care

- The Department, which represents a major purchaser of health care, faces challenges in adopting tenets of the expanding patient-safety movement, which focuses on quality improvement, measurement, root-cause analysis, transparency, and public reporting.

- The OIG's recent work on adverse events underscores the significance of this challenge. OIG reported that 13.5 percent of hospitalized Medicare beneficiaries experienced serious adverse medical events that prolonged a hospitalization, required life-sustaining intervention, or contributed to permanent harm or death and that another 13.5 percent of beneficiaries experienced temporary-harm events requiring medical intervention. These events, nearly half of which (44 percent) were preventable, cost the Medicare program $324 million in additional costs in a single month.

- The Department continues to make hospital, nursing home, and dialysis facility ratings available to consumers. AHRQ has also made considerable progress in implementing Patient Safety Organizations (PSO), which encourage clinicians and health care organizations to voluntarily report and share quality and patient safety information without fear of legal discovery. PSOs play an important role in collecting and studying data regarding adverse events.

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HHS Semiannual Regulatory Agenda

HHS Semiannual Regulatory Agenda

- Proposed Rules include:
  - Medicaid Program Integrity: Registration of Billing Agents, Clearing Houses, or Other Alternate Payees
  - Proposed Rule expected October, 2011

- Final Rules include:
  - Enhanced Federal Funding for Medicaid Eligibility Determination and Enrollment Activities

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2012 Proposed Physician Fee Schedule

2012 Proposed Physician Fee Schedule—Three Day Payment Window

- On July 1, 2011, CMS issued proposed payment rate and policy changes for the Medicare physician fee schedule that would go into effect for calendar year (CY) 2012.
- The proposed rule will be published in the July 19, 2011, Federal Register.
- Among other changes, CMS would modify payment for physician services that are subject to the so-called "Three-Day Payment Window."
  - This rule provides that certain services furnished to Medicare beneficiaries in the three days preceding an inpatient admission are included in the hospital's Hospital Inpatient Prospective Payment System payment, instead of being paid for separately as Part B services.
  - Under the rule, hospitals must include on the claim form for a Medicare beneficiary's inpatient stay the technical component of outpatient diagnostic services and admission-related nondiagnostic services if they are delivered within the three-day period.
- Under the proposed rule, physician practices that are wholly owned or operated by a hospital and that occur during the patient's stay would be reimbursed at a lower rate as though the services had been delivered in a hospital setting.

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2012 HOPD Rates

- On July 1, 2011, CMS also issued a proposed rule with policy and payment changes for Hospital Outpatient Departments (HOPDs) and Ambulatory Surgical Centers (ASCs).
- The proposed rule would affect Medicare payments commencing in calendar year (CY) 2012.
- The proposed rule will be published in the July 18, 2011, Federal Register.
- Among others, the HOPD proposed rule would incorporate changes to physician outpatient supervision levels

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2012 HOPD Rates—Outpatient Supervision

- There are no changes proposed to hospital outpatient diagnostic supervision levels.

- CMS proposes to modify the manner in which the minimum levels of supervision for therapeutic services provided in hospital outpatient departments are determined by establishing the Ambulatory Payment Classification (APC) Panel as the independent review panel to make recommendations to CMS regarding whether individual outpatient hospital therapeutic services should be furnished under general, direct, or personal supervision.

- Parties would be permitted to request a change to the supervision level assigned to services.

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Proposed 2012 HOPD Payment Policies and Rates

2012 HOPD Rates—Outpatient Supervision

- CMS proposes to adopt the definitions of the terms "personal" and "general" supervision in Medicare Physician Fee Schedule for purposes of interpreting the requirements for providing services to hospital outpatients.

- CMS anticipates that it will extend the notice of non-enforcement for direct supervision in CAHs and rural hospitals through CY 2012.

- CMS also proposes changes to clarify that all hospital outpatient therapeutic services that are paid for under OPPS are subject to certain payment conditions including the provider-based and under arrangements rules.

- CMS specifically states its intent to prevent ASCs from furnishing hospital outpatient services under arrangements.

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Follow-Up

- Questions?

questions@aegis-compliance.com

audiocourses@aegis-compliance.com

- Next Lecture:

Tuesday, July 26, 2011

12pm CT/1pm ET

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