

FALL 2012 CMS CONFERENCE



TRANSCRIPT

Day 1 08a: PartD RAC Update

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Well, I'd like to thank most of you for all staying for the Part D RAC. Let's see. I guess I'll wait for most of these people to leave. Again, my name is Frank Chartier. This is Tanette Downs. We're both from the Division of Plan Oversight and Accountability and we're here to talk about the updates to the Part D RAC. For those of you that were at the spring conference, my section of the presentation will be more of just an overall what it was last time, so.

Okay. I'll start with the RAC program history and background, move to the RAC audit process which includes the pre-audit phase, the audit phase, and the post-audit phase. Then we'll take some questions.

Okay. The history of the RAC. The RAC program was congressionally mandated to identify improper payments and recoup those overpayments. The RAC program is responsible for – and this is the RAC program including fee for service and the RAC in Part D – identifying and correcting past improper payments to the Medicare and managed organizations in the prescription drug plans and Medicare providers, the implementing procedures to help CMS, the plans, you know, intermediaries, carriers and the MACs, implement actions to prevent future improper payments. And just to specify, DPOA, Division of Plan Oversight and Accountability, is strictly speaking to the Part D RAC, so we are currently overseeing the Medicare prescription drug Part D RAC program. The history of the Part D RAC basically started with the Medicare prescription drug benefit Part D. It came into existence from the Medicare Prescription Drug Improvement and Modernization Act of 2003. Then the fee for service RAC was implemented as a demonstration project in 2006. CMS permanently implemented it in 2009, October of 2009, and the Part D RAC was basically put into implementation or started through the ACA Section 6411D of the Affordable Care Act expanded the use for RACs from fee for service into the Medicare Part C and D programs.

This is an overall picture of how the Part D RAC operates basically with the Center for Program Integrity overseeing the contracts of three contractors. The main contractor is the Part D RAC, which is ACLR Strategic Business Solutions. Then we have two semi-support contractors, one being the data validation contractor, which is Levanta, and the other being Part D RAC Outreach and Education. The Part D RAC purpose is to analyze previously-paid individual Medicare Part D claims which are prescription drug events and other financial information. They correct past improper payments to the Medicare Part D plans and provide information to CMS to help prevent future improper payments. It refers any potential fraud instances to CMS as well, so if they're out there and they see outliers that may be fraudulent in nature, they'll contact us and we'll help with the Medic, which is basically our contractor that assists with the detection and prevention of fraud, waste and abuse.

Now I'll go through the actual audit process. This is what the CMS and the RAC and the DBC and Outreach and Education activities consist of beginning with the pre-audit phase. The pre-audit phase basically is CMS determining audit criteria and scope to conduct these audits on the previous Medicare Part D payments. So CMS will identify a year and issue and have the RAC begin the audit phase. So the audit is when a RAC actually conducts an investigation of these improper payments, analyzes and detects the improper payments for the calculation of the Medicare impact and then notifies the Part D plans of the impact. And then the post-audit is the identified improper payments are collected from the plans, and if there is a finding of the RACs that the plan would like to appeal, this is the time where the plan would actually appeal that decision. And I'll go into each of these phases in a little bit more detail.

So the pre-audit phase. CMS mandates review of contracts by issue type for a specified audit year and audit issue. The plan Part D RAC audit issues currently – which means could expand – are the excluded providers, which are the Part D RAC reviews the PDE of records submitted by Part D drug prescribers or filled by a Part D provider who were excluded from Medicare at the time of the claim, physicians or pharmacies, any type of excluded entity. Duplicate payments. That's also an audit issue that we're reviewing. It's not currently under audit, but it is basically the PDE submitted for same beneficiary, same medication, for the same or closely-matching dates. Then there is DIR, which is the Part D RAC reviews the information submitted to CMS regarding DIR to determine whether amounts were forwarded and used for reconciliation match what actually occurred. That's another audit issue that we currently are reviewing but not an actual audit exists of it at this moment.

Okay. The New Issue Review Board, which is hilarious to say out loud, the NIRB, and additional audit issue may be proposed through the NIRB. The NIRB is a multi-member entity within CMS and it basically considers new audit issues as they come to light, so CMS, the RAC, the plans, any other potential audit issues that any entity that is a stakeholder wishes to bring to the NIRB would be reviewed. And then CPI leads the NIRB and reaches out to subject matter experts to get further insight as to whether we should go with the audit or have the RAC perform the audit of those new issues.

Okay. The audit phase. I'll go through each one of these steps. This is the fun part of my presentation. The first step is just to obtain the information from CMS. Second step, to review the PDEs or other data needed to conduct the audit. Third step is to request additional information, maybe. And then the fourth step – this is another great acronym – prepare the Improper Payment Review Package, the IPRP. I get the good acronyms.

The data validation process. This is after the audit process of the RAC. This is where the data validation contractor, which I previously mentioned being Levanta is the DVC. They would perform analysis on what the RAC's findings were and then create a validation finding file, basically agreeing or disagreeing with the RAC, and then – and CMS would step in and resolve any RAC or DVC disputes – and then that would lead to a finalization of the audit findings, and we would then send out the notification of improper payment letters with the amount owed.

Okay, the RAC audit steps. It's basically exactly the same as the previous slide, but “obtain supporting documentation.” This would be the RAC going out and basically getting the PDE data

from CMS to analyze, data mine and review. Step two would be to review the PDEs or data needed to conduct the audit, so if they're doing the excluded provider, they're reaching out getting the PDEs; if they're doing the DIR, they'd be going out and getting your bids, and DIR information, and then after the documentation is compiled, the RAC can conduct analysis and data mining and impact calculations on the audit to identify the improper payments from the plan. Step three would be request additional information. This is as needed, so this might not be a step that you as a plan would actually see. If the RAC needs additional information, they will reach out to the individual plans. And if an improper payment is identified, they may or may not send an RFI. Step four would be to prepare the IPRP. After the RAC identifies an improper payment, it basically compiles a package and that package contains all the information necessary for the DVC, or the Data Validation Contractor, to review, which includes any type of support for that audit finding.

Perform data analysis check. I kind of just went over this, but the Data Validation Contractor receives the IPRP and performs an analysis of it – I don't want to say the acronym again – with a sample of associated PDE records, then they create a validation finding which supports the RAC's findings, and then sends those findings, along with the improper payment amount, to CMS, which then – oh, well first – sorry, I should have skipped to the next slide – they resolve any RAC or DVC findings of disputes. CMS is actually in charge of – I did not do that. Do you know why it went backwards or? I like going backwards anyway. Oh, now it's forward. If the DVD and RAC cannot resolve disputes, the RAC shall notify CMS, CMS is the final decision maker between the two parties. Basically CMS has the right to either agree or disagree with the RAC and DVC.

And then we send out the notification of improper payment letter, which basically announces the findings, the support, and the amount owed or due back to CMS. Once that is issued, we follow to the next audit phase, which is the post-audit phase, which Tanette will cover.

All right, good afternoon, everyone. It's almost time to go home, so I'm going to be brief and give you an opportunity to ask questions. I'm going to talk about the post-audit phase, which consists of reviewing the collection process and it just outlines the general appeals process.

Okay, the RAC remains involved for post-audit issues. Most of you know the RACs send out the notice of improper payment letters and they identify the improper payments that are collected from plans. So they send out the letters along with the supporting documentation for how the improper payment was calculated. The RAC also is involved with the appeal and payment information, and the RAC will assist CMS if needed on appeal issues.

Once we've identified an overpayment, payment adjustments will be made at the contract level. An interim adjustment in the amount owed will be made to the contract monthly payment which will be reflected in its membership detail report approximately two months from the date of the notice of improper payment letter. Now prior to CMS running the final reconciliation, the offset will be credited at the contract level and PDEs identified by the RAC that were originally paid in error will be included in the final reconciliation calculation. The interim adjustments will be reversed during the reconciliation of the final Part D reconciliation.

Frank talked about some of the contractors that we have, and one of the other contractors we have is the Part D Outreach and Education contractor. The Part D RAC communication and education is a

process that's ongoing. Therefore, CMS has contracted with Strategic Health Solutions and Strategic's role is to conduct educational activities related to the RAC program. They'll facilitate the dissemination of information about the RAC program and educate Part D plan sponsors about the RAC audit and appeals process. We are working on a training PowerPoint presentation, and we hope to post this to our Part D RAC website, so if you have any questions you can just always go back to this training PowerPoint presentation once it's posted to the website.

RAC audit appeal issues. The plan sponsors can appeal the determination made by the Part D RAC that an overpayment was made to them based on their payment of a claim involving an excluded pharmacy or excluded prescriber. They can also appeal the amount of the overpayment or both. Audit issues that are not appealable. Plan sponsors cannot appeal the methodology and standards that the RAC used to identify and calculate the overpayments, plan sponsors cannot use or include new payment information that was not considered by the RAC as part of its review in their appeal. PDEs submitted by the plan sponsor subsequent to the final reconciliation for Plan Year 2007 constitutes new payment information and plan sponsors should not include it as part of their appeal.

Plan sponsors can only appeal the specific issues that are identified in the notification of improper payment letter. Code of Federal Regulations provide for specific reasons for which CMS may reopen and revise an initial or reconsidered final payment information. Plan sponsors cannot appeal any issues related to CMS re-openings of the PDE and payment information in question in the RAC appeal process.

Now there are instances where an excluded provider can legitimately provide services to beneficiaries and where prescriptions written by excluded providers can properly be filed. Providers may be granted a waiver by the Office of Inspector General and may legitimately furnish services and write prescriptions within the scope of the waiver. Plans may appeal under these grounds and should provide documentation demonstrating that the plan obtained and properly applied the waiver. Similarly, otherwise excluded providers may legitimately furnish services or write prescriptions in certain emergency situations. Plans may appeal under these grounds and should provide documentation demonstrating how the regulatory emergency situation requirement was met.

Finally, plans may appeal if the provider furnished services or wrote a prescription during a federal disaster or other public health emergency and should provide documentation demonstrating that the service was provided during that time period and was within the applicable geographical location.

Okay, we're going to go over the appeals process. We have a two-level appeal process. The first level is the request for redetermination. This appeal with supporting documentation must be emailed to ACLR and CMS at the email address listed on the screen. The contract number and the words RAC Appeal must be in the email subject line. All appeal documents must contain the contract number and be legible and understandable.

The second level of appeals is called the request for reconsideration. This appeal will be submitted to CMS at another email address, and that's also on the screen, and the subject line should read RAC

Request for Reconsideration. A plan sponsor cannot submit any new supporting documentation at this level of appeal.

Before I get to resources I want to talk about our timeline a little bit. Plan sponsors have 30 days from the date of the notification of improper payment letter to submit a written request for redetermination along with the supporting documentation. What happens at that point is that someone from Program Integrity will respond with an email of receipt to the plan sponsor and begin the first level of appeal. CPI will send the plan sponsor and the RAC the first-level appeal decision and provide the plan sponsor with information on how to file the second-level appeal. Once the second-level appeal information is received, plan sponsors will have 30 days to request reconsideration of CMS's request for redetermination decision. If the plan sponsor does not file a second-level appeal during the 30-day time period, the first-level appeal decision will be deemed a final decision and CPI will begin the payment adjustment process. However, if the plan sponsor files a request for reconsideration, CPI leadership will review the request and issue a final decision.

There are lots of resources out there for you. We have the Medicare Part D Recovery Audit Program website, and the address is listed on the screen. The website will be updated periodically to insure that Part D plan sponsors have the most up-to-date information. If you all have questions, you can contact the partd underscore raccommunications at cms dot hhs dot gov email to obtain answers to general questions or applicable guidance outlining the redetermination and review processes. The plans can also receive educational updates about the Part D RAC program by submitting your name, title, company name, plan ID, phone number and email address to this mailbox. Now if the Part D plan sponsors would like to discuss the process by which ACLR, the Part D RAC, detected or calculated the overpayments, they may direct their questions directly to ACLR.