

Related Change Request (CR) #: N/A

Medlearn Matters Number: SE0469

Related CR Release Date: N/A

MMA – The Centers for Medicare & Medicaid Services (CMS) Recovery Audit Contract (RAC) Initiative

Provider Types Affected

Physicians, providers, and suppliers, especially in California, Florida, and New York

Provider Action Needed

Physicians, providers, and suppliers should note that this initiative is designed to determine whether the use of Recovery Audit Contracts (RACs) will be a cost-effective means of ensuring that you receive correct payments and to ensure that taxpayer funds are used for their intended purpose. As the states with the largest Medicare expenditure amounts, California, Florida, and New York have been selected for pilot RACs that will begin during the first part of 2005 and last for three years. Contractors selected for this pilot program will identify and collect Medicare claims overpayments that were not previously identified by the Medicare Affiliated Contractors (MACs), which include carriers, fiscal intermediaries (FIs), and Durable Medical Equipment Regional Carriers (DMERCs)).

Background

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA, Section 306) directs the secretary of the U.S. Department of Health and Human Services (HHS) to demonstrate the use of RACs under the Medicare Integrity Program in 1) identifying underpayments and overpayments, and 2) recouping overpayments under the Medicare program (for services for which payment is made under Part A or Part B of Title XVIII of the Social Security Act).

A small percentage of claims (< 5 percent) are examined during medical review of claims performed by the MACs, and in annual studies of the Medicare program, claims payment error rates of between 6 percent and 10 percent have been identified. It is further estimated that in the last two fiscal years, billions of dollars have been inappropriately paid out by Medicare. There is growing concern that the Medicare Trust Funds may not be adequately protected against erroneous payment through current administrative procedures.

This pilot program is designed to determine whether the use of RACs will be a cost-effective means of adding resources to ensure correct payments are being made to providers. Contractors selected for this pilot program will identify and collect Medicare claims overpayments that were not previously identified by the MACs. To accomplish this, the following is planned:

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- There will be RACs for both Medicare Secondary Payer (MSP) and non-MSP claims and activity.
- Compensation for RACs will be provided through retention of a percentage of the overpayment recoveries.

The following provides additional details about the RACs pilot program:

- Claims reviewed by RACs will have been submitted to the carriers/intermediaries at least a year before to ensure that the ordinary processing will have been completed.
- RACs will 1) perform data analysis to identify areas of investigation, and 2) request claims history information from the carriers/intermediaries.
- Non-MSP RACs will identify and recover claims overpayments only. They will not be permitted to establish cost report overpayments.
- RACs will apply national coverage policies and Local Coverage Determinations (LCDs) that have been approved by the MACs.
- The collection policies to be applied by this pilot will be the same as those currently in effect for the carriers/intermediaries, including assessment of interest on the portion of any debt that is unpaid 30 days after issuance of the demand letter.
- No new policy will be applied. In addition:
 - Providers will be permitted to appeal any negative determinations to their MAC; and
 - If underpayments are determined, the information will be forwarded to the MACs for processing and payment.

CMS selected the following three states with the largest Medicare benefit payment amounts as the pilot states for the Recovery Audit Contracts:

- California
- Florida
- New York

CMS released a Request for Proposal (RFP) to interested qualified bidders and expects the contractor selections to be made in the beginning of 2005. It is expected that RACs will start work in May of 2005, and the duration of the pilot contracts will be three years.

Each of the three pilot states will have 1) one contractor for non-MSP claims overpayment recovery and 2) another (or possibly the same) contractor for MSP recoveries. To avoid a conflict of interest, current Medicare contractors are not eligible to bid on these contracts.

A complete evaluation of the pilot program will be made before extending it in the three designated states or to additional states.

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Additional Information

If you have any questions, please contact your carrier/intermediary at their toll-free number, which may be found at:

<http://www.cms.hhs.gov/medlearn/tollnums.asp>

Find out more about the Medicare Prescription Drug and Modernization Act of 2003 (MMA) at the following CMS web site:

<http://www.cms.hhs.gov/medicarereform/>

In addition, Section 306 was taken from the MMA and is provided below:

House Rpt.108-181 - PROVIDING FOR CONSIDERATION OF H.R. 1, THE MEDICARE PRESCRIPTION DRUG AND MODERNIZATION ACT OF 2003, AND H.R. 2596, HEALTH SAVINGS AND AFFORDABILITY ACT OF 2003

SEC. 306. DEMONSTRATION PROJECT FOR USE OF RECOVERY AUDIT CONTRACTORS.

(a) IN GENERAL- The Secretary shall conduct a demonstration project under this section (in this section referred to as the 'project') to demonstrate the use of recovery audit contractors under the Medicare Integrity Program in identifying underpayments and overpayments and recouping overpayments under the Medicare program for services for which payment is made under part A or B of title XVIII of the Social Security Act. Under the project-

- (1) Payment may be made to such a contractor on a contingent basis;
- (2) Such percentage as the Secretary may specify of the amount recovered shall be retained by the Secretary and shall be available to the program management account of the Centers for Medicare & Medicaid Services; and
- (3) The Secretary shall examine the efficacy of such use with respect to duplicative payments, accuracy of coding, and other payment policies in which inaccurate payments arise.

(b) SCOPE AND DURATION -

(1) SCOPE- The project shall cover at least 2 States that are among the States with-

- (A) The highest per capita utilization rates of Medicare services, and
- (B) At least 3 contractors.

(2) DURATION - The project shall last for not longer than 3 years.

(c) WAIVER - The Secretary shall waive such provisions of title XVIII of the Social Security Act as may be necessary to provide for payment for services under the project in accordance with subsection (a).

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(d) QUALIFICATIONS OF CONTRACTORS-

(1) IN GENERAL- The Secretary shall enter into a recovery audit contract under this section with an entity only if the entity has staff that has the appropriate clinical knowledge of and experience with the payment rules and regulations under the Medicare program or the entity has or will contract with another entity that has such knowledgeable and experienced staff.

(2) INELIGIBILITY OF CERTAIN CONTRACTORS- The Secretary may not enter into a recovery audit contract under this section with an entity to the extent that the entity is a fiscal intermediary under section 1816 of the Social Security Act (42 U.S.C. 1395h), a carrier under section 1842 of such Act (42 U.S.C. 1395u), or a Medicare Administrative Contractor under section 1874A of such Act.

(3) PREFERENCE FOR ENTITIES WITH DEMONSTRATED PROFICIENCY- In awarding contracts to recovery audit contractors under this section, the Secretary shall give preference to those risk entities that the Secretary determines have demonstrated more than 3 years direct management experience and a proficiency for cost control or recovery audits with private insurers, health care providers, health plans, or under the Medicaid program under Title XIX of the Social Security Act.

(e) CONSTRUCTION RELATING TO CONDUCT OF INVESTIGATION OF FRAUD- A recovery of an overpayment to a provider by a recovery audit contractor shall not be construed to prohibit the Secretary or the Attorney General from investigating and prosecuting, if appropriate, allegations of fraud or abuse arising from such overpayment.

(f) REPORT- The Secretary shall submit to Congress a report on the project not later than 6 months after the date of its completion. Such reports shall include information on the impact of the project on savings to the Medicare program and recommendations on the cost-effectiveness of extending or expanding the project information means information about a conviction for a relevant crime or a finding of patient or resident abuse.

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