COMMONWEALTH of VIRGINIA
Department of Medical Assistance Services

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November 1, 2017

MEMORANDUM

TO: The Honorable Thomas K. Norment, Jr.
Co-Chairman, Senate Finance Committee

The Honorable Emmett W. Hanger, Jr.
Co-Chairman, Senate Finance Committee

The Honorable S. Chris Jones
Chairman, House Appropriations Committee

FROM: Cynthia B. Jones
Director, Virginia Department of Medical Assistance Services

SUBJECT: Report on the Cost Recovery Activities

The 2017 Appropriation Act, Item 306 P states:

The Department of Medical Assistance Services shall have the authority to pay contingency fee contractors, engaged in cost recovery activities, from the recoveries that are generated by those activities. All recoveries from these contractors shall be deposited to a special fund. After payment of the contingency fee any prior year recoveries shall be transferred to the Virginia Health Care Fund. The Director, Department of Medical Assistance Services, shall report to the Chairmen of the House Appropriations and Senate Finance Committees the increase in recoveries associated with this program as well as the areas of audit targeted by contractors by November 1 each year.

Should you have any questions or need additional information, please feel free to contact me at (804) 786-8099.

CBJ/

Enclosure

pc: The Honorable William A. Hazel, Jr., MD, Secretary of Health and Human Resources

Annual Report: Contingency Fee-Based Recovery Audit Contractors (RACs) – FY 2017

A Report to the General Assembly

November 1, 2017

Report Mandate:

2017 Appropriation Act, Item 306 P The Department of Medical Assistance Services shall have the authority to pay contingency fee contractors, engaged in cost recovery activities, from the recoveries that are generated by those activities. All recoveries from these contractors shall be deposited to a special fund. After payment of the contingency fee any prior year recoveries shall be transferred to the Virginia Health Care Fund. The Director, Department of Medical Assistance Services, shall report to the Chairmen of the House Appropriations and Senate Finance Committees the increase in recoveries associated with this program as well as the areas of audit targeted by contractors by November 1 each year.

Background

Recovery Audit Contractor (RAC) is a term used to describe auditing firms who review medical claims for over- and under-payments and are paid a contingency fee based on actual recoveries resulting from their audits. Section 6411 of the Patient Protection and Affordable Care Act, (PPACA), expanded the RAC program to Medicaid, and required states to enter into a contract with a Medicaid RAC.

Virginia's 2010 Appropriation Act (Item 297 VVVV) and all subsequent appropriations authorized the Virginia Department of Medical Assistance Services (DMAS) to employ RAC auditors and pay them a contingency fee based on the recoveries generated by their audit activities. Under the Virginia RAC contract, DMAS pays a contingency fee of 9.3 percent of the actual amounts recovered as a result of RAC audit activities. RAC recoveries are deposited into a special fund, out of which the contingency fee payments are made to the Medicaid RAC.

Actions Taken To Date

Virginia's RAC audits used data analysis to identify claims that violated medical billing guidelines based on irregularities found in claims data. The RAC examined claims from physicians, durable medical equipment providers, hospitals and other provider types. Their analysis found claims that were not billed in accordance with DMAS provider manuals, Medicaid guidelines, or industry standards. Overpayment letters were issued to providers to collect the improperly paid amounts identified through these analyses.

About DMAS and Medicaid

DMAS' mission is to ensure Virginia's Medicaid enrollees receive high quality and cost effective health care.

Medicaid plays a critical role in the lives of over a million Virginians, providing health care for those most in need. Medicaid enrollees include children, pregnant women, parents and care takers, older adults and individuals with disabilities. Virginians must meet income thresholds and other eligibility criteria before qualifying to receive Medicaid benefits.

Medicaid covers primary health care services, inpatient and outpatient services that support individuals in need of behavioral health support including addiction and recovery treatment. Medicaid is also covers long term supports and services, making it possible for thousands of Virginians to remain in their homes or to access residential and nursing home care.

Quick Medicaid facts:

- Covers 1 in 8 Virginians
- Covers 1 in 3 births and 33% of children
- Supports 2 in 3 nursing facility residents

Virginia Medicaid and Children's Health Insurance Program (CHIP) are administered by the Department of Medical Assistance Services (DMAS) and is jointly funded by Virginia and the federal government under the Title XIX and Title XXI of the Social Security Act. Virginia generally receives $1 of federal matching funds for every $1 Virginia spends on Medicaid.

Effective October 2015, the Virginia RAC contractor, Health Management Systems (HMS), informed DMAS that they had made a business decision to no longer participate in the RAC program. Although the contract ended in October 2015, DMAS continues to conduct collection activities from the overpayments that the RAC identified.

As of June 30, 2017, the Agency has collected $561,081.08 in payments that arose from the DMAS-approved, completed RAC audit proposals. The contingency fees paid were $52,180.33. The four completed RAC audits and their results are discussed in detail below.

Pulmonary Diagnostic Procedures and Evaluation & Management (E&M) Services

This audit examined claims for pulmonary diagnostic procedures to identify physicians who had improperly billed for E&M services on the same day. The RAC reviewed 4,206 paid claims in DMAS data for which E&M services had been billed. Final overpayment letters for all of these claims were issued to 387 providers.

New Patient Visits

This audit examined claims for new patient visits, which are billed at a higher rate than regular office visits. According to American Medical Association guidelines, a patient can only be considered a new patient once every three years. The RAC reviewed 462 paid claims in DMAS data for which New Patient services had been billed. Final overpayment letters for all of these claims were issued to 178 providers.

Billing of Miscellaneous Durable Medical Equipment (DME) Codes

This audit examined claims for DME services/supplies/items that utilized a generic miscellaneous code rather than the category-specific codes that DMAS has directed providers to use. The RAC reviewed 362 paid claims in DMAS data for which DME miscellaneous codes were billed. Final overpayment letters for all of these claims were issued to 10 providers.

Fraud, Waste and Abuse Scenarios

Data mining identified 9,110 claims with issues including: supplemental codes billed without the appropriate primary procedure; billing separately for services that should have been included under the global surgery code billed; claims lacking a valid “place of service” code based on the service/procedure billed or per Virginia Medicaid Provider manual requirements; and some additional cases related to improper billing of new patient visits. As a result of this data analysis, 9,110 claims from 358 providers were identified that contained overpayments.

Summary

RAC audit activities resulted in recoveries totaling $561,081.08 since inception. Effective October 2015, the Virginia RAC contractor, HMS, informed DMAS that they had made a business decision to no longer participate in the RAC program. RAC contractors in Virginia and other states have a limited volume of overpayment opportunities that can be identified through data analysis without intensive medical record review. Because the contingency fee on the RAC contract cannot exceed 12 percent of collected overpayments, audits that require medical record review are generally cost prohibitive for vendors. DMAS uses strong front-end claims edits which prevents easily-identified overpayments. Therefore, a successful RAC project will require novel approaches to detect and recover improper payments.

The Centers for Medicare and Medicaid Services granted DMAS an exception to the federal requirement to maintain a RAC while DMAS procures another vendor for these activities. DMAS is currently in the process of procuring a new RAC vendor.