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Regulatory: The Health and Human Services 2012 Work Plan

HHS plans to address shortcomings with Medicare Administrative Contractors

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By Lisa Noller

The U.S. Department of Health & Human Services (HHS) Office of Inspector General (OIG) recently issued its 2012 Work Plan, which identifies the agency's wide-ranging plans and priorities for the upcoming fiscal year. The 165-page document describes ongoing reviews the agency will continue in the new year as well as newly initiated reviews of its own programs and operations. These announced reviews cover the spectrum of all state and federal HHS activities, including quality of care audits, claims processes/reimbursement reviews, and fraud and abuse analyses.

Among the many initiatives included this year, the Work Plan announced the agency's intent to review the work of Medicare Administrative Contractors (MAC). MACs play an increasing role in facilitating the Medicare program. Historically, 48 private Medicare contractors, known as fiscal intermediaries, handled Medicare's claims administration activities, including processing requests for reimbursement and post-payment audits of alleged fraud and abuse. In 2003, the Centers for Medicare and Medicaid Services (CMS) initiated Medicare contracting reform aimed at streamlining the process, in particular replacing the old patchwork system of 48 existing fiscal intermediaries with 23 jurisdictional-based MACs. All MAC contracts are competitively bid, one-year contracts with potential for a four-year renewal.

A primary purpose of the MACs is to reduce payment errors by preventing overpayments for claims tainted by error, fraud or abuse. Accordingly, MACs initially review claims to determine whether they are in compliance with Medicare's coverage, coding, payment, and billing policies. MACs have authority to reimburse providers for claims submitted to CMS, which makes their pre-payment submission screening a true gate-keeping function. MACs also are tasked with enrolling health care providers and suppliers in the Medicare program, educating providers about billing requirements, handling claims appeals and answering provider inquiries. Moreover, CMS announced that beginning in January, MACs will take over the responsibility of issuing demand letters to recoup alleged Medicare overpayments as part of the Recovery Audit Contractor Program.

While the MACs take on these essential responsibilities, criticism of their work has become more widespread. A recent report from the Government Accountability Office (GAO) indicated that like the fiscal intermediaries before them, the MACs have struggled with a backlog of claims and physician enrollment glitches, and have mishandled claims, causing significant delay in receiving payments.

CMS recently conducted audits that have identified claims errors in the MAC payment process, causing the agency growing concern that MACs may have been reimbursing providers for improperly submitted claims at the same rate as the fiscal intermediaries before them. In addition, in 2005, the GAO reported that CMS expected contracting reform to generate savings totaling more than $1.9 billion through reduced spending on Medicare administration and from reduced improper payments, but CMS has not quantified the actual savings realized. And, given that MACs have not entirely replaced fiscal intermediaries, the government is paying for both government contractors while saving less than anticipated.

Given the critical and costly role of these MACs, as well as CMS's ongoing concerns, the 2012 Work Plan announced HHS-OIG would focus on reviewing alleged payment errors made by MACs, as well as reviewing the MACs' methods of detecting and deterring fraud in certain targeted sectors such as home health care. In short, OIG will now also be more involved in the MACs' data analysis, pre-payment claim reviews, post-payment claim reviews and medical review of claims. OIG believes this will act as a check and balance to ensure the government does not pay claims submitted in error or as a result of fraud.

Providers should feel some relief that the OIG will begin scrutinizing the work of MACs, given their central role in facilitating the Medicare program and their reported failings. On the other hand, the Work Plan now introduces another entity into the claims submission, processing and review procedure, which may cause more headaches for providers.

While OIG always has had the ability to intervene where there are allegations of fraud or abuse, their presence at the claims submission stage as well might be unwelcome. While OIG's review is active, providers should continue to monitor which entity is reviewing their submissions, and take care to respond to the appropriate audience. Moreover, in jurisdictions where OIG and the MAC are scrutinizing claims, providers may want to choose their audience when addressing concerns raised by one or the other entity.

About the Author

Lisa Noller

Lisa M. Noller is a partner and member of the Government Enforcement, Compliance & White Collar Defense; Business Litigation & Dispute Resolution and Securities Enforcement & Litigation Practices at Foley & Lardner LLP. She can be reached at lnoller@foley.com.

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