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October 14, 2011 Vol. IX Issue 40

## Final Rule Implements State Requirements for Medicaid Recovery Audit Contractors

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Providers will have yet another audit function scrutinizing their claims for payment when the Medicaid Recovery Audit Contractors (RACs) become effective on January 1, 2012. In a Final Rule published in the *Federal Register* on September 16, 2011, the Centers for Medicare and Medicaid Services (CMS) finalized the framework for the Medicaid RAC program.<sup>1</sup>

While CMS would prefer to structure the Medicaid RAC program in the same basic way the Medicare RAC program is organized, a one-size, fits all approach is not practicable given the variance in State Medicaid Plans. States have the authority to develop and administer the Medicaid RAC programs and will be required to contract with Medicaid RACs.

### **The Purpose of Medicaid RACs and Difference from Other Medicaid Auditing Bodies**

Medicaid RACs will review Medicaid post-payment claims submitted by providers of services for which payment may be made under the Medicaid State Plan or a waiver of the Medicaid State Plan to identify overpayments and underpayments. CMS stated that Medicaid RACs are an efficient way to identify Medicaid payment errors, in the same way the Medicare RACs identify Medicare payment errors. Much of the commentary addressed in the Final Rule questioned the similarities between the Medicaid RAC program and the federal Medicaid Integrity Contractor (MIC) or the various states' Medicaid Fraud Control entities. CMS drew the distinction by emphasizing the MIC and the state Fraud Control units are fraud seeking entities. Specifically, the MIC is an arm of CMS, concerned with

regional and national audit issues that may be inappropriate for a state-based Medicaid RAC to handle. The Medicaid RACs will address state-specific payment errors.

In response to commenters' concerns about minimizing the potential for multiple audits of the same claims, states are charged with coordinating auditing efforts between RACs and other auditing bodies. Medicaid RACs should not audit claims that have already been audited or that are currently being audited by another entity. In addition, a Medicaid RAC must report fraud or criminal activity to the appropriate law enforcement officials whenever it has reasonable grounds to believe that such activity has occurred. States are required to submit reports outlining performance of its Medicaid RAC contractor, including number of cases referred for suspicion of fraud.

### **Program Elements - Overlap with Medicare RAC Program**

While CMS is not prescribing every element of the Medicaid RAC program to the states, many provisions of the Medicaid RAC program will closely match existing Medicare RAC program requirements, and CMS' intent is clear that the Medicaid RAC programs should be similar in design wherever practicable to the Medicare RAC program. Specific program similarities will include:

*Education and Outreach:* Includes notification to providers of audit policies and protocols and provider education/outreach. However, CMS is not requiring states to provide coding or billing guidelines.

*Informed Review:* Medicaid RACs must hire certified coders, unless the state determines that certified coders are not required for the effective review of Medicaid claims, and at least one Medical Director who is a medical doctor or an osteopathic.

*Transparency and Objective Criteria:*

- Minimum customer service measures such as providing a toll-free customer service telephone number in all correspondence sent to providers and staffing the telephone number during normal business hours;
- Compiling and maintaining provider approved addresses and points of contact;
- Mandatory acceptance of provider submissions of electronic medical records;
- Notifying providers of overpayment findings within 60 calendar days;
- A 3-year maximum claims look-back period; and
- A state established limit on the number and frequency of medical records requested by a RAC.

CMS strongly encouraged states to adopt other Medicare RAC program elements, including medical necessity reviews, extrapolation of audit findings, external validation of accuracy of findings, and types of claims audited.

Additionally, the Final Rule allows states to contract with multiple RACs, and the possibility exists for states to join forces and form regional Medicaid RACs, mirroring the regional organizational structure of Medicare RACs. Differing Medicaid programs in and among states prevented CMS from requiring the organization of the Medicaid RACs into regions. Allowing a state to procure its own RAC contract gives the state the ability to contract for its specific Medicaid program needs.

### **Program Elements - Divergence from Medicare RAC Program**

States have complete flexibility to determine their own policies in many areas:

#### *Universe of Claims to be Reviewed*

States have the ability to decide whether Medicaid Managed Care Claims will be subject to review by the Medicaid RAC. For states that have largely migrated to a Managed Care-based Medicaid program, this option would seemingly be exercised. As previously discussed, Medicaid RACs can only review claims that have not been reviewed by any other entity.

#### *Appeals Process*

While CMS will allow states to design a Medicaid RAC appeals process or use existing Medicaid appeals processes, CMS believes that most, if not all, states will use its currently existing Medicaid administrative appeals infrastructure for a provider to appeal an adverse Medicaid RAC determination. In the Final Rule, CMS did not give any indication regarding whether states will add additional personnel in their respective appeals departments to handle the Medicaid RAC appeals. Providers may experience delays in resolution of any Medicaid appeal with the addition of RAC appeals to some states' already lengthy administrative appeal dockets.

#### *Contingency Fee Rates*

States have the ability to establish their own contingency fee rates for Medicaid RAC contractors and the process of coordinating the recoupment of overpayments with their RACs because some state laws may prohibit delegation of collected overpayments to contractors.

While states determine the contingency fee paid to the Medicaid RAC, the Final Rule limits the Federal Financial Participation (FFP) to the largest contingency fee paid to a Medicare RAC contractor (currently 12.5%). Any additional contingency fee payment above the current 12.5% must be funded with state dollars, must come only from amounts recovered and must be based on a percentage of the recovered overpayment amount.

States also have the ability to decide to pay the contingency fee (1) when the overpayment is identified or (2) after the overpayment is completely adjudicated and all appeals available to the provider are exhausted.

### *Underpayments*

Payment to a Medicaid RAC for identifying underpayments may be made in any amount as the states may specify. Currently, Medicare RACs are paid a contingency fee to identify underpayments, similar to the way in which they are paid to identify and recover overpayments. Consistent with a state's obligation to ensure that it pays the correct amount to the right provider for the appropriate service at the right time for the right beneficiary, the methodology a state chooses must adequately incentivize the detection of underpayments. CMS indicated that it may consider future additional regulation specifically addressing underpayments.

### *Effective Date*

States are required to implement their Medicaid RAC programs by January 1, 2012. States that may be unable to meet this deadline may request delayed implementation from CMS. Additionally, CMS will provide support and technical assistance to states during the implementation process. Therefore, there is no global phase-in strategy for the Medicaid RACs.

<sup>1</sup> This Final Rule adds new regulatory provisions at 42 CFR § 455.500 through § 455.518 and implements Section 6411 of the Patient Protection and Affordable Care Act, which directs states to establish programs in which they contract with Medicaid RACs.

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