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## Medicaid RACs: Tool of transparency or torment?

By Rebecca Jones McKnight

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Children often share a fascination with ants. As a child, you may have watched worker ants crossing your sidewalk, carrying seemingly impossible loads of food back to the queen and her brood. This fascination with ants often leads children to use glass—a rather simple substance—as a tool to learn more about ants.

Maybe you set up a glass ant farm (technical term: formicarium) to provide a window into the inner workings of an ant colony, watching the ants go about their ant business. Maybe you used a magnifying glass to examine ants more closely, marveling at their mandibles, and being thankful that the 1954 movie *Them!* (in which atomic tests caused ants to mutate into giant man-eating monsters) was, in fact, fiction. But maybe there was a kid on your block who did not share your appreciation for our diligent insect friends. With a less benevolent interest in these creatures, he used his magnifying glass as a tool to torment unassuming ant victims.

On September 14, 2011, the Centers for Medicare & Medicaid Services (CMS) issued its anxiously awaited final rule on state Medicaid Recovery Audit Contractor (RAC) programs. The final rule implements section 6411 of the Patient Protection and Affordable Care Act, which requires states to

establish a program with one or more Recovery Audit Contractors (RACs) in order to identify underpayments and overpayments to Medicaid, and to recoup the overpayments.

In other words, to see whether the worker ants are shortchanging the queen.

CMS issued a proposed rule on Medicaid RACs on November 10, 2010. The original due date for states to implement RACs was April 1, 2011. It became clear, however, that this was not a realistic time frame. On February 1, 2011, CMS announced that the proposed implementation date would be pushed back to await the final rule.

Now the time is at hand. Under the final rule, states must have Medicaid RAC programs in place by January 1, 2012. Will Medicaid RACs be a tool of transparency into provider payment practices, or a tool of torment for providers already subject to numerous types of government oversight and inquiry?

### Why is that kid eyeballing me?

The Medicaid RAC program draws on history. After a demonstration period for the Medicare RAC program identified over \$1 billion in improper payments, Congress permanently authorized that program in the Tax Relief and Health Care Act of 2006 (TRHCA). Congress required CMS to push the program out to all the states. This law and the program that implemented it influenced the development of the Medicaid RAC rules.

Legislators viewed the Medicare RAC demonstration period as a major success. Stakeholders, however, had their concerns. They cited inconsistency in the RACs' documentation of "good cause" for reviewing claims and lack of physician presence on RAC staffs. CMS addressed these concerns when it implemented its permanent Medicare RAC program. Stakeholders also took issue with the contingency fee payment structure required by TRHCA. Although TRHCA mandated that RACs be paid on a contingency fee basis, CMS's implementation of the program provided that if a RAC's determination were overturned at any stage of the appeals process, the RAC would be required to return the related contingency fee payment.

Medicaid providers may feel they're already thoroughly watched and examined through the glass. They have already been subject to their share of audits through programs such as the Medicaid Audit Medicaid Integrity Contractors (Audit MICs). The new Medicaid RACs will not replace existing Medicaid audit programs; they will create yet another oversight and scrutiny mechanism. CMS anticipates "working both internally and with the States to minimize [the] administrative burden" of overlapping audits.<sup>1</sup> Providers remain skeptical.

Even within this context, and with the benefit of lessons learned from the Medicare RAC program, providers were concerned. Seventy-six commenters weighed in on the November 10, 2010 proposed rule. As a result of "numerous comments" from stakeholders, CMS made some modifications to the proposed Medicaid RAC program in the final rule. That said, many of the key proposed elements remain. Although the rule itself is not that lengthy, the proposed Medicaid RAC regulations garnered significant attention, and CMS spent more than 100 pages addressing comments and defending its approach. The final rule:

- provides guidance to states on federal/state funding of state start-up, operation, and maintenance costs of Medicaid RACs;

- provides guidance on the payment methodology for state payments to Medicaid RACs;
- directs states to ensure that adequate appeal processes are in place for providers to dispute adverse determinations made by Medicaid RACs; and
- directs states to coordinate with other contractors and entities that audit Medicaid providers, as well as state and federal law enforcement agencies.

### Should I be worried?

With the thought of the beam of illumination narrowing, and hearing a sizzle in their minds, providers have concerns. Who will be behind the glass, looking in? Will it be Dr. Dolittle Jr.<sup>2</sup> or "The Good Son?"<sup>3</sup>

Under the final rule (42 C.F.R. §§ 455.500 - .518), a Medicaid RAC must demonstrate to a state that it has the "technical capability" to carry out required activities. RACs must employ trained medical professionals in good standing with the state to review Medicaid claims. Unless a state obtains an exemption, each Medicaid RAC must hire a minimum of one full-time employee medical director who is a Doctor of Medicine or Doctor of Osteopathy. The rule also requires Medicaid RACs to hire certified coders, unless the state determines that certified coders are not required for the effective review of Medicaid claims. The rule provides additional elements of "customer service" that RACs and states must develop to provide education and outreach to providers, including:

- Communication of audit policies and protocols;
- Minimum customer service measures, such as:
  - providing a toll-free customer service telephone number staffed during normal business hours, and
  - compiling and maintaining provider approved addresses and points of contact;
- Mandatory acceptance of provider submissions of electronic medical records on CD/DVD or via facsimile at the providers' request;

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- Notifying providers of overpayment findings within 60 calendar days;
- Unless a state obtains an exemption, a 3-year maximum claims look-back period; and
- Unless a RAC obtains an exception from a state, the RAC must follow state-established limits on the number and frequency of medical records requested by a RAC.

### Can I trust the kid with the magnifying glass?

Are that kid's parents paying him by-the-ant to act as an amateur exterminator? The use of contingency fees for RAC compensation has continued to raise provider concerns. One commenter said contingency fee structures have the "overwhelming tendency to push auditors 'to take a chance' and inappropriately deny claims." Another commenter maintained contingency fees "perversely incentivize...RACs to engage in bounty hunting, which leads to increased expenses and administrative burdens for providers."<sup>4</sup>

It is notable that in the Medicare RAC pilot program, 96% of the errors identified by the RACs were overpayments. A substantial number of the RACs' payment denials were not upheld on appeal.

CMS's responses emphasized that the statute requires Medicaid RACs to be paid on a contingency fee basis. Neither CMS nor the states have discretion to change this basic approach to compensation, unless state law prohibits the arrangement. CMS also asserted that the methodology "has been a standard practice accepted among private health care payers for more than 20 years," and that it had "surveyed States that have RAC-like programs which utilize a contingency fee payment structure and ha[d] not learned of any circumstances in which RACs were improperly incentivized to recover overpayments from Medicaid providers."<sup>5</sup>

CMS also cited, as a safeguard, the final rule's provision requiring that RACs return contingency fees within a reasonable time frame if a Medicaid RAC determination is reversed at any level of appeal.

### But I'm tired of being a science project!

Inquisitive scientific minds are all well and good, but what happens when the ant that has been captured for observation in an ant farm is finally released at a parent's behest, only to be captured by another well-meaning child? Commenters were concerned with duplication of existing program integrity efforts. Several commenters suggested this could ultimately impact provider participation and patient access to care.

CMS disagreed. CMS does not think the Medicaid RAC program is duplicative of the federal national audit program in which federal MICs conduct audits of Medicaid providers. CMS considers MICs and RACs "fundamentally different" and "complementary," with MICs addressing vulnerabilities at the regional and national level, and RACs addressing state-specific vulnerabilities, tailored to the characteristics of each state's Medicaid program. According to CMS, Congress directed the establishment of Medicaid RACs "with full awareness of the various program integrity initiatives for which it had given previous authority" and "Congress did not relax any of those previously authorized program integrity activities."<sup>6</sup> As a result, CMS believes Congress intended Medicaid RACs to supplement previously authorized program integrity activities.

### Prepare to be examined

Medicaid compliance should be at the top of providers' lists for compliance activities. While states are developing their Medicaid RAC programs, providers should not sit idly by. With states moving to implement the Medicaid RAC tool, providers should ensure they are ready to be examined, with comprehensive Government Audit Committees prepared to address Medicaid RAC issues, among others. These multi-disciplinary committees should review claims and denial data for warning signs; develop standard approaches to responding to RAC requests; design standard correspondence and appeal letters that

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support claims as appropriate from coding, clinical, and legal perspectives; and determine the best approach for coordination of these efforts. In our experience with Medicare RACs, providers are usually fully capable of doing all of this with a reasonable amount of outside legal support, as opposed to outsourcing all or substantial parts of these tasks to lawyers or consultants. ■

1. Medicaid Program; Recovery Audit Contractors, 76 Fed. Reg. 57,808, 57,812 (Sept. 16 2011)
2. From the children's classic *The Story of Doctor Dolittle* by Hugh Lofting, Peter Glassman, Fredrick McKissack.
3. From the 1993 psychological thriller film *The Good Son*, directed by Joseph Ruben and written by Ian McEwan, starring Macaulay Culkin, Elijah Wood, and Wendy Crewson.
4. Medicaid Program; Recovery Audit Contractors, supra note 1, at 57,814, 57,823.
5. Medicaid Program; Recovery Audit Contractors, supra note 1, at 57,824.
6. Medicaid Program; Recovery Audit Contractors, supra note 1, at 57,816.

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