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MEDICAID PROGRAM RECOVERY AUDIT CONTRACTORS

December 2010

I. Overview

Having recovered more than one billion dollars in alleged overpayments through the Medicare Recovery Audit Contractors (RAC) program, the federal government has decided that the Medicaid Programs throughout the United States should be subjected to the same types of audits. The Patient Protection and Affordable Care Act (Pub. L. 111-148, enacted on March 23, 2010 as part of "Healthcare Reform") mandates that every state that participates in the Medicaid Program must institute a Medicaid RAC process. On November 10, 2010, CMS issued proposed rules to provide guidance to states regarding funding for start-up, operation, and maintenance costs for Medicaid RACs. The proposed rule also details what CMS expects of the Medicaid RACs and how it expects states to exercise their review authority over the Medicaid RACs. The proposed rule can be found at 75 Fed. Reg. 69037.

II. The Healthcare Reform Act

Section 6411 of the Healthcare Reform Act requires states to establish programs in which they would contract with one or more Medicaid RACs by December 31, 2010. The Medicaid RACs would review Medicaid claims submitted by providers of services for which payment may be made under the Medicaid Program. Medicaid RACs would identify underpayments, and identify and collect overpayments. Many of the requirements for Medicaid RAC contracts will be based on the experience gained from the Medicare RAC Program.

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III. Medicaid RACs

A. General Requirements

States are required to "establish" their Medicaid RAC Programs by December 31, 2010, via the State Plan Amendment process. However, the Medicaid RAC Programs do not have to be "implemented" until April 1, 2011, unless CMS moves this date further back.

Medicaid RACs would review post-payment claims for improper payments, overpayments, as well as underpayments consistent with state laws and regulations. The Medicaid RACs will be a supplemental approach to the Medicaid program integrity efforts already underway to ensure that states make proper payments to providers. Since the Medicaid RACs are supplemental to existing efforts, states must maintain their existing their existing program integrity efforts uninterrupted with respect to levels of funding and overall activity.

B. Contractor Payments

States can make payments to their RAC Contractors only from amounts recovered. The state's contract with the Medicaid RAC contractor must be made on a contingent fee basis. CMS is not prescribing any specific contingency fee rate for states but is proposing "guidelines" states are to following when deciding upon the proper contingent fee rate.

CMS notes that its Medicare RAC contractors currently are paid an average contingency fee rate of 10.86 percent with the highest contingency fee being 12.50 percent. CMS proposes that states not contract to pay more than the then highest Medicare RAC contingency fee rate unless the state requests an exception and provides CMS with an acceptable justification for paying a higher contingency fee. If the state does not request and receive the exception, CMS proposes that it not provide Federal financial participation (FFP) with respect to any amount of a state's contingency fee in excess of the then highest Medicare RAC contingency fee rate. Any amount paid over the then highest Medicare RAC contingency fee rate would have to come exclusively from state funds.

Under the above requirements the maximum contingency rate that states can agree to when states implement their RAC programs no later than April 1, 2011, will be 12.50 percent.

With respect to underpayments, CMS notes that it pays it RAC contractors the same contingency amount for identifying underpayments as it does for identifying and collecting overpayments. For the Medicaid RAC Program CMS states that the states can follow this same model or the state can elect to establish a set fee or some other fee structure for the identification of underpayments.

C. What Medicaid RACs Will Be Required to Provide

Similar to the Medicare RAC Program, the Medicaid RAC contractors will be required to employ trained medical professionals to review Medicaid claims. CMS advises states to consider establishing requirements regarding the documentation of good cause to review a claim. CMS states that the Medicaid RACs are to "ensure that [the state] pays the right amount to the right provider for the right service at the right time for the right recipient.

States must have an adequate appeals process for healthcare providers to challenge adverse Medicaid RAC determinations. States are free to use their existing appeals infrastructure or create a new one.

D. Enhanced Focus on Criminal Prosecutions

In an interesting aside, CMS notes that its Medicare RACs identified over one billion dollars in improper Medicare payments but referred only two cases of potential fraud to CMS for further investigation and possible criminal prosecution. The Office of the Inspector General opined that there were so few referrals for prosecution because the Medicare RACs would receive their contingency fees for identifying and collecting overpayments but not for making referrals for criminal prosecution.

CMS does not want this pattern of lack of referrals for criminal prosecution to be part of the Medicaid RAC Program so advises states to design their Medicaid RAC Programs "to ensure that the Medicaid RACs report instances of fraud and/or criminal activity in addition to the pursuit of overpayments." CMS states that "whenever RACs have reasonable grounds to believe that fraud or criminal activity has occurred, they must report it to the appropriate law enforcement officials."

IV. Conclusion

States must enter into contracts with their Medicaid RAC Contractors by December 31, 2010. The Medicaid RAC Program will be quite similar to the current Medicare RAC Program. Perhaps the biggest difference between the two programs is that the Medicaid RAC Program will begin with a stronger emphasis on referring findings to law enforcement officials where fraud or other violations of the law are suspected.