Report on
MEDICARE COMPLIANCE
Volume 21, Number 12 • March 26, 2012

Medicaid RACs Are Gearing Up, but MICs Get Bad Marks in New Report

Medicaid RACs are now active in at least three states and are slowly gearing up across the country. Now that hospitals in New Jersey, South Carolina and Indiana have received requests for medical records from their newly minted Medicaid RACs, the next round of program-integrity games have begun.

The government has high hopes for overpayment recovery from the contingency-fee contractors, with projected savings of $630 million by fiscal year 2016 — a stark contrast to new findings that federal Medicaid integrity contractor (MIC) audits have largely been a bust so far.

"There's lots of enthusiasm for how effective Medicaid RACs are expected to be," says Atlanta attorney Sara Kay Wheeler, with King & Spalding.

But they are not the only Medicaid audit game in town. CMS is taking steps to make MICs more effective and pressing states to increase oversight of Medicaid managed care programs, while the OIG 2012 Work Plan has set its sights on "potentially excessive Medicaid payments for inpatient and outpatient services," among other Medicaid targets.

Meanwhile, by statute, health care organizations must return Medicaid and Medicare overpayments within 60 days of identifying them, even though the proposed regulation interpreting that health reform requirement extends only to Medicare fee-for-service *(RMC 2/20/11, p. 1).* And Sec. 6401(a) of the health reform law makes effective compliance programs a condition of enrollment for both Medicare and Medicaid; proposed regulations will hopefully be issued soon.

Medicaid RACs: New Kid on the Block

But the new kid on the block is Medicaid RACs, which were required by Sec. 6411 of the health reform law and were slated to be up and running on Jan. 1, 2012, according to the final CMS regulation published Sept. 16, 2011. That hasn't happened everywhere yet, but 21 states had a Medicaid RAC contractor selected as of March 20, according to Paul Spencer, compliance officer for Fi-Med Management in Wauwatosa, Wis. A few states couldn't get any vendors to bid on RAC contracts, Spencer says. He speculates that while CMS allows a 12.5% contingency fee, some states may have laws capping it at a lower percent, scaring off potential suitors.

CMS requires some basic standards for Medicaid audits that clearly result from the learning curve associated with Medicare RACs, says Judy Waltz, with Foley & Lardner LLP in San Francisco. For example, each Medicaid RAC must hire a licensed doctor of medicine or osteopathy to act as the RAC's medical director, and must hire certified coders. States will decide how many medical records they can request from providers and how often. Medicaid RACs must operate a toll-free customer service phone line during normal business hours and each Medicaid RAC must work with the state to develop an education and outreach program for providers that includes notification of audit policies and protocols.

States, not RACs, will report fraud to Medicaid fraud control units or other law enforcement, Wheeler says.

There is a three-year look-back period for Medicaid RAC audits, Wheeler says. RACs are required to accept electronic medical record submissions from providers, and notify them of audit findings within 60 days, Wheeler says. It's up to states whether RACs are permitted to do medical necessity reviews, whether to extrapolate findings into larger overpayment determinations and how to handle appeals, Wheeler says. New York City-based contractor HMS is turning out to be a big player in the Medicaid RAC game, and it has signed a contract with Milliman for admission-necessity screening criteria, Wheeler says. (HMS owns HealthDataInsights, a Medicare RAC.)

Hospitals Should Start Networking

And states decide whether to require Medicaid RACs to post their audit targets the way Medicare RACs do, she says. "I suspect it will be inherent in the contractual relationship," she says. In the Indiana RAC program, Medicaid providers will be subject to Medicaid credit balance reviews, automated reviews and complex reviews, according to a February 2012 presentation by HMS and Thomson Reuters. The presentation states that the Indiana Medicaid agency will provide "final approval of the type of audits the RAC will deploy for each provider and/or audit project," according to information from Wheeler. However, it's unclear whether Indiana will require HMS, its Medicaid RAC,

to notify providers and suppliers of approved audit issues before launching the audits, she says.

Medicaid RACs are required to review fee-for-service claims, Wheeler notes, but CMS has been less definitive about whether Medicaid managed care is fair game. In the final September 2011 Medicaid RAC rule, CMS did not exclude Medicaid managed care. Instead, it allowed states to make that decision. The states will look at what it would mean to have Medicaid managed care in the universe of audits. It's unclear whether the audits would focus on how Medicaid managed care plans submit data to Medicaid agencies, or on payments to managed care plans or both. Either way, providers will be affected, Wheeler says, because ultimately managed care plans are a vehicle to pay providers.

Hospitals should be gearing up for Medicaid RACs. "Hospitals have been hit incredibly hard by Medicare RACs, and RAC coordinators in hospitals should talk to RAC coordinators in other states," Spencer says. Because CMS does not require Medicaid RACs to post their audit targets, the Medicaid experience may require a lot of networking. Hospitals may have to scramble with Medicaid RACs even more than they do for Medicare RACs.

Early Assessment of MICs Is Not Favorable

Meanwhile, MICs got a bad report card. Congress probably won't be too thrilled with OIG's "early assessment" of the effectiveness of MICs that perform audits. According to a report released March 20, "few of the audits assigned to Audit MICs from January through June 2010 identified overpayments."

OIG examined the results of the 370 audits assigned to audit MICs — which audit Medicaid claims based on leads from "review MICs" — and interviewed officials from CMS, audit MICs and state Medicaid oversight agencies. *The results:* 81% of the audits didn't identify overpayments or are unlikely to. "Only 11 percent of assigned audits were completed with findings of $6.9 million in overpayments" — and 90% of it stemmed from "collaborative audits" (conducted with help from CMS, states and review MICs), according to the OIG report (OEI-05-10-00210).

So what was the problem? Audit MICs were "hindered," OIG concluded, partly because "audit targets were poorly identified" and were often "inappropriate." There were also problems with the Medicaid Statistical Information System (MSIS) data used in MIC audits, so sometimes audit MICs were sent on a wild goose chase. For example, they audited claims for services supposedly provided to patients after they died, but it turned out the dates of death were incorrect.

Given its findings, OIG recommends more collaborative audits, better selection of audit targets and perhaps the consolidation of review and audit MICs under one program integrity contractor. Also, MICs need access to more reliable data, and the review MICs should do a better job analyzing it. As OIG has said before, CMS should implement "T-MSIS," a more advanced version.

In a written response, CMS Acting Administrator Marilyn Tavenner told HHS Inspector General Dan Levinson that CMS "has dramatically increased the number of collaborative audits assigned to audit MICs." It's also working on several fronts to improve data quality and selection. And "CMS is evaluating options for awarding new contracts to include consolidating certain tasks and requirements," she wrote.

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