



HMS Education Series

Frequently Asked Questions

Medicaid RACs: The Impact on MCOs Webinar December 14, 2010

1. Can you tell us what states have issued Medicaid RAC RFPs so far?

It's important to distinguish between states that have issued RAC RFPs and states that have issued RAC-like RFPs, meaning Medicaid RACs are part of a larger procurement. Massachusetts and Pennsylvania have issued *RAC-like* RFPs. The states that have issued true Medicaid RAC RFPs are New Mexico, Tennessee, Indiana, Kansas, New Hampshire, Utah, Mississippi, and Rhode Island. Additionally, several states are working with their current RAC-like contingency fee post pay review contractors to leverage these contractors for their Medicaid RAC.

2. Is there a possibility that CMS may grant states with heavy managed care populations an exception? It was mentioned earlier that some states have asked CMS to be exempt because of this.

To our knowledge, no state has been awarded an exception. Tennessee is a high managed care state and they recently procured and awarded this contract.

3. Will MHPA be commenting on the proposed rule?

Yes, MHPA will be submitting comments in response to the proposed rule.

4. Can you clarify what is meant by RAC-like contracts?

The term *RAC-like* is a term used by states that have been operating recovery audit programs or contracts prior to the Affordable Care Act.

5. It was mentioned that both Tennessee and New Mexico included auditing of MCOs, did the RFPs contain information on how they proposed to do so?

The RFPs contained minimal language on how the audits should be conducted. Interested contractors were, however, able to ask clarifying questions as part of the procurement process. In some instances the state was able to add some clarification. In other instances the questions were not clearly addressed. The most relevant example of a question needing clarity was on the subject of the validation of the overpayments for encounter data. It was not clarified *how* the contractor serving the state would be able to validate the overpayment, and whether the contractor would defer to the payment criteria of the Medicaid agencies or to the MCOs.

6. I understand that States must have a RAC type contract in place by April 2011. Must plans also have one in place by April?

The legislation--and thus far CMS's guidance--has been silent on the impact of Medicaid RACs on plans. At this time, there is no requirement that plans put a RAC or RAC-like process in place. In addition, to date, no state has required this of their plans; however, we anticipate that this will change over time, and there *will* be requirements of plans. What those requirements are will depend on how this is approached by the states.

7. If we have additional questions, who should we contact at both HMS and MHPA?

At HMS the contact is Phyllis Hartstein and she can be reached at phartstein@hms.com, while at MHPA the contact is Thomas Johnson, his e-mail address is tjohnson@mhpa.org.

8. Will the plans "feel" a difference between RAC and RAC-like contractors?

The major difference between the two will be the timing and methodology of the contract between the State and the Contractor; there is likely to be little or no impact on providers and/or plans.

9. Do you know if the RAC applies to the Territories including Puerto Rico and the US Virgin Islands?

Yes, the territories are included in the Medicaid RAC component of the Affordable Care Act.

10. What are the risks, if any, for MCOs if they decide to partner directly with Medicaid RACs?

Plans will need to explore the risks of this approach, as part of developing the relationship with the State(s). If they engage in joint auditing, then they will need to figure out what their exposure is, since the state contractor will know at a detailed level, about their provider contracts, payment methods, and overpayments. If they implement an "MCO RAC" that mirrors the state's standards, and they operate an expanded RAC-like program that parallels—but is separate from—the state, plans can keep more control, and may reduce their exposure to being audited by the state.

11. What do you believe the biggest impact will be on Medicaid MCOs' fraud departments?

Over time, overpayments will become more of the responsibility of the claims departments. The fraud departments will have the opportunity to focus on true fraud—those situations that may lead to patient abuse, provider actions which have a criminal component (no service actually provided, no real provider, etc.).

12. Is it safe to assume that if an MCO is at risk, all overpayment recoveries are then maintained by the MCOs? What about overpayments identified and recoveries collected in an environment where a plan is partially at risk?

These are good questions, to which there are not yet answers. The legislation is specific about CMS recovering the federal share of overpayments; however, the model appears to be the fee-for-service one where CMS pays a specified percentage of the claim amount. It is silent about MCOs, and about overpayment recovery in a managed care environment.

13. You stated that the scope of the Medicaid RACs must be "broad." Can you expand on this?

While the Medicare RACs focus on acute care facilities, some states have already reached out to CMS and have been given feedback that CMS is not likely to approve a Medicaid RAC that doesn't include a broader scope of services, such as home health, hospice, DME, long term care, and home and community-based waiver services. Further, as CMS focuses on the prevention of fraud, they are increasing their attention to excluded providers. This issue may well become an important part of the RAC initiative.