



Healthcare Reform Webinar Series

Medicaid RACs—The Impact on MCOs

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INTRODUCTION

Medicaid Recovery Audit Contractors (RACs) are a major component of the Affordable Care Act (ACA). While CMS continues to provide guidance to **state Medicaid agencies** on how to implement a RAC strategy, CMS has not yet indicated how RAC legislation will impact **Medicaid Managed Care Organizations (MCOs)**.

Relevant statistics on MCOs and the Medicaid program:

- While growth in enrollment in the Medicaid program increased seven percent from June 2008-June 2009, **enrollment in Medicaid health plans increased more than 11%**.
- Medicaid health plan enrollment **increased by almost 2.4 million members in 2009**—reaching more than **23.4 million Americans nationwide**.
- About 47% of all Medicaid beneficiaries are now enrolled in a Medicaid health plan.
- Almost 75% of the individuals in Medicaid are enrolled in some form of managed care—up from 55% ten years ago
- Medicaid enrollment is projected to **grow by between 16 and 24 million members** when the Medicaid program is expanded in 2014.

Medicaid health plan enrollment has surged in recent years due in large part to the fact that the plans are mutually beneficial: states pay a capitated rate to the plans, which, in turn, provide Medicaid members access to an expanded network of physicians and specialists, and assume financial responsibility for the members' care. This approach is more cost-effective than Medicaid's fee-for-service method, and is profitable for MCOs as well. Now, with nearly half of all Medicaid beneficiaries in some form of managed care, it is likely that many states will look to incorporate the managed care population in their RAC solutions.

Goals

The webinar explored the potential relationship between RACs and MCOs by:

- Sharing what we know about Medicaid RACs
- Educate and increase awareness
- Discussing significant implications that the RAC program has for MCOs

PART I: What We Know About Medicaid RACs

Background: The first RACs were implemented in three states—California, New York, and Florida—in 2003 as a **Medicare** demonstration project. The goal of the project was to determine whether RACs would be a cost-effective way of ensuring that providers and suppliers received correct payments for their Medicare Parts A and B claims.

Over the demonstration period, RAC contractors recovered \$900 million in overpayments. Based on this success, CMS directed that the Medicare RAC process be rolled out nationwide in 2007.

Section 6411 of the ACA expands the current RAC program to Medicaid and Medicare Parts C and D. The provisions require states to contract with one or more Medicaid RACs to identify overpayments and underpayments, and recover overpayments on a contingency fee basis.

Unlike Medicare, Medicaid programs are state-administered. For this reason, CMS is giving states some flexibility in how they design their RAC programs. Some stipulations, however, are universal.

CMS's Guidelines and Requirements for Medicaid RACs:

- States that already conduct post-payment claim audits for Medicaid will be permitted to continue these efforts, so long as their efforts satisfy RAC requirements and are coordinated in a customized RAC approach.
- Medicaid RACs must be paid a contingency fee based on **overpayments** actually recovered from providers, but states may define their own fee structure for services to identify **underpayments**.
- Medicaid RACs are meant only to supplement existing program integrity efforts, and will be required to coordinate efforts with existing contractors.
- States will be required to develop an adequate appeals process so that providers may challenge Medicaid RAC determinations if necessary. If a provider appeals to the state, the state may, in turn, appeal to CMS.
- The federal government will pay 50% of the cost of operating and maintaining each state's RAC program.
- While Medicare RACs were primarily focused on hospital clinical reviews, Medicaid RACs must account for a much larger variety of services, including home health, hospice, DME, long-term care, and home and community waiver services.
- 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 Medicaid RAC initiative.
- States must submit a State Plan amendment to CMS by December 31, and fully implement their RAC programs by April 1, 2011.

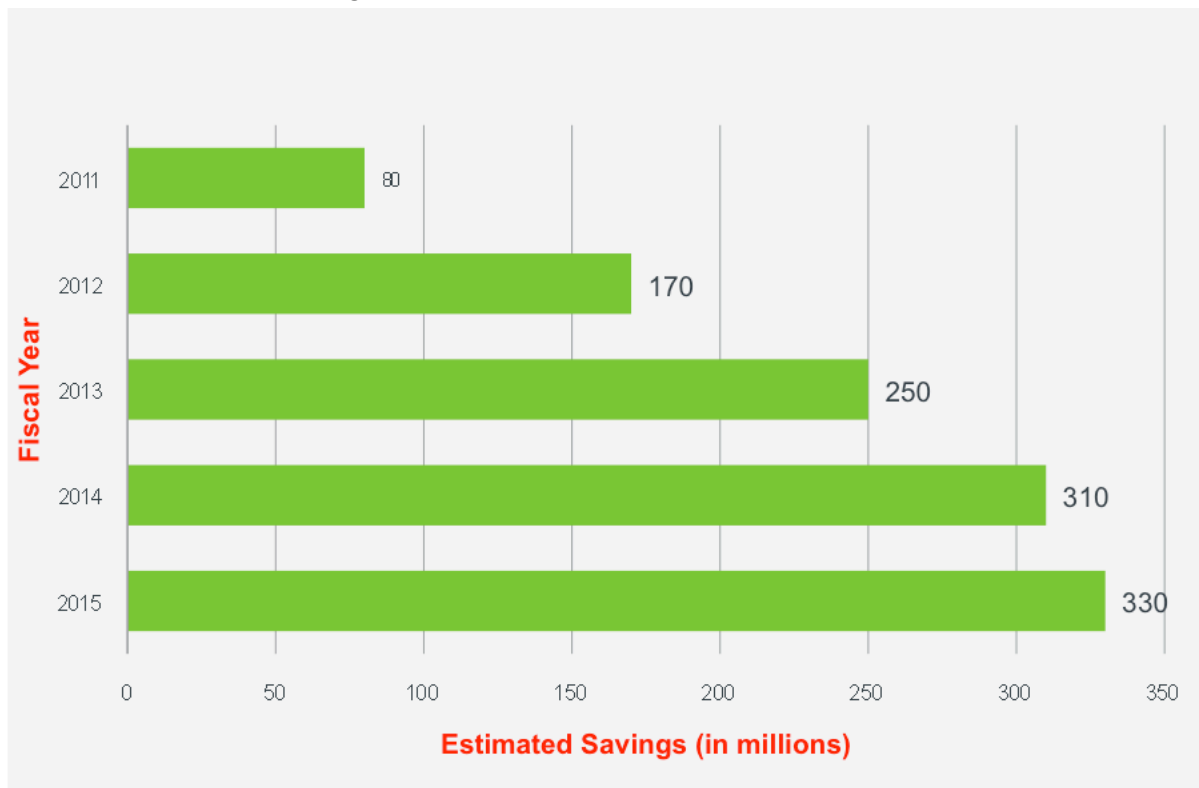
States will be allowed to seek exceptions to some or all of the RAC contracting requirements; however, CMS will rarely grant complete exceptions, and only under the most compelling circumstances.

On October 29, CMS held a webinar in which they provided states with a statement of work to use to develop RAC RFPs. CMS also released a proposed rule on Medicaid RACs, which is open for comment until January 10, 2011. (Links to our responses to CMS are available on www.hms.com/webinars.)

State Response To-Date: At least 10 states had “RAC-like” program integrity contracts in place prior to the implementation of the ACA. Many of these states are evaluating their current contractors to ensure that the services they are providing meet RAC requirements, and submitting a State Plan amendment to formalize these contractors as their CMS-Compliant RAC vendors.

At the time of this webinar, these 10 states have issued Medicaid RAC or RAC-like RFPs: Pennsylvania, Utah, Virginia, Kansas, Tennessee, New Mexico, New Hampshire, Massachusetts, Rhode Island, and Mississippi.

Potential Financial Impact of Medicaid RACs: CMS’s Office of the Actuary projects substantial savings for the federal Medicaid budget.



PART 2: Significant Implications for MCOs

Three recent Medicaid RAC RFPs formally addressed MCOs by either including or excluding provisions to audit their encounter claim data. *An “encounter claim” is essentially a report of each service provided to a Medicaid member by an MCO.

- Utah **excluded** MCO encounter claim audits from their RAC scope for health plans that were considered at-risk. **An “at-risk” plan is paid a fixed fee to assume financial responsibility for a Medicaid member.*
- New Mexico and Tennessee **included** MCO encounter claim audits in their RAC scope. In both of these states, the MCOs are at risk for all claim payments, so they routinely perform their own post-payment audits.

Questions for States

States that choose to include MCO encounter claims in their RAC audits will have to ask themselves the following questions:

- How will the state identify and validate the overpayments and underpayments related to encounter data?
- Will the state’s RAC contractor possess the subject matter expertise to understand each MCO’s unique payment rules to ensure correct payment is pursued?
- Will the MCOs be included in the state-directed RAC process? Will the MCOs be invited to stakeholder meetings, appeals hearings, etc.?
- How will the state’s RAC contractor coordinate their efforts with MCO’s existing program integrity solutions?

Options for Plans

Because CMS has not specified how RACs apply to MCOs, plans actually have some latitude to determine their own role within a RAC solution:

Option #1—Resistance: MCOs may take actions to exclude themselves from RAC activities based on the logic that they are:

- Not mentioned in RAC legislation
- Paid on a capitation basis and assume risk from the state, making them already incentivized to minimize incorrect payments

Option #2—Proactive Approach: MCOs can adopt their own RAC-like program based on the ACA’s RAC model that incorporates MCO-specific payment standards and reimbursement processes. This way, an MCO can satisfy their own auditing requirements while also ensuring that the state’s RAC standards are met.

MCOs may also choose to partner with states early on to help shape scope, business rules, and appeals processes. There are two different partnering approaches to consider:

1. Implementing an integrated RAC with the state. This approach would allow data to be combined across multiple payors/providers, and enable the use of technology across platforms. Looking at claims cohesively would not only be more cost-effective, but the larger data set would also make problems more obvious. The downside to this approach is that it could prohibit payors from perceiving the details within individual provider environments.

2. Mirroring the state's standards in its own independently operated RAC-like audit program. This approach would allow each plan to maintain independent relationships with its providers and retain full control of its operations while working with the state to expose problem providers.

Option #3—Delay: MCOs may determine that it is in their best interest to see how their states approach RACs, or they may find that their states are not yet ready to include MCOs in their RAC solutions. It is important that MCOs be aware of the potential risks to inaction. These include:

- Provider abrasion and confusion regarding payment standards, processes for reimbursement of over/underpayments, and the legal authority of the RAC to conduct audits;
 - Confusion regarding who gets the recovery—the plan (with adjusted capitation rates) or a combination of the plan, the state, and CMS;
- Confusion regarding who is responsible for reimbursing overpayments when the provider is not required to reimburse, citing contract issues or plan payment standards.

Evaluating Other Potential Risks

Plans should evaluate the potential that MCOs could be treated as a target of RAC reviews, rather than a partner to States. Several disadvantages could result from States auditing MCO claims in conjunction with Fee-for-Service claims, including:

- Recovering from providers using State payment standards (which may not mirror plan payment standards or provider agreements);
- Holding plans accountable for inappropriate payments, and adjusting capitation payments to account for these issues.

PART 3: Proactive Solutions

There are a number of proactive solutions that MCOs can adopt:

- I. **Advance Reviews:** Review their own payment and auditing standards in advance of the State's review to ensure that they mirror or exceed the State's standards. If necessary, be prepared to explain why any of the state's findings are immaterial.
- II. **Take Action Early:**
 - **Identify Provider exclusions/ongoing credentialing:** If a provider is excluded from any Medicaid program in the country, it is excluded from **all**. The federal share of funds paid to an excluded provider must be returned to CMS, regardless of whether they are recovered. So the standard approach to credentialing will no longer be sufficient.
 - **Targeting outlier claims:** Determine if they were paid correctly, and identify outlying providers.
 - **Conduct Provider audits:** Particularly for outlier claims and providers.
- III. **Adopt Mandatory Provider Compliance Programs**

By shifting the responsibility for demonstrating compliance to the providers, and including mandatory reporting of overpayments, plans can better focus their limited resources on key outliers, potential new issues, and true fraud.

IV. **Provider Contract Assessments**

Plan recovery efforts are often stymied by provisions in provider contracts that:

- Limit access to records,
- Permit reviews within timeframes too short to allow for problem identification,
- Allow providers to fall back on ambiguous language that seems to excuse inappropriate payments.

MCOs should review their contracts with providers to ensure that they do not contain language or provisions that would prohibit recoveries.

PART 4: Getting Started

We encourage plans to perform a Gap Analysis between your State's RAC audit scope and your current post-payment auditing and recovery. As you perform the gap analysis, consider:

- Your State's RACs plan regarding MCOs; their short-term goals; how and when the RACs will be implemented. Ask for a copy of the State Plan Amendment related to RAC audits.
- Each state is developing its own unique solution to the RAC requirements. If you operate in more than one state, you will need to be aware of any variations.
- How your current audit and recovery initiatives overlap state initiatives. Be prepared to either modify or justify your approach when your efforts differ, and to coordinate your post-pay recovery processes with RAC auditors.
- Any Medicaid RAC requirements that your program integrity initiatives do not currently address to determine vulnerability.

Preventing Provider Abrasion

MCOs historically have been very concerned with provider abrasion. When contract language or policies are ambiguous, or particular providers are essential to the strength of the provider network, plans have been reluctant to press for justified recoveries. Many plans are concerned that State Agencies won't support them in the case of a provider appeal, causing substantial provider issues.

Positive Impact of RACs on Providers

CMS's general approach is designed to create buy-in from providers, by:

- Including under/overpayments to assure correct payments
- Conducting provider education to minimize future errors.

Once you understand the state's approach and have designed your own, we recommend that you communicate with providers regarding the RAC initiative to ensure that they understand what the state and MCOs are auditing, how the pieces fit together, and their obligations.

Most providers are already familiar with Medicare RAC audits, but will need to understand the differences on the Medicaid side. If you choose to use a contractor for some your RAC-like activities, it may be a good idea to introduce the contractor at provider association meetings in order to:

- Establish their credentials,
- Provide transparency regarding goals, timing, and process, and
- Reassure providers that they will have access to knowledgeable customer service as they become accustomed to the new processes.

Clear and open communication between states, MCOs, and providers is the key to ensuring that the RAC initiatives are carried out efficiently and achieve their intended results.

SUMMARY

To sum up, Medicaid RACs are a major component of the Affordable Care Act. Although the legislation is silent regarding its impact on MCOs, it is unlikely that the requirements will apply only to the Medicaid lives in fee-for-service. And the indications from early RFPs are that in heavily managed care states, plans must be and will be included in some way.

Right now, as CMS and the State Agencies are formulating their approach to RACs and the MCO roles, plans have an opportunity to shape their future. We encourage you to work together with MHPA; the Medicaid Managed Care and Program Integrity Divisions in your state; and provider associations and enrolled providers, to make sure that this initiative achieves its goals of reducing fraud, waste, and abuse in the Medicaid payment system. And to do it in a way that best meets the needs of all stakeholders: beneficiaries, providers, payors, and taxpayers.