Contingency Fees Comments

Comment: One commenter inquired whether RAC determinations include cost-based adjustments or cost-based settlements. This commenter also wanted to know whether contingency fees would be paid to a Medicaid RAC for those determinations.

Response: We understand that certain States use cost reports for reimbursement of Medicaid claims. Accordingly, States need the flexibility to structure their RAC programs to permit review of cost-based services to identify and recover potential overpayments as well as identify underpayments. Therefore, contingency fees are payable to a Medicaid RAC for the identification and recovery of overpayments from cost-based service providers. With regard to whether a RAC determination can include cost-based settlements, we believe the State has the authority to make adjustments to a provider's cost report and/or cost-based settlements based upon a RAC determination.

Comment: One commenter indicated that the proposed rule fails to require RACs to return their contingency fee if a denial is overturned at any stage of the appeals process. Another commenter suggested that allowing States to determine at what stage in the Medicaid RAC process, post-recovery, that the RACs will receive contingency fees preserves an unacceptable risk of improper incentives which might otherwise encourage a Medicaid RAC to prematurely or even improperly identify and recover funds from a provider. Another commenter suggested that RACs should be paid upon recovery rather than after adjudication.

Response: With regard to the timing of RAC payments, we are finalizing the requirement at § 455.510(b)(2) that States must have the flexibility to determine at what stage of the audit process their RACs may receive contingency fees for the collection of overpayments from Medicaid providers. In addition, if the provider appeals the overpayment determination and the determination is reversed at any level of the appeals process, we are also requiring Medicaid RACs to return their contingency fees within a reasonable timeframe as prescribed by the State, as reflected in this final rule at § 455.510(b)(3). For example, a State should specify in its contract with the Medicaid RAC the timeframe in which the State expects the RAC to return the contingency fee, that is, repayment will occur on the next applicable invoice. As we indicated in the proposed rule, payments to RACs may not be made based upon amounts merely identified but not recovered or amounts initially recovered from providers but that are subsequently repaid due to determinations made in appeals proceedings. Accordingly, if a State pays a contingency fee to a RAC based upon amounts recovered prior to the conclusion of the appeals process that is available to a provider, then the RAC must return the portion of the contingency fee that corresponds to the amount of the overpayment that is reversed at any level of appeal. We do not believe that this improperly incentivizes a RAC to identify and recover funds from a provider.

Comment: One commenter suggested that CMS' illustration regarding the timing of payment to the RAC that would permit payment to the RAC when it recovers an overpayment but would subsequently require reimbursement by the RAC if the recovery is overturned on appeal, is directly contrary to CMS' interpretation of "payments to contractors may not be made based upon amounts merely identified but not recovered, or amounts that may initially be recovered but that subsequently must be repaid due to determinations made in appeals proceedings."

Response: We disagree with the comment. The illustration mentioned by the commenter is consistent with the Act which requires the amount paid to a RAC to be from the overpayment

amount recovered. If a State pays a RAC prior to the adjudication of the appeals process, then the RAC must refund the amount paid by the State within a reasonable timeframe as prescribed by the State, in connection with the overpayment in the event the overpayment is reversed at any level of appeal. For example, a State should specify in its contract with the Medicaid RAC the timeframe in which the State expects the RAC to return the contingency fee, that is, repayment will occur on the next applicable invoice.

Comment: One commenter indicated that the cap on contingency fees creates an unnecessary administrative burden on States with smaller Medicaid programs which may not be able to attract qualified contractors at the rate provided for in the proposed rule. Specifically, the commenter stated that it is administratively burdensome to pay for the excess with State only funds or request and receive an exception to the cap. Commenters further indicated that the market should determine an equitable contingency fee rate on a State by State basis. Another commenter indicated that limiting contingency rates will create the unintended consequence of limiting recoveries. This commenter was concerned that artificial rate caps would preclude an auditing firm from uncovering complex improper payments because it will not be able to do so profitably. Alternatively, another commenter suggested raising the cap to 18 percent but CMS should continue to have an exception process. Finally, other commenters indicated that strict limits should be set on the amount of contingency fees.

Response: We believe that the contingency fee rates for identifying and collecting overpayments should be reasonable and determined by each State, taking into account factors, for example, the level of effort to be performed by the RAC and the size of the State's Medicaid population. We recognize that each State has different considerations and must tailor its Medicaid RAC activities to the unique factors of its own State. Nevertheless, based upon our experience with the Medicare RACs, we believe that the contingency fee paid to a State Medicaid RAC should not be in excess of the highest fee paid to a Medicare RAC unless the State can provide sufficient justification. The Medicaid RAC contingency fee limit may be adjusted periodically to maintain parity with the Medicare RAC contingency fee cap.

Comment: One commenter requested that CMS use guidance as reflected in the Medicare RAC SOW to pay contingency fees to identify underpayments.

Response: We disagree with the commenter. Section 1902(a)(42)(B)(ii)(II) of the Act requires States to pay Medicaid RACs for the identification of underpayments from amounts recovered and "in such amounts as the State may specify." Therefore, States have discretion to pay RACs for the identification of underpayments so long as the payments are from amounts recovered. In FY 2010, the Medicare RACs identified and corrected $92.3 million in combined overpayments and underpayments. Eighty-two percent of all RAC corrections were collected overpayments, and 18 percent were identified underpayments that were refunded to providers. We expect that States will realize a similar ratio of overpayments to underpayments in connection with the implementation of the Medicaid RAC program. That is, CMS requires at § 455.510(c)(2) that States must "adequately" incentivize the detection of underpayments identified by the RACs. We will evaluate individual States' indicators of adequacy, using the Medicare RAC benchmark, and will examine the trends among the States over several years.

Comment: One commenter requested clarification regarding whether the contingency fee percentage may vary according to a specific Medicaid RAC focus area of review.

Response: We do not object to a State using a tiered structure for contingency fee payments to its Medicaid RAC, so long as the maximum fee percentage does not exceed the highest fee we pay to the Medicare RACs. We will not pay FFP for amounts paid to RACs above the highest fee paid to Medicare RACs, unless the State requests and is granted an exception to that maximum rate. Any tiered structure must also ensure that the Medicaid RACs are incentivized to identify underpayments as well as overpayments.

Comment: One commenter requested clarification of CMS' expectations with regard to fees paid for the identification of underpayments when a State lacks the legal authority to pay fees for the action. This commenter recommended that CMS consider including alternatives that achieve the goal to incentivize the identification of underpayments.

Response: If a State is legally prohibited from requiring a RAC to identify underpayments, then a State may submit to CMS a written request for an exception related to this requirement.

Comment: One commenter opposed any exception to an increase in the FFP limit as a result of an exception to pay a Medicaid RAC a contingency fee that is higher than the Medicare RAC contingency fee. The commenter maintains that the contingency fee structure is inappropriate for any RAC program because it "perversely incentivizes RACs to engage in bounty hunting, which leads to increased expenses and administrative burdens for providers." In addition, this commenter stated that allowing the State to obtain exceptions for the maximum FFP is needless and exacerbates the predatory nature of RAC audits.

Response: The statute requires Medicaid RACs to be paid on a contingency basis for the identification of overpayments. Thus, States do not have an option with regard to the method of payment for the identification of overpayments for their RACs unless State law prohibits the arrangement. We also recognize that certain States may need an exception to the contingency fee cap. For example, States with small Medicaid populations may need to pay a much larger contingency fee rate to attract RAC contractors to work in their State. Accordingly, under certain circumstances, a State may request authorization to pay a RAC a higher contingency fee than the maximum amount for which FFP is paid. Therefore, we disagree that exceptions to pay a RAC a higher contingency than the Medicare RAC contingency fee rate of 12.5 percent are never justified.

Comment: Several commenters suggested that the proposed contingency fee structure imposes no disincentive on RACs for pursuing situations where there is little or no solid evidence of an overpayment. The commenters recommended that payments to RACs should: (1) Be made only upon conclusion of all provider appeals; and (2) not compensate RACs for the timerequired for appeals to be exhausted. A few commenters also suggested that RACs should be required to pay a penalty to compensate providers for claims ultimately determined to be unfounded or falsely identified.

Response: As previously stated, we have surveyed States that have RAC-like programs which utilize a contingency fee payment structure and have not learned of any circumstances in which RACs were improperly incentivized to recover overpayments from Medicaid providers. In addition, our evaluation of the Medicare RAC program provides a basis for contingency payments to RACs for the identification and recovery of overpayments. Therefore, we will not compel States to require RACs to pay a penalty to providers for claims ultimately determined to

be unfounded. With regard to the timing of payments to RACs, States need the flexibility to determine the most appropriate payment methodology given the uniqueness of its own State. Accordingly, States should decide when it is most appropriate to pay Medicaid RACs for their work.

Comment: Several commenters suggested that because the law provides a strong financial incentive for RACs to focus on overpayments and not the identification of underpayments, CMS should require States to apply the same contingency fee schedule for overpayments to underpayments. One commenter stated that the "small, flat fee" for underpayments is unacceptable. This commenter also suggested that CMS should require States to increase their underpayment fee when RACS are not applying a balanced approach to identifying underpayments and overpayments.

Response: With regard to underpayments, we have proposed that a State may choose to pay its RAC a contingency fee for the identification of underpayments, similar to Medicare RACs, or a State may opt to establish a set fee or some other structure for the identification of underpayments. We believe that States should have the flexibility to determine the best payment structure consistent with their State Plans. We also included language in the final rule at § 455.10(c)(2) indicating that States must adequately incentivize their RACs to identify underpayments. In FY 2010, 82 percent of all Medicare RAC corrections were collected overpayments, and 18 percent were identified underpayments that were refunded to providers. We expect that States will realize a similar ratio of overpayments to underpayments in connection with the implementation of the Medicaid RAC program. We will evaluate individual States' indicators of adequacy, using the Medicare RAC benchmark, and will examine the trends among the States over several years.

Comment: One commenter suggested that CMS clarify that underpayments discovered through RAC audits are only payable if claims are filed by the provider within prescribed timeframes.

Response: Generally, RACs are required to review post-payment claims. If a Medicaid claim is not timely filed by a provider, then it would seem that the claim is not payable. Accordingly, these claims should not be subject to RAC review. If a RAC identifies an underpayment and the time for re-filing a claim has passed in accordance with State law, we believe the State has the discretion to determine whether the provider may re-file the claims with the correct information.

Comment: One State commenter indicated that the proposed rule does not state that underpayments must be reimbursed. This commenter stated that providers are responsible for reviewing their remittance advice to determine if they were paid correctly. Further, any adjustments must be made within specific timeframes. This commenter stated that requiring States to reimburse providers for underpayments outside of existing timeliness rules is not appropriate.

Response: The Act mandates that RACs be compensated for the identification of underpayments to providers. While the statute is silent regarding the remittance of underpayments to providers as a result of RAC identification of the underpayments, we are concerned about provider participation in the Medicaid program as well as States making proper payments to providers. Accordingly, we believe that States should compensate all providers for any identified underpayments to the extent possible and consistent with State law. States must

notify providers of underpayments that are identified by their Medicaid RACs. We have included this requirement in this final rule at § 455.510(c)(3).

Comment: One commenter appreciated the flexibility extended to States regarding the fees paid to RACs for the identification of underpayments. The commenter, however, disagreed with CMS' approach with regard to the possibility of additional rulemaking should CMS deem it necessary as a result of future CMS review of data, indicating that RACs are not appropriately incentivized to identify underpayments. This commenter believes any further Federal regulation of underpayment identification will create an undue burden on the States and requested that it be removed from consideration.

Response: We appreciate the comment. However, the burden of potential future rulemaking is outside the scope of this final rule. Nevertheless, further rulemaking may be necessary to achieve the statutory mandate for Medicaid RACs to identify underpayments. Accordingly, we have maintained this language in this final rule.

Comment: Several commenters suggested that CMS should require SMAs to: (1) Monitor the volume of underpayment audits conducted by the RACs; (2) increase the underpayment fee if a RAC is not applying a balanced approach to identifying underpayments and overpayments; and (3) include information on the general methods used to identify Medicaid underpayments in the RAC annual report as well as the steps taken to ensure a balance between underpayment and overpayment review. Another commenter recommended that the Medicaid RAC be required to submit annual reports that include information on methods used to identify underpayments, the number of underpayments identified, and any steps taken to ensure that underpayments are addressed.

Response: As stated in the proposed rule, we expect to monitor the methodologies and amounts paid by States to Medicaid RACs to identify underpayments. We may consider future rulemaking depending on the data we review regarding RAC incentive to pursue underpayments. At this time, we are not requiring States to submit annual reports. However, we plan to issue sub-regulatory guidance on future reporting requirements. Accordingly, we will consider the commenters' suggestions regarding the data elements for an annual report. At this time, we will not require States to increase the fee paid to RACs for the detection of underpayments.

Comment: One commenter requested clarification as to whether States can choose to issue payments only to certain providers based upon underpayments that are identified by the RAC versus identified underpayments of all providers. This commenter also mistakenly asserted that Medicaid RACs are only paid for dollars recovered on overpayments and suggested that RACs also be paid for the identification of underpayments.

Response: States are required to pay RACs for the identification of overpayments as well as the identification of underpayments.Although the statute is silent regarding actual payments to providers as a result of RAC identification of underpayments, we believe that States should compensate all providers for any identified underpayments consistent with State law.

Comment: One commenter suggested that Medicaid RACs should be required to identify underpayment determinations and ensure that the underpayments are remitted to providers in a timely fashion. In addition, this commenter suggested that the States and/or CMS should ensure

that Medicaid RACs have the system capability to identify underpayments before they begin auditing claims.

Response: The Act requires States to establish programs to contract with a Medicaid RAC for the purpose of, in relevant part, identifying underpayments. Accordingly, the task of identifying underpayments should be included in the SOW that is part of the contract between a State and its RAC. Therefore, we will assume that a State has verified that its RAC has the capability to identify underpayments even before a RAC has begun auditing claims. With regard to remittance of underpayments, it is the State that is responsible for the payment, not the RAC. The RAC is required to identify, not remit, an underpayment. Although we recognize that the State has discretion with regard to timing of the remittance of underpayments, we encourage States to remit identified underpayments to providers within a reasonable timeframe.

Comment: One commenter pointed out that the proposed rule indicates that "CMS contracts with Medicare RACs to identify and recover overpayments from Medicare providers, and to identify and pay underpayments to Medicare providers." (Emphasis added). This commenter requested that CMS clarify this statement given that he has not found any other reference to RACsmaking payments to Medicare providers for identified underpayments.

Response: We agree with the commenter. Medicare RACs do not pay underpayments to Medicare providers. The Medicare program pays underpayments to providers.

Comment: One commenter disagrees with CMS' proposed approach to publishing the maximum Medicaid RAC contingency fee consistent with the schedule of publishing the maximum Medicare RAC contingency fee every 5 years. The next update is scheduled for 2013. Specifically, the commenter stated that because fee structures can change over the life of a contract, CMS should publish any modifications to the Medicare RAC payment methodology and contingency rates within 30 days of the modification as opposed to the existing 5-year schedule. In addition, another commenter suggested not requiring the States to conform to the Medicare timetable because Medicaid RACs will be tailored to each State's needs and States need the ability to set rates and increases that are not restricted by Medicare requirements.

Response: While we proposed to publish the maximum Medicaid RAC contingency fee consistent with the highest Medicare RAC fee, a State is not precluded from increasing the rate paid to its RAC outside of that schedule if necessary. To the extent that a State needs to increase the rate paid to its RAC before the expiration of the scheduled 5-year Medicare RAC contingency fee, the State can submit a SPA describing that an increase is required to reflect whether the State is paying the amount above the Medicare rate with State-only funds, or is requesting matching FFP.

Comment: One commenter suggested removing the contingency fee cap because it will allow States to pursue individualized RAC programs that align the fees with the complexity and scale of the workload and allow smaller States to garner a larger field of bidders from which to choose. Another commenter indicated that States need the flexibility to establish contingency fees separately from Medicare due to the difficulty States will have in reacting to the changes associated with the implementation of a RAC program in light of various State budgeting and contracting/procurement constraints. In addition, a commenter suggested that States need the ability to set rates and increases that are not restricted by Medicare requirements because the

Medicaid RAC program needs to be tailored to each State's needs. Therefore, commenters suggested not requiring the States to conform to the higher Medicare contingency fee rate cap.

Response: Based upon our experience with the Medicare RACs, we believe that the contingency fee paid to a State Medicaid RAC should not be in excess of the highest fee paid to a Medicare RAC unless the State can provide sufficient justification. We recognize that States with small Medicaid populations may need to pay a much larger contingency fee rate to attract the RAC contractors to work in their State. For example, if a State receives a proposal from a prospective contractor for a contingency fee that is higher than the maximum contingency fee set by CMS for Medicare RACs but it accurately reflects the scope of work to be performed in that particular State, then the State should submit a request for an exception to CMS for consideration.

Comment: One commenter believes that the Affordable Care Act does not specifically mandate that a State Medicaid RAC contingency fee be linked to the Medicare RAC maximum contingency fee. One commenter stated that the contingency fee cap is not in the best interests of the Federal Government, the State or the taxpayer, and is not consistent with the law. Commenters suggested letting the competitive procurement process define the contingency fee percentage limit for Medicaid, as was done for the Medicare RAC program at its inception. One commenter requested that State contingency-based recovery contracts competitively procured at a higher percentage rate be "grandfathered" in at those higher rates with a State commitment to transition to the lower percentage limit with the next procurement cycle.

Response: Section 1902(a)(42)(B)(i) of the Act requires States to "establish a program under which the State contracts (consistent with State law and in the same manner as the Secretary enters into contracts with recovery audit contractors under section 1893(h) [of the Act], subject to such exceptions or requirements as the Secretary may require . * * *" Although the Act does not specifically set the State Medicaid RAC contingency fee, we believe that the contingency fee paid to a State Medicaid RAC should not be in excess of the highest fee paid to a Medicare RAC unless the State can provide sufficient justification that it is consistent with the statute. If a State cannot procure a contractor at the 12.5 percent rate, then a State can request an exception from CMS. For those States that may already have a RAC-like program in place in which the contingency fee is higher than the Medicare rate, we will work with these States to establish an acceptable resolution, which may or may not include "grandfathering" in the higher rate.

Comment: One commenter requested clarification with regard to the process associated with State requests for approval to pay a RAC a contingency fee that is higher than the 12.5 percent cap set by CMS. This commenter questioned how CMS will assure nationwide consistency on contingency rate approval decisions if States have to submit their requests for approval to the appropriate CMS Regional Office(s). Other commenters wanted clarification regarding the general exception process.

Response: Generally, State requests for approval for exceptions from the requirements of the RAC program, including higher contingency fees, are made using the SPA process and are determined by the Secretary, through delegated authority provided to CMS. CMS, through partnerships between CPI, the Center for Medicaid, CHIP and Survey & Certification (CMCS), and individual CMS Regional Offices, reviews and considers requests for exceptions. CMS strives to ensure consistency to the extent possible with regard to responses to State exception

requests. We will review all relevant facts and circumstances surrounding requests for an exception. If a State's request for a higher contingency fee is denied, the decision is appealable to the Departmental Appeals Board. State commenters with additional questions regarding the process associated with exceptions to the RAC program, including questions about the SPA process, should contact their CMS Regional Office.

Comment: One commenter expressed concern that CMS will be injecting itself into a State's decision-making process on a Federal mandate by denying a State's request for using a higher contingency rate and the associated FFP.

Response: Generally, when a State completes a new State Plan preprint page or SPA because of changes in its Medicaid program, it must be approved by CMS in order for the State to receive Federal matching funds. This holds true for the majority of changes to a Medicaid program when FFP is at issue, not just with regard to the Medicaid RAC program. We have the authority to approve a SPA when FFP is at issue. If we deny a SPA or elements thereof, then the State has the right to appeal the decision.

Comment: One commenter recommended that States be given the flexibility to deploy the most appropriate procurement process for their individual State so long as they are within the legal confines of State and Federal procurements laws and regulations, including bundling Medicaid RAC procurements with other services or combining multiple States with one RAC vendor. Another commenter requested that the bundling of RAC services with other recovery services—such as a TPL contractor—should not be permitted because it will limit competition by excluding the most qualified Medicaid RAC firms. This commenter suggested that TPL contractors may not have the skill set to effectively handle complex reviews.

Response: We expect that all States will procure a RAC contractor. If a State feels that its unique situation may preclude it from meeting this expectation, a State must submit a request for an exception to CMS. However, if a State is interested in "bundling" its RAC procurement with other services performed by an existing contractor, then the State must execute a separate task order outlining the requirements of the RAC program with the existing contractor. If a number of States are interested in combining resources and utilize one contractor for their respective RAC programs, we do not object if there are no conflicts of interest and the arrangement comports with Federal and State law.

Comment: One commenter suggested that States should be permitted to apply for an exception from the RAC program to the extent that a State is unable to attract and acquire a RAC vendor.

Response: States are required to procure a RAC contractor. To the extent that a State is having difficulty procuring that contractor, then that State should contact CMS to discuss a potential resolution, which may include additional time to procure a qualified contractor. It is unlikely that we will grant an exception from the entire RAC program as a result of a State needing additional time to procure a RAC vendor.

Comment: One commenter requested public access to the payment rates furnished to Medicaid RACs, similar to the public availability of Medicare RAC payment rates.

Response: We decline to require States to publicly post their Medicaid RAC payment rates. However, we encourage States to make this information available to the extent possible to promote transparency.

Comment: One commenter requested that CMS allow States to engage in contractual agreements with RACs that limit RAC reimbursements to an amount less than the total amount recovered, but to grant States flexibility in meeting this requirement. This would include allowing States to recover from the provider both the amount of the overpayment and the contingency fee when overpayments have been identified.

Response: Section 1902(a)(42)(B)(i) of the Act mandates that payments made to RACs "shall be made to such contractor only from amounts recovered" and that the payments "shall be made on a contingent basis." Allowing States to recover the contingency fee for the RAC from the provider is inconsistent with the language in the statute. To the extent that State law prohibits it from complying with the statute, then the State should submit a request for an exception to CMS for consideration.

Comment: One commenter indicated that a large number of pharmacy claims being audited include those claims that are questionable due to administrative or clerical errors. This commenter suggested that providers should only be expected to pay the part of the claim that is determined to be an overpayment, not the "clean" portion of the claim or those resulting portions of the claim that are the result of technical or administrative errors.

Response: Medicaid RACs are statutorily mandated to audit Medicaid claims for the purpose of identifying and recouping overpayments as well as identifying underpayments. We would expect a provider to return any identified overpayment to the State Medicaid program. To the extent there are additional errors associated with the claim that do not relate to the RAC's required purpose, the issue is outside the scope of the proposed rule.

Comment: One commenter requested clarification about the following statement in the proposed rule: "States must ensure that they do not pay in total RAC fees more than the total amount of overpayments collected." Specifically, the commenter inquired whether this is in the aggregate across all audits during a particular time period or if it applies to one particular audit.

Response: States must track the aggregate of claims that are identified as overpayments to appropriately calculate the contingency fees owed to the RAC. States must also account for the costs associated with the identification of underpayments. States must ensure that they do not pay in total RAC fees more than the total amount of overpayments collected.