

Medicaid Recovery Audit Contractors (RAC) Update

Special points of interest:

- Medicaid Recovery Audit Contractors (RAC) Update
- Medicaid Audit Alert: Are you in collaboration?
- General Considerations in the Governance Structure of a Compliance Program
- An Expanded Audit Universe

As highlighted in our last newsletter, the Department of Social Services (DSS) is required to hire a Medicaid Recovery Audit Contractor (RAC) to audit Medicaid provider's paid claims. By the time you read this article, DSS will be in the final stages, or will have completed the process, of hiring a Medicaid RAC for Connecticut. DSS has chosen Health Management Systems (HMS) to be the RAC and as soon as the contract is finalized, Connecticut Medicaid providers should be prepared to

have yet another audit group reviewing their records and billings.



HMS is best known in Connecticut as the third party liability contractor for DSS. HMS has also been performing credit balance audits of hospitals and long term care providers for DSS over the last 10 years. HMS will be paid on a

contingency basis, meaning that for every dollar in audit adjustments reported, they will keep a percentage as their fee. This is the same type of fee arrangement that HMS has with DSS for the credit balance audits and during the 10 years that those audits have been performed, HMS has identified \$150 million in recoveries. What's more, HMS' website states that they have, "recovered over \$5 million for New York State and reviewed over \$80 million in

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Medicaid Audit Alert: Are you *in* collaboration?

The TCORS Medicaid Audit Team continuously examines recent and ongoing audit reports to keep Connecticut healthcare providers informed on the latest DSS' trends with regards to audit findings. Our current review indicates that DSS is imposing monetary adjustments for lack of written (or invalid) collaborative agreements on file between the performing APRN, PA, or Pharmacist and the physician. In effect, they are denying payment for these services if the written collaborative agreement is not in place and/or updated yearly.

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Medicaid Recovery Audit Contractors (RAC) Audit (cont'd from page 1)

potential Medicaid overpayments relating to billing errors and under-reported third party payments” - all within a *three month* period! With this type of aggressive auditing, providers need to be on the alert if they are subject to an audit by HMS.

Since these Medicaid RAC audits are new, not only in Connecticut but throughout the country, they will evolve over time and will, undoubtedly, have issues that will need to be addressed. Providers subjected to an audit by HMS, must exercise diligence in reviewing any audit adjustments to ensure that the adjustments are supported by regulations and are consistent with proper auditing procedures and practices. TCORS' Medicaid Audit staff is available to assist any provider, whether they have been notified that they will be audited, are currently being audited, or have been audited. We can work with the provider from the beginning of the audit process right through any appeal.

Medicaid Audit Alert (cont'd from page 1)

DSS previously cited their reasoning based on a Provider Bulletin from February 1, 2004 which states the following:

“a hospital will be considered in compliance...if there are signed and dated agreements on file at the hospital documenting arrangements for coverage, liability, and either collaboration (for APRNs), a clinical practice relationship (for LNs) or supervision (for PAs) that have been agreed to by the physicians...must be renewed not less than once per calendar year.”

In more recent audit reports, DSS now cites the Department of Public Health regulations, Chapter 378 Nursing, Section 20-87a, which states, in part, the following:

“*In all settings*, the APRN may, *in collaboration* with a physician licensed to practice medicine in this state, prescribe, dispense and administer medical therapeutics and corrective measures and may request, sign for, receive and dispense drugs...The collaboration shall address [the] level of consultation and referral, coverage for the patient in the absence of the APRN, a method to review patient outcomes and a method of disclosure of the relationship to the patient...[and] shall be in writing.”

In view of DSS' audit findings on this issue, it is clear that DSS can, and will, apply this finding to any type of provider: hospitals, clinics, mental health clinics, etc. Therefore, it is imperative that Connecticut providers take all necessary measures to ensure that they have collaborative agreements on file for each APRN, LNM or PA and also include a method, such as a signed form, to disclose this relationship to the patient(s). By having signed and dated documentation, updated yearly, providers can avoid being cited on this finding and thereby, reduce the cost of adjustments during a post-payment audit review.



General Considerations in the Governance Structure of a Compliance Program

Determining the governance structure or chain of command of a compliance program should begin with reference to the relevant compliance program guidelines that were discussed in the last newsletter. In particular, the following guidelines are relevant:

- Oversight by high-level personnel
- Due care in delegating substantial discretionary authority to oversight personnel

These criteria may have different meanings and require different governance structures depending

on the nature of a provider's business, organization and ownership.

Take the case of a small, closely held organization owned by a sole shareholder. That owner, by default, would be well advised to take control of his organization's compliance responsibilities and program. Such an owner should involve employees in the compliance program as discussed below.

A larger organization, with a board of directors should consider forming a compliance committee of the board. The responsibilities of such a committee should be incorporated in a resolution or

charter that is approved by the board. Such a committee initially will work with management in selecting and appointing a compliance officer. The board committee should then work with the compliance officer and management to review and approve the participants in and components of the compliance program, for example, the code of conduct. Once the program is established, the board committee should periodically monitor the compliance program by regular meetings with the compliance officer and, if necessary, other important members of a management compliance committee who are responsible for implementing the compliance program.

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Protect your organization from costly financial disallowances and extrapolated adjustments

An Expanded Audit Universe

Elimination of Managed Care:

As the State of Connecticut grapples with an unprecedented \$3 billion dollar plus budget deficit for each of the next two fiscal years, Medicaid providers need to be aware of the consequences of recent budget proposals and how they affect the audits of Medicaid providers.

One of the major budget changes proposed by Governor Malloy is to discontinue managed care for Medicaid recipients and to replace it with a program that will utilize an Administrative Service

Organization (ASO). This will result in a number of changes for providers who service Medicaid recipients that were previously in the managed care program. One of the residual effects of this change could have a direct impact on individual provider's audit exposure.

Since the introduction of Medicaid managed care in Connecticut years ago, the audits of all claims paid by the managed care organizations (MCOs) were the responsibility of the MCOs. The audit of providers by the Department of Social Services (DSS) did not include these Medicaid managed care claims as part of their audit universe. Now, with the elimination of managed care, all of these claims that had once been paid by the MCOs will be

processed for payment like fee-for-service claims and paid by HP (p/k/a EDS). Consequently, all of these paid claims will come under the audit scrutiny of DSS. What does this entail for Medicaid providers?

The biggest impact will simply be the large increase in the paid claims universe for some providers subject to an audit by DSS. For providers that serviced both traditional fee-for-service Medicaid recipients and managed care recipients, their audit exposure from a DSS audit was only limited to the fee-for-service claims. With the implementation of the proposed change, all of the paid claims will now be included in the universe of claims audited by DSS.

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General Considerations (cont'd from page 3)

The board committee should not be involved in the day-to-day administration of the compliance program, such as in employee educational meetings, resolution of internal problems or dealings with outside regulators. However, it should be advised of major internal or external problems and may also have involvement in the resolution of such problems. Major problems would be generally defined as those with the potential to have a material adverse impact on the finances, operations or reputation of the provider. The board of director's involvement in the compliance program sends a powerful signal to management and employees, as well as outside regulators, that the organization takes its compliance obligations seriously and is making a good-faith effort to achieve them.

The compliance officer will be the linchpin and fulcrum, so to speak, of the compliance program. The compliance officer should be an executive officer, who has regular interaction with and access to the rest of management in order to be well informed and familiar at all times as to the affairs and operations of the organization. Compliance obligations of health care providers often are based on a blend of legal, financial, regulatory and other factors. Needless to say, the compliance officer must have appropriate education, training, experience and a verified background that confirms integrity of the highest order.

The governance structure of the compliance program must encompass all divisions and operating units of the organization in both a functional and geographic sense. For example, in the first respect, the compliance officer may want to include a representative, presumably the manager, from billing, clinical, quality assurance, environmental, human resources and/or maintenance

departments. In the second respect, providers that have numerous locations or offices where care is delivered should consider having a representative from each location serve on the management compliance committee. Selection of such representatives should be guided by, among other things, a risk assessment of departments and locations. The participants in the management compliance committee must be carefully selected based on their knowledge of operations, applicable legal and regulatory requirements, and other factors such as their maturity, integrity, sense of responsibility, and ability to communicate well with employees and management. Where applicable and appropriate, members of the management compliance committee should receive outside education and training on a regular basis. Participation in industry groups also can be helpful in this regard.

The governance framework and structure of the compliance program is the starting point for promoting a culture of legal compliance and adherence to ethical guidelines. Obviously, this effort must be more than just a paper chase... it requires real time dedication, effort, and regular participation and attention at all levels of the organization. Perhaps, the only thing worse than no compliance program is a compliance program that is put to paper and then ignored or followed in a token or symbolic manner. Efforts of organizations to adopt, implement, and sustain bona fide compliance programs will be rewarded by savings achieved from adoption of best practices and avoidance of fines, penalties or recoupments. And when inadvertent violations occur, the notice a bona fide compliance program will receive from regulators may help to mitigate the consequences of such violations.

An Expanded Audit Universe (cont'd from page 3)

This increase could have a major impact on the extrapolated audit disallowance amounts since the extrapolation formula is driven by the size of the universe. For example, under the existing system, if a provider that billed both fee-for-service and managed care had a fee-for-service universe of 10,000 claims and a managed care universe of 3,000 claims, DSS would only audit and extrapolate over the universe of 10,000 claims. Assuming a 100 claim sample and an average error per sample case of \$20.00, the extrapolated audit disallowance would be \$200,000.00. Using the same figures in the above example, but applying them to the proposed ASO system, the audit universe would include all 13,000 claims and the sample size would remain 100, but the extrapolated amount would increase to \$260,000.00.

Another group impacted is providers that mainly serviced the managed care population. For this group there was little or no exposure to a DSS audit. Once managed care is eliminated, these provider's fee-for-service claims will be exposed to a DSS audit for the first time.

Legislation passed in 2010 allowed DSS to contract with an ASO, but the former administration decided against pursuing this course of action. Under Governor Malloy's administration, however, the savings for this change have been included in the budget. Thus, it is highly likely that in the near future the MCOs will no longer be servicing the Medicaid population and claims formerly paid by MCOs will be paid as fee-for-service claims and be subject to usual DSS Medicaid audit scrutiny. During this transition period, Medicaid providers should take steps to ensure that they are compliant with DSS regulations and documentation requirements. Having a compliance program that actively monitors Medicaid billings and supporting documentation can go a long

way in protecting providers from incurring unnecessary and costly audit disallowances.



Increase in Budgeted Audit Savings Will Impact Providers:

As discussed in our last newsletter, projected Medicaid audit disallowances are used to decrease the Medicaid expenditure line item when the state budget is compiled. In reviewing Governor Malloy's budget, there is a substantial increase in the amount of audit disallowances estimated for the next two fiscal years. Actual audit adjustments and cost avoidance for fiscal year 2009-2010 totaled \$15,300,000.00. For fiscal years 2011-12 and 2012-13 the state budget shows savings from audits of \$26,100,000.00 and \$29,000,000.00 respectively. These figures show an overall increase of \$13,700,000.00 in just three years!

In order to achieve these projected audit savings DSS will have to perform more audits, increase the number of audit adjustments and/or increase the number of audit findings. DSS will work to obtain these results by using their own audit staff and the newly hired Medicaid Recovery Audit Contractor (RAC) and providers should be prepared to see more Medicaid auditors, auditing more claims and using a finer tooth comb. Providers need to prepare for this increased audit scrutiny by being familiar with the audit process, understanding their rights and knowing how to exercise those rights in the most effective way.

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**Contact Jim Wietrak and/or Robert Tobin
To Set Up A Personalized Meeting**

COMING SOON: QUESTIONS & ANSWERS

We invite you to submit questions of general interest to you and other providers.

The questions we choose to address will be selected in our sole discretion.



**SUBMIT YOUR QUESTIONS AND/OR
COMMENTS TO:
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James Wietrak (Director of Medicaid Audit Services at TCORS)

Prior to joining the firm as a director of Medicaid audit services Mr. Wietrak was the Acting Deputy Commissioner of the Connecticut Department of Social Services. As such he was responsible for the operations of the DSS Bureau of Administration. From 1993- 2009 Mr. Wietrak was the Director of Quality Assurance at DSS, where he directed audits of Medicaid providers and directed recipient and provider fraud prevention and detection activities. He also served as the DSS Project Manager for the department's Data Warehouse and Decision Support System and directed third party liability and asset recovery projects that resulted in recovery and cost avoidance of \$190 million annually. Additionally, he directed quality control reviews of Medicaid, Food Stamps and other federally funded assistance programs. From 1984 - 1993 Mr. Wietrak managed audits of Medicaid providers, fraud prevention and detection activities, and audits of the General Assistance Program.



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