2011 HOUSE INDUSTRY, BUSINESS AND LABOR

HB 1448

2011 HOUSE STANDING COMMITTEE MINUTES

House Industry, Business and Labor Committee
Peace Garden Room, State Capitol

HB 1448
January 26, 2011
13485

☐ Conference Committee

Committee Clerk Signature Ellen LeDang

Explanation or reason for introduction of bill/resolution:

Relating to requiring the state auditor to contract for recovery audits; and to declare an emergency

Minutes:

Chairman Keiser: Opens the hearing on HB 1448.

Blair Thoreson~Representative District 44: (See attached testimony 1).

Representative N Johnson: Is there an ending date?

Blair Thoreson: I not certain.

Representative Amerman: Generally when audits are done, who do they report to their findings?

Blair Thoreson: The auditor's office would contract to provide these. I would assume that they would work with them. It's more a way to reclaim money coming back to the state so they would work with the auditor in that manner.

Representative Nathe: The winning bidder and state will agree on the set percentage that the recovery auditor will retain, do you know what the industry standard is?

Blair Thoreson: I do not.

Representative Boe: Who would we be getting this money back from, the county, cities, who would we be trying to get that back from?

Blair Thoreson: I believe it's mostly outside companies that are contracted with the state.

Vice Chairman Kasper: How do these audits differ from the state auditor's does in their normal course of doing business?

Blair Thoreson: That would be best for them to identify that.

Vice Chairman Kasper: These types of audits are being done in other states and how they are going?

Blair Thoreson: That is correct; there are other states that are doing these now. There is federal legislation which required this to do some of the changes in health care so they are being done in that area but also in other areas.

Vice Chairman Kasper: Your testimony says that the bid is going to be on a percentage of share bases where there is no cost to the state. The company coming in only receives payment if they recover something with a percentage of that payment, in that light, you have any idea of you could come up with a fiscal note with this magnitude if we are going to get money, not spend money?

Blair Thoreson: I did see the fiscal note just prior to coming here for the testimony. I see where there is a general appropriation fund for this biennium and that's identified by the auditor's office. Two auditors would need to be hired for this biennium and an additional for the next. Frankly, I'm not sure where that comes from. What I understand from this process, the only part the auditor's office is some information sharing with the company which is contracted where they would provide them with the data and they would go ahead and look for the information and reclaiming of the funds.

Representative Ruby: This bill will create greater transparency in state government. Could you explain how it will encourage public/private partnerships?

Blair Thoreson: The state government would contract with a private company to provide this service. We would work with them and they have expertise in this area. They look for these types of situations and would be able to reclaim money back to state on behalf of the tax payer.

Benjamin Gerber~Lobbiest for Recovery Audit Specialists, LLC: (see attached testimony 2). North Dakota is in an interesting situation compared to other states. North Dakota can show other states how to be fiscally responsible and make sure your payments are accurate when the times are good as well as when they are bad. The federal has paid particular attention to implement recovery audits. Also, known in the industry as RACK audits as a way to trim budgets and to decrease fraud and abuse. A lot of issues that are found through these recover audits are black and white issues. An example that is most common across industry and is found in about 3% of claims is with PBM's (Pharmacy Benefit Management). PBMs bills the health care provider for a medication under the contract was $18 and they bill them for $35. That is a big area where we find the most abuse and errors that are charged to the government and then get passed on to the tax payers. It takes 5-10 days for a recovery audit company to take a data dump and the state auditor oversees the process. A report is then issued to the state auditor and also to each agency with a plan on how they can avoid these types of fraudulent mispayments or over payments in the future. They work with the agency to solve the problem. Within 14-21 days they have analyzed all the data, identified the payments and then they turn them over to the state auditor or the specific agency that they identified the mispayments with. They then decide which ones are worth going after and which aren't based on the type of payment or typographical error. Within 60 days most government contracts have, if they

don't they should have, a dispute resolution clause. If the vender does dispute, then there will be a dispute resolution phase. Then within 6-9 months, 90% of the identified funds will likely be recovered which is typical of the industry. The 3 areas that we find the most errors with on a recovery bases are account payable, medical and Medicaid claims. Those are the biggest and we find the most abuse and that's why federal legislation has mandated them in the Medicare/Medicaid state administered programs and pharmacy claims reviews.

Representative Amerman: We have audits, in WSI we have performance audits every 2 years and when we hire someone it's in the sum of a couple 100 thousand dollars. If we hire a recovery audit and they don't find anything, they don't get paid, what is the typical payout?

Benjamin Gerber: There is an RFP, so it's a private contract. It depends on the state and where they are actually auditing. One thing that is important is that there be one RFP and not multiple RFPs, it doesn't allow companies to cherry pick which agencies that are more profitable.

Representative M Nelson: Are recovery auditors generally from the amount paid, identified or recovered.

Benjamin Gerber: It's based on what they recover, so if they recover 90% they only receive their share of the 90%.

Representative M Nelson: What is your rate of false positives?

Benjamin Gerber: I'm not sure of the error rate. Almost all government contracts, they should, have the dispute resolution, if they can point out to the agency that they were correct. There is mathematical formulas that are used and have been around and perfected by professionals to limit identification of false positives.

Representative M Nelson: You keep using the word fraud, could you define how you are using that word?

Benjamin Gerber: When I use fraud, I should be more specific. I referencing to overpayments, payments under the contract that are not legal, so they violated the terms of the contract.

Chairman Keiser: In terms of recovery, the option for repayment or set up, how is that determined which approach used?

Benjamin Gerber: A 180 days can be a long time, for example a vender has already spent and there is no cash flow to repay, if they were awarded another government contract, that could be offset.

Chairman Keiser: That is negotiated on a case by case?

Benjamin Gerber: Yes.

Representative Kreun: In section 5, the purpose of improper payment and you go through duplicate payments, what happens if there's a discrepancy? There is a project for 15 million dollars and they indicate that they owe the state back 200,000 dollars. To prove that isn't the case, who pays that contractor to go back and prove that he is correct?

Benjamin Gerber: My understanding is that would be on the specific vendor and that would be the cost of doing business with the state.

Representative Kreun: When you are paid on a commission bases, it's easier to define improper payment easier than if you were paid by the hour. If there is a discrepancy, there should be some protection for that individual that has to spend thousands of dollars to say that wasn't fraudulent or improper.

Chairman Keiser: Are you familiar with this application process in the private sector outside the government?

Benjamin Gerber: It's been very successful in the private arena.

Representative Nathe: So the process goes, we hire these outside auditors, does the auditor's office in the state, do they get a progress report and are they involved in the day to day operations?

Benjamin Gerber: Yes, there would be involvement. When you do these audits, you need the government agency that is involved with it to issue the RFP.

Representative Nathe: They are working side by side?

Benjamin Gerber: Yes, the goal is to assist them and not work against them.

Chairman Keiser: Anyone else here in support, in opposition to HB 1448?

Bob Peterson~State Auditor of North Dakota: (see attached testimony 3).

Representative Amerman: In the section that states "the recovery, you must allow a consultant or the state auditor in the recovery process" now, if the consultant was involved in the recovery process and there was a long time vendor to the state but they found some discrepancies and they want to recover that, in that process, could they turn that vendor over to a collection agency?

Bob Peterson: I do not know the answer to that; you would have to ask the industry experts?

Vice Chairman Kasper: Near the end of your testimony you said under the summary, "we received conflicting information as to whether or not the federal government in regards to contingency payments as allowable costs" how long will it take to find the answer to the question you don't have right now?

Bob Peterson: I could not give you a timeline, as I did state though to get an answer from the federal government, a definitive answer, it's has to be in writing.

Gordy Smith~State Auditor's Office: When we do the single audit, the audit out of all the federal funds that the state receives, we are required to do it once every two years. We are doing it right now; it recovers about 3 billion dollars worth of payments. If we find something wrong, the feds tell us to call it a "question cost" and they are required by law to respond by 6 months any of the findings to the agencies to tell them how they are going to resolve it. The feds may say, it was an honest mistake, we don't care and say just take it out of the next draw down. In those they are required by law to finish them up in 6 months and the majority doesn't do it. I have gotten findings that were 4 years old. I talked to a federal representative and he told me he had concerns. In federal circular 87, it's specifically says that contingency payments are not allowed. However, one of the states that I received information from indicated that something was issued 4 or 5 years ago, they would allow that. So, I want it settled before we get into the mess and then federal government would be mad because we have given some of the money away. Whatever the resolution is, that's what the answer is.

Vice Chairman Kasper: There is a way that you can get the answer? What are other states doing?

Bob Peterson: No we have not really had time to develop all the questions or the answers to this particular bill. We didn't find out about it until last week. Yes, we can certainly contact the federal government and ask them what their view is towards contingency payments. Again, you want something in writing.

Vice Chairman Kasper: As I listen to your testimony and made notes, I wrote fix, fix, fix, it appears to me that it could be fixed with amendments to address your concerns.

Bob Peterson: I would have to see the amendments first.

Vice Chairman Kasper: With your approval, we could go forward. You indicated on point 6 the 30 day deadline relating to the determination of whether the contractor may peruse improper payment, you say 30 days is to short, what would be a reasonable period of time that would meet your concerns?

Bob Peterson: When we talked to our federal contacts, he said, you know if you gave 50 Medicaid payments to 3 people, it would take them more than 30 days to work through 50 payments. I don't know what the answer is. Your experts might have those answers.

Vice Chairman Kasper: You indicated that Texas and Virginia only recovered a million dollars each, if we were to recover a million dollars in our audit, wouldn't you think that would be a significant number for our state to recover?

Bob Peterson: For Texas, didn't they look at 57 billion dollars?

Vice Chairman Kasper: Yes, they did.

Bob Peterson: To get to 57 billion dollars it would take how many bienniums? Then recover a million dollars over how many bienniums, meanwhile you are going to pay FTEs about a 150 thousand dollars a year, for 10 years you will have spent 1.5 million to recover a million? No, I don't think it will be cost efficient.

Vice Chairman Kasper: If we moved this out of your office and put it into OMB where it might be better served? Would it relieve your heartburn?

Bob Peterson: Yes, it would relieve my heartburn.

Representative Boe: You touch on how the federal government has implemented an improper payment recovery act of 2010, how far back can they audit?

Bob Peterson: Defer to Mr Gordy Smith.

Gordy Smith: The federal government, depending on the nature of what the error was, if it's out in out fraud, which is difficult to approve, they can go back a long ways. If it's a continuing program with them, they could net it against the next draw down.

Representative Boe: Does it matter whose mistake it was?

Gordy Smith: From the point of the recovery audit itself. Short of a mistake by the federal government, it does not matter to the recovery audit firm because they going to throw it out because it was a payment in error. From the federal government's perspective and that's who you are dealing with, then I think to some degree matters if it was more fraudulent. Then I'm saying they have the ability to sanction the entity, both with penalties, interest or with some legal proceedings so I think they would care. As far as the recover audits would go, if they just said, we paid you 100 thousand and by contract you only deserved the 90 thousand, we don't care, we just want the 10 thousand back.

Representative Clark: Would Medicare payments fall under this audit.

Gordy Smith: Yes, it would certainly include any payments that state government makes to outside parties. I think it would.

Representative Clark: That would include payments to Medicare recipients.

Gordy Smith: Unless it's exclusive, I don't know how is doesn't.

Representative Clark: From time to time articles in the paper about Medicare fraud being rampant in this country. I heard the figure of 60 billion dollars a year included in those numbers. This seems to me there is room to recover out there.

Gordy Smith: I certainly think there could be in Medicaid and I've seen these articles. I'm sure they are out there. We did a performance audit on the Medicaid fraud provider and recipient here in North Dakota and one of the things we noted in here was that each state has a medical fraud unit. North Dakota is the only one without it. The federal paying 90% of the costs to operate that for the first 3 years and 75% of the costs after 3 years to me if

we are really concerned about Medicaid then I rather see us invest matching money in that 10% the first year and 25% the second year. I thought that they were recovering $2.60 for every dollar they spent Medicaid control fraud unit.

Chairman Keiser: Does the state auditor's department currently do RACK forms of audits, when you do an audit on an entity, you are looking at the performance audit, are we looking at the payments made.

Gordy Smith: First they will attack the financial audits and they have to be done every 2 years. There is a number of entities, the bank of North Dakota, Job Service and WSI where we contract with an outside firm who does those audits every year because of the state's financial statements. In most of those, we go in and test expenditures. We would do in some of the overall analysis you would let the computer analyze for anomalies. Firms are doing is what we call analytical review, they would look at what's strange and pass that on to us. That's where our man power would be spent in looking at them and making a determination based on something.

Chairman Keiser: In the printing industry all jobs are bid and when we lose the bid we tend to follow up on the job. We find that the materials used were different than what was spec'd. We protest, nothing is done and they get away with it and it has become the standard of the industry.

Gordy Smith: I fully believe that happens. We have fewer people today than we had 20 years ago and fewer FTEs also. We know how big government has gotten in the state of North Dakota and federal government in those years. For us to get everything done that was statutorily required, that's what we do. I would agree on this, if the RFP that has been issued with specific specs, to me there should be a contract and should be able to check and determine that. I agree, if they are not meeting specs, they should lose there their contract or do the additional work.

Chairman Keiser: I've seen the same situations in other industries where bids are let and the winning bid is the low bid and the contractor has been able to go back to the state agencies and say we made a big mistake. The state agency suddenly makes a material change in the bid. I see a place for this kind of thing in government but what are you are doing doesn't pick that stuff up and it can't because if happening every day.

Gordy Smith: I would say that number one, the odds of us picking up on this are less than if we did a focused effort and did these computer assisted audits techniques. Could we come across it, yes, have we come across with the federal government, certainly have with question costs. I agree with you.

Chairman Keiser: According to law it has to be a CPA or could it be a CPA firm.

Gordy Smith: I would assume that it would be a CPA firm.

Vice Chairman Kasper: Could you get a copy of the Attorney General opinion that you were referring to?

Gordy Smith: Certainly.

Bob Peterson: Representative Clark, I was informed that the state doesn't make Medicare payments only Medicaid payments.

Chairman Keiser: The state does pay a share of Medicare for dual eligibles. I don't know it we make the payment but we do have state dollars in Medicare.

Chairman Keiser: Anyone else here to testify in opposition, in the neutral position of HB 1448? We will reopen the hearing a week from today at 8 am.

2011 HOUSE STANDING COMMITTEE MINUTES

House Industry, Business and Labor Committee
Peace Garden Room, State Capitol

HB 1448
February 2, 2011
13892

☐ Conference Committee

Committee Clerk Signature

Explanation or reason for introduction of bill/resolution: Relating to requiring the legislative management to contract for recovery audits; to provide an expiration date; and to declare an emergency.

Minutes:

Chairman Keiser: We will open the hearing on HB 1448. Is there anyone here to testify in support of HB 1448?

Mark Briggs~Veridus~ Recovery Audit Specialists: I want to give you an overview because Arizona, the state I am from, is the only state in the country that has issued an RFP of the sort that would be reflected by this bill and has awarded the contract and is not underway in work. I think the bill is fairly self-explanatory. Recovery audits are not something where a recovery audit contract walks into a small business and demands to see their records. Recovery audit firms audit the state's payment systems and their contracts with these folks and if there is a dispute or discrepancy between them, then they may be asked to produce records to indicate why the finding was incorrect. Another thing that recovery audits are not is an audit or an attempt to collect funds from individuals. Payroll taxes, employment benefits, and things of that sort are not something that recovery audit contractors take a look at. Last year the federal government passed the health care legislation, part of which requires each state to have a recovery audit contract on their Medicaid program implemented by April 1, 2001. In addition to that, there is a piece of legislation called the Improper Payment Elimination and Recovery Act of 2010. In these days it passed Congress unanimously and was signed by the President last July. That legislation requires all federal agencies that have over a million dollars of spending in a given year to present a recover audit plan and start implementing it. Some of those federal dollars are going to come downhill to states and when the feds have to come and look for their money, if states haven't looked for it first in a way that the feds agree, they will implement their own audit and then be getting their money back. On e of the advantages of doing recovery audits at the state level is that we are hoping that the states can get exemptions that have already done the audits in these areas across a broader area of their budget rather than just the Medicaid RAC audit and that you would get a waiver from any federal audit that comes or at least have a chance to. If you do that, what we think will happen is that you will get credit for doing that audit work in recovering federal dollars. In doing so, at the Medicaid RAC audit level, they are talking about finalizing rules that would indicate that the state would receive about 12.5% of the recovered federal dollars right off the top as an administrative fee and in addition keep about 45% of the recovered federal

dollars. Now whether it will have to stay in your Medicaid program or can go to your general fund and things of that nature we don't know yet but that is what we would expect to see.

Chairman Keiser: Questions?

Vice Chairman Kasper: Can you tell us something about your company and other companies like you that are doing these types of audits?

Mark Briggs: I can speak mainly to the Recovery Audit Specialists Company. It is a combination of a couple legacy companies that have been doing this for about 40 years in both the private and public sector. They have done audits mainly at the federal level in the government side but in the private sector side they have doing this for a long time for large corporations like Wal Mart and the like. The recovery audit firms basically specialize in 3 buckets of auditing. One is pharmacy benefit portions of your medical spend, the second is the non-pharmacy portion, and finally everything else which they call accounts payable auditing. The pharmacy benefits and medical non-pharmacy tend to be fairly technical areas that require proprietary software which firms like Recovery Audit Specialists do have and update all the time. That is one difference between any state audit function and a specialized firm is that we have the proprietary software that the states don't have. Another thing is because these firms go around the country and look at different budgets and different scenarios, they have a much broader base of knowledge about how errors happen within payment systems and they can bring that experience to any given state. Working hand in hand with the auditor or treasurer of the state can be a powerful understanding about what is going on in the state with the experience in broader context. There are no out-of-pocket costs to the state on this. I can tell you that there is no need for three fulltime employees to administer this contract in Arizona. I can also say that the timelines on this bill, again just in Arizona, the governor vetoed legislation like this last year which I was shocked to hear but then I heard from our governor and she said never mind, it is a great idea, and I just want to be in control of it. The main idea is that we come in and we just need access to data and to contracts and then consult with people. We are doing all the work and we only get paid based on what the state recovers so the state doesn't pay out a lot of money and administering the contract from the people we have talked to in Arizona, they have done it with existing employees in a state that has frankly cut their payrolls drastically because we have massive budget deficit. I am hopeful that North Dakota can look at this and hopefully see a way to figure out how its staff could administer this.

Representative N Johnson: I noticed in the legislation that is proposed that there is nothing about an appeal process, it is a state agency. You look at something and they think maybe what you found is an error. Is there any kind of appeals process built in and how has that been handled?

Mark Briggs: I believe that a swift, easy, and transparent appeals process is critical to this working well. I believe that it should be done on more of rule making level and not a statutory level because you get into a lot of detail about how that process works. What we've seen that works pretty well is when there is a period of time after a contract or a vendor gets the claims. The bill says that the contractor must bring back its findings to the state and present findings to each agency, would be my suggestion, who understands the contract that is being administered there, not at the auditor level or the treasurer's office

level, but down at the agency level where we are operating with people hand in hand on doing the audit. Those people then look at that and are able to bring their knowledge about the contract and are able to eliminate some of the false positives. After that a notice would be sent to the vendor saying we have this number of claims, here are the details about them, and if you have any dispute about them you need to let us know within a certain period of time. At that time I think the next best thing to do is to make people sit down face to face in a room and have a contractor, the vendor, and the person from the proper state agency and just talk about it. If not then have an administrative appeal process that can be quickly and easily done without a lot of costs to the business people. Keep the lawyers out and have it so people can get through the process quickly and fairly. There can be legitimate disputes about things that need to be hashed out between parties. A vast majority of the time it really comes down to whether you are supposed to be paying $1.48 per pill and you are paying $12 per pill there isn't a lot to argue about. A lot of times it is just an error that people can see. One thing I think is important that I didn't say earlier about what recovery audit contracts are not is that we as recovery audit contractors don't say whether the job was done well enough. We don't go out and look at whether the road was grated to speck.

Representative N Johnson: What happens if you find that the state is underpaid?

Mark Briggs: If the state is underpaid we let the state know about that too. Now there are some folks that have suggested that the recovery audit contractors are too incented to find overpayments only because they are not getting paid on underpayments. We generally call the underpayments out if we find them and then really don't get paid on them because it is not a claim that costs the state money and then the state should rectify those underpayments.

Representative Nathe: What are we looking at to recover? Have you done any estimates for North Dakota? What are we looking at for a percentage of recovery money?

Mark Briggs: We have some done some calculations. With error rates of about a 3% in medical and a .1% error rate in medical spend. We also look at your state budget and how much of it approximately are payroll and I just estimate that it is around 50%. We also look at the number years we are going to look at initially which is 4 and then we also look at what percentage of your medical spend is managed care vs. fee for service because manage care is a much lower error rate because you are really paying a certain rate. When you add all that together and then you figure out this federal split on the Medicaid dollars and all of that, we come up with about 5 to 15 million. That is what we expect to find based on those estimates. Until we get in here we don't know. My best guess would be that it is closer to the 5 million than it is to the 15 million but that is just a guess.

Representative Nathe: It seems to me that there is actually more money to be found on the Medicaid side of things than say I am working with the vendors.

Mark Briggs: I think on a percentage basis that would be true. On raw dollars it comes down to how much of your budget is medical vs. non-medical and how much of that is payroll etc. I think in North Dakota it was starting to get fairly equal between those two chunks of money.

Representative Nathe: Walk me through the collection process with a non-medical vender. Say we have overpaid the vendor 1,000 dollars, who collects that money? Who goes out there and says you owe us a certain amount of dollars?

Mark Briggs: Generally speaking there are two paths you can take in this collection process. From what I understand from North Dakota law is that one of these would seem on first look to be the better route. The statute allows you to go either way. The two routes are you have the recovery audit contracting firm do all of it for you. Another path is to have the state, after the claim has been approved, have the contractor contact the vendors and start working through that process. Then the state actually gets the money back into its account and then remits payment to the contractor. My understanding of North Dakota is that process of going back to the state and then out to the contractor may cause appropriations difficulties and require further legislation to allow for that.

Vice Chairman Kasper: One of the concerns we heard last week from the auditor's office was that in the bill we use the word audit. Some questions were raised that only CPA firms can audit. I would assume that we could change the word audit to still do what we wish to do and solve that little concern they have.

Mark Briggs: I think that is correct. We could call it cost recovery consulting if you want. The industry calls it recovery audit and that is what it is called at the federal level.

Vice Chairman Kasper: I want to clarify about the federal law requiring. Is it correct that the federal government has now said in statute that Medicare and Medicaid must be audited and if the state doesn't do it, the federal government will?

Mark Briggs: I think that's slightly off. My understanding is that the way the federal regulations are is that the threat of pulling federal funding is how that is dealt with. If you don't comply with the various ways to go through with it then the treat would be that your federal piece of the funding would be withheld for your state.

Vice Chairman Kasper: Would you be able to provide the committee the documentation on what you just said about the federal government requiring these things and the process we are going to have to go through?

Mark Briggs: Are you speaking about the Medicaid side or the non-Medicaid?

Vice Chairman Kasper: All of it.

Mark Briggs: Yes. I've given Ben Gerber, who represents us and is our lobbyist here in this state, a copy of a letter that is very instructive and lays this out from October 1 of last year from CMS to each Medicaid director across the country. That letter lays out where the requirement came from and what they are doing about it. It has a form letter on the back where you check the box to tell everybody about your program and your audit plan to get it approved. On the non-Medicaid side, the regulations from OMB have not been finalized yet. I am expecting them this month and then the agencies will start rolling out their own plans pursuant to that.

Representative Amerman: You mentioned Arizona. Is this run through the auditor's office in Arizona?

Mark Briggs: No it is not. The auditor office in Arizona is a legislatively appointed office which is why the governor vetoed the legislation that called for the auditor in Arizona. In some states where it is a constitutional office, like North Dakota, I don't know if we really have an analog to your auditor. In Arizona it is being run out of the Department of Administration which I don't believe North Dakota has an analog to that.

Representative Amerman: When you contract an RFP, how long does the contract for a recovery audit firm normally run?

Mark Briggs: There are two general ways this has been handled in the past at the state level. One has been a contract due at a specific period of time. That should not take more than a year to implement and complete. There is another type of contract where it is kind of a year-over-year contract for a certain number of years that would start running into those succession issues you raised. I would suggest an initial contract of a 4 year look back and then a biennial re-awarding of the contract to whichever firm the state wants to use. I would suggest that because you don't want to be locked in with someone if they aren't doing a good job but if they are doing a good job you can always rehire them.

Representative Boe: Is all the recovered money the property of the state of North Dakota or could some of that money actually be the property of the federal government?

Mark Briggs: If you are auditing dollars that came from the federal government then it would be the federal government's money. If it is state dollars then it is state money.

Representative Boe: If the money is recovered and part of it belongs to the feds and part of it to the state, would the auditing firm determine who gets which check and disperse that accordingly before we get ours or would we get the whole amount and then have to owe that?

Mark Briggs: I'm not exactly sure how you would administer it but make no mistake if Recovery Audit Specialists was working for the state, the state would be Recover Audit Specialists' client and as long as the state wasn't asking us to do anything illegal and the state said it wanted to hold the money first and then figure out where it needed to go then that is what we would do. Of course if there were a federal court that put us under order that we needed to escrow the funds or something like that, then we would have to do that.

Representative Clark: I understand you use proprietary software in your business in conducting the audit. I'm curious how does the data come to you? Is there a data dump that you get from the state or do they give you stacks of paper? How does that system work?

Mark Briggs: The answer is both. In the medical side it is much more data driven and is electronically transferred. Even in the most automated of circumstances where your payment information and your claim information are very electronic, you still have to look at

the physical contract between the state and the vendor to find out what was agreed to be paid and on what time frame. That paper needs to be input into our software system manually so that it starts checking and cross checking across at least 30 data fields in a pharmacy benefit scenario for example to make sure that those prices, discounts, and rebates and what not have all been properly applied. It is a combination.

Representative Frantsvog: Under the terms of this bill, if your company were awarded a contract, what time frame would you suspect it would take to perform that audit and would you actually have a team physically located onsite or would your team be offsite someplace?

Mark Briggs: For the time frame for highly electronic payment data I would think that if the state was turning over data quickly, there would be about 60 days for that data to be processed, discussed, and then formal claims to be presented. Usually those vendors have ongoing contracts with the state and therefore want to have a good relationship with the state and have payments coming to them from the state that can be used to offset the overpayments in the past. So the collections process a lot of times can go fairly quickly. I would say within 90 days after starting the claims process you're probably going to see about 80% of everything you are ever going to collect be collected. Now if you have an adjudication procedure in this state for claims that are being disputed, that could influence that time period. On the non data heavy side, there is a lot more people. You are going to have some electronic data and then you will have a lot of paper data that need to be reviewed. There is a lot of manual invoicing etc. That slows everything down so you could probably add 60 days on to everything I just said about the data specific side to the more non data heavy side. As a result I think you could say that from the day you award the contract, within a year or maybe even 9 months you are probably going to collect about 90% of what you are ever going to collect.

Representative M Nelson: Could I get a simplified example on how the federal funds are handled? Say you recover a dollar of federal funds. Does that dollar go back and you don't get paid or does the dollar go back and the state pays you 20 cents or do you get that dollar and the feds get 80 cents and you get 20 cents? How does that end up happening.

Mark Briggs: Let me address that through Medicaid. In that context what the federal guidelines have said is that the federal government will reimburse the state or allow the state to keep 12.5% of the recovered federal dollars right off the top as a fee for doing the work. After that 12.5% is taken off the top, my understanding is that the federal government intends to take about 55 cents of the remaining dollar and 45 cents would remain with the state. Since the recovery audit contractor works for the state and not the federal government, what I would expect would happen there is that if that 12.5% number covers the percentage that is being paid to the contractor that is pretty much the end of the story. If the percentage in Arizona, for example, and under their contract is 13% then the state from its 45% keep would then have that extra .5% that it would pay to the contractor out of the state's dollars.

Representative Sukut: Can you summarize through this whole process from beginning to end what your relationship would be with the state auditor's office? What is the involvement there?

Mark Briggs: I'd hope it would be friendlier than the testimony I read last week. Hopefully we could work through those issues and all agree on a process. Our expectation from the auditor's office, and I'm not speaking about this state's auditor's office I'm just saying that the entity that would be administering the contract which could be anyone the legislature chooses I suppose, they would be the coordination point for our firm. Initially they would gather the appropriate people from the appropriate agencies, identify them, and bring them together for an audit planning meeting. That involves a secretary calling to those agencies and coming up with everybody's availability and setting up a meeting. Then we would have that meeting where we would discuss what we intend to do, how we intend to do it, and put an audit plan on the table. This would have a lot of detail so the people involved have an understanding. Then after that the recovery audit contractor would be interfacing with each of those agencies designees as their contact point to receive that data and then come back to those agencies at the same time with the auditor and say here are our findings. The auditor's office would probably just be there to understand or know that findings have now been presented. The other part I would say the auditor's office would do is if there were some problems then they could probably be the mediating force to see what the problem is between the contractor and agency and resolve that. The appeal process would be something that I would imagine would be overseen by if not administered by the auditor's office.

Vice Chairman Kasper: Could you turn to page 2 starting on line 11it talks about that you cannot disclose confidential information that is provided to you or the auditing company and then on line 26 it also says the auditing company wouldn't have access to information that is deemed to be confidential. First off I don't see anything where we make the process and the information that you are going to obtain and look at confidential. Shouldn't there be a confidentiality clause that protects the work of the auditing company from being disclosed to the public when it shouldn't be?

Mark Briggs: I think that is such a standard thing to have in a contract in our industry that maybe having it in a law just doesn't occur. I think the broad language here where it says it must include reasonable safeguards and penalties to prevent the wrongful disclosure of confidential information by the contractor. It doesn't say individuals it means all confidential information so I think that envelops that right there. I would strongly encourage and would expect that we would a confidentiality provision within the contract itself. Some of this information is covered by federal law but some of it is not and it needs to be handled through a contract if there is no legal confidentiality overlay from a statutory perspective.

Vice Chairman Kasper: Under North Dakota Open Records law, if we don't make the process confidential, the information could become an open record and I am concerned that we have the proper confidentiality agreement in place and it might have to be statutory.

Mark Briggs: I'm not familiar with the contours of your freedom on information statutes in the state. I think it's a tight rope that needs to be walked.

Vice Chairman Kasper: Findings are one thing but the data you are gathering in between and looking at are totally separate.

Mark Briggs: I totally agree. That is a succinct way of saying the things that should be kept confidential vs. not.

Vice Chairman Kasper: On line 26 it says if we have records that are deemed confidential that you can't look at them. Does that area prohibit you from doing the type of audit that should be done? I have no way of knowing what records right now may fall under that category.

Mark Briggs: I am not aware of any records that fall into that category. It is catch-all language because we don't want this statute to run headlong into another statute. I am not personally aware of any data owned by the state that could not or should not be used by the state with an authorized contractor on the state's behalf.

Representative Amerman: I believe you said that Arizona is the only state so far that has instituted recovery audit systems.

Mark Briggs: Yes as far as a broad statewide recovery audit. It's the only state that we are aware of that has put an RFP that has been awarded. So far Arizona is the only one. In Colorado legislation was passed and their governor actually signed it that authorizes a similar audit. We still don't have an RFP awarded in Colorado. There are about 20 states that have simply Medicaid RAC audit RFPs on the street which are simply narrowly focused to address the federal mandate of the Medicaid program recovery audit contractor audits.

Representative Amerman: So there are other states pursuing this type of legislation. Is the language in here specific for North Dakota or is this a type of model that other states are using?

Mark Briggs: Different states are approaching this differently. This piece of legislation was designed for North Dakota but was based on a baseline of a form or model that we have been working on with various legislators and policy makers around the country.

Representative Gruchalla: We are always asked what surrounding states are doing. What are Minnesota, South Dakota, and Montana doing in this regard?

Mark Briggs: Right now in those states that you mentioned, for example Mr. Gerber's firm represents us also in Minnesota and as they say we move a lot slower here, they don't have legislation pending right now. Your governor could have directed some agency to issue an RFP for this already. Most executive branch folks have not gone ahead and done that yet but pursuant to legislation they've even found it easier to move forward because they are working under a force of law rather than just a policy decision that was made at the executive branch level. In some states this legislation is required just because of the way appropriations or the way other issues are structured in that state.

Representative Boe: Arizona did not do this legislatively they did this by executive order?

Mark Briggs: Yes.

Chairman Keiser: Has there been discussion about sharing the recovery with the department rather than sending it back to the general fund within states?

Mark Briggs: Yes, it's been talked about. I think it is a valid thing to think through. In Colorado for example there is thought that people may have to be brought in to help out. There has been some talk in Colorado through rule making to apportion a certain capped amount to an agency that has had an audit going on and has findings so that they have some of those recovered dollars come back into the agency and also frankly motivate them.

Chairman Keiser: Anyone else here to testify in support? In opposition to HB 1448?

Shelly Peterson~President of the North Dakota Long Term Care Association (NDLTCA): (see attached testimony 1).

Chairman Keiser: What process are you using to audit claims today within your industry?

Shelly Peterson: Our association does not do audits. The Department of Human Services under the Medicaid Integrity Program does audits and they have been doing audits of our long-term care providers. I don't know if Medicaid testified last week but they could tell you about any recoveries we have had in the state and anything that has been found that is inappropriate or fraudulent. I don't believe there has been that many. I know a number of our members have had small claims of stuff that has been miscoded but we have not been made aware of anything. The Department of Human Services actually does a really good job educating and informing their Medicaid audit program. I think Medicaid would best be able to answer that.

Representative Nathe: You state in your testimony that if we were to pass HB 1448 it would cause disruption to the operation of providers and the provision of care. How would the audit disrupt care?

Shelly Peterson: It's not as though facilities are overwhelmed with a number of staff. Administrative costs of long-term care are very few. It's time consuming pulling proper records and information and thus your nurses and others that are familiar with medical necessity and other issues are pulled from the floor to help in pulling the proper records. In the Wall Street Journal there was an article last week and they talked about, for the first time in a state's recovery, that they did not recover any dollars and in fact had to pay back more to providers than they ever recovered. It was a very interesting article.

Chairman Keiser: I do encourage members to get a copy of that article. Is there anyone else to testify in opposition?

Jerry Jurena~President of the North Dakota Hospital Association: (see attached testimony 2).

Representative Ruby: Do you have any data or percentage of recovery that the current audits you are doing are capturing?

Jerry Jurena: No I don't. I do know that Medicare audits are going on in the state but I have no information. There have been no complaints coming to the association's office that we need to look into.

Representative Nathe: Your main opposition to the bill is because basically there is enough audits going on right now, correct?

Jerry Jurena: Yes.

Representative Nathe: What is your reaction to Mr. Briggs' comments that he thinks they can recover anywhere from 5 to 15 million dollars? Obviously they think there is enough out there that is not being audited correctly or not being found. What is your comment on that?

Jerry Jurena: I'm not sure where they would find that. With the Medicare audits that are mandated I think the state doing their Medicaid audits are doing a great job. That statement comes across to me as someone is not doing their job.

Chairman Keiser: Do you know on the audits that are being done if they are extrapolating their findings or are they auditing all accounts?

Jerry Jurena: I could only go back to when I was in Rugby. We had an audit with lab testing. When that happened they came in and took a look at a few charts and we found that we were misinterpreting a rule. So we went back in and had to take a look at two years worth of data. It wasn't extrapolated it was you need to go back in and look.

Chairman Keiser: Further questions? Anyone else to testify in opposition?

Jaclyn Bugbee~Director of Development at St Alexius Medical Center: (see attached testimony 3).

Rod St. Aubyn~Blue Cross Blue Shield North Dakota: On this particular one I found it interesting because you just had a bill hearing on HB 1418 and that was the PBM audit bill. I encourage you to look at the differences and the standards of the particular bill and that really deals with recovery as well. Look at the standards that were proposed in that bill and what are proposed in this bill. I think you will find it very striking. I think this will be contradictory if HB 1418 is passed and this one is passed. I am assuming that we will be subject to one of these appeals as our PBM can only look at 40 claims. This one is really unlimited. Under the PBM bill the auditor cannot receive a percentage of what is recovered. This one specifically says that is how they are going to be paid so there is really not limit. This bill talks about a 4 year look back period and I believe the PBM bill talked about 18 months so how are you going to ever reconcile one or the other? Concerns I note on this is the appeal process. What if the recovery auditor indicates that these are what we identify as things that should be reimbursed for recoupment? What if they are wrong? What is the appeal process? I know that Rep. N Johnson had noted the same thing. Limits of when the audits can be done. The other people that have testified said they were opposed to this because of the numerous audits. I have to say that as an insurance company we are also faced with numerous audits. Who pays for the lost time from the company? There is no limitation on these recovery audits. They could look at every claim. It is to their advantage

the more errors they find. In terms of the PBM bill it talks about the auditor must be a licensed North Dakota pharmacist in some of those situations. This one doesn't have a requirement. It could be anyone. I guess I encourage you to look at this very seriously and look at the differences in terms of the standards they are establishing for the PBM audit recoveries and the standards they are establishing for this bill. It is quite striking.

Chairman Keiser: Anyone here to testify in opposition? Neutral testimony for HB 1448?

Maggie Anderson~Director of the Medical Services Division of the Department of Human Services: (see testimony 4).

Chairman Keiser: The ruling in yesterday in Florida and in talking with Jerry I was very concerned about the frontier provision and whether payments would continue to be forthcoming and I asked Jerry what is going to happen and he said number one we don't know and number two, some payments had already been sent but it is conceivable that they will withhold payments until this gets resolved at the federal level. So if we are doing all of these things because of PPACA, are they being put on hold?

Maggie Anderson: With the recovery audit contractor we are moving forward with writing our request for proposal. At this point there would be no expenditure of money on that particular proposal because in essence it is a recovery of money and unless the state is unable to negotiate a contingency fee of close to what the Medicare is, we would have that issue where we'd need to request an exception. Outside of that we are not adding staff to do that or doing any additional expenditure. The National Correct Coding Initiative, when we wrote our request for proposal for the MMIS back in 2005, we had that claims editing piece built into that proposal so we had planned to do that all along. It just became required through the Affordable Care Act. I don't see us going back on that. It really has been effective.

Chairman Keiser: Anyone else here to testify in a neutral position? We have a request from Rep. Nathe if the auditor would come forward.

Representative Nathe: Mr. Smith in our last hearing on this bill the gentleman you work for Mr. Peterson expressed some serious discomfort on this bill by having this in your office. Is there anything that you heard today that may change your mind on this or is there anything we can do to help alleviate that discomfort if we leave this bill in the auditor's office?

Gordy Smith~CPA: There was never any intent on our part when we testified before or today on any bill to indicate that we weren't going to cooperate or that we wouldn't help as best we can. I can promise this committee and Mr. Briggs that if this bill passed exactly as it is, the auditor's office would have a very professional relationship with whoever the recovery audit firm is and we would do everything we could to make it a success. We still have a lot of concerns. I tried to gather some more information to alleviate those. I talked to Texas who has gone through this process, I talked to Colorado who issued an RFP in this process, and I talked to Virginia who has been through this process. One of the things Texas did was took a lot and their cut off, in our bill our cut off is 500,000 dollars, was 100 million dollars over a biennium. Any agency that was under 100 million they didn't look at.

When I had received some survey data from Texas, I said before there was 57 billion dollars looked at and 1 million recovered, but in talking to the person that helps run this, they also did a look specifically at some Medicaid payments and their recovery rates were a little better. They looked only at inpatient costs. They took a 10% sample of all of them processed which totaled 1.8 billion dollars and they were able to recover 12.7 million dollars of that amount. They indicated that when the recovery auditor came in and worked with the individual agencies on pulling stuff, that there was a fair amount of work that was necessary at the agency level. When I talked to Virginia they had something similar they did exclude Medicaid specifically from their recovery audit. They also indicated that there was a lot effort at the agency level. I talked to somebody with Colorado and they have theirs out. When we came up with our fiscal note we got Colorado's fiscal note. It was interesting because he told me that it started out in the governor's office then it moved to the auditor's office and then he said it moved to his office in the Department of Administration. And the way he put it was the music stopped before I could hand the hand grenade off. So he said he is responsible for it. We got our fiscal note specifically from what they did. Once they excluded the agencies he estimates they are going to look at 2.7 billion dollars worth of expenditures. I don't know what ours will end up being with a 9.3 billion dollar budget after you take out payroll and everything else. In his fiscal note they are only anticipating collecting 592 thousand dollars out of those 2.7 billion. I tried to get more and I'd say I probably have less heart burn with how the federal government is going to handle it because it sounds like they are going to take their share which is what they always do. The biggest concern we have is that the federal government is going to come in like they do with their recovery audit firm and when they find something they are simply going to remove that from the agency's federal funding and then the state of North Dakota is going to be stuck trying to collect that from whatever source it is. I have some concerns in this bill. The appeal process essentially came to us and we have 30 days in which all the states I talked to thought it would be very problematic. If we are going to do that what a lot of them said ends up happening is they go to the agency, the agency is able to pull documentation, they sit down with the contracted auditor and say they don't think it is improper and they try to resolve it. Then it comes to the agency to be the final arbiter of whether it is or isn't. I think in those deals it would be awfully hard and would entail a lot of work but that is better to me than having whoever whether it be OMB or us or some other agency look at every single claim as the bill has, and approve them before anything happens.

Chairman Keiser: Further questions? We will close the hearing on HB 1448.

2011 HOUSE STANDING COMMITTEE MINUTES

House Industry, Business and Labor Committee
Peace Garden Room, State Capitol

HB 1448
February 7, 2011
14146

☐ Conference Committee

Committee Clerk Signature

Explanation or reason for introduction of bill/resolution: Relating to requiring the state auditor to contract for recovery audits; and to declare an emergency.

Minutes:

Chairman Keiser: We will open on HB 1448. This is the recovery audits bill.

Vice Chairman Kasper: This is almost a hog house. I'll walk through the amendments. I talked with Rep. Carlson about making a change to put the oversight of this recovery audit in the legislative management division and that is what this does. The first item on page one has legislative management to contract for improper payment identification and recovery services. Item 1 the legislative management committee will contract on behalf of the state with a single qualified and experienced in proper payment identification recovery services consultant firm. The auditor had a concern about the word audit. We are now calling it improper payment identification and recovery services. The testimony was from the gentleman from Arizona is if you have one firm do the audit for the entire state, you will get a much better rate in percentage contract than you would if you separate them. We are saying this would be a single contract by one firm negotiated by the legislative management council. Item A, the contract would meet or exceed the requirements of applicable federal and state law to avoid duplication. It will include in item C recommendations from accruement to accounting and payment policies. Number 2 beginning on July 1, 2013, and each biennium thereafter, the legislative management shall contract to do the same type of audits. Number 3, a contract issued under this section must provide for a reasonable compensation paid by the state to the improper payments firm. It must allow the consultant or the state to pursue recovery. One of the concerns the auditor had was where the funds are going to be. Who is going to collect and could there be concern about the payments firm putting the money in the wrong spots. It would probably be housed in the treasurer's department but I'm sure that would be part of the contract that is negotiated. On page 2, item C, the contract must allow for the consultant to review payments that have been previously audited. I think that would be in there so there is no duplication of effort. Item D must include reasonable safeguards including nondisclosure so that we keep items confidential that should be confidential. Item E is a big thing we heard about in other bills and it must prohibit the consultant from using extrapolation or sampling. So you can't look at one or two items and then say everything like that for the last 2 years we are assuming is there and extrapolate big numbers. Item F outlines what may not allow a review or a recover of and that is the payment to a vendor at least 180 days after the date

the payment was made. You can't look at employees' payroll payments, retirement plans, loans, bonds, related interest, or unemployment compensation benefits. Number 4, each state agency with payments being reviewed shall provide the consultant with cooperation. Item 5, in the event of more than 60 days after notification a write in by the consultant of an identified improper payment to legislative management or its designee shall notify the consultant if the consultant is not authorized the improper recovery and then I would assume that the legislative management or its designee would do that. On the top of page 3, A, a finding that a payment identified as improper by the consultant on the grounds of being an underpayment is actually in the correct amount. Number 6, if the consultant identifies a pattern of improper payments to a specific vendor the legislative management may authorize the consultant to conduct a review of up to one additional prior biennium. Item 7, the consultant on behalf of the state shall recover from the vendor's improper payment that have been made unless the legislative management notifies the consultant in writing of the state's intention to recover any such authorized payments. Item 8, upon the request of the legislative management not the consultant, the attorney general shall bring and pursue any illegal action that the attorney general determines as necessary. For purpose of the section in proper payment means any payment made in an incorrect amount whether an underpayment or overpayment and it defines some areas in there. It defines vendor in item 10. Item 11, the legislative management shall implement any rules necessary to create a process by which the consultant and the vendors may appeal. Item 12 I think I quite important. A state agency may not enter into a contract for the provision of improper payment identification and recovery services without the prior consent of the legislative management. We are not going to allow state agencies to run out there and do their own audits because that is the responsibility of this process. At this time I would move the amendment.

Representative Ruby: Second.

Chairman Keiser: Discussion?

Representative N Johnson: There was some discussion earlier about if they were billed a certain amount and what they collected was different. If you go for finding the whole thing or if it was just the part above what was the actual cost. Remember when we talked about that in committee? Is that something that would be in the RFP perhaps?

Vice Chairman Kasper: I'm sure all those items would be outlined in an RFP that would discuss those things. I would think the industry that does these things would probably have some simple language that could be provided to the legislative management that is sort of used nationally.

Representative Frantsvog: I want to refer to number 1 on page 1 of amendment. It says to perform an improper payment identification or recovery process of payments made to vendors during the previous 4 fiscal years by agencies that have an annual budget exceeding 500,000 dollars regardless of whether the agencies had had an internal or third party reviewers or auditors. If they've been audited previously, what would you expect to find? Isn't this process somewhat similar to an internal audit?

Vice Chairman Kasper: If you recall the gentleman from Arizona indicated that they have proprietary software that looks very differently at their audits than the state auditors do with their type of audit. They go much deeper and have their software that for 6 or 7 years that has been constantly getting better. I don't think duplication it would just be further in depth.

Representative Amerman: On page 1, item 2, is that something that is already done or is that something legislative management can do?

Vice Chairman Kasper: This area is the enabling area to give the legislative management the opportunity to enter into these contracts. Currently we don't have this type of an audit going on in our state. Mark Briggs indicated that these audits are being required now by the federal government and if we don't enter into them as a state, the federal government is going to come in and do it for us.

Chairman Keiser: This is a tough area. I cannot support this because it is going to create a lot of problems. Number one the federal funding for various programs does require a certain degree of audits to be done. We are seeing them. The proper agencies are currently contracting for it. There may be audits in the future that this entity could do but if you follow the logic through that they shall contract, so it's not optional and the only reimbursement is on a contingency basis. If the only way they are going to get paid is on contingency basis, they are not going to be interested in auditing 100% of the criteria in a Medicare/Medicaid foundation program. The key point is on page 4, number 12 that no agency can enter into another audit. This is a perfect area that we should require legislative management to study in the interim and give it to the right committee to dig in and find out what we are doing and what we should be doing.

Vice Chairman Kasper: On item 12, it says it may not enter a contract for the provision of improper identification and recovery services. It does not say that the agencies cannot be audited by the auditor's office of anybody else. It just says that if we are going to do one of these recovery audits looking for the funds, it has to go through legislative management. I don't think it prohibits any other audit. I believed when we used the language shall, that is still up to the legislative management committee. If they decide they are not going to shall, I don't know if they have to. I think they have the prerogative to say no.

Chairman Keiser: I think the language is generally shall consider in the other legislation but we could certainly ask for clarification. We don't have a new fiscal note on the amendment. It does say just based on a contingency so maybe there is no fiscal impact.

Vice Chairman Kasper: The contract is a contingency contract that says there is no cost to the state. I don't see why we would need one.

Chairman Keiser: I think we are ok on the fiscal note.

Representative Nathe: Wasn't the fiscal note originally because the auditor's office?

Chairman Keiser: I think Rep. Kasper is right. Based on a payment of a contingency basis there shouldn't be a fiscal note. This is a recovery of money you weren't going to get.

Representative Sukut: I'm confused on the legislature management part of this. If they are going to manage this and oversee the contracts, are they available on a daily basis to make decisions? Is there some time lapse in there?

Chairman Keiser: They do meet on a regular basis. I am certain that they would assign it to staff to track on the financial side.

Representative Frantsvog: The state auditor's office said that they would hire 2 additional personnel in the upcoming biennium and then 1 additional again the biennium after. We're to understand now that legislative management would hire nobody?

Vice Chairman Kasper: Yes because if you recall the testimony from Mark Briggs, he said there is very little time or expense to any state agency when they do their audits because they are doing the work. They provide a report that is presented to the legislative management committee and then that committee then decides what they are going to do with the report. They said there was no need for new FTEs or a lot of staff time. That is what they are hired to do.

Chairman Keiser: Further discussion? We will do a voice vote.

Voice vote: Motion carries.

Chairman Keiser: The amendments are on the bill and we have HB 1448 in front of us as amended.

Vice Chairman Kasper: I move a do pass as amended.

Representative Nathe: Second.

Representative Gruchalla: I'm going to resist the do pass. From what I'm hearing the state auditor is still opposed to the bill. The Long Term Care Association, the North Dakota Hospital Association, the representative from St. Alexius came in, and Blue Cross Blue Shield is opposed to it. Most of the reasons are because they are already doing this. It sounds like a really new programs and I think we are rushing and need some more study on it.

Vice Chairman Kasper: There is very little time being used not only by legislative management but also by the entities that are being audited. With the reluctance for Blue Cross, it is because, from my perspective, they don't want their PBM audited. Their PBM has probably never been audited. Other states are looking at PBMs and finding hundreds of thousands and in some cases millions of dollars of errors. I'm not sure we will find the large abuses but the fact is we don't know and from my perspective we have nothing to lose. This is being done nationwide and the federal government is saying we have to do it. There is no reason not to move forward and let the legislative management take their time. If they think they need more time they can slow the process down.

Chairman Keiser: There were two states that looked at this and Arizona's governor vetoed it and then decided to do it executive and then Colorado passed it. Have either one of the started?

Representative Ruby: I think it makes sense to do it and have the state in control of that. I also don't necessarily like all these associations what they think we should do. I know they can give input and that's fine but just because they are all against it is necessarily the way we need to make the decision. I think anytime the state can recover mistakes it should be able to.

Chairman Keiser: We have the motion for a do pass as amended on HB 1448 and we will take the roll. We have two options. One is to keep debating it and swish somebody's mind or send it out without recommendation. Or there is always a third option to further amend. What are the wishes of the committee? We don't have to take action either.

Representative Nathe: If it helps matters any as far as moving the vote along, Rep. Kasper had stated that maybe after two years we take a look at this bill and then reevaluate it then. I would suggest we put a sunset clause on this. I would offer an amendment for a sunset.

Vice Chairman Kasper: Second.

Chairman Keiser: Further discussion?

Vice Chairman Kasper: If we don't do it the federal government will. So do we want our state agency to be in charge of it or do we want the federal government to come in and run the show? As far as the expansion, the legislative management does not have to expand it. They could if they wanted to but they could only go where the federal government is going to go anyway. I think it is our obligation to keep state control of anything we can and if it is going to happen by the federal government we can't wait two years because they are going to be in here and I don't know anything that they do better than what we can do. The sunset I agree on.

Chairman Keiser: I'm not sure what Rep. Kasper is referring to that they might do it in the future. They are doing it. We are audited constantly at Medcenter and we are paying and they're recovering money. We always have. It is just this group would be doing the audit vs. the current group that is doing the audit in my opinion.

Representative Ruby: I think having this for 2 years with the sunset clause is our study. That gives us our proof of whether it works or not. If it doesn't work then it is gone.

Chairman Keiser: Further discussion?

Voice vote: Motion carries.

Representative N Johnson: I would move to further amend. Legislative management shall consider contracting on behalf making it not mandatory and not optional just in case it does pass it has optional language rather than mandatory. It would read on that first line by

August 1, 2011, the legislative management shall consider contracting on behalf of the state.

Vice Chairman Kasper: Second.

Chairman Keiser: Further discussion on the amendment? We will try a voice vote.

Voice vote: Motion carries.

Chairman Keiser: The amendment is on the bill.

Vice Chairman Kasper: I move a do pass as amended.

Representative Ruby: Second.

Chairman Keiser: Discussion?

Representative Amerman: When I have the associations, these are entities within our state and I'm not so sure where the origin of this bill comes from. To me it is something that isn't needed.

Chairman Keiser: Further discussion? We will take the roll on a do pass that is three times amended on HB 1448. I think we should send it out without recommendation.

Representative N Johnson: Maybe a hog house into a study resolution?

Vice Chairman Kasper: I hate to be repetitious but if we don't do this the federal government is going to do it. This is different than the audits that they are already doing. This is a different audit. They will do it. They will control it and we will have no say in it whatsoever. If you think there is concern about the associations with the state doing the audit, wait until the federal government gets involved.

Representative Nathe: I'd like to make a motion to send it out without recommendation.

Representative N Johnson: Second.

Chairman Keiser: Further discussion?

Representative Nathe: I want to explain my motion. I think since we can't come to an agreement here I think putting it out on the floor and taking about it with the assembly is the way to go.

Chairman Keiser: We will take the roll. We will close on HB 1448.

7 YEAS 7 NAYS 0 ABSENT
WITHOUT RECCOMENDATION CARRIER: Rep. M. Nelson

2011 HOUSE STANDING COMMITTEE MINUTES

House Industry, Business and Labor Committee
Peace Garden Room, State Capitol

HB 1448
February 8, 2011
14190

☐ Conference Committee

Committee Clerk Signature

Explanation or reason for introduction of bill/resolution:

Minutes:

Chairman Keiser: We will reopen HB 1448. Last time we had a vote of 7 and 7. I misapplied the rule. I thought we had to stay 7 and 7 but we actually need a majority report to send out. We have to have a formal recommendation for the committee report to be without recommendation and then a majority of the member need to vote for that. First of all we have to reconsider our actions by which we acted on 1448. Do I have a motion?

Vice Chairman Kasper: So moved.

Representative Nathe: Second.

Chairman Keiser: Further discussion?

Representative Amerman: I don't like this bill and I don't believe it is something we should put on the books but there might be something in there that we could use some time. I'd like to make a motion to hog house this into a study. Is that appropriate at this time?

Chairman Keiser: That is appropriate. I would encourage you and I don't want to force you in any way, I just suggest to you that there are two ways to do a study and one is shall consider and the other is shall study. I think this is an issue where I would support shall study. We have to vote to reconsider first. Voice vote.

Voice vote: Motion carries.

Chairman Keiser: Now we have the motion to put a hog house amendment on the bill and it would be a shall study.

Representative Boe: Second.

Vice Chairman Kasper: I hope you resist the motion on the study. We had a lengthly discussion yesterday about what this bill does and we have a sunset clause on it. The sunset clause I think is the study. We all know what happens in interim committees. We sit around and we hear testimony about what might happen and what might not happen and

then we really don't know what is going to happen. If we would allow this audit to go through if the bill passes on the floor of the house, we have our study because we have actual facts. Legislative management with their oversight on this bill and with the reporting mechanisms and all the checks and balances we have on the bill, I think we won't get any better study than if we pass the bill.

Chairman Keiser: Further discussion? We will take the roll to apply an amendment that would require a study on this issue.

Roll call vote: 8 yeas, 6 nays, 0 absent. Motion carries.

Vice Chairman Kasper: What would be the procedure to have a minority report on this bill in light of the action we just took for a study? We would not have this bill before the chamber if we don't have a minority report.

Chairman Keiser: That is true and they are entirely different. We did put the other amendments on the bill so the bill will be on the 6th order as it was yesterday with the new amendment on the 6th order and you can debate it and pull it off at that time.

Representative Ruby: Wouldn't those amendments that we put on need to be approved by the 6th order? So it would almost need a minority report.

Chairman Keiser: I think you need a minority report. I think you make a motion to adopt the other set of amendments and if that fails then you request a minority report.

Vice Chairman Kasper: We've already adopted the amendments so we have those amendments on the bill.

Chairman Keiser: The best thing to do is to hold our actions till we check. This point on HB 1448, the committee has adopted the amendment. We will hold it until we find out how to achieve what Rep. Kasper wants. We will close on HB 1448.

2011 HOUSE STANDING COMMITTEE MINUTES

House Industry, Business and Labor Committee
Peace Garden Room, State Capitol

HB 1448
February 9, 2011
14244

☐ Conference Committee

Committee Clerk Signature

Explanation or reason for introduction of bill/resolution:

Minutes:

Chairman Keiser: We will open on HB 1448. We don't have the bill before us but the chair would entertain a motion to reconsider our action by which we passed out HB 1448 as amended.

Representative Ruby: I so move.

Representative Nathe: Second.

Chairman Keiser: I apologize for this but I take 100% responsibility for this. Had we acted the way we should have and if I had been directing the actions correctly on the day that we had the tie vote twice and we had a motion to send it out of committee without recommendation, I should have instructed the committee that we actually needed a majority vote so when we sent it out it was wrong. I hope the committee will support the motion to reconsider and then vote as you feel. Further discussion? We will take a roll call vote on the motion to reconsider.

Roll call vote: 8 yeas, 6 nays, 0 absent. Motion carries.

Chairman Keiser: Committee we have HB 1448 as amended into a study resolution before us.

Vice Chairman Kasper: I want to be right procedurally because I do have an amendment I want the committee to consider and I don't support the study resolution.

Chairman Keiser: You have to move to amend the bill as amended.

Vice Chairman Kasper: One of the concerns that the Hospitals and the Long Term Care Association and others had was that there would be a duplicative audit in the area of Medicare. The recovery audits do not audit Medicare because they are federal funds not state funds. What this amendment would do is take out Medicare audits totally and take away the concern of a lot of the providers in our state. This is not in proper form but it does say that.

Chairman Keiser: We have to go back even further because the bill as it now stands before the committee is a study resolution. We have to have an amendment that would return it to the status it was as a bill. I think what you want is to move to take it back to its amended form prior to the study resolution and then further amend.

Vice Chairman Kasper: I would motion to go back to the prior form before it became a study resolution.

Representative Ruby: Second.

Chairman Keiser: We did place an amendment on the bill and then we would further amend it by adding this language to the bill. If the committee is comfortable doing it then I am.

Representative Boe: My notes indicate that we had two amendments on there before we switched.

Chairman Keiser: That is correct. In its amended form that we had reached some degree of consensus on. Anyone want to hold it further until you see it?

Representative Nathe: Does this get rid of all the amendments that we put on it or just the study?

Chairman Keiser: The study resolution amendment which hog housed the bill. It returns the bill to what it was when it had the two previous amendments on it. It returns it to that status. Further discussion?

Vice Chairman Kasper: Committee members I think one of the biggest contentions was the concern of our health care providers of having to go through an additional Medicare audit. The recovery audits don't audit Medicare they only audit areas that have state funds involved and so to attempt to solve that issue and maybe take away some concerns from some of the health care providers, that is the purpose of going back and seeing if we can put it in a bill form as opposed to a study resolution. I hope the committee would consider going back to the original bill as amended. We can have a debate on that issue and if it ends up being a study resolution so be it.

Representative Nathe: I'm going to support this. I would like to see this bill go on the floor and get its day in court. If the assembly decides to do it then great and if not then so be it.

Representative Amerman: I support the study. I think it is a right step for the state so we know better what we are dealing with. I'm not sure if these amendments solve everything but we can discuss them when it is time.

Vice Chairman Kasper: Another item of deep importance on this bill is the fact that we are going to have 2 choices of who is going to be doing these recovery audits. If we don't take action on this bill, we have a certain choice that is going to be the federal government that will do these audits plain and simple because they are being required by the federal government. If we pass this bill with amendments on it, we have control as a state. If you

need to have an appeal process or any concern you would then be able to deal with a state agency as opposed to a federal agency. I think that is a key part of what this bill is getting to. If you like the federal government telling us what to do and you want people of North Dakota to contact the federal government for appeals, then don't support the bill. If you agree that we don't want the federal government to do things we can do ourselves, then you would support the motion to reconsider.

Representative N Johnson: What we just got handed out was different from the first one we got handed so I'm not sure.

Vice Chairman Kasper: That is true and I guess we'd have to ask Ben which amendment he wishes because I see there are two.

Chairman Keiser: He wants the first amendment. This is the amendment that is being proposed. HB 1448 shall not impose an additional improper payment and recovery service or recovery audit rack on health care providers on the Medicare or Medicaid budget if an improper payment and recovery service or rack is done and meets or exceeds the requirements of applicable federal and state law.

Representative N Johnson: That is not the right language. We can't put HB 1448 shall not impose.

Chairman Keiser: We will take the roll for the motion to restore the original amended version.

Roll call vote: 11 yeas, 3 nays, 0 absent: Motion carries.

Chairman Keiser: The vote has been approved. Are there further amendments?

Vice Chairman Kasper: I don't know how you would like to proceed but if you want to get this amendment to get this in proper form? I would move that we adopt the amendment as offered by the short paragraph by Benjamin Gerber that says HB 1448 shall not impose an additional improper payment and recovery service or recovery audit rack on health care providers on the Medicare or Medicaid budget if an improper payment and recovery service or rack is done and meets or exceeds the requirements of applicable federal and state law.

Representative Ruby: Second.

Chairman Keiser: Further discussion?

Vice Chairman Kasper: Whether you agree or not how you are going to vote finally on the bill, I would encourage you to adopt the amendment because it makes it a better bill and solves a lot of problems.

Chairman Keiser: We will take a voice vote.

Voice vote: Motion carries.

Chairman Keiser: The additional amendment is on the bill and we have HB 1448 as amended three times before us.

Representative Ruby: I would like to make a motion to remove the word consider. We put that on and I can understand the idea that in one case it was almost it being proposed as a study. I think the two years that this is sunset to, is our study. I so move.

Vice Chairman Kasper: Second.

Chairman Keiser: The motion will strike "consider" and return "shall" to the language. Further discussion?

Representative Amerman: Will this become law on August 1, if it passes?

Chairman Keiser: Yes.

Representative Amerman: Legislative management shall consider by August 1, so that means they would have to consider before this becomes law?

Chairman Keiser: If it does become law, the legislative management committee will be meeting immediately following the session and up until August 1, and can take action on behalf of laws that will be forthcoming.

Vice Chairman Kasper: I also want to remind the committee that we also have the sunset clause on the bill. If we implement the recovery audit and sunset it in two year we will have real data that shows exactly what the recovery audit did. If the data shows it is a waste of time or we have problems from problems we aren't addressing in the bill, it sunsets and we can address it or change it in two years.

Chairman Keiser: Further discussion? We will take the roll on the proposed amendment to strike "consider" and return to "shall."

Roll call vote: 6 yeas, 8 nays, 0 absent. Motion fails.

Representative Ruby: I move a do pass as amended.

Vice Chairman Kasper: Second.

Representative M. Nelson: As part of this discussion it was the idea of reconsidering today was that it should have went out without recommendation. Now do we have to vote down a do pass and vote down a do not pass in order to send it out without recommendation?

Chairman Keiser: If on this motion and vote there is a majority it goes out in that form. If it is a tie we can try the alternative. We will take the roll on do pass as amended.

Roll call vote: 7 yeas, 7 nays, 0 absent.

Chairman Keiser: We do have a tie vote. There can be two motions at this point. One would be to send it out as a do not pass or to send it out without recommendation.

Representative Ruby: I motion to send it out without recommendation.

Representative Nathe: Second.

Chairman Keiser: Further discussion? We will take the roll for a without recommendation report on HB 1448 as amended.

8 YEAS 6 NAYS 0 ABSENT WITHOUT RECOMMENDATION as Amended CARRIER: Rep. M. Nelson

FISCAL NOTE

Requested by Legislative Council
02/14/2011

Amendment to: HB 1448

1A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

	2009-2011 Biennium		2011-2013 Biennium		2013-2015 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues	$0	$0	$0	$0	$0	$0
Expenditures	$0	$0	$0	$0	$0	$0
Appropriations	$0	$0	$0	$0	$0	$0

1B. **County, city, and school district fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

2009-2011 Biennium			2011-2013 Biennium			2013-2015 Biennium		
Counties	Cities	School Districts	Counties	Cities	School Districts	Counties	Cities	School Districts
$0	$0	$0	$0	$0	$0	$0	$0	$0

2A. **Bill and fiscal impact summary:** *Provide a brief summary of the measure, including description of the provisions having fiscal impact (limited to 300 characters).*

Engrossed House Bill No. 1448 provides that the Legislative Management consider contracting on behalf of the state for improper payment identification and recovery audits.

B. **Fiscal impact sections:** *Identify and provide a brief description of the sections of the measure which have fiscal impact. Include any assumptions and comments relevant to the analysis.*

Engrossed House Bill No. 1448 provides that by August 1, 2011, the Legislative Management shall consider contracting on behalf of the state with a consulting firm to perform an improper payment identification and recovery audit for the previous four fiscal years.

The bill also provides that beginning July 1, 2013, the Legislative Management contract for an improper payment identification and recovery audits; however, the bill is effective through July 31, 2013, and after that date is ineffective.

3. **State fiscal effect detail:** *For information shown under state fiscal effect in 1A, please:*
   A. **Revenues:** *Explain the revenue amounts. Provide detail, when appropriate, for each revenue type and fund affected and any amounts included in the executive budget.*

It is not possible to determine the amount of revenue that may be generated from the recovery audits.

B. **Expenditures:** *Explain the expenditure amounts. Provide detail, when appropriate, for each agency, line item, and fund affected and the number of FTE positions affected.*

If the Legislative Management chooses to contract for recovery audits and if the contract is structured to provide that the consultant is paid on a contingency basis as a specified percentage of improper payments identified and recovered, the estimated effect on expenditures would be less than $5,000.

The estimated effect on expenditures of the Attorney General is unknown.

C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, for each agency and fund affected. Explain the relationship between the amounts shown for expenditures and appropriations. Indicate whether the appropriation is also included in the executive budget or relates to a*

continuing appropriation.

The appropriation bills for the Legislative Management and the Attorney General do not include appropriations for expenses relating to recovery audits.

Name:	Allen H. Knudson	**Agency:**	Legislative Council
Phone Number:	328-2916	**Date Prepared:**	02/14/2011

FISCAL NOTE

Requested by Legislative Council
01/26/2011

REVISION

Bill/Resolution No.: HB 1448

1A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

	2009-2011 Biennium		2011-2013 Biennium		2013-2015 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues	$0	$0	$0	$0	$0	$0
Expenditures	$12,624	$0	$285,375	$0	$306,600	$0
Appropriations	$12,624	$0	$285,375	$0	$306,600	$0

1B. **County, city, and school district fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

2009-2011 Biennium			2011-2013 Biennium			2013-2015 Biennium		
Counties	Cities	School Districts	Counties	Cities	School Districts	Counties	Cities	School Districts
$0	$0	$0	$0	$0	$0	$0	$0	$0

2A. **Bill and fiscal impact summary:** *Provide a brief summary of the measure, including description of the provisions having fiscal impact (limited to 300 characters).*

State Auditor would hire & pay a consultant to detect and recover improper payments to state's vendors.

State Auditor would hire 2 auditors for 2011-2013, and 1 additional auditor for 2013-2015.

It is not possible to determine amount of general funds necessary to pay consultants for services.

B. **Fiscal impact sections:** *Identify and provide a brief description of the sections of the measure which have fiscal impact. Include any assumptions and comments relevant to the analysis.*

Section 1 of this bill would have an unknown fiscal impact on the State Auditor's Office.

Section 2 of this bill would have an unknown impact on the Attorney General's Office.

3. **State fiscal effect detail:** *For information shown under state fiscal effect in 1A, please:*
   A. **Revenues:** *Explain the revenue amounts. Provide detail, when appropriate, for each revenue type and fund affected and any amounts included in the executive budget.*

It is not possible to determine the amount of revenue this bill might generate.

B. **Expenditures:** *Explain the expenditure amounts. Provide detail, when appropriate, for each agency, line item, and fund affected and the number of FTE positions affected.*

Expenditure amounts in 1.A. above represent only salary and supply costs for additional State Auditor employees.

The expenditure amounts for paying a consultant are unknown.

The expenditures incurred by the Attorney General's Office are unknown.

C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, for each agency*

and fund affected. Explain the relationship between the amounts shown for expenditures and appropriations. Indicate whether the appropriation is also included in the executive budget or relates to a continuing appropriation.

The appropriation amount in 1.A. above represents only salary costs of additional State Auditor employees.

The appropriation necessary for paying a consultant is unknown.

The appropriation necessary for the Attorney General's Office is unknown.

Name:	Ed Nagel	**Agency:**	Office of the State Auditor
Phone Number:	328-4782	**Date Prepared:**	01/26/2011

FISCAL NOTE

Requested by Legislative Council
01/19/2011

Bill/Resolution No.: HB 1448

1A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

	2009-2011 Biennium		2011-2013 Biennium		2013-2015 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues	$0	$0	$0	$0	$0	$0
Expenditures	$12,624	$0	$141,888	$0	$149,100	$0
Appropriations	$12,624	$0	$141,888	$0	$149,100	$0

1B. **County, city, and school district fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

2009-2011 Biennium			2011-2013 Biennium			2013-2015 Biennium		
Counties	Cities	School Districts	Counties	Cities	School Districts	Counties	Cities	School Districts
$0	$0	$0	$0	$0	$0	$0	$0	$0

2A. **Bill and fiscal impact summary:** *Provide a brief summary of the measure, including description of the provisions having fiscal impact (limited to 300 characters).*

State Auditor would hire and pay a consultant to detect and recover improper payments made to the state's vendors.

It is not possible to determine the amount of general funds necessary to pay consultants for these services.

Expenditures incurred by the Attorney General are unknown.

B. **Fiscal impact sections:** *Identify and provide a brief description of the sections of the measure which have fiscal impact. Include any assumptions and comments relevant to the analysis.*

Section 1 of this bill would have an unknown fiscal impact on the State Auditor's Office.

Section 2 of this bill would have an unknown impact on the Attorney General's Office.

3. **State fiscal effect detail:** *For information shown under state fiscal effect in 1A, please:*
   A. **Revenues:** *Explain the revenue amounts. Provide detail, when appropriate, for each revenue type and fund affected and any amounts included in the executive budget.*

It is not possible to determine the amount of revenue this bill might generate.

B. **Expenditures:** *Explain the expenditure amounts. Provide detail, when appropriate, for each agency, line item, and fund affected and the number of FTE positions affected.*

Expenditure amounts in 1.A. above represent only salary and supply costs of an additional State Auditor employee.

The expenditure amounts for paying a consultant are unknown.

The expenditures incurred by the Attorney General's Office are unknown.

C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, for each agency and fund affected. Explain the relationship between the amounts shown for expenditures and*

appropriations. Indicate whether the appropriation is also included in the executive budget or relates to a continuing appropriation.

The appropriation amount in 1.A. above represents only salary costs of an additional State Auditor employee.

The appropriation necessary for paying a consultant is unknown.

The appropriation necessary for the Attorney General's Office is unknown.

Name:	Ed Nagel	**Agency:**	Office of the State Auditor
Phone Number:	328-4782	**Date Prepared:**	01/24/2011

11.0538.02002
Title.

Prepared by the Legislative Council staff for
House Industry, Business and Labor
February 7, 2011

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1448

Page 1, line 2, replace "state auditor" with "legislative management"

Page 1, remove lines 7 through 24

Page 2, remove lines 1 through 31

Page 3, replace lines 1 through 17 with:

"**Legislative management to contract for improper payment identification and recovery services.**

1. By August 1, 2011, the legislative management shall contract on behalf of the state with a single qualified and experienced improper payment identification and recovery services consultant firm to perform an improper payment identification and recovery process of payments made to vendors during the previous four fiscal years by or through state agencies that have an annual budget exceeding five hundred thousand dollars regardless of whether the agencies have had internal or third-party reviewers or auditors perform similar reviews or audits in the past. Any specific improper payment identified by a previous review or audit is not eligible for identification or recovery under this section. Improper payments identified and recovered may include state or federal funds of any character, including grants. The identification and recovery process must:

   a. Where practicable, simultaneously meet or exceed the requirements of applicable federal law and state law to avoid duplication of effort;

   b. Be designed to identify improper payments to the state's vendors; and

   c. Include recommendations for improvements to accounting and payment policies and procedures of state agencies.

2. Beginning on July 1, 2013, and each biennium thereafter, the legislative management shall contract on behalf of the state for improper payment identification and recovery processes on the payments made by the state to vendors during the previous two fiscal years in accordance with subsection 1.

3. A contract issued under this section:

   a. Must provide for reasonable compensation paid by the state to the consultant on a contingency basis as a specified percentage of the total amount of improper payments identified by the consultant and authorized for recovery or payment by the state in accordance with subsection 7;

   b. Must allow the consultant or the state to pursue recovery of any improper payment identified by the consultant, including recovery through rebates, price reductions, discounts, additional or upgraded goods or services, favorable contract terms, cash payments, lien

proceeds, garnishments, or setoffs against future payments made by the state to vendors that previously received improper payments;

c. Must allow for the consultant to review payments that have been previously audited or reviewed by internal or external reviewers or auditors and found to be correct or proper, if the legislative management determines the consultant is reasonably likely to newly identify a material amount of improper payments among those previously audited or reviewed payments;

d. Must include reasonable safeguards, including nondisclosure obligations, to prevent the wrongful disclosure of confidential information by the consultant or its employees or agents in accordance with all applicable laws;

e. Must prohibit the consultant from using extrapolation or sampling in the improper payment identification review process, except when no other method can be practicably used to conduct the review in an effective manner, as determined by the legislative management or its designee at the applicable state agency; and

f. May not allow a review or recovery of:

(1) A payment to a vendor until at least one hundred eighty days after the date the payment was made;

(2) State employee payroll payments;

(3) Retirement plan payments to former or current state employees;

(4) Loans, bond debt service, and related interest; or

(5) Unemployment compensation payments, judgments, and settlements.

4. Notwithstanding any other provision of law, each state agency with payments being reviewed shall provide the consultant with prompt cooperation with the review, identification, and recovery process, as reasonably requested by the consultant, including providing the consultant with access to any information in the custody or control of the state or its vendors which is necessary or desirable to achieve optimal performance of the review, payment, or the recovery of improper payments. An agency may not provide the consultant access to any record if disclosure of the record to the consultant is otherwise prohibited by law despite the consultant's authorization to act on behalf of the state and contractual obligation not to disclose the record.

5. As soon as practicable, but in no event more than sixty days after notification in writing by the consultant of an identified improper payment, the legislative management or its designee at an applicable state agency shall notify the consultant in writing if the consultant is not authorized to pursue the improper payment for recovery, or the state is not intending to pay the balance of an improper payment to the applicable vendor, as the case may be. The notice from the state to the consultant must contain an explanation for the determination. The legislative management or its designee at an applicable state agency shall base the determination on either:

a. A finding that a payment identified as improper by the consultant on the grounds of being an underpayment is actually in the correct amount; or

b. The reasonable unlikelihood of recovering the improper payment, whether due to an erroneous identification by the consultant, the vendor being insolvent, or other substantially similar circumstances.

6. If the consultant identifies a pattern of improper payments to a specific vendor, the legislative management may authorize the consultant to conduct a review of up to one additional prior biennium of payments to the vendor.

7. The consultant, on behalf of the state, shall recover from vendors improper payments that have been identified by the consultant and authorized by the state, unless the legislative management notifies the consultant in writing of the state's intention to recover any such authorized payments. Any funds recovered by the consultant on behalf of the state may not be commingled with other funds and must be held in a separate bank account until paid to the state by the consultant. The consultant may deduct from the funds recovered by the consultant on behalf of the state any fees owed to the consultant by the state under the contract. The consultant shall provide the state with detailed statements and reconciliations for the bank account on a monthly basis during the term of the consultant's contract with the state.

8. Upon the request of the legislative management, the attorney general shall bring and pursue any legal action the attorney general determines is reasonably necessary to recover an improper payment.

9. For the purposes of this section, "improper payment" means any payment made in an incorrect amount, whether an underpayment or overpayment; a payment to an incorrect payee; or a payment for an incorrect reason or purpose, including:

a. A duplicate payment;

b. A payment of a fraudulent or erroneous invoice or bill;

c. A payment based on a failure to apply an applicable discount, rebate, allowance, or price reduction;

d. A payment for goods or services not provided or rendered in whole or in part;

e. A payment for incorrect or unauthorized goods or services; and

f. A payment made in violation of a contractual provision.

10. For the purposes of this section, "vendor" means a person that receives payment directly from the state.

11. The legislative management shall implement any rules necessary to create a process by which the consultant and vendors may appeal whether a payment identified by the consultant as an improper payment is an improper payment, and in which amount. The appeal process may differ

from agency to agency, as determined by the legislative management to be desirable and proper.

12. A state agency may not enter a contract for the provision of improper payment identification and recovery services without prior consent of the legislative management."

Renumber accordingly

Date: Feb 7 - 2011

Roll Call Vote # 1

2011 HOUSE STANDING COMMITTEE ROLL CALL VOTES

BILL/RESOLUTION NO. 1448

House **House Industry, Business and Labor** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number 11.0538.02002

Action Taken: ☐ Do Pass ☐ Do Not Pass ☐ Amended ☐ Adopt Amendment

Motion Made By Kasper Seconded By Ruby

Representatives	Yes	No	Representatives	Yes	No
Chairman Keiser		X	Representative Amerman		
Vice Chairman Kasper			Representative Boe		
Representative Clark			Representative Gruchalla		
Representative Frantsvog			Representative M Nelson		
Representative N Johnson					
Representative Kreun					
Representative Nathe					
Representative Ruby					
Representative Sukut					
Representative Vigesaa					

voice vote - motion carries

Total Yes _____ No _____

Absent _____

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Date: Feb 7-2011

Roll Call Vote # 2

2011 HOUSE STANDING COMMITTEE ROLL CALL VOTES

BILL/RESOLUTION NO. 1448

House **House Industry, Business and Labor** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: ☒ Do Pass ☐ Do Not Pass ☒ Amended ☐ Adopt Amendment

Motion Made By Kasper Seconded By Nathe

Representatives	Yes	No	Representatives	Yes	No
Chairman Keiser		✓	Representative Amerman		✓
Vice Chairman Kasper	✓		Representative Boe		✓
Representative Clark	✓		Representative Gruchalla		✓
Representative Frantsvog		✓	Representative M Nelson	✓	
Representative N Johnson		✓			
Representative Kreun		✓			
Representative Nathe	✓				
Representative Ruby	✓				
Representative Sukut	✓				
Representative Vigesaa	✓				

Total Yes 7 No 7

Absent 0

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

tie

Date: Feb 7-2011

Roll Call Vote # 3

2011 HOUSE STANDING COMMITTEE ROLL CALL VOTES

BILL/RESOLUTION NO. 1448

House **House Industry, Business and Labor** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: ☐ Do Pass ☐ Do Not Pass ☒ Amended ☐ Adopt Amendment

Motion Made By Nathe Seconded By Kasper

Representatives	Yes	No	Representatives	Yes	No
Chairman Keiser			Representative Amerman		
Vice Chairman Kasper			Representative Boe		
Representative Clark			Representative Gruchalla		
Representative Frantsvog			Representative M Nelson		
Representative N Johnson					
Representative Kreun					
Representative Nathe					
Representative Ruby					
Representative Sukut					
Representative Vigesaa					

motion Carries

Total Yes _____ No _____

Absent _____

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

2yr Sunset

Date: Feb 7 - 2011

Roll Call Vote # 4

2011 HOUSE STANDING COMMITTEE ROLL CALL VOTES

BILL/RESOLUTION NO. 1448

House **House Industry, Business and Labor** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: ☐ Do Pass ☐ Do Not Pass ☐ Amended ☐ Adopt Amendment

Motion Made By N Johnson Seconded By Kasper

Representatives	Yes	No	Representatives	Yes	No
Chairman Keiser			Representative Amerman		
Vice Chairman Kasper			Representative Boe		
Representative Clark			Representative Gruchalla		
Representative Frantsvog			Representative M Nelson		
Representative N Johnson					
Representative Kreun					
Representative Nathe					
Representative Ruby					
Representative Sukut					
Representative Vigesaa					

motion carries

Total Yes _____ No _____

Absent _____

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

further to further amend
~~make it optional to~~
consider
→ shall contracting

Date: Feb 7, 2011

Roll Call Vote # 5

2011 HOUSE STANDING COMMITTEE ROLL CALL VOTES

BILL/RESOLUTION NO. 1448

House **House Industry, Business and Labor** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: ☒ Do Pass ☐ Do Not Pass ☒ Amended ☐ Adopt Amendment

Motion Made By Kasper Seconded By Ruby

MOTION TO WITHOUT RECOMENDATION - Nathe Second - N. Johnson

Representatives	Yes	No	Representatives	Yes	No
Chairman Keiser		✓	Representative Amerman		✓
Vice Chairman Kasper	✓		Representative Boe		✓
Representative Clark	✓		Representative Gruchalla		✓
Representative Frantsvog		✓	Representative M Nelson	✓	
Representative N Johnson		✓			
Representative Kreun		✓			
Representative Nathe	✓				
Representative Ruby	✓				
Representative Sukut	✓				
Representative Vigesaa	✓				

Total Yes 7 No 7

Absent 0

Floor Assignment REP. GRUCHALLA

If the vote is on an amendment, briefly indicate intent:

3 amendements → Without Recommendation

Hold. FOR FURTHER COMMITTEE WORK

Date: Feb 8, 2011

Roll Call Vote # 1

2011 HOUSE STANDING COMMITTEE ROLL CALL VOTES

BILL/RESOLUTION NO. 1448

House **House Industry, Business and Labor** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: ☐ Do Pass ☐ Do Not Pass ☐ Amended ☐ Adopt Amendment

Motion Made By Kasper Seconded By Nathe

Representatives	Yes	No	Representatives	Yes	No
Chairman Keiser			Representative Amerman		
Vice Chairman Kasper			Representative Boe		
Representative Clark			Representative Gruchalla		
Representative Frantsvog			Representative M Nelson		
Representative N Johnson					
Representative Kreun					
Representative Nathe					
Representative Ruby					
Representative Sukut					
Representative Vigesaa					

Total Yes _____ No _____

Absent _____

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

MOTION TO reconsider - MOTION CARRIES

Date: Feb 8, 2011

Roll Call Vote # 2

2011 HOUSE STANDING COMMITTEE ROLL CALL VOTES

BILL/RESOLUTION NO. 1448

House **House Industry, Business and Labor** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: ☐ Do Pass ☐ Do Not Pass ☐ Amended ☒ Adopt Amendment

Motion Made By Amerman Seconded By Boe

Representatives	Yes	No	Representatives	Yes	No
Chairman Keiser	✓		Representative Amerman	✓	
Vice Chairman Kasper		✓	Representative Boe	✓	
Representative Clark		✓	Representative Gruchalla	✓	
Representative Frantsvog	✓		Representative M Nelson	✓	
Representative N Johnson	✓				
Representative Kreun	✓				
Representative Nathe		✓			
Representative Ruby		✓			
Representative Sukut		✓			
Representative Vigesaa		✓			

Total Yes 8 No 6

Absent D

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Hoghouse – shall HOLD FOR COMMITTEE ACTION

Date: Feb 9, 2011

Roll Call Vote # 1

2011 HOUSE STANDING COMMITTEE ROLL CALL VOTES

BILL/RESOLUTION NO. 1448

House **House Industry, Business and Labor** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: ☐ Do Pass ☐ Do Not Pass ☐ Amended ☐ Adopt Amendment

Motion Made By Ruby Seconded By Nathe

Representatives	Yes	No	Representatives	Yes	No
Chairman Keiser	✓		Representative Amerman		✓
Vice Chairman Kasper	✓		Representative Boe		✓
Representative Clark	✓		Representative Gruchalla		✓
Representative Frantsvog	✓		Representative M Nelson		✓
Representative N Johnson		✓			
Representative Kreun		✓			
Representative Nathe	✓				
Representative Ruby	✓				
Representative Sukut	✓				
Representative Vigesaa	✓				

Total Yes 8 No 6

Absent 0

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Reconsider

Date: Feb 9, 2011

Roll Call Vote # 2

2011 HOUSE STANDING COMMITTEE ROLL CALL VOTES

BILL/RESOLUTION NO. 1448

House **House Industry, Business and Labor** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: ☐ Do Pass ☐ Do Not Pass ☐ Amended ☐ Adopt Amendment

Motion Made By Kasper Seconded By Ruby

Representatives	Yes	No	Representatives	Yes	No
Chairman Keiser	✓		Representative Amerman		✓
Vice Chairman Kasper	✓		Representative Boe	✓	
Representative Clark	✓		Representative Gruchalla		✓
Representative Frantsvog		✓	Representative M Nelson	✓	
Representative N Johnson	✓				
Representative Kreun	✓				
Representative Nathe	✓				
Representative Ruby	✓				
Representative Sukut	✓				
Representative Vigesaa	✓				

BK to prior form before study resolution

Total Yes 11 No 3

Absent 0

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

take out Medicare Audits

return to orig status w/ the 2 amendments

PURPOSED AMENDMENT
BY BEN GERBER

understanding their electronic data storage and contract administrative process, and if they chose, a review of claims that are identified as improper by the consultant. The bill does not require any state agency to review claims identified as improper.

***Concern**: "This bill is about addressing improper payments in health care."*

FACT: Most importantly this bill expands recovery audits to areas OUTSIDE of healthcare. As a state we still spend hundreds of millions of dollars on other areas that are not looked at like the health care industry. If we only listen to the vocal health care opponents, we are neglecting our duty to look at state payments to all areas of government.

Also, we would like to offer an amendment to this bill that removes a constant concern heard from opponents that these audits will be duplicative.

Amendment Language: "HB 1448 shall not impose an additional improper payment and recovery service or Recovery Audit (RAC) on healthcare providers on the Medicare or Medicaid budget if an improper payment and recovery service or RAC is done and meets or exceeds the requirements of applicable federal and state law."

Thank you once again for the opportunity to address issues regarding HB 1448. We would greatly appreciate your favorable consideration.

Sincerely,

Benjamin Gerber

Date: Feb 9, 2011

Roll Call Vote # 3

2011 HOUSE STANDING COMMITTEE ROLL CALL VOTES

BILL/RESOLUTION NO. 1448

House **House Industry, Business and Labor** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: ☐ Do Pass ☐ Do Not Pass ☐ Amended ☒ Adopt Amendment

Motion Made By Kasper Seconded By Ruby

Representatives	Yes	No	Representatives	Yes	No
Chairman Keiser			Representative Amerman		
Vice Chairman Kasper			Representative Boe		
Representative Clark			Representative Gruchalla		
Representative Frantsvog			Representative M Nelson		
Representative N Johnson					
Representative Kreun					
Representative Nathe					
Representative Ruby					
Representative Sukut					
Representative Vigesaa					

voice vote - motion carried

Total Yes _____ No _____

Absent _____

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

from Ben Gerber

Date: Feb 9, 2011

Roll Call Vote # 4

2011 HOUSE STANDING COMMITTEE ROLL CALL VOTES

BILL/RESOLUTION NO. 1448

House **House Industry, Business and Labor** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: ☐ Do Pass ☐ Do Not Pass ☐ Amended ☒ Adopt Amendment

Motion Made By Ruby Seconded By Kasper

Representatives	Yes	No	Representatives	Yes	No
Chairman Keiser		✓	Representative Amerman		✓
Vice Chairman Kasper	✓		Representative Boe		✓
Representative Clark	✓		Representative Gruchalla		✓
Representative Frantsvog		✓	Representative M Nelson	✓	
Representative N Johnson		✓			
Representative Kreun		✓			
Representative Nathe	✓				
Representative Ruby	✓				
Representative Sukut	✓				
Representative Vigesaa		✓			

Total Yes 6 No 8

Absent 0

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

strike consider.
return shall MOTION FAILS

Date: Feb 9, 2011

Roll Call Vote # 5

2011 HOUSE STANDING COMMITTEE ROLL CALL VOTES

BILL/RESOLUTION NO. 1448

House **House Industry, Business and Labor** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: ☒ Do Pass ☐ Do Not Pass ☒ Amended ☐ Adopt Amendment

Motion Made By Ruby Seconded By Kasper

Representatives	Yes	No	Representatives	Yes	No
Chairman Keiser	✓		Representative Amerman		✓
Vice Chairman Kasper	✓		Representative Boe		✓
Representative Clark	✓		Representative Gruchalla		✓
Representative Frantsvog		✓	Representative M Nelson		✓
Representative N Johnson		✓			
Representative Kreun		✓			
Representative Nathe	✓				
Representative Ruby	✓				
Representative Sukut	✓				
Representative Vigesaa	✓				

Total Yes 7 No 7

Absent 0

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

11.0538.02003
Title.03000

Adopted by the Industry, Business and Labor Committee

February 9, 2011

VK 2/10/11

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1448

Page 1, line 2, replace "state auditor" with "legislative management"

Page 1, line 2, after the semicolon insert "to provide an expiration date;"

Page 1, remove lines 7 through 24

Page 2, remove lines 1 through 31

Page 3, replace lines 1 through 17 with:

"**Legislative management to contract for improper payment identification and recovery services.**

1. By August 1, 2011, the legislative management shall consider contracting on behalf of the state with a single qualified and experienced improper payment identification and recovery services consultant firm to perform an improper payment identification and recovery process of payments made to vendors during the previous four fiscal years by or through state agencies that have an annual budget exceeding five hundred thousand dollars regardless of whether the agencies have had internal or third-party reviewers or auditors perform similar reviews or audits in the past. Any specific improper payment identified by a previous review or audit is not eligible for identification or recovery under this section. Improper payments identified and recovered may include state or federal funds of any character, including grants. The identification and recovery process must:

   a. Where practicable, simultaneously meet or exceed the requirements of applicable federal law and state law to avoid duplication of effort;

   b. Be designed to identify improper payments to the state's vendors; and

   c. Include recommendations for improvements to accounting and payment policies and procedures of state agencies.

2. Beginning on July 1, 2013, and each biennium thereafter, the legislative management shall contract on behalf of the state for improper payment identification and recovery processes on the payments made by the state to vendors during the previous two fiscal years in accordance with subsection 1.

3. A contract issued under this section:

   a. Must provide for reasonable compensation paid by the state to the consultant on a contingency basis as a specified percentage of the total amount of improper payments identified by the consultant and authorized for recovery or payment by the state in accordance with subsection 7;

   b. Must allow the consultant or the state to pursue recovery of any improper payment identified by the consultant, including recovery through rebates, price reductions, discounts, additional or upgraded

goods or services, favorable contract terms, cash payments, lien proceeds, garnishments, or setoffs against future payments made by the state to vendors that previously received improper payments;

c. Must allow for the consultant to review payments that have been previously audited or reviewed by internal or external reviewers or auditors and found to be correct or proper, if the legislative management determines the consultant is reasonably likely to newly identify a material amount of improper payments among those previously audited or reviewed payments;

d. Must include reasonable safeguards, including nondisclosure obligations, to prevent the wrongful disclosure of confidential information by the consultant or its employees or agents in accordance with all applicable laws;

e. Must prohibit the consultant from using extrapolation or sampling in the improper payment identification review process, except when no other method can be practicably used to conduct the review in an effective manner, as determined by the legislative management or its designee at the applicable state agency; and

f. May not allow a review or recovery of:

(1) A payment to a vendor until at least one hundred eighty days after the date the payment was made;

(2) State employee payroll payments;

(3) Retirement plan payments to former or current state employees;

(4) Loans, bond debt service, and related interest; or

(5) Unemployment compensation payments, judgments, and settlements.

4. Notwithstanding any other provision of law, each state agency with payments being reviewed shall provide the consultant with prompt cooperation with the review, identification, and recovery process, as reasonably requested by the consultant, including providing the consultant with access to any information in the custody or control of the state or its vendors which is necessary or desirable to achieve optimal performance of the review, payment, or the recovery of improper payments. An agency may not provide the consultant access to any record if disclosure of the record to the consultant is otherwise prohibited by law despite the consultant's authorization to act on behalf of the state and contractual obligation not to disclose the record.

5. As soon as practicable, but in no event more than sixty days after notification in writing by the consultant of an identified improper payment, the legislative management or its designee at an applicable state agency shall notify the consultant in writing if the consultant is not authorized to pursue the improper payment for recovery, or the state is not intending to pay the balance of an improper payment to the applicable vendor, as the case may be. The notice from the state to the consultant must contain an explanation for the determination. The legislative management or its

designee at an applicable state agency shall base the determination on either:

a. A finding that a payment identified as improper by the consultant on the grounds of being an underpayment is actually in the correct amount; or

b. The reasonable unlikelihood of recovering the improper payment, whether due to an erroneous identification by the consultant, the vendor being insolvent, or other substantially similar circumstances.

6. If the consultant identifies a pattern of improper payments to a specific vendor, the legislative management may authorize the consultant to conduct a review of up to one additional prior biennium of payments to the vendor.

7. The consultant, on behalf of the state, shall recover from vendors improper payments that have been identified by the consultant and authorized by the state, unless the legislative management notifies the consultant in writing of the state's intention to recover any such authorized payments. Any funds recovered by the consultant on behalf of the state may not be commingled with other funds and must be held in a separate bank account until paid to the state by the consultant. The consultant may deduct from the funds recovered by the consultant on behalf of the state any fees owed to the consultant by the state under the contract. The consultant shall provide the state with detailed statements and reconciliations for the bank account on a monthly basis during the term of the consultant's contract with the state.

8. Upon the request of the legislative management, the attorney general shall bring and pursue any legal action the attorney general determines is reasonably necessary to recover an improper payment.

9. For the purposes of this section, "improper payment" means any payment made in an incorrect amount, whether an underpayment or overpayment; a payment to an incorrect payee; or a payment for an incorrect reason or purpose, including:

a. A duplicate payment;

b. A payment of a fraudulent or erroneous invoice or bill;

c. A payment based on a failure to apply an applicable discount, rebate, allowance, or price reduction;

d. A payment for goods or services not provided or rendered in whole or in part;

e. A payment for incorrect or unauthorized goods or services; and

f. A payment made in violation of a contractual provision.

10. For the purposes of this section, "vendor" means a person that receives payment directly from the state.

11. The legislative management shall implement any rules necessary to create a process by which the consultant and vendors may appeal whether a

payment identified by the consultant as an improper payment is an improper payment, and in which amount. The appeal process may differ from agency to agency, as determined by the legislative management to be desirable and proper.

12. A state agency may not enter a contract for the provision of improper payment identification and recovery services without prior consent of the legislative management.

13. Under this section, no additional or duplicate improper payment identification and recovery processes may be conducted on payments made by the state if any recovery audit or improper payment identification and recovery process that meets or exceeds applicable federal and state law has been previously conducted on those payments.

SECTION 2. EXPIRATION DATE. This Act is effective through July 31, 2013, and after that date is ineffective."

Renumber accordingly

Date: Feb 9, 2011

Roll Call Vote # 6

2011 HOUSE STANDING COMMITTEE ROLL CALL VOTES

BILL/RESOLUTION NO. 1448

House **House Industry, Business and Labor** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: ☐ Do Pass ☐ Do Not Pass ☒ Amended ☐ Adopt Amendment

Motion Made By Ruby Seconded By Nathe

Representatives	Yes	No	Representatives	Yes	No
Chairman Keiser	✓		Representative Amerman		✓
Vice Chairman Kasper		✓	Representative Boe		✓
Representative Clark		✓	Representative Gruchalla		✓
Representative Frantsvog	✓		Representative M Nelson	✓	
Representative N Johnson		✓			
Representative Kreun	✓				
Representative Nathe	✓				
Representative Ruby	✓				
Representative Sukut	✓				
Representative Vigesaa	✓				

Total Yes 8 No 6

Absent 0

Floor Assignment M Nelson

If the vote is on an amendment, briefly indicate intent:

w/out recommendation

REPORT OF STANDING COMMITTEE

HB 1448: Industry, Business and Labor Committee (Rep. Keiser, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **BE PLACED ON THE CALENDAR WITHOUT RECOMMENDATION** (8 YEAS, 6 NAYS, 0 ABSENT AND NOT VOTING). HB 1448 was placed on the Sixth order on the calendar.

Page 1, line 2, replace "state auditor" with "legislative management"

Page 1, line 2, after the semicolon insert "to provide an expiration date;"

Page 1, remove lines 7 through 24

Page 2, remove lines 1 through 31

Page 3, replace lines 1 through 17 with:

"**Legislative management to contract for improper payment identification and recovery services.**

1. By August 1, 2011, the legislative management shall consider contracting on behalf of the state with a single qualified and experienced improper payment identification and recovery services consultant firm to perform an improper payment identification and recovery process of payments made to vendors during the previous four fiscal years by or through state agencies that have an annual budget exceeding five hundred thousand dollars regardless of whether the agencies have had internal or third-party reviewers or auditors perform similar reviews or audits in the past. Any specific improper payment identified by a previous review or audit is not eligible for identification or recovery under this section. Improper payments identified and recovered may include state or federal funds of any character, including grants. The identification and recovery process must:

   a. Where practicable, simultaneously meet or exceed the requirements of applicable federal law and state law to avoid duplication of effort;

   b. Be designed to identify improper payments to the state's vendors; and

   c. Include recommendations for improvements to accounting and payment policies and procedures of state agencies.

2. Beginning on July 1, 2013, and each biennium thereafter, the legislative management shall contract on behalf of the state for improper payment identification and recovery processes on the payments made by the state to vendors during the previous two fiscal years in accordance with subsection 1.

3. A contract issued under this section:

   a. Must provide for reasonable compensation paid by the state to the consultant on a contingency basis as a specified percentage of the total amount of improper payments identified by the consultant and authorized for recovery or payment by the state in accordance with subsection 7;

   b. Must allow the consultant or the state to pursue recovery of any improper payment identified by the consultant, including recovery through rebates, price reductions, discounts, additional or upgraded goods or services, favorable contract terms, cash payments, lien proceeds, garnishments, or setoffs against future payments made by the state to vendors that previously received improper payments;

c. Must allow for the consultant to review payments that have been previously audited or reviewed by internal or external reviewers or auditors and found to be correct or proper, if the legislative management determines the consultant is reasonably likely to newly identify a material amount of improper payments among those previously audited or reviewed payments;

d. Must include reasonable safeguards, including nondisclosure obligations, to prevent the wrongful disclosure of confidential information by the consultant or its employees or agents in accordance with all applicable laws;

e. Must prohibit the consultant from using extrapolation or sampling in the improper payment identification review process, except when no other method can be practicably used to conduct the review in an effective manner, as determined by the legislative management or its designee at the applicable state agency; and

f. May not allow a review or recovery of:

(1) A payment to a vendor until at least one hundred eighty days after the date the payment was made;

(2) State employee payroll payments;

(3) Retirement plan payments to former or current state employees;

(4) Loans, bond debt service, and related interest; or

(5) Unemployment compensation payments, judgments, and settlements.

4. Notwithstanding any other provision of law, each state agency with payments being reviewed shall provide the consultant with prompt cooperation with the review, identification, and recovery process, as reasonably requested by the consultant, including providing the consultant with access to any information in the custody or control of the state or its vendors which is necessary or desirable to achieve optimal performance of the review, payment, or the recovery of improper payments. An agency may not provide the consultant access to any record if disclosure of the record to the consultant is otherwise prohibited by law despite the consultant's authorization to act on behalf of the state and contractual obligation not to disclose the record.

5. As soon as practicable, but in no event more than sixty days after notification in writing by the consultant of an identified improper payment, the legislative management or its designee at an applicable state agency shall notify the consultant in writing if the consultant is not authorized to pursue the improper payment for recovery, or the state is not intending to pay the balance of an improper payment to the applicable vendor, as the case may be. The notice from the state to the consultant must contain an explanation for the determination. The legislative management or its designee at an applicable state agency shall base the determination on either:

a. A finding that a payment identified as improper by the consultant on the grounds of being an underpayment is actually in the correct amount; or

b. The reasonable unlikelihood of recovering the improper payment, whether due to an erroneous identification by the consultant, the vendor being insolvent, or other substantially similar circumstances.

6. If the consultant identifies a pattern of improper payments to a specific vendor, the legislative management may authorize the consultant to conduct a review of up to one additional prior biennium of payments to the vendor.

7. The consultant, on behalf of the state, shall recover from vendors improper payments that have been identified by the consultant and authorized by the state, unless the legislative management notifies the consultant in writing of the state's intention to recover any such authorized payments. Any funds recovered by the consultant on behalf of the state may not be commingled with other funds and must be held in a separate bank account until paid to the state by the consultant. The consultant may deduct from the funds recovered by the consultant on behalf of the state any fees owed to the consultant by the state under the contract. The consultant shall provide the state with detailed statements and reconciliations for the bank account on a monthly basis during the term of the consultant's contract with the state.

8. Upon the request of the legislative management, the attorney general shall bring and pursue any legal action the attorney general determines is reasonably necessary to recover an improper payment.

9. For the purposes of this section, "improper payment" means any payment made in an incorrect amount, whether an underpayment or overpayment; a payment to an incorrect payee; or a payment for an incorrect reason or purpose, including:

   a. A duplicate payment;

   b. A payment of a fraudulent or erroneous invoice or bill;

   c. A payment based on a failure to apply an applicable discount, rebate, allowance, or price reduction;

   d. A payment for goods or services not provided or rendered in whole or in part;

   e. A payment for incorrect or unauthorized goods or services; and

   f. A payment made in violation of a contractual provision.

10. For the purposes of this section, "vendor" means a person that receives payment directly from the state.

11. The legislative management shall implement any rules necessary to create a process by which the consultant and vendors may appeal whether a payment identified by the consultant as an improper payment is an improper payment, and in which amount. The appeal process may differ from agency to agency, as determined by the legislative management to be desirable and proper.

12. A state agency may not enter a contract for the provision of improper payment identification and recovery services without prior consent of the legislative management.

13. Under this section, no additional or duplicate improper payment identification and recovery processes may be conducted on payments made by the state if any recovery audit or improper payment identification and recovery process that meets or exceeds applicable federal and state law has been previously conducted on those payments.

SECTION 2. EXPIRATION DATE. This Act is effective through July 31, 2013, and after that date is ineffective."

Renumber accordingly

2011 TESTIMONY

HB 1448

Testimony 1

House Industry, Business, and Labor Committee
Rep. George Keiser, Chair
Wednesday, January 24, 2011

Testimony in support of HB 1448 by: Rep. Blair Thoreson - District 44

Thank you Mr. Chairman and Members of the Committee. House Bill 1448 intends to create greater transparency in state government and will encourage public-private partnerships. This bill requires that the North Dakota State Auditor issue a single RFP to initiate recovery audits on any state agency with a budget greater than $500,000.00. The first RFP will be for a recovery audit that looks back over the last four years, however, subsequent recovery audits will occur 6-months after the end of every biennium reviewing payments made during the previous biennium.

A recovery audit is a process in which payments made by the State to vendors are examined for errors, such as duplicate payments, overpayments, payments made to the wrong payee, and/or fraudulent payments. The process is done on a contingent basis, at no cost to the taxpayer, and the winning bidder and the state agree on a set percentage that the recovery auditor will retain as payment from the actual reclaimed funds.

Recovery Auditors **will not** in this case audit payroll or other payments typically made to individuals, nor will Recovery Auditors audit managed care medical expenditures. Recovery Auditors identify improper payments utilizing proprietary, HIPAA-compliant software, and review vendor payments on a claim-by-claim basis (not as a sample audit), helping the state recover misspent funds.

Recovery Audits have become extraordinarily popular with state governments looking to trim huge deficits, or in the case of North Dakota, to ensure efficient use of our state's precious taxpayer dollars. Through this bill, we can become a model of how government should run all the time, and not just in the good times or the bad times.

The industry approximates that a Recovery Audit on North Dakota's budget may identify $10-20 million dollars that would go right back to the State of North Dakota. This estimate is based on the assumption that there is a recovery rate of 0.1% on non-medical payments and 3% on medical-related payments, a benchmark in the recovery audit industry. In other words, the taxpayer wins by ensuring their dollars are not used in an improper manner.

This bill has bipartisan sponsorship and fits well with the State's agenda of fiscal responsibility and efficient use of taxpayer dollars. I appreciate your time and favorable consideration of House Bill 1448.

Ben Gerber

Testimony 2

RECOVERY AUDIT SPECIALISTS, LLC

January 17, 2011

STATE OF NORTH DAKOTA EXECUTIVE SUMMARY

What is a "Recovery Audit"?

A recovery audit is a process in which payments made by the State to vendors are examined for errors, such as duplicate payments, overpayments and payments to the wrong payee. RAS does not audit payroll or other payments typically made to individuals, nor does RAS audit managed care medical expenditures. When Recovery Audit Specialists, LLC ("RAS") conducts a recovery audit, its auditors identify improper payments and help the State recover misspent funds. RAS auditors, utilizing proprietary, HIPAA-compliant software, review vendor payments on a claim-by-claim basis, as opposed to a "sample" audit.

Process and Timeline

5-10 days to download contractual and payment data stored electronically. Data that is not stored electronically will take longer to gather and input, depending on format and ease of accessibility.

14-21 days to analyze downloaded payment data and begin producing reports of improper payments for review and approval by the State before recovery is attempted.

60 days after the State has approved the recovery and any appeals procedure for the vendor to dispute the recovery claim has concluded, RAS will have collected approximately 80% of the improper payments that it will eventually recover.

6-9 months after beginning its work, RAS will have recovered 90% of all most all erroneous payments are recovered throughout state agencies regardless of data storage format

If RAS begins work on September 1, 2011and the time for a vendor to appeal an alleged improper payment is 30 days or less, a significant portion of the improper payments that can be recovered by RAS should be back in the State's coffers by the end of that year.

Financial Costs and Benefits

RAS is paid a percentage of the improper payments it recovers for the State. If RAS does not find money for the State, RAS does not get paid. The costs to the State are basically time spent by State employees in downloading data, reviewing reports and approving recovery. In North Dakota, RAS estimates that a recovery audit performed on the entire State budget for the past **three fiscal years** would yield approximately **$10 - $20 million** in recovered improper payments. This rough estimate is based on several assumptions, such as a recovery rate of 0.1% of non-medical payments and 3% of medical-related payments, which are generally accepted benchmarks in RAS's industry.

Federal Executive Orders and Legislation

President Obama has signed two executive orders mandating recovery audits, the most recent of which was in March 2010. http://www.whitehouse.gov/the-press-office/president-obama-announces-new-effort-crack-down-waste-and-fraud The President's executive orders mimic most of the recovery audit provisions in the "IPERA" (improper payments elimination and recovery act) legislation making its way through Congress this session. HR 3393 passed out of the House unanimously, and its companion piece, S 1508, passed the Senate unanimously on June 23, and we are hearing that it should get out of conference committee later this month and the President would be disposed to signing it quickly. Under IPERA, all significant federal funding that flows down to state and local governments will be subject to a recovery audit. OMB is currently reviewing suggestions from state and local governments on how best to incent them to participate in or initiate such audits. Based on information expressed informally by OMB, one suggestion is that the state or local government performing an audit that recovers improper payments of federal funds would be entitled to keep 25%-30% of those federal funds rather than remit them back to the federal government. The OMB guidelines and regulations are expected in July 2010.

RECOVERY AUDIT SPECIALISTS, LLC - THE COMPREHENSIVE SOLUTION FOR ACCOUNTS PAYABLE, MEDICAL AND PHARMACY RECAPTURE AUDITS

Over the past year, the Administration and Congress have sharpened their focus on improved financial management of federal expenditures. Of particular interest is reducing the incidence of improper/erroneous payments through stronger accountability requirements in two principal areas:

- identification of improper payment types and their root causes
- application of an audit program to determine specific instances of improper payments and a plan to recapture the misspent funds.

These new requirements that are contained in pending federal legislation, the *Improper Payments and Recovery Audit Act*, are being implemented by the President's November 20, 2009 Executive Order 13520, *Reducing Improper Payments* and his March 10, 2010 Presidential Memorandum to Executive Agencies, *Finding and Reducing Improper Payments.*

The Office of Management and Budget (OMB) issued the requirements for determining potential improper payments and preparing plans to recapture them on March 22, 2010. Additional OMB guidance is expected in June 2010, on actions agencies will be expected to take to meet the audit requirements.

The March 10, 2010 Presidential Memorandum expands Payment Recapture Audits, which it defines as *"effective mechanisms for detecting and recapturing payment errors paid to contractors or other entities whereby highly skilled accounting specialists and fraud examiners use state-of-the-art tools and technology to examine payment records and uncover such problems as duplicate payments, payments for services not rendered, overpayments, and fictitious vendors ...* ***One approach that has worked effectively is using professional and specialized auditors on a contingency basis, with their compensation tied to the identification of misspent funds."***

Expected results are not just the recovery of improper payments, but also a description of systemic issues that lead to improper payments. These issues may run the gamut from duplicate payments to incorrect amounts paid to payments that should not have been made. This may be of particular concern in the grants arena.

Identification and documentation of improper payments, their causes and amounts overpaid by claim, is followed by a corrective action plan to reduce and eventually eliminate future improper payments. The goal is to move toward an operating environment in which improper payments are truly the exception.

RAS auditors identify improper payments and help you recover misspent funds. Our comprehensive solutions examine expenditures for goods and services to vendors, pharmacy benefit managers (PBM) and third party administrators (TPA). RAS auditors and specialized software scrutinize every state agency's payments, state employee and retiree medical and pharmacy benefits and Medicaid.

Three Types of Audits

RAS comprehensive solutions cover three unique audit types: Accounts Payable, Medical and Pharmacy. Upon completion of the recovery audit we develop a management report and personally review the findings and present recommendations to address Executive Agency specific financial challenges. Our recommendations show you how to correct financial deficiencies in order to save money going forward.

Accounts Payable

- Perform an efficient review of Accounts Payable, contracts and purchasing records, verify invoice terms and conditions
- Identify payment errors including, but not limited to: overpayments, duplicate payments, pricing errors, invoicing errors, missed rebates or discounts, and other recoveries that the Designated Official agrees was improperly spent
- Exclude payments for state employee payroll and benefit payments from audits

Medical and Medicaid Claims Review

Providing administrative overpayment medical audits since 1989, we help self-funded employers optimize their health plan's performance by identifying claims that are the responsibility of another party. Our comprehensive audit screens 100% of paid claims (no sampling) in over 40 Recovery Modules; using the most sophisticated query logic and case detection software in the industry. RAS will:

- Accept your data in any format
- Verify eligibility on all claims before moving on to expert review
- Follow through on claim recovery findings to ensure future savings
- Respect your existing procedures—reduce costs without changing coverage

Pharmacy Claims Review

Review and re-price 100% of pharmacy claims, compare those claims to the terms and conditions of the PBM contract(s). Historically, we find the PBM in violation of their contract 100% of the time. Here are some of the data types we review:

- AWP discounts, DAW code, NDC numbers, date of service, MAC cost, mail/retail indicators, quantity dispensed, dispensing fee, member co-pays, amount paid, fill too soon violation, excluded drugs by NDC and name, specialty drugs, prior authorizations and brand substitutions
- If requested, provide the agency and PBM all improperly paid claims with reason code for each disallowance and the amount overcharged per claim
- We provide a report of how many claims (brand/generic/mail order) were reviewed by year, how many were overcharged and the total amount of improper payments made to providers

Payment Recapture Audit Process

- **Agree on audit target areas.** This is most likely addressed in a Statement of Work and/or proposal.

- **Develop the basic approach to audit.** The audit parameters will have been described in the contractor's proposal. The approach varies by type of audit. For procurement auditing much can be accomplished using the state agency's data, with some interaction with vendors. Grants, on the other hand, will probably require examining records of sub-grantees or others.

- **Determine necessary documentation.** Identify where the documentation is located and determine the best way to obtain it.

- **Gather documentation (without overburdening state agency staff).** The expectation is that most of the documentation will be automated. The objective then, is how best to acquire the data and convert it into secure data-bases to be used for the audit. Once an audit begins the quality of, and any gaps in data, should become evident.

- **Perform the audit.** A number of steps taken here will be proprietary. Our objective is to quickly determine trends and identify improper payments for rapid recovery. Examples of improper payments include duplicates, incorrect amount paid, incorrect pricing and/or application of inappropriate rates of various types, contract violations and discounts not taken.

- **Start to report on findings.** Documenting findings is a continuous process throughout the effort. Reports will continue to be refined to meet three objectives:

    - List improper payments and any apparent trends
    - Describe control issues that lead to improper payments
    - Develop plan to alleviate any control problems

- **Submit claims to state agency for collection.** Our experience is that 90 percent of all claims are recovered. Industry standards reveal an improper payment rate of:

    - 1/10 to 3/10 of a percent in the procurement area
    - 3 to 8 percent in medical claims and pharmacy benefits

- **Develop final report.** Combine interim report findings, including suggestions for next steps, which may run from straightforward changes in procedures and responsibilities to more complex systemic modifications. Some of the suggestions for improved controls may have been implemented earlier when RAS first identified and reported the concern to the state agency.

Frequently Asked Questions on the OMB Guidelines for Recapture Audits

Who Must Have An Audit?

Every department, agency, or instrumentality in the executive branch of the United States must have an audit. However, for federal agencies that enter into contracts with a total value of more than $500 million in a fiscal year, (almost all) a recovery audit program is a required element of their internal controls over contractor payments.[1]

May Agencies Use Alternative Sampling Methods?

Yes, but they must be approved by the OMB in advance.[2] For example CMS may petition to use its existing method of sampling as described in "Calculating State Error Rates in PERM"[3] where a $2 error on a single $18 Medicaid claim was the supporting information for a $4 Million dollar request for repayment from a State program.[4]

Must State Programs That Are Federally Funded Be Audited?

The agency is required to examine "federally-funded, state-administered programs (e.g., Medicaid, TANF, Title I Grants to States, Child and Adult Care Food Program) that receive part of their funding from the Federal Government, but are administered, managed, and operated at the State or local level"[5] States are however, encouraged to perform their own audits and submit the results on error rates to the federal agency.

What Is The Definition of a Contingency Recovery Audit?

A Recovery Audit Contingency Contract is a contract for recovery audit services in which the recovery audit contractor is paid a portion of the amount recovered. The amount the contractor is paid, generally a percentage of the recoveries, is based on the amount actually collected based on the evidence discovered and reported by the recovery audit contractor to the appropriate agency official.[6]

May Recovery Audit Services Be Performed By Contractors?

Yes. Agency heads may enter into any appropriate type of contract, including a contingency contract for recovery audit services.[7]

What Is The Proper Disposition Of Recovered Amounts?

Funds collected under a recovery audit program are used to pay the audit expenses, including to contractors for recovery audit services, and then credited to the original appropriation if possible.[8]

What Reports Must Be Made Available To The Public?

Agencies must specifically report the "high dollar" errors to the Inspector General and post the data, including the Agency and Contractor, on the recapture audit website. [9]

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[1] Part 3A, Page 13 Issuance of Part III to OMB Circular A-123, Appendix C
[2] Part 1F, Page 8 Issuance of Part III to OMB Circular A-123, Appendix C
[3] Calculating State Error Rates in Perm
[4] Page 18, Line 10 of Graphic Calculating State Error Rates in Perm
[5] Part 1H, Page 9 Issuance of Part III to OMB Circular A-123, Appendix C
[6] Part 3C2, Page 14 Issuance of Part III to OMB Circular A-123, Appendix C
[7] Part 3G, Page 17 Issuance of Part III to OMB Circular A-123, Appendix C
[8] Part 3J, Page 18 Issuance of Part III to OMB Circular A-123, Appendix C

PROGRAMS FOR WHICH ERRONEOUS PAYMENT INFORMATION IS REQUESTED

Erroneous payment information is requested for the following:

Department of Agriculture
- Food Stamps
- Commodity Loan Program
- National School Lunch and Breakfast
- Women, Infants, and Children

Department of Defense
- Military Retirement
- Military Health Benefits

Department of Education
- Student Financial Assistance
- Title I
- Special Education—Grants to States
- Vocational Rehabilitation Grants to States

Department of Health and Human Services
- Head Start
- Medicare
- Medicaid
- TANF
- Foster Care—Title IV-E
- State Children's Insurance Program
- Child Care and Development Fund

Department of Housing and Urban Development
- Low Income Public Housing
- Section 8 Tenant-Based
- Section 8 Project Based
- Community Development Block Grants (Entitlement Grants, States/Small Cities)

Department of Labor
- Unemployment Insurance
- Federal Employee Compensation Act
- Workforce Investment Act

Department of Treasury
- Earned Income Tax Credit

Department of Transportation
- Airport Improvement Program
- Highway Planning and Construction
- Federal Transit—Capital Investment Grants
- Federal Transit—Formula Grants

Department of Veterans Affairs
- Compensation
- Dependency and Indemnity Compensation
- Pension
- Insurance Programs

Environmental Protection Agency
- Clean Water State Revolving Funds
- Drinking Water State Revolving Funds

National Science Foundation
- Research and Education Grants and Cooperative Agreements

Office of Personnel Management
- Retirement Program (CSRS and FERS)
- Federal Employees Health Benefits Program (FEHBP)
- Federal Employees' Group Life Insurance (FEGLI)

Railroad Retirement Board
- Retirement and Survivors Benefits
- Railroad Unemployment Insurance Benefits

Small Business Administration
- (7a) Business Loan Program
- (504) Certified Development Companies
- Disaster Assistance
- Small Business Investment Companies

Social Security Administration
- Old Age and Survivors' Insurance
- Disability Insurance
- Supplemental Security Income Program

[9] Part 3 C2i Page 19 Issuance of Part III to OMB Circular A-123, Appendix C

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

SMDL# 10-021
ACA# 10

October 1, 2010

Re: Recovery Audit Contractors (RACs) for Medicaid

Dear State Medicaid Director:

This letter is part of a series of letters intended to provide preliminary guidance on the implementation of the Affordable Care Act (P. L. 111-148). Specifically, this letter provides initial guidance on section 6411 of the Affordable Care Act, *Expansion of the Recovery Audit Contractor (RAC) Program*, which amends section 1902(a)(42) of the Social Security Act (the Act) requiring States to establish programs to contract with RACs to audit payments to Medicaid providers by December 31, 2010. The Centers for Medicare & Medicaid Services (CMS) expects States to fully implement their RAC programs by April 1, 2011. As required by statute, CMS will be issuing regulations in this area shortly, providing additional guidance.

State Medicaid RACs

Under Section 1902(a)(42)(B)(i) of the Act, States and Territories are required to establish programs to contract with one or more Medicaid RACs for the purpose of identifying underpayments and overpayments and recouping overpayments under the State plan and under any waiver of the State plan with respect to all services for which payment is made to any entity under such plan or waiver. States must establish these programs in a manner consistent with State law, and generally in the same manner as the Secretary contracts with contingency fee contractors for the Medicare RAC program.

States and Territories will need to submit to CMS a State plan amendment (SPA) through which the State will either attest that it will establish a Medicaid RAC program by December 31, 2010, or indicate that it is seeking an exemption from this provision. State programs to contract with Medicaid RACs are not required to be fully operational by December 31, 2010. States should submit Medicaid RAC SPAs to their respective CMS Regional Offices.

Many States already have experience utilizing contingency-fee-based Third Party Liability recovery contractors. CMS will allow States to maintain flexibility in the design of Medicaid RAC program requirements and the number of entities with which the States elect to contract within the parameters of the statutory requirements. There are a number of operational and policy considerations in State Medicaid RAC program design (some of which will be discussed in greater depth in future rulemaking) such as:

a. Qualifications of Medicaid RACs;
b. Required personnel - for example physicians and certified coders;
c. Contract duration;
d. RAC responsibilities;
e. Timeframes for completion of audits/recoveries;
f. Audit look-back periods;
g. Coordination with other contractors and law enforcement;
h. Appeals; and
i. Contingency fee considerations.

Finally, we note that States may not supplant existing State program integrity or audit initiatives or programs with Medicaid RACs. States must maintain those efforts uninterrupted with respect to funding and activity.

Exceptions

Section 1902(a)(42)(B)(i) of the Act specifies that States shall establish programs under which they contract with Medicaid RACs subject to such exceptions or requirements as the Secretary may require for purposes of a particular State. This provision enables CMS to vary the Medicaid RAC program requirements. For example, CMS may exempt a State from the requirement to pay Medicaid RACs on a contingent basis for collecting overpayments when State law expressly prohibits contingency fee contracting. However, some other fee structure could be required under any such exception (e.g., a flat fee arrangement).

States that otherwise wish to request variances with respect to, or an exception from, Medicaid RAC program requirements will need to submit to CMS requests in writing from the State's Medicaid Director to the CMS/ Medicaid Integrity Group. We will evaluate requests from States in a timely manner. CMS anticipates granting complete Medicaid RAC program exceptions rarely and only under the most compelling of circumstances.

As noted above, all States will need to submit SPAs which either attest that they will establish compliant Medicaid RAC programs, or indicate the reason for not doing so. For States that require a State legislative change granting authority to establish a Medicaid RAC program, the SPA can be submitted indicating that the Medicaid RAC program cannot be established until legislative authority is granted.

Contingency Fees and Other Payment Matters

Sections 1902(a)(42)(B)(ii)(I) and (II) of the Act provide that payments to Medicaid RACs are to be made only from amounts "recovered" on a contingent basis for collecting overpayments and in amounts specified by the State for identifying underpayments. CMS will not dictate contingency fee rates, but will establish a maximum contingency rate for which Federal Financial participation (FFP) will be available. This rate will be the highest contingency fee rate that is paid by CMS under the Medicare RAC program.

Currently, the four Medicare RAC contracts have an established period of performance of up to five years, beginning in 2009. The highest contingency fee rate is 12.5 percent. To make States aware of future Medicaid RAC contingency fee cap amounts, we expect to publish in a *Federal Register* notice, no later than December 31, 2013, the highest Medicare RAC contingency fee rate. This rate will apply to FFP availability for any Medicaid RAC contracts with a period of performance beginning on or after July 1, 2014. The established cap would be in place based on the period of performance of the Medicare RAC contracts. A State that determines that it must pay a contingency rate above CMS' ceiling rate (for example, in order to attract any qualified Medicaid RAC applicants) may request a waiver from CMS, or may elect to pay the differential amount between the ceiling and amount paid solely from State funds.

Contingency fee rates for identifying and collecting overpayments should be reasonable and determined by each State, taking into account factors including, but not limited to, the level of effort to be performed by the RAC, the size of the State's Medicaid population, the nature of the State's Medicaid health care delivery system, and the number of Medicaid RACs engaged. A State may pay Medicaid RACs on a contingency fee or flat fee basis for identifying underpayments and the percentage or amount may vary based on factors such as the amount of the identified underpayment. Whichever methodology a State employs, it should be appropriately structured to incentivize the Medicaid RAC to identify underpayments.

A State must refund the Federal Medical Assistance Percentage (FMAP) share of the net amount of overpayment recoveries after deducting the fees paid to Medicaid RACs. In other words, a State must take a Medicaid RAC's fee payments "off the top" before calculating the FMAP share of the overpayment recovery owed CMS. Overpayments are to be reported on the amount remaining after the fees are paid to the Medicaid RAC. This treatment of the fees and expenditures is linked directly to the specific statutory language implementing the Medicaid RAC requirements. It does not apply to any other provisions of Medicaid overpayment recoveries. Section 1902(a)(42)(B)(ii)(IV)(aa) of the Act also provides that amounts spent by a State to carry out the administration of the program are to be reimbursed at the 50 percent administrative claiming rate. CMS will share in States' expenditures through both the contingency fee with respect to payments to the Medicaid RACs and the administrative match for qualified administrative costs associated with the State's implementation and oversight of the Medicaid RAC program.

The total fees paid to a Medicaid RAC include both the amounts associated with (1) identifying and recovering overpayments, and (2) identifying underpayments. Due to the statutory limitations, total fees must not exceed the amounts of overpayments collected. We do not anticipate this will be a problem for States. Our experience with Medicare RAC contractors is that overpayment recoveries exceed underpayment identification by more than a 9:1 ratio. Therefore, a State will not need to maintain a reserve of recovered overpayments to fund RAC costs associated with identifying underpayments. However, the State must maintain an accounting of amounts recovered and paid. The State must also ensure that it does not pay in total Medicaid RAC fees more than the total amount of overpayments collected.

Because of the limitations placed on FFP by Section 1108(g) of the Act, Territories must assess the feasibility of implementing and funding Medicaid RACs in their jurisdiction. CMS will provide technical assistance to the Territories on how to implement the provisions in Sections 1902(a)(42)(B)(ii)(I), (II), and (IV) of the Act in their locality. CMS is encouraging the Territories to review the requirements of these provisions including regulations, when published, and contact the New York or San Francisco Regional Office to work on submitting a SPA or requesting an exception.

Appeals

Section 1902(a)(42)(B)(ii)(III) of the Act requires States to have an adequate process for entities to appeal any adverse decisions made by the Medicaid RACs. Each State has existing administrative appeals processes with respect to audits of Medicaid providers. So long as States are able to accommodate Medicaid RAC appeals within their existing Medicaid provider appeal structure, CMS is not requiring States to adopt a new administrative review infrastructure to conduct Medicaid RAC appeals.

Reporting

States will be required to report to CMS their contingency fee rates, along with other Medicaid RAC contract metrics such as the number of audits conducted, recovery amounts, number of cases referred for potential fraud, contract periods of performance, contractors' names, and other factors such as whether a State has implemented provider or service-specific Medicaid RACs. States will report certain elements of this information via the quarterly Form CMS-64, and other information via separate data reporting forms CMS will require.

Coordination

Section 1902(a)(42)(B)(ii)(IV)(cc) of the Act requires that CMS ensure that States and their Medicaid RACs coordinate their recovery audit efforts with other entities. These entities include contractors or entities performing audits of entities receiving Medicaid payments, as well as with Federal and State law enforcement entities including the U.S. Department of Justice, (including, without limitation, the Federal Bureau of Investigation), the Department of Health and Human Services' Office of Inspector General, State Medicaid Fraud Control Units (MFCUs), and State Surveillance and Utilization Review Units. We will work systematically, both internally and with States, to minimize the likelihood of overlapping audits.

States should ensure that contracts with Medicaid RACs provide that any indication of Medicaid (or other health care) fraud or abuse discerned by the Medicaid RACs will be referred timely either to the State MFCU or directly to an appropriate law enforcement organization. Likewise, States must take affirmative steps to ensure that Medicaid RACs do not duplicate or compromise the efforts of other contractors, entities or agencies that may be undertaking a fraud and abuse investigation. Such coordination should be undertaken in advance of any audit by a Medicaid RAC, and may be accomplished by negotiating a memorandum of understanding or reaching

another agreement between the Medicaid RAC and other Federal and State contractors or entities performing Medicaid audits, as well as the aforementioned law enforcement agencies. CMS expects that States will also provide ongoing information on the nature and direction of their respective Medicaid RAC activities. Moreover, CMS will issue supplemental guidance regarding the interface between Medicaid RACs and CMS' Medicaid Integrity Contractors at a later date.

Section 6411(a)(2)(A) of the Affordable Care Act requires CMS to coordinate the expansion of the RAC program to Medicaid with the States, particularly with respect to States that enter into contracts with Medicaid RACs prior to December 31, 2010. CMS will provide technical assistance and support to States to ensure these programs are compliant with Medicaid RAC program requirements, and will provide continuing guidance through the CMS Medicaid Program Integrity Technical Advisory Group.

Enclosed with this letter is a draft SPA preprint form in which States may attest to the implementation of the Medicaid RAC program, or indicate that the State does not intend to operate a program in accordance with the statutory requirements of Section 6411 of the Affordable Care Act, along with its reason(s) for not doing so. Additionally, the draft preprint requires States to attest that they are in compliance with the provisions of the Medicaid RAC program and, where appropriate, provide additional program details. Currently, CMS is seeking Office of Management and Budget approval to utilize the preprint. Accordingly, this form is recommended for use by States, but not required, until the Paperwork Reduction Act process is completed.

We look forward to our continuing work together as we implement this important legislation. If you have questions regarding the information presented in this letter, please contact Ms. Angela Brice-Smith, Director of the Medicaid Integrity Group, Center for Program Integrity, at Angela.Brice-Smith@cms.hhs.gov or 410-786-4340.

Sincerely,

/s/

Peter Budetti, M.D., J.D.
Deputy Administrator & Director
Center for Program Integrity

/s/

Cindy Mann
Deputy Administrator & Director
Center for Medicaid, CHIP and Survey & Certification

Enclosure
cc:

CMS Regional Administrators

CMS Associate Regional Administrators
Division of Medicaid and Children's Health

State Program Integrity Directors

Richard Fenton
Acting Director
Health Services Division
American Public Human Services Association

Joy Wilson
Director, Health Committee
National Conference of State Legislatures

Matt Salo
Director of Health Legislation
National Governor's Association

Carol Steckel
President
National Association of Medicaid Directors

Debra Miller
Director of Health Policy
Council of State Governments

Christine Evans, M.P.H.
Director, Government Relations
Association of State and Territorial Health Officials/

Alan Weil, J.D., M.P.P.
Executive Director
National Academy for State Health Policy

DRAFT – Medicaid State Plan Preprint Page -- DRAFT

Revision: State _____

PROPOSED SECTION 4 - GENERAL PROGRAM ADMINISTRATION

4.5 Medicaid Recovery Audit Contractor Program

Citation	
Section 1902(a)(42)(B)(i) of the Social Security Act	_____The State has established a program under which it will contract with one or more recovery audit contractors (RACs) for the purpose of identifying underpayments and overpayments of Medicaid claims under the State plan and under any waiver of the State plan. ____The State is seeking an exception to establishing such program for the following reasons:
Section 1902(a)(42)(B)(ii)(I) of the Act	_____The State/Medicaid agency has contracts of the type(s) listed in section 1902(a)(42)(B)(ii)(I) of the Act. All contracts meet the requirements of the statute. RACs are consistent with the statute. Place a check mark to provide assurance of the following: _____The State will make payments to the RAC(s) only from amounts recovered. _____The State will make payments to the RAC(s) on a contingent basis for collecting overpayments.
Section 1902 (a)(42)(B)(ii)(II)(aa) of the Act	The following payment methodology shall be used to determine State payments to Medicaid RACs for identification and recovery of overpayments (e.g., the percentage of the contingency fee): _____ The State attests that the contingency fee rate paid to the Medicaid RAC will not exceed the highest rate paid to Medicare RACs, as published in the Federal Register. _____ The State attests that the contingency fee rate paid to the Medicaid RAC will exceed the highest rate paid to Medicare RACs, as published in the Federal Register. The State will only submit for FFP up to the amount equivalent to that published rate.

	_____The contingency fee rate paid to the Medicaid RAC that will exceed the highest rate paid to Medicare RACs, as published in the Federal Register. The State will submit a justification for that rate and will submit for FFP for the full amount of the contingency fee.
Section 1902 (a)(42)(B)(ii)(II)(bb) of the Act	_____The following payment methodology shall be used to determine State payments to Medicaid RACs for the identification of underpayments (e.g., amount of flat fee, the percentage of the contingency fee):
Section 1902 (a)(42)(B)(ii)(III) of the Act	_____ The State has an adequate appeal process in place for entities to appeal any adverse determination made by the Medicaid RAC(s).
Section 1902 (a)(42)(B)(ii)(IV)(aa) of the Act	_____ The State assures that the amounts expended by the State to carry out the program will be amounts expended as necessary for the proper and efficient administration of the State plan or a waiver of the plan.
Section 1902(a)(42)(B)(ii)(IV(bb) of the Act	_____ The State assures that the recovered amounts will be subject to a State's quarterly expenditure estimates and funding of the State's share.
Section 1902 (a)(42)(B)(ii)(IV)(cc) Of the Act	_____ Efforts of the Medicaid RAC(s) will be coordinated with other contractors or entities performing audits of entities receiving payments under the State plan or waiver in the State, and/or State and Federal law enforcement entities and the CMS Medicaid Integrity Program.

Testimony 3

STATE AUDITOR
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TESTIMONY BEFORE THE INDUSTRY, BUSINESS AND LABOR COMMITTEE

HB 1448

Presented by Robert R. Peterson

Good afternoon Mr. Chairman and members of the Industry, Business and Labor Committee

I'm here to testify in opposition to HB 1448. I have listed 8 bullet points below detailing our concerns.

1. The feasibility of meeting the contract deadline listed on page 1, line 8;
2. No process included in legislation relating to appropriate payment of contractor;
3. Authority to allow a contractor to keep a percentage of recovery of improper payments with federal funds
4. Authority to collect alleged improper payments;
5. Likelihood of CPA firms responding to the Request for Proposal (RFP);
6. The 30 day deadline relating to determination of whether the contractor may pursue the improper payment.
7. Placement of this responsibility within the State Auditor's Office.
8. Are "special funds" included?

1. Inability to Meet the Contract Deadline

My office will not be able to meet the July 1, 2011 deadline for a contract to be in place (page 1, line 8). The RFP for such a large undertaking would take an extensive time to prepare. Potential vendors for this type of work would most likely be limited to large national CPA firms since the term "audit" is used.

The Attorney General's Office has issued a formal opinion that indicates if the term "audit" is used in law the work must be done by a CPA. These CPA firms would have to be given a reasonable amount of time in order to review the RFP and prepare a response including information on which the bid could be evaluated. For purposes of reference, the RFP for the WSI performance evaluation is a much smaller project and the firms are provided 6-8 weeks to respond.

If the bill were passed with an emergency measure by March 31, 2011 this would only provide us 3 months to complete an RFP, circulate it nationally, obtain bids, evaluate these bids and get a contract signed. This is not a realistic timeframe.

2. No Process Included in Legislation Relating to Appropriate Payment of Contractor

This bill does not establish a process for the appropriate payment to the contractor. There is no fund established to deposit the recovered payments into and no appropriation authority is established for the payment of the contractor's fee (a percentage of recovered improper payments). All of the recovered funds would have to be deposited to the credit of the state and the contractor would then have to be paid. The agency that originally made the improper payment could receive the entire recovered payment and make the payment to the contractor. However this also presents concerns depending on the source of the original payment (federal /state general fund etc) and whether the transaction and subsequent recover of the improper payment crossed biennial lines.

Article 10, Section 12 of North Dakota's Constitution requires all public monies to be deposited to the credit of the state. A Supreme Court decision (Billey vs Stockman's Association) makes it unallowable to "net" the transaction and allow the contractor to keep their portion of the recovered improper payment. All public monies first have to be deposited to the credit of the state and then payment made to the contractor.

3. Authority to Allow a Contractor to Keep a Percentage of Recovered Improper Payments of Federal Funds

The legislation includes federal funds as part of this process and there is a concern as to whether the State of North Dakota has the authority to allow a contractor to keep a percentage of federal funds relating to the recovery of improper payments. My office has audited federal funds received by the State of North Dakota for over two decades and if there are improper uses of federal funds all of the monies are typically returned to the federal government.

We have received conflicting information relating to this issue during our research. However this issue would have to be resolved in writing from the federal government prior to bidding a contract.

In discussing this legislation with a federal representative he indicated that generally contingency payments are not an allowable cost for federal programs. In addition he indicated that the contractor's payments are based on the recovery of improper payments, however the federal government will want its share of any improper payments whether or not they are recovered. Thus it would be possible for the State of

North Dakota to end up with a liability to the federal government while not recovering the improper payment.

For example, generally speaking the state's Federal Medical Assistance Percentage (FMAP) rate is approximately 64%, meaning the federal government assumes 64% of the costs of certain programs. If the contractor found a $1 million payment in one of these programs that was improper, whether the funds were recovered or not the federal government would want it's share ($640,000 in this case) from the State of North Dakota. So if the third party that received this payment was either insolvent or would become insolvent if the amount were repaid, it's conceivable that the state would receive nothing but would owe the federal government the $640,000.

4. Authority to Collect the Alleged Improper Payments

On page 2, starting on line 3 the bill requires that the contract "Must allow the consultant or the state to pursue recovery of any improper payments detected by the consultant...." I have a concern about North Dakota's legal authority to allow a contracted vendor to recover alleged improper payments from those that received payment (which would include private entities).

The entities who received alleged improper payments might disagree with that assessment and could resist collection efforts. There could be instances where this would involve some sort of legal action and it isn't clear as to who pays for the legal fees incurred by the contractor.

If the State of North Dakota is the entity that would pursue recovery of the alleged improper payments, it appears the Attorney General would be responsible and might need additional staff.

5. Likelihood of CPA Firms Responding to Request for Proposal

I don't know how many CPA firms will respond to the proposal due to concerns with 100% of their charges being contingent upon the recovery of improper payments. Audit billing rates for experienced auditors in national CPA firms would likely be a minimum of $200 per hour and it's unlikely that most firms will commit to a project that theoretically could result in a substantially smaller amount of revenue for the firm.

In addition the legislation indicates that the contingent fee is based on the amount of recovery of improper payments. In many cases the time period between a determination that a payment was improper and the actual collection may be extensive due to legal determinations and procedures or a final decision from a federal entity.

6. 30 Day Deadline Relating to Determination of Whether Contractor May Pursue Improper Payment

On page 2 starting with line 28, the bill establishes a 30 day deadline during which the State Auditor is to determine if the contractor is authorized to pursue the improper payment for recovery. The bill goes on to say this determination is to be based on "reasonable unlikelihood of recovering the improper payment".

My first concern is being able to meet this requirement for all alleged improper payments within 30 days. If the contractor's fee is based solely on the collection of improper payments the contractor could submit as many potential improper payments as possible. Even if the Auditor's Office has 2 to 3 FTEs to review hundreds or thousands of payments, it would be impossible to meet the 30 day deadline.

The next question is what basis we have to make a determination of whether the alleged improper payment is worth pursuing. My office would need substantial evidence to accompany each alleged improper payment to determine whether the contractor made an error or whether it is likely that the amount will be collected. In cases where a vendor disputed the payment as improper, there may be legal determinations that need to be made by the Attorney General's Office.

7. Placement of This Responsibility in the State Auditor's Office

Our research indicates that most states do not have a recovery audit program in place. It appears the states of Colorado, Texas, Missouri and Virginia are examples of states that have (or had) recovery programs in place. The states that have such a program have generally located it either in the Office of Management and Budget or the Procurement agency for the state. In none of these states was the program located in the state audit organization.

The federal government has recently implemented the Improper Payment and Recovery Act of 2010 which requires **federal** agencies to conduct payment recapture audits (recovery audits). However this act does not pertain to state governments.

Our research indicates Texas and Virginia have had disappointing results in their recovery audit process. In Texas the contractor looked at more than $57 billion of expenditures and they collected slightly more than $1 million dollars of overpayments (less than 2/1000's of a percent). The state indicated that if the results continue, they are not anticipating renewing the contract.

In Virginia the same is true and that state has since declined to continue the program as a result of lower than expected results (they collected approximately $1 million from the 5 years of expenditures the contractor reviewed).

In discussing this legislation with a federal representative he indicated that his experiences indicate that initially the contractor identifies a payment as improper and the vendor disagrees and appeals the determination. He stated that in many cost recovery programs the success rate of these appeals was 50%. Therefore many of the larger alleged improper payments turned out to be allowable.

8. Are "Special Funds" Included?

Page 1, lines 14-15 indicate "Payments audited may include state or federal funds of any character, including grants." It is unclear whether this would include special funds which represent a significant portion (approximately 1/3) of the state's budget. If the bill's sponsors intended for these special funds to be included, we have concerns over the legal authority to allow a contractor to keep a percentage of the improper payments recovered.

For example, if a contractor found improper payments from monies collected for hunting and fishing licenses or driver's license fees the question is whether state law would allow the contractor to legally retain a percentage of the amount recovered.

SUMMARY

This legislation as written is difficult if not impossible to implement. As I indicated the deadlines in the bill will not be met. We also have received conflicting information as to whether or not the federal government regards contingency payments as allowable costs. Therefore the federal government may not permit North Dakota to authorize a contractor to retain a percentage of improper federal payments. Instead the federal agencies will want to receive all reimbursements of such payments. If "special funds" are included, we have a concern relating to those funds.

As our fiscal note shows, our research indicates that we would need 2 additional FTE in the first biennium and another FTE in the second biennium for a total of 3 in order to implement the legislation. We don't believe this will result in the most effective and efficient use of those FTE.

The legislation does not establish a clear process for how the payments are to be made to the contractor. The state's constitution and the cited Supreme Court decision do not permit "netting" of the improper payment recovered with the contractor's contingency fee. Therefore the entire recovery of an improper payment would need to be deposited to the credit of the state and then payment made to the contractor. Depending on the source of the original payment this could present additional challenges. This is also true if the original payment was made in one biennium and the recovery was made in a subsequent biennium.

The legislation could result in an increased workload for the Attorney General's Office for the actual collection process of the alleged improper payments. In addition there could be legal proceedings that will occur when a vendor disagrees with the designation of a payment as "improper" which result in legal fees.

Our research indicates that other states who have undertaken recovery audits have had mixed results and none of them have located the responsibility within their audit organization.

Therefore I would request that the committee give this bill a "do not pass" recommendation.

Mr. Chairman that concludes my testimony.

Testimony 1

Testimony on HB 1448
House Industry, Business & Labor Committee
February 2, 2011

Good Morning Chairman Keiser and members of the House Industry, Business and Labor Committee. My name is Shelly Peterson, President of the North Dakota Long Term Care Association (NDLTCA). Our Association represents 163 long term care facilities in North Dakota. They are dedicated to continuous improvement in the delivery of professional and compassionate care provided by over 14,000 caring employees to more than 16,000 of our states frail, elderly and disabled citizen who live in nursing facilities, basic care facilities and assisted living residences.

We appreciate the opportunity to testify on HB 1448 and request that you give it a unanimous DO NOT PASS vote.

Today, our nursing facility and basic care members are currently subject to audits by the state's routine program integrity audits, CMS's Medicaid Integrity Audits, as well as audits conducted by other state and federal entities. Further CMS is mandated by the Affordable Care Act to impose yet another layer of Medicaid program auditing.

Attached please find two handouts. One is dated January 10, 2011 addressed to CMS Administrator Berwick from the American Health Care Association, our national affiliate. The letter outlines our concerns with the proposed rule, Medicaid Program; Recovery Audit Contractors, Proposed Rule, 75 Federal Register 69037 mandated by the Affordable Care Act.

The second attachment is a summary of the Federal Government Medicare/ Medicaid Integrity Programs and Fraud Investigations affecting long-term care providers.

The handout was put together to help facilities fully understand the numerous Medicare and Medicaid Integrity Programs aimed at detecting and preventing fraud.

Please take a little time and review the handouts. In doing so, you will be overwhelmed with the complexity of the "fraud detection" programs currently impacting long term care providers.

The imposition of an additional state audit program outlined in HB 1448 will result in duplicative auditing, excessive administrative and processing costs and increased disruption to the operation of providers and the provision of care.

On 01/31/11 OIG posted a special training, announcing six free OIG compliance training sessions in Houston, Tampa, Kansas City, Baton Rouge, Denver and Washington from February – May 2011. They announced the training as an opportunity for providers to hear more about the OIG's plans for promulgating the final rule that we're expecting under the Patient Protection and Affordable Care Act (PPACA) from HHS, OIG. The PPACA requires all nursing facilities to develop and implement an effective compliance and ethics program by 2013.

Last year, our Association provided 33 different training sessions, most of them necessary because of new federal regulations. In those 33 different training sessions, we trained just under 4,000 individuals. Facilities are spending a tremendous amount of money on training; they want to be in compliance with all regulations.

NDLTCA and our members are as concerned as you are in the matter of detecting fraud. It does damage to government programs, such as Medicare and Medicaid, cost to the federal and state governments and harm to good providers, beneficiaries and tax payers.

Given we already have numerous audit recovery programs and more coming under Health Care Reform; please do not pass HB 1448.

Thank you for considering our perspective and position. I would be happy to address any question.

Shelly Peterson, President
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January 10, 2011

Donald M. Berwick, MD
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health & Human Services
200 Independence Avenue, SW
Room 314-G
Washington, DC 20201

Re: CMS-6034-P: Comments on *Medicaid Program; Recovery Audit Contactors, Proposed Rule*,75 Federal Register 69037 (November 10, 2010)

The American Health Care Association (AHCA) appreciates the opportunity to comment on the proposed rule, *Medicaid Program; Recovery Audit Contactors, Proposed Rule*, 75 Federal Register 69037 (November 10, 2010).

AHCA is the nation's leading long term care organization. AHCA and our membership of nearly 11,000 non-profit and proprietary facilities are dedicated to continuous improvement in the delivery of professional and compassionate care provided daily by millions of caring employees to more than 1.5 million of our nation's frail, elderly, and disabled citizens who live in nursing facilities, assisted living residences, subacute centers, and homes for persons with mental retardation and developmental disabilities.

In the preamble to the Proposed Rule, the Centers for Medicare and Medicaid Services (CMS) provides background information on Medicaid auditing programs. It explicitly recognizes that providers are currently subject to audits by the states' routine program integrity audits, CMS' Medicaid Integrity Contractors' audits, as well as audits conducted by other State and Federal entities. We understand that CMS is mandated by the Affordable Care Act (ACA) to impose yet another layer of Medicaid program auditing.

Thus, while we provide below our recommendations on various facets of this program, one of AHCA's chief concerns is that the imposition of an additional audit program will result in duplicative auditing, excessive administrative and processing costs, and increased disruption to the operation of providers and the provision of care. We, therefore, urge CMS to use the authority granted to it to exempt states that have current integrity efforts underway from having to establish a Medicaid Recovery Audit Contractor (RAC) Program.

Our second major concern is that the lessons learned from the Medicare RAC Demonstration and the improvements in that program provided by the permanent RAC scope of work will not be applied to this Medicaid RAC program. AHCA was at the forefront of the effort to reverse the procedural and substantive problems with the Medicare RAC demonstration contractors and to insert into the permanent scope of work reasonable and necessary safeguards for providers.

We are, therefore, asking CMS to apply as many of the Medicare RAC improvements as possible to the Medicaid RACs. Every opportunity should be taken to streamline processes and practices that achieve appropriate reimbursement auditing while avoiding any overly aggressive behavior by the Medicaid RACs.

Recommendation Summary

As indicated in the discussion above and in more detail below, our key recommendations to CMS are as follows:

- Exempt states from having to develop Medicaid RACs whenever possible;

- Provide explicit instructions for the coordination of all reviewing entities
  - Prevent RACs from auditing those claims that **have previously undergone** some kind of complex review by another Medicaid claims contractor.
  - Prohibit Medicaid RACs from conducting audits on claims that **are under review** by a MIP contractor or other entity.
  - Require states to have a data warehouse that contains information on which claims are unavailable for Medicaid RAC review.

- Not require that Medicaid RACs be paid with contingency fees if the state does not wish (not just when a state statute forbids the use of contingency fees);
  - Require that if RACs are paid with contingency fees in the state, those fees would be paid after all appeals of a claim overpayment determination are completed.
  - Provide extremely tight monitoring of Medicaid RAC review, auditing behavior, and denial patterns, if CMS interprets Section 6411 of the ACA to mandate contingency fees regarding overpayments;

- Review the state appeals processes to determine and ensure their reasonableness. At a minimum, CMS should very closely monitor the different appeals systems and remain alert to the pleas of providers if unreasonableness, inconsistency and unnecessary complexity overwhelm provider efforts at compliance;
  - Require or recommend the addition of a "Discussion Period" in state appeals systems for Medicaid RACs and the providers to discuss a denial before it is appealed in order to avoid the costly and burdensome appeals process wherever possible;
  - Require or strongly recommend that, states require RACs to document "good cause" before the RAC reviews a claim, and establish minimum requirements for the documentation of "good cause." We also urge CMS to monitor Medicaid RACs' compliance with "good cause" documentation requirements.
  - Prohibit, or at the very least impose limitations on, extrapolation in the Medicaid RAC program. We have serious concerns about allowing Medicaid RACs with little to no Medicaid audit experience, much less statistical training, to

extrapolate from a sample of Medicaid claims rather than review each one. The temptation will simply be too great for Medicaid RACs to use extrapolation as an easy way to reap huge contingency fees.

- Require states to institute an approval process for new issues similar to that for Medicare RACs, and to post those issues on the Internet;

- Require each Medicaid RAC to hire a physician Medical Director to oversee the medical record review process, assist nurses, therapists, and certified coders upon request, and manage quality assurance procedures. Medicaid RAC staff should be adequate in number and specialty according to the nature of Medicaid issues.

- Mandate that a "lookback" audit period be no greater than 3 years;

- Apply the Medicare RAC improvements to the Medicare RAC program including the actions provided in Section VII of these comments.

Discussion

I. Exceptions From Medicaid RAC Programs (42 §455.516)

CMS proposes at 42 CFR § 455.516, *Exceptions from Medicaid RAC Programs*, that "[a] State may seek to be excepted from some or all Medicaid RAC contracting requirements by submitting to CMS a written justification for the request and getting CMS approval."

In the preamble discussion to the Proposed Rule, CMS provides examples of exceptions to states implementing a Medicaid RAC program. Two of these examples pertain to exceptions from one or more aspects of the program such as providing an exception to the state from paying Medicaid RACs on a contingency basis. The third example is that of a complete exception from the program – that is, CMS has the authority to except a state from implementing all of the requirements of the Medicaid RAC program. CMS makes clear that it anticipates granting complete Medicaid RAC program exceptions "rarely," and only under the most compelling of circumstances.

Section 6411(a) of the Affordable Care Act specifies that states shall establish programs under which they contract with Medicaid RACs subject to such exceptions or requirements as the Secretary may require for purposes of a particular state. In the letter to State Medicaid Directors, CMS indicates that this provision provides CMS with broad authority to grant exceptions. We recommend that CMS not take the position, as it has, that granting complete Medicaid RAC program exceptions will be granted "rarely" and only under the most compelling of circumstances as stated in the preamble. Rather, it is our recommendation that complete exceptions should be consistently granted under certain specified conditions.

For example, a complete exception of the Medicaid RAC requirements should be granted to a state that can demonstrate that it has already completed a comprehensive program of Medicaid Integrity program audits or is in the process of completing such. It is our understanding that there are several states that are in this situation. Some of these states may have experienced audits under their own state initiative only to be re-audited under a CMS state Medicaid initiative.

Granting a complete exception to all of the requirements of the Medicaid RAC program will accomplish at a minimum two important goals: First, it will protect the state from further expenses for a program of Medicaid audits that have been completed in a manner satisfactory to the state Medicaid integrity offices and/or to the CMS Medicaid Integrity Program. Second, it will relieve providers of the expense and disruption of a second or third round of Medicaid integrity audits, which, logic dictates, would have seriously diminishing marginal returns and minimal, if any, real value. Thus, multiple audits, many inescapably redundant, is a serious resource issue for providers. The amount of resources that any provider has for dealing with such intrusive and intense inquiries is limited and is taken from the areas of operation where quality must be the highest priority.

Lastly, we question CMS' assertion that the states have no option to choose either a Medicaid Integrity Contractor (MIC) or a Medicaid RAC. CMS identifies Medicaid RACs as a "supplemental approach"[1] to Medicaid program integrity efforts already underway to ensure that states make proper payments to providers and that Medicaid RACs do not replace any existing state program integrity or audit initiatives or programs. CMS directs that "[s]tates must maintain their existing program integrity efforts uninterrupted with respect to levels of funding and activity."[2]

If the ACA, the Medicaid statute, or other applicable federal or state law does not dictate such retention, the states should be able to use the Medicaid RAC audit to replace or consolidate existing program integrity and audit initiatives in order to be more fiscally responsible and cost-effective in their approach to fraud, waste and abuse. The biggest resource loss to a state would be to require states to maintain MICs and Medicaid RACs.

II. Coordination (42 CFR § 455.508 and 42 CFR §455.510)

Supporting the argument for CMS granting complete exceptions where appropriate is CMS' acknowledgment of the problems created by the existence of multiple auditing entities. CMS acknowledges the myriad of entities that audit: these entities include but are not limited to the HHS–OIG, the U.S. Department of Justice, including the Federal Bureau of Investigation, State Medicaid Fraud Control Units (MFCUs), State routine program integrity audits, State Surveillance and Utilization Review Units, and CMS Medicaid Integrity Contractors' audits.[3]

CMS' fix, however, for duplicative and redundant audits is vague and inadequate. Under 42 CFR § 455.508 it simply requires the auditing entity to coordinate its efforts with the state as well as all of the above referenced auditing entities. As for states, it gives them "the discretion to coordinate with Medicaid RACs regarding the recoupment of overpayments." While in the preamble text it appears to clarify that this "discretion" pertains solely to the manner in which states will coordinate with Medicaid RACs' regarding recoupment of overpayments, there is no further elaboration.[4]

The preamble discussion in the Proposed Rule does not improve or clarify matters. Unfortunately what CMS seems to be focusing on is not the plight of providers subject to the jurisdiction of all these agencies and entities but rather the success of the various auditing entities – and the

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[1] 75 Federal Register 69037, at 69039, 11/10/2010.

[2] Ibid.

[3] 75 Federal Register at 69042.

[4] 75 Federal Register at 69040.

necessity of not stepping on each other's toes. CMS recognizes that coordination may be a challenge because of the number of other agencies or entities that may be conducting audits, but stresses that states are obligated to ensure that Medicaid RACs do not duplicate or compromise the efforts of other entities performing audits, including law enforcement that may be investigating fraud and abuse. CMS advises that one approach to ensure coordination is for states to establish Memoranda of Understanding (MOUs) with their State Medicaid Fraud Control Units (MFCUs), program integrity units or other law enforcement agencies.

Thus the net result of the proposed rule itself and the preamble text is complete vagueness on what essentially constitutes "coordination." We urge that this omission be rectified. Improvements should include preventing RACs from auditing those claims that **have previously undergone** some kind of complex review by another Medicaid claims contractor. We also urge CMS to revise the final rule to specifically prohibit Medicaid RACs from conducting audits on claims that **are under review** by a MIP contractor or other entity.

As with the Medicare RAC program, all Medicaid auditors and RACs should be required to use a RAC data warehouse to identify any claims that are being reviewed by the RAC or other Medicaid auditor. Even in the demonstration phase, CMS had established a data warehouse that contained information on which claims were unavailable for RAC review.[5] **The same should be done for the Medicaid RAC program**. Many states have already contracted privately with data mining companies, such as CDR in South Carolina and HMS in North Carolina, on a contingency fee basis. There is only so much information and data that can be audited in a long term care facility and now it appears that the same data could be audited three or more times with a great probability of duplication. This is extremely burdensome on long term care providers.

We ask that CMS take a long look at the multiplicity of auditing entities and the impact on providers and try to achieve some guaranteed streamlining and priorities before the Medicaid RACs begin their work. Again, states should be required to have a data warehouse that contains information on which claims are unavailable for Medicaid RAC review.

III. Payments to RACs – Contingency Fees (42 CFR §455.510)

We are fundamentally opposed to contingency fees in the area of Medicare and Medicaid auditing. As we saw in the Medicare RAC demonstration, this type of payment has the overwhelming tendency to push auditors "to take a chance" and inappropriately challenge claims. The perverse incentives and resulting abuses that stem from contingency fees have long been evident in the tactics employed by private collection agencies, for example.

For the provider, this type of auditing behavior is devastating. In our numerous pleas to CMS regarding the demonstration, we highlighted the horrific costs incurred by providers in fighting denials, particularly in California, and the extremely high percentage of denials overturned, i.e., an appeal could be won by the provider, but tremendous cost had been incurred and the damage was done in terms of reputation, reallocation of resources, etc.

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[5] *Medicare Recovery Audit Contracting, Weaknesses Remain in Addressing Vulnerabilities to Improper Payments, Although Improvements Made to Contractor Oversight*, GAO-10-143, March 2010.

We must be concerned about the inherent bias of contingency fee contractors. CMS had indicated in the recent Letter to State Medicaid Directors[6] that it might exempt a state from the requirement to pay Medicaid RACs on a contingent basis for collecting overpayments when state law expressly prohibits contingency fee contracting. We believe that CMS might have the authority to grant exceptions to the contingency fee payment method in broad terms, and not only when state law prevents it, as noted in the CMS Letter. However, if CMS reads Section 6411 of the ACA to mandate contingency fees regarding overpayments, then we recommend that the agency provide extremely tight monitoring of Medicaid RAC review, auditing behavior, and denial patterns. We also recommend that the contingency fee not be paid to the Medicaid RAC until the appeal process for the claim overpayment determination has been completed. This will help reduce the incentive for RACs to quickly reach a determination that the claim was overpaid.

In the Proposed Rule, CMS indicates that there is precedent for State Medicaid contingency fee contracts for purposes of recovering Medicaid overpayments subject to third party liability (TPL) requirements and that, in addition, several states currently contract with contingency fee contractors to recover Medicaid overpayments unrelated to TPL. CMS also refers to a memorandum to CMS' Regional Administrators dated November 7, 2002, in which it revised its policy prohibiting Federal financial participation (FFP) for states to pay costs to contingency fee contractors, unrelated to TPL.[7] CMS clarified its policy stating that CMS would allow FFP for contingency fees if the "intent of the contingency fee contract produced Medicaid program savings, not additional expenditures for FFP."[8]

Indeed, the revised policy allows contingency fee payments if the following conditions are met:

> (1) The intent of the contingency fee contract must be to produce savings or recoveries in the Medicaid program;
> (2) the savings upon which the contingency fee payment is based must be adequately defined and the determination of fee payments documented to CMS's satisfaction.[9]

It is clear that CMS is focusing on avoiding the pitfalls to the government regarding contingency fee methodology[10] but nowhere in the Proposed Rule does CMS indicate that it is clearly aware of the abuses to providers, as clearly evidenced in the Medicare RAC Demonstration, by the inherent nature of contingency fee payments.

Again, AHCA recommends that CMS provide extremely tight monitoring of Medicaid RAC review, auditing behavior, and denial patterns.

IV. Medicaid RAC Provider Appeals (42 CFR §455.512)

The ACA requires states to have an adequate process for entities to appeal any adverse decisions made by the Medicaid RACs. Each state has existing administrative appeals processes with respect to audits of Medicaid providers. CMS indicates that so long as states are able to

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[6] Letter from Peter Budetti, MD, JD and Cindy Mann to State Medicaid Directors, Recovery Audit Contractors (RACs) for Medicaid, SMDL# 10-021, ACA# 10, 10/1/2010.

[7] 75 Federal Register at 69039.

[8] Ibid.

[9] Ibid.

[10] That there are serious pitfalls for government is documented in *Medicaid Financing, States Use of Contingency-Fee Consultants to Maximize Federal Reimbursements Highlights Need for Improved Federal Oversight*, Report to the Chairman, Committee on Finance, U.S. Senate, GAO-05-748, June, 2005.

accommodate Medicaid RAC appeals within their existing Medicaid provider appeal structure, CMS is not requiring states to adopt a new administrative review infrastructure to conduct Medicaid RAC appeals.

While it is tempting to call for a uniform appeals process, it would appear that the best approach is to permit state specific appeals processes given certain circumstances. The processes should be reviewed if possible by CMS to determine their reasonableness. The time frames for filing and decisions should allow providers to more easily keep track of all the levels of reconsideration and review and timely filing dates for all the levels. At a minimum, CMS should very closely monitor the different appeals systems and remain alert to the pleas of providers if unreasonableness, inconsistency and unnecessary complexity overwhelm provider efforts at compliance.

1. Discussion Period

We urge that CMS require or recommend the addition of a "discussion period" in state appeals systems. In designing the permanent Medicare RAC program, CMS has provided a "discussion period" for RACs and the providers to discuss the denial before it is appealed in order to avoid the costly and burdensome appeals process wherever possible. This "discussion period" is intended to provide an opportunity for RACs and providers to share information to confirm the accuracy of the RAC's findings.

The "discussion period" has the potential to reduce the number of inappropriate denials in the Medicare RAC program. The Medicaid RAC program should likewise consider requiring if possible or recommending the addition of a "discussion period" in state appeals systems. State Medicaid agencies should participate in the discussion period when issues are raised regarding RAC interpretation of the state plan and other Medicaid payment policies. CMS and the states should also monitor how Medicaid RACs observe the discussion period so that it is not treated as a mere formality but, rather, a meaningful opportunity for the parties to address any errors in the determination.

2. Limitation on Look-back Period

In addition, the "look-back period" under the Medicaid RAC program should be uniform across states and no greater than 3 years. Although each state may have its own appeal process, the "look-back" period should be consistent among all states as some states do not currently have clear limitation periods. We believe that the best approach would be to have a national standard similar to that of the Medicare RACs that "does not exceed" 3 years.

3. Good Cause for Reviewing a Claim

Another appeals related issue that could present problems is the concept of "good cause." In the Proposed Rule, CMS notes that states may consider establishing requirements regarding the documentation of "good cause" by the Medicaid RACs to review a claim.[11] CMS explains that the OIG had identified to CMS a number of concerns and processes needing improvement in the Medicare RAC program and that, for example, Medicare RACs were reportedly inconsistent in documenting their "good cause" for reviewing a claim. AHCA had brought this problem to the attention of both CMS and the OIG.

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[11] 75 Federal Register at 69040.

In the permanent Medicare program RAC program, CMS directed Medicare RACs to consistently document their "good cause" for reviewing a claim. We believe states should adopt the concept of "good cause" by requiring that Medicaid RACs document "good cause" before auditing the claim.

In the Medicare audit context, "good cause" is defined under 42 CFR 405.986 as: (1) there is new and material evidence that was not available or known at the time of the determination or decision, and may result in a different conclusion; or (2) the evidence that was considered in making the determination or decision clearly shows on its face that an obvious error was made at the time of the determination or decision.

CMS could use the Medicare definition as a floor in its regulations for Medicaid RAC audits. In addition, Medicaid providers should have the right to challenge a lack of "good cause" by Medicaid RACs as an appealable issue. We also urge CMS to monitor the use of "good cause" by Medicaid RACs and establish requirements for "good cause" documentation.

4. Extrapolation

Lastly, while permitted in some auditing programs, we strongly recommend that CMS prohibit the use of extrapolation in the Medicaid RAC program. At the very least, CMS should impose limitations on extrapolation in this program. Our members have found that the use of statistical extrapolation by Medicare contractors is frequently abused, resulting in outsized overpayment demands that impose significant financial and operating distress on long term care providers. Moreover, flaws in the sampling methodology and execution are all too common.

Since these problems occur with Program Safeguard Contractors (PSCs), Zone Program Integrity Contractors (ZPICs) and other contractors that have purportedly been well-trained in such methods, we have serious concerns about allowing Medicaid RACs with little to no Medicaid audit experience, much less statistical training, to extrapolate from a sample of Medicaid claims rather than review each one. The temptation will simply be too great for Medicaid RACs to use extrapolation as an easy way to reap huge contingency fees.

V. Issue Approval Process

We ask that CMS institute an issue approval process similar to that now provided in the permanent RAC program. While Medicaid programs differ in various ways, there is nevertheless, enough commonality to afford some type of approval process that would address the issue, the provider type, the error type and the policy violated. Approved issues should be posted on the Internet.

VI. Required Personnel

As it has done with Medicare RACs, CMS should require each Medicaid RAC to hire a physician Medical Director to oversee the medical record review process, assist nurses, therapists, and certified coders upon request, and manage quality assurance procedures. Medicaid RAC staff should be adequate in number and specialty according to the nature of Medicaid issues.

VII. Actions to Assist Providers

In a recent CMS MLN Matter issuance, CMS provided a list of requirements that have been developed to assist providers in ensuring the timely submission of sufficient documentation to support the services billed.[12] In addition to our comments above, we believe that similar mandates should be placed on the Medicaid RACs, including the following:

- As was done in the permanent Medicare RAC program, Medicaid RACs should be required to enter into a provider education period before beginning claims review so that Medicaid providers in the state understand the state Medicaid RAC program, the requirements of the program, and how to interact with the RAC;
- Medicaid RACs should be required to identify any underpayment determinations and ensure that such underpayments are remitted to providers in a timely fashion. The states and/or CMS should ensure that Medicaid RACs have the systems capability to identify underpayments before they begin auditing claims.
- Medicaid RACs should be required to obtain approval from the state's Medicaid agency to audit new payment issues;
- The number of medical records should be limited;
- The deadlines for submission of medical records must be clearly indicated in ADR letters;
- One additional contact with the provider should be initiated by the Medicaid RAC before issuing a denial for a failure to submit documentation;
- Extension requests must be accepted and reviewed if providers are unable to submit documentation timely;
- Suggested documentation that will assist RACs in adjudicating the claim should be clearly indicated in ADR letter;
- Submission of medical records on CD/DVD or the faxing of medical records should be allowed; and
- CMS should assist the Medicaid RACs is establishing a web-based system similar to the Medicare RACs enabling the Medicaid RACs to
    - Indicate the status of a provider's additional documentation requests on their claim status websites;
    - Provide a web-portal so providers can customize their address and identify an appropriate point of contact to receive ADR letters; and
    - Post all approved issues under review on their websites.

Conclusion

AHCA is as concerned as the government in the matter of rooting out fraud because of the damage it does to government programs such as Medicare and Medicaid, the cost to the federal and state governments, and the financial, operational and emotional costs to good providers and harm to beneficiaries and taxpayers generally.

What we ask for is a reasonable and rational auditing environment and enforcement structure that is based on minimizing the duplication of audit functions, federal and state oversight of Medicaid RAC activities, and transparency with Medicaid providers. We believe that this will enable providers to furnish needed care, continue to improve quality, and develop the strengths and skills

[12] MLN Matters Number SE 1024 Revised 2010.

necessary to invest in the future by meeting the truly exciting and positive challenges of health care reform.

Again, thank you for considering the recommendations provided above. Please feel free to contact me or Elise Smith at 202-898-6305.

Sincerely,

David Hebert
Senior Vice President for Policy

cc: Peter Budetti, MD
Cindy Mann

American Health Care Association

National Center for Assisted Living

AHCA/NCAL SUMMARY OF FEDERAL GOVERNMENT MEDICARE/MEDICAID INTEGRITY PROGRAMS AND FRAUD INVESTIGATIONS AFFECTING LONG TERM CARE (LTC) PROVIDERS (JANUARY 2011)

This chart, in the nature of a side-by-side, provides information on the array of integrity programs at the Centers for Medicare & Medicaid Services (CMS). There are several such programs for Medicare and Medicaid and others that affect both Medicare and Medicaid. There also are various CMS offices with a broad array of responsibilities for either or both programs.

Our goal is to provide members with an overview into who the reviewing entities are their roles, programs and responsibilities; specifically, what they are looking for. We intend to update this chart as we learn more and to put out targeted information on specific programs as they evolve.

If you have any questions please contact Dianne De La Mare ddmare@ahca.org (Compliance Programs and Medicaid), and Elise Smith esmith@ahca.org (Medicare) and Priscilla Shoemaker pshoemaker@ahca.org (Fraud Enforcement, Investigation and Prosecution).

Medicare:	**Medicaid:**
CMS, Medicare Integrity Program (MIP) "Program Integrity" refers to all CMS programs aimed at: ▪ Detecting and preventing fraud in the Medicare fee-for-service, Medicare Advantage and Part D programs; ▪ Ensuring the integrity of the Medicare fee-for service enrollment process; and ▪ Promoting compliance with Medicare rules. Congress enacted a provision in HIPAA that established **MIP**. HIPAA provided CMS with dedicated funding to conduct program integrity activities. The Program Integrity Group is responsible for the goals of the MIP. It is part of the CMS Office of Financial Management (OFM) which has overall responsibility for the fiscal integrity of all CMS programs and develops and performs all benefit integrity policy and operations in	**CMS, Medicaid Integrity Program (MIP)** Created under the Deficit Reduction Act of 2005 (DRA), and the first comprehensive Federal strategy to prevent and reduce fraud, waste and abuse in the Medicaid program. CMS has two broad responsibilities including: ▪ Hire Medicaid Integrity Contractors (MICs) to review Medicaid provider activities, audit claims, identify overpayments and educate providers/others in Medicaid integrity issues; and ▪ Provide effective support and assistance to the States in their efforts to combat Medicaid provider fraud and abuse. The States remain primarily responsible for combating Medicaid fraud. Along with these responsibilities, DRA, Section 1936, requires that CMS develop a 5-year Comprehensive Medicaid Integrity Plan (CMIP) in consultation with internal/external partners. The first CMIP, covering

coordination with other CMS components.

CMS Contacts:

- Director Position currently vacant
- Peter Budetti, M.D., J.D.Deputy Administrator and Director, Center for Program Integrity, 202-205-9220, Peter.Budetti@CMS.hhs.gov
- Lisa Vriezen, Deputy Director (410-786-1492, lisa.vriezen@cms.hhs.gov)

FYs 2006-2010 was published in 2006 at http://www.cms.hhs.gov/DeficitReductionAct/Downloads/CMIP2006.pdf.

The Medicaid Integrity Group (MIG) is part of the CMS Center for Medicaid and State Operations (CMSO), which is the focal point for all CMS activities relating to Medicaid, Children's Health Insurance Program, Clinical Laboratory Improvement Act (CLIA), survey and certification and all interactions with States and local governments. CMSO also provides leadership to the **MIP**.

The Medicaid Integrity Group (MIG):

- Detects/prevents fraud, waste and abuse in Medicaid;
- Supports/assists the States;
- Identifies overpayments and decreases inappropriate payment of Medicaid claims;
- Educates providers/States on payment integrity and quality of care issues;
- Makes referrals of suspected practices/providers to Federal/State law enforcement agencies; and
- Conducts state-of-the-art data mining and analysis to identify emerging trends.

MIG Offices include:

- Division of Medicaid Integrity Contracting (DMIC): Oversees procurements, evaluation and oversight of MICs.
- Division of Fraud Research & Detection (DFRD): Oversees the development of strategies to review Medicaid data to assist the Medicaid Integrity Contractors (MICs).
- Division of Field Operations (DFO): Approximately 40 staff working in New York, Chicago, Atlanta, Dallas and San Francisco Offices. Conduct State Medicaid program integrity reviews, coordinates audits and provide support.

CMS Contacts:

- Angela Brice Smith, Medicaid Integrity Director (410-786-4340, Angela.Brice-Smith@cms.hhs.gov)
- Paul Miner, Deputy Director (410-786-5937, Paul.Miner@cms.hhs.gov)
- Robb Miller, Division of Field Operations (DFO) Director (312-353-0923, Robb.Miller@cms.hhs.gov)

Go to https://www.cms.gov/MedicaidIntegrityProgram/ to find all of the CMS' **MIP** documents.

CMS, Provider Compliance Group (Medicare and Medicaid):

The Provider Compliance Group (PRG) also is part of the CMS' OFM. However, it has responsibilities for both Medicare and Medicaid to:

- Implement/maintain Medical Review activities;
- Administer the CERT and PERM programs;
- Conduct data analysis and assesses scope and severity of suspected vulnerabilities; and
- Administer the RAC program.

CMS Contacts:

- George Mills, Director (410-786-1808, george.mills@cms.hhs.gov)
- Bill Gould, Deputy Director (410-786-1458, William.Gould@cms.hhs.gov)

Contractors/Programs:

Technically speaking, PSCs and ZPICs are the **MIP** contractors. However, MACs can qualify as ZPICs. More importantly, there is cooperation among the various claims review contractors and **MIP** contractors. In order to meet the overall goal of program integrity, PSCs, ZPICs, Affiliated Contractors (ACs) and MACs must ensure that they pay the right amount for covered and correctly coded services rendered to eligible beneficiaries by legitimate providers. CMS strategies in meeting this goal include:

- Preventing fraud through effective enrollment and through education of providers and beneficiaries;
- Early detection through, for example, medical review and data analysis; and
- Close coordination with partners, including PSCs, ZPICs, ACs, MACs, and law enforcement agencies.

Therefore, we are providing information on the principal integrity contractors and Medicare improper payment review entities that impact skilled nursing facilities. These are: PSCs/ZPICs, CERTs, MACs, RACs, and the HHS, Office of Inspector General (OIG).

Contractors/Programs:

CMS has established 3 different types of MICs including the Review-of-Provider MIC, Audit MIC and Education MIC.

- **Review-of-Provider MICs** analyze claims to identify potential vulnerabilities; provide leads/target audits to Audit MICS; use data-driven approaches to focus on aberrant billing practices (data mining); and work with DFRD. Review MICs, as of 1/11, are as follows:
  - **Regions I/II (CT, MA, ME, NH, NJ, NY, PR, RI, VT, USVI):** Thomson Reuters;
  - **Regions III/IV (AL, DC, DE, FL, GA, KY, MD, MS, NC, PA, SC, TN, VA , WV):** Thomson Reuters;
  - **Regions V/VII (IA, IL, IN, KS, MI, MN, MO, NE, OH, WI):** AdvanceMed;
  - **Regions VI/VIII (AR, CO, LA, MT, ND, NM, OK, SD, TX, UT, WY):** AdvanceMed; and
  - **Regions IX/X (AK, AM. Samoa, AZ, CA, Guam, HI, ID, N. Marianna Isl, NV, OR, WA):** AdvanceMed.

- **Audit MICs** conduct post-payment audits; perform field audits and desk reviews and identify overpayments. Audit MICs make

PSC/ZPIC -- Program Safeguard Contractor/Zone Program Integrity Contractor: The PSC and the ZPICs are responsible for preventing, detecting, and deterring Medicare fraud. The PSCs and the ZPICs identify and prevent fraud by:

- Identifying program vulnerabilities;
- Proactively identifying incidents of potential fraud that exist within its service area and taking appropriate action on each case;
- Investigating (determining the factual basis of) allegations of fraud made by beneficiaries, providers, CMS, OIG, and other sources;
- Exploring all available sources of fraud leads in its jurisdiction, including the Medicaid Fraud Control Unit (MFCU) and its corporate anti-fraud unit;
- Initiating appropriate administrative actions to deny or to suspend payments that should not be made to providers where there is reliable evidence of fraud;
- Referring cases to the OIG, Office of Investigations for consideration of civil and criminal prosecution and/or application of administrative sanctions;
- Referring any necessary provider and beneficiary outreach to the Provider Outreach and Education (POE) staff at the AC or MAC;
- Initiating and maintaining networking and outreach activities to ensure effective interaction and exchange of information with internal components as well as outside groups;

The PSCs and the ZPICs are required to use a variety of techniques, both proactive and reactive, to address any potentially fraudulent billing practices including:

- Pursuing leads through data analysis, the Internet, the Fraud Investigation Database (FID), news media, etc; and
- Generating and/or identifying leads by any internal, AC, or MAC component, and not just the PSCs and ZPICs (e.g., claims processing, data analysis, audit and reimbursement, appeals, medical review, enrollment).
- The PSCs and the ZPICs function in:
    - Seven zones based on MAC jurisdictions;
    - Five "hot spots" (CA, FL, IL, NY, TX); and
    - Two other zones which include 24 states with limited incidence of fraud. These will continue using proven PSCs.

referrals to HHS, OIG, which, in turn share with State M. . J. Audit MICs, as of 1/11, are as follows:

- **Regions I/II (CT, MA, ME, NH, NJ, NY, PR, RI, VT, USVI):** Improving Healthcare for the Common Good (IPRO);
- **Regions III/IV (AL, DC, DE, FL, GA, KY, MD, MS, NC, PA, SC, TN, VA , WV):** Booz Allen Hamilton contract re-competed (9/09) and awarded to Health Integrity;
- **Regions V/VII (IA, IL, IN, KS, MI, MN, MO, NE, OH, WI):** Health Integrity;
- **Regions VI/VIII (AR, CO< LA, MT, ND, NM, OK, SD, TX, UT, WY):** Health Management Solutions (HMS); and
- **Regions IX/X (AK, AM. Samoa, AZ, CA, Guam, HI, ID, No. Marianna Isl, NV, OR, WA):** Health Management Solutions (HMS).

- **Education MICs** will develop training materials and awareness campaigns; highlight value in preventing fraud and abuse. Contracts were awarded to Strategic Health Solutions (SHS) to:
    - create a gap analysis of existing education/training efforts; develop fraud/waste/abuse education and training materials and materials for accurate billing for services; and
    - develop educational curriculum via web-based and traditional methods; educate Medicaid providers about Medicaid Integrity and quality of care.

MII (Medicaid Integrity Institute): National training facility for State Medicaid program integrity employees. Established at existing DOJ prosecutor training facility. DOJ staff partners with MIG and states to design courses for State Medicaid Program Integrity employees. The goal is to meet state training needs and establish credentialing process for State Medicaid Program Integrity.

PERM (Payment Error Rate Measurement) Program measures improper payments in the Medicaid program and the Children's Health Insurance Program (CHIP). PERM is designed to comply with the *Improper Payments Information Act*. For PERM, CMS is using a national contracting strategy consisting of three contractors to perform statistical calculations, medical records collection and medical/data processing

I[redacted]termediaries (FIs) and Medicare Administrative Contract[redacted] (MACs)

- The goal is to help prevent improper payments;
- Medicare claims processing contractor, through analysis of claims data and evaluation of other information (e.g., complaints), identifies suspected billing problems. Medical review activities are targeted at identified problem areas appropriate for the severity of the problem;
- If the MAC verifies that an error exists through a review of a small sample of claims, the contractor classifies the severity of the problem as minor, moderate, or significant and imposes corrective actions; and
- There can be pre-payment and postpayment review.

Comprehensive Error Rate Testing (CERTs):

- The main objective of these programs is to measure the degree to which CMS and its contractors are meeting the goal of "Paying It Right."
- CMS established two programs to monitor the accuracy of the Medicare Fee For Service (FFS) Program: the CERT program and Hospital Payment Monitoring Program (HPMP). HPMP monitors PPS short-term and long-term acute care inpatient hospital; discharges. CERT program monitors all other claims.
- The CERT program produces a national Medicare FFS error rate as required by the Improper Payments Information Act.
- CERT monitors and reports the accuracy of Medicare FFS payments made by Carriers, Durable Medical Equipment Regional Carriers (DMERCs), FIs and the new MACs.

Recovery Audit Contractors (RACs):

- The goal is to detect and correct past improper payments so that CMS and carriers, FIs and MACs can implement actions that will prevent future improper payments.
- The Tax Relief and Health Care Act of 2006 made the RAC program permanent.
- RACs are required to apply statutes, regulations, CMS national coverage, payment, and billing policies, as well as LCDs that have been approved by the Medicare claim processing contractors.
- There are four RAC Regions and a different contractor for each region:
  - Region A: Diversified Collection Services, Inc. of

[redacted]eview of selected State Medicaid and CHIP fee-for-service (F[redacted] managed care claims.

- In 2006, CMS reviewed only FFS Medicaid claims.
- Beginning in 2007, CMS expanded PERM to include reviews of FFS and managed care claims, as well as beneficiary eligibility, in both the Medicaid and CHIP programs.
- Groups of States are selected for PERM Program participation on a rotation basis once every 3 years as follows:
  - 2007 – AL, CA, CO, GA, KY, MD, MA, NE, NH, NJ, NC, RI, SC, TN, UT, VT, WV
  - 2008 – AK, AZ, DC, FL, HI, ID, IO, LA, ME, MI, MO, NE, NY, OR, SD, TX, WA
  - 2009 – AR, CO, DE, ID, IL, KA, MI, MN, MO, NM, ND, OH, OJK, PA, VI, WI, WY
  - 2010 – AL, CA, CO, GA, KY, MD, MA, NE, NH, NJ, NC, RI, SC, TN, UT, VT, WV
  - 2011 - AK, AZ, DC, FL, HI, IN, IO, LA, ME, MS, MO, NE, NY, OR, SD, TX, WA

Database:

MMIS (Medicaid Management Information System) is the master claims database, which identifies potential Medicaid claims problems. The regional office receives a subset of the MMIS database and the staff uses that subset for research to identify algorithms, etc. Once an issue is identified, the staff pulls the provider number from the subset, and the CMS Regional office sends a letter to the respective state's OIG to ascertain whether any of the providers are already under audit/investigation. CMS has identified problems with the database including: data is stale and the database doesn't provide a contact name/number. OIG released a report in August 2009, *MSIS Data Usefulness for Detecting Fraud, Waste, and Abuse*, which can be found at http://oig.hhs.gov/oei/reports/oei-04-07-00240.pdf.

State Medicaid Integrity Program:

MFCU (Medicaid Fraud Control Unit) is a single identifiable entity of state government, annually certified by the HHS Secretary that conducts a statewide program for the investigation and prosecution of health care providers that defraud the Medicaid program. A MFCU also reviews complaints of abuse or neglect of nursing facility residents. The MFCU is

Livermore, California: ME, NH, MA, RI, CT, VT, NY, PA, NJ, DE, MD and DC.
  - Region B: CGI Technologies and Solutions, Inc. of Fairfax, Virginia: MN, WI, MI, IL, IN, OH, KY.
  - Region C: Connolly Consulting Associates, Inc. of Wilton, Connecticut: CO, NM, TX, OK, AR, LA, AL, FL, SC, NC, VA, TN, GA, WV and MS.
  - Region D: HealthDataInsights, Inc. of Las Vegas, Nevada: AK, WA, OR, CA, NV, ID, MT, WY, UT, AZ, ND, HI, SD, NE, KS, IO and MO.

- Comprehensive information on the RACs can be found on the dedicated AHCA RAC web site. This includes up-to-date lists of all CMS approved issues for SNFs. http://www.ahcancal.org/facility_operations/MedicareRAC/Pages/default.aspx

- In addition each RAC contractor has its own website for CMS approved issues.

- RAC Region Web Sites for Issues Approved By CMS
  - Region A -- http://www.dcsrac.com/issues.html
  - Region B -- http://racb.cgi.com/Issues.aspx?st=1
  - Region C -- http://www.connollyhealthcare.com/RAC/pages/approved_issues.aspx
  - Region D -- https://racinfo.healthdatainsights.com/Public/NewIssues.aspx

- RAC CMS Project Officers
  - RAC Region A -- CMS project officer: Scott Wakefield Telephone: (410) 786-4301 • E-mail: Scott.Wakefield@cms.hhs.gov
  - RAC Region B -- CMS project officer, Scott Wakefield. Telephone: (410) 786-4301 • E-mail: Scott.Wakefield@cms.hhs.gov
  - RAC Region C -- CMS project officer: Amy Reese. Telephone: (410) 786-8627 • E-mail: Amy.Reese@cms.hhs.gov
  - RAC Region D -- CMS project officers: Brian Elza,

charged with investigating fraud in the administration of the prog[illegible] and for providing for the collection or referral for collection to the responsible State agency.

Medicaid Recovery Audit Contractors (Medcaid RACs)

- Section 6411 of the Affordable Care Act (Pub. L. 111– 148, enacted on March 23, 2010) requires states to establish programs in which they would contract with 1 or more Recovery Audit Contractors (Medicaid RACs) by December 31, 2010.

- The Medicaid RACs would review Medicaid claims submitted by providers of services for which payment may be made under section 1902(a) of the Act or a waiver of the State plan. Medicaid RACs would identify underpayments, and identify and collect overpayments from providers.

- On November 10, 2010.CMS issued a proposed rule implementing the program . AHCA submitted comments on January 10, 2011. A few of our key recommendations to CMS were as follows:
  - Exempt states from having to develop Medicaid RACs whenever possible;
  - Not require that Medicaid RACs be paid with contingency fees if the state does not wish (not just when a state statute forbids the use of contingency fees);
  - Review the states' appeals processes to determine and ensure their reasonableness.
  - Require or strongly recommend that, states require RACs to document "good cause" before the RAC reviews a claim, and establish minimum requirements for the documentation of "good cause." Urge CMS to monitor Medicaid RACs' compliance with "good cause" documentation requirements.
  - Prohibit, or at the very least impose limitations on, extrapolation in the Medicaid RAC program.
  - Require states to institute an approval process for new issues similar to that for Medicare RACs, and to post those issues on the Internet;
  - Require each Medicaid RAC to hire a physician Medical Director to oversee the medical record review process,

Telephone: (410) 786-7456 • E-mail: brian.elza@cms.hhs.gov	assist nurses, therapists, and certified coders u[redacted]uest, and manage quality assurance procedures. o Mandate that a "lookback" audit period be no greater than 3 years; o Apply the Medicare RAC improvements to the Medicaid RAC program. • AHCA will report on the final rule when it is issued.

Joint Agency Integrity Programs:

- HHS/DOJ Health Care Fraud Prevention and Enforcement (**HEAT**), was announced in May 2009, and is a joint task force consisting of senior level leadership from both departments. In 2010, HHS/DOJ Heat held a series of Regional Health Care Fraud Prevention Summits throughout the U.S. HEAT is originally built on the successful OIG-DOJ Medicare Fraud Strike Force initiated in South FL, and has expanded to other metropolitan areas across the country. HEAT: a) enlists providers to help ensure integrity of billing practices, and will focus on both Medicare and Medicaid providers who HHS/DOJ believe are cheating the government; b) has Strike Force teams in Miami, Los Angeles, Detroit and Houston; and c) is helping State Medicaid officials conduct provider audits and monitor activities to detect fraudulent activities.

- **Medi-Medi Program**: T he Deficit Reduction Act of 2005 (DRA), enacted in February 2006, established an additional activity under the Medicare Integrity Program (**MIP**), and provided $12 million in funding for the Medi-Medi Program in fiscal year 2006.10 0Pub. L. No. 109-171, § 6034(d), 120 Stat. 4, 77 (2006) (to be codified at 42 U.S.C. § 1395ddd(b)(6) and 1395i(k)(4)(D)). This program is designed to identify improper billing and utilization patterns by matching Medicare and Medicaid claims information on providers and beneficiaries to reduce fraudulent schemes that cross program boundaries. The statute appropriates funds for CMS to contract with third parties to identify program vulnerabilities in Medicare and Medicaid through examining billing and payment abnormalities. These funds also can be used in connection with the Medi-Medi program for two other purposes: (1) coordinate actions by CMS, the states, the Attorney General, and the HHS OIG to protect Medicaid and Medicare expenditures and (2) increase the effectiveness and efficiency of both Medicare and Medicaid through cost avoidance, savings, and recouping fraudulent, wasteful, or abusive expenditures.

OIG Testimony:

2010

09-22-2010

Testimony of Daniel R. Levinson, Inspector General (PDF), before the Subcommittee on Health of the House Committee on Energy and Commerce on cutting waste, fraud, and abuse in Medicare and Medicaid

09-15-2010

Testimony of Daniel R. Levinson, Inspector General (PDF), before the Subcommittee on Health of the House Committee on Energy and Commerce on the integrity of Medicare's coverage of durable medical equipment and supplies (DME)

06-15-2010

Testimony of Lewis Morris (PDF), Chief Counsel to the Inspector General, before the Subcommittees on Health and Oversight of

the U.S. House Ways and Means Committee on Reducing Fraud, Waste and Abuse in Medicare

03-04-2010

Testimony of Daniel R. Levinson, Inspector General (PDF) before the Subcommittee on Labor, Health and Human Services, Education, and Related Agencies of the House Committee on Appropriations on efforts to combat health care fraud, waste, and abuse in Medicare and Medicaid

Testimony of Timothy J. Menke (PDF), Deputy Inspector General for Investigations Before the Subcommittee on Crime, Terrorism, and Homeland Security of the House Committee on the Judiciary on law enforcement activities to combat Medicare and Medicaid fraud

Testimony of Omar Perez (PDF), Special Agent with the Office of Inspector General Before the Subcommittee on Labor, Health and Human Services, Education, and Related Agencies of the House Committee on Appropriations on investigative efforts to combat Medicare and Medicaid fraud

2009

06-25-2009

Testimony of Daniel R. Levinson, Inspector General (PDF), before the Subcommittee on Health of the House Energy and Commerce Committee on Health Care Reform: Opportunities to Address Waste, Fraud and Abuse

05-06-2009

Testimony of Daniel R. Levinson, Inspector General (PDF), before the Senate Special Committee on Aging on fraud in the Medicare and Medicaid programs and recommendations for reducing this fraud while maintaining a high level of services for providers and patients participating in the Medicare and Medicaid programs

04-22-2009

Testimony of Lewis Morris (PDF), Chief Counsel to the Inspector General, before the U.S. Senate Homeland Security and Governmental Affairs Subcommittee on Federal Financial Management, Government Information, Federal Services, and International Security on Eliminating Waste and Fraud in Medicare and Medicaid

Medicare and Medicaid Fraud Enforcement , Investigation and Prosecution

Significance: Medicare and Medicaid audits now are more likely to be followed by investigation and prosecution for health care fraud. Recent legislation has given both federal and state agencies a tremendous amount of power in dealing with fraud in the health care industry. Private citizens, beneficiaries and employees are being encouraged by government and plaintiffs bar to pursue civil health care fraud cases against medical providers with the lure of increased monetary incentive. Potential criminal and civil liability for a health care provider under these statutes is significant. Additionally, the government now has the ability to exclude providers from federal programs based only on certain evidence or an indictment in the absence of proven provider guilt. Because of the new federal focus on Health Care fraud, it is imperative that health care providers be aware of potential exposures to a variety of civil and criminal charges and to prepare to react and respond appropriately.

I [redacted] Source/Government Return on Investment: The Health C[redacted]ud and Abuse Control Program, established by the Health Insu[redacted] Portability and Accountability Act of 1997, provides an annual funding s[redacted]m for the DOJ to combat Medicare and Medicaid fraud. The previous level of funding to the Health Care Fraud and Abuse Account (HCFAC) was $1.172 billion in mandatory base funding, and $311 million in proposed discretionary funding. Following the March 23, 2010 enactment of the Patient Protection and Affordable Care Act (PPACA) funding for fraud and abuse enforcement has increased by $100 million in additional funds at a rate of $10 million per year for FYs 2010 through 2020. The Health Care and Education Reconciliation Act (HCERA) of 2010 added another $250 million to the fight against Medicare and Medicaid fraud, waste and abuse. Increased funding is most likely because government return on taxpayer investment has risen significantly under law enforcement's heightened efforts. Just take recovery estimates under the federal False Claims Act as an example.

HHS and DOJ released a report, *Health Care Fraud and Abuse Control Program (HCFAC) Annual Report for FY 2010,* showing that the government's health care fraud prevention and enforcement efforts recovered more than $4 billion in taxpayer dollars in Fiscal Year (FY) 2010. This is the highest amount ever recovered in one year. In 2009, HHS and DOJ enhanced their coordination through HEAT and have expanded Medicare Fraud Strike Force teams, as well as hosting a series of regional fraud prevention summits around the country and sending letters to state attorneys general urging them to work with HHS and federal, state and local law enforcement officials to mount a substantial outreach campaign to educate seniors and other Medicare beneficiaries about how to prevent scams and fraud. In 2010, HEAT and the Medicare Fraud Strike Force continued to expand local partnerships and helped educate Medicare beneficiaries about how to protect themselves against fraud. Also in 2010, the total number of cities with Strike Force prosecution teams was increased to seven, all of which have teams of investigators and prosecutors dedicated to fighting fraud. The Strike Force teams use advanced data analysis techniques to identify high-billing levels in health care fraud hot spots so that interagency teams can target emerging or migrating schemes along with chronic fraud by criminals masquerading as health care providers or suppliers. To obtain a copy of the report go to http://www.oig.hhs.gov/publications/hcfac.asp. The report also is discussed on an HHS press release on fraud and abuse enforcement efforts at http://www.hhs.gov/news/press/2011pres/01/20110124a.html.To obtain more information on the joint DOJ-HHS Strike Force activities, go to http://www.StopMedicareFraud.gov/. Additionally, from 1986 to 2008 False Claims Act (FCA) settlements and judgments amounted to $21.6 billion and more than 66% ($14.3 billion) of that amount has resulted from health care settlements and judgments. At the same time, the whistleblower (qui tam) recoveries under both federal and state FCA statutes have dramatically increased as well. During roughly that same period of time, the whistleblower share in health care FCA has increased dramatically as well. In 1988 whistleblowers' share in $2.5 million in FCA recoveries was just $88,750. In 2008 whistleblowers' share of $1.1 billion in healthcare FCA recoveries jumped to $183 million.

Agency Coordination: Primary responsibility for enforcing federal laws regarding health care fraud rests with the Department of Justice (DOJ) and United States Attorneys. The Federal Bureau of Investigations (FBI) plays a major role in assisting the DOJ in investigating and developing health care fraud cases. Within the Department of Health and Human Services, the Office of Inspector General (OIG) is responsible for investigating fraud cases and bringing enforcement actions involving administrative sanctions. Individual states have their own Medicaid Fraud Control Units (MFCU) and local prosecutors can bring such cases as well. Private companies that contract with the CMS to administer such programs as MACs, RACs, etc. have some responsibilities in this area reviewing claims, detecting upcoding and other improper billing practices, etc. and recovering overpayments. Finally in certain circumstances private parties can pursue health care fraud through a civil lawsuit, although the government has the option of taking over the case.

Investigation and Prosecution As of March 2010, PPACA increased the HHS Secretary's ability to conduct investigations related to issue subpoenas but also to require the attendance and testimony of witnesses and the production of any other evidence that relates to matters under investigation. Investigations into Medicare and Medicaid Fraud begin with the OIG. OIG investigators have the power to execute search warrants and serve subpoenas in connection with their investigation. In cases involving suspected Medicaid Fraud, the OIG has delegated its investigative activities to the MFCUs established by individual states. The majority of MFCUs are located within State Attorneys General offices. MFUCs have the power to issue subpoenas, serve and execute search warrants, and take sworn statements. Once investigators have reason to believe a law has been broken, the situation is reported to the U S. Attorney General (AG) and the FBI. The AG's office coordinates further investigation and determines whether to

submit the case to a grand jury. If the investigation is conducted by a Medicaid Fraud Control Unit, the MFCU has the authority to prosecute criminally, or refer the matter to the applicable district or county attorney for prosecution. The MFCU also may coordinate its activities with federal investigators.

Choice of Law and Remedy: In dealing with Medicare and Medicaid fraud and abuse, the appropriate law enforcement entity (ies) can choose among a wide array of criminal, civil and administrative responses. On the criminal side, offenses can be addressed with general statutes or with health care specific statues. In addition to possible criminal liability, providers also are exposed to substantial civil liability for health care fraud under the Civil False Claims Act and the Civil Monetary Penalties Law. The government in many cases will pursue both civil and criminal liability for the same action In 2010, the Patient Protection and Affordable Care Act (PPACA) made important changes to key fraud and abuse statutes. Specifically, certain provisions of the Federal False Claims Act (FCA) at §§ 3729, et seq. have been altered in a manner calculated to increase whistleblower litigation. . Effective January 2011, PPACA establishes new grounds for mandatory exclusion from the Medicaid program, for individuals or entities that: (1) have been terminated from Medicare or another Medicaid program; and (2) that own, control or manage an entity that has delinquent unpaid overpayments, is suspended, excluded or terminated from participation, or is affiliated with a suspended, excluded or terminated individual or entity. New grounds for imposition of permissive exclusion include providers who make a knowing false statement, omission or misrepresentation of material fact in any application agreement, bid or contract to participate or enroll in a federal healthcare program and any provider who obstructs a program audit and/or investigation (prior law only applied to the obstruction of a criminal investigation). Two additional changes under PPACA worth noting here are the new provision that allows the government to suspend Medicare and Medicaid payments pending a "credible" investigation of fraud and the

Criminal:	**Civil:**
General federal statues include: ▪ conspiracy to defraud the U.S. (18 U.S.C. Secs. 286,371); ▪ false statements (18 U.S.C. Sec. 101); ▪ mail fraud (18 U.S.C. Sec. 1341); ▪ wire fraud (18 U.S.C. Sec 1343); and ▪ money laundering (18 U.S.C. Secs. 1956, 1957). Health care specific federal statutes include: ▪ kickbacks (42 U.S.C. Sec. 1320a-7(b)); ▪ health care fraud (18 U.S.C. Sec. 1347); ▪ theft or embezzlement (18 U.S.C. Sec. 669); ▪ false statements (18 U.S.C. Sec. 1035 and 42 U.S.C. Sec. 1320a-7b(a)); ▪ obstruction of criminal investigations (18 U.S.C. Sec. 1518); and ▪ money laundering (18 U.S.C. Sec. 1956(a) (1)). Depending upon the statute(s) applied, those individual or entities convicted of health care fraud face punishment in terms of fines amounting anywhere from $1,000 to $250,000 and prison terms ranging from 5 years to a 20 years to life sentence in cases where severe bodily injury or death are attributed to the fraud and abuse.	Federal Civil statutes include: The civil False Claims Act ("FCA"), 31 U.S.C. §§ 3729-3733, is the government's primary tool for combating fraud. The statute imposes liability on persons who (1) knowingly present false or fraudulent claims to the United States, (2) knowingly make false records or statements to get false or fraudulent claims paid, or (3) conspire to defraud the government by getting a false or fraudulent claim paid. 31 U.S.C. §§ 3729(a) (1)-(3). The statute provides for treble damages plus penalties of $5,500 - $11,000 for each false claim. In 2005, The Deficit Reduction Act (DRA)of gave states an incentive to enact laws as stringent as the federal FCA. DRA allows a state to retain an extra 10 percent of recovered Medicaid funds, which otherwise would be returned to the federal government, if the state has a false claims statute at least as effective as the federal FCA. The FCA permits private citizens, known as *qui tam* plaintiffs or "relators," to hire attorneys and file actions asserting violations of the Act on behalf of the United States. Such actions are filed under seal, and the Department of Justice ("DOJ") has the opportunity to investigate the action and decide whether to intervene in the lawsuit and take the lead in prosecuting the action. If the government declines to intervene, relators

and their attorneys can proceed with the action. The incentive [redacted]tors and their attorneys is financial – if the action is successful, the relator receives up to 30 percent of the proceeds awarded.

Recent cases involve the use of the FCA to enforce other program rules or norms including compliance with the anti-kickback and self-referral (Stark) statutes as well as quality standards.

In 2009, under the Federal Enforcement Recovery Act, Congress provided an additional $165 million in new funding and amended the federal FCA in several significant ways:

- Expands presentment of claims to cover claims submitted to government contractors or grantees which means claims presented to Medicaid may now be subject to FCA.
- Expands liability to include failure to timely repay overpayments ('reverse" FCA).
- Allows government complaints, for the purposes of statute of limitations, to "relate back," to the filing date of the complaint of the person originally filing the action.
- Broadens individuals who can issue a civil investigative demand (CID) to include "designees" of the AG.
- Provides that information obtained by AG or designee may be shared with relator (whistleblower).
- Whistleblower protections expanded to contractors and agents (in addition to employees).
-

In 2010, PPACA dramatically altered the "public disclosure" and "original source" provisions of the FCA that may allow whistleblowers (*qui tam* plaintiffs) to more easily file a suit based on already "public" information and material with little or no first hand knowledge under very limited to no jurisdictional bar.

Exclusion from the Medicare and Medicaid Programs: In addition to the penalties mentioned above, the health care provider is subject to expulsion from the Medicare and Medicaid programs. 42 U.S.C.1320a-7(a) (3) now provides for mandatory exclusion upon a felony conviction of fraud in connection with the delivery of health care item or service, or with respect to any act or omission in a government health care program. Such exclusion from participation is for a period of not less than five years. Also, 42 U.S.C. §1320a-7(b) provides for the permissive exclusion of a provider for a conviction relating to the obstruction of an investigation; submitting claims for excessive charges that do not rise to the level of fraud, failure to disclose statutorily required information and failure to provide required access to records. Such exclusion is for a minimum of three years.

One of the most potent weapons in the prosecutor's arsenal, however, is the power to suspend and withhold a provider's payments under Medicare upon

indictment or other reliable evidence of fraud. Under 42 C.F.R. §405.370 and 42 C.F.R. §405.370 such payments can be suspended without a hearing once the prosecutor has obtained an indictment. As a result, the government is able to exert tremendous pressure on targeted health providers to force settlement.

Compliance Program

What is a corporate compliance program? Simply stated, a corporate compliance program is a written and operational program specifying an organization's policies, procedures, and actions within a process to help prevent and detect violations of Federal and State laws and regulations. The benefits of a strong program go well beyond regulatory and legal compliance to also include operational benefits. An effective corporate compliance program will help ensure that a facility's organizational structure, people, processes and technology are all working in harmony to manage risks, improve customer satisfaction, enhance facility operations, improve quality of health care services, oversee vendors and reduce overall costs.

Alot has been discussed and written specifically about nursing facility (NF) corporate compliance since the OIG first published voluntary guidance in March 2000. In 2008, the discussion intensified when the OIG published a supplement to its 2000 NF guidance, and encouraged assisted living facility (ALF) and other long term care providers to establish and maintain effective compliance programs, with the goal to improve quality of care and services. With the passage of the Patient Protection and Affordable Care Act (PPACA), all nursing facilities must have a working compliance program by March 2013. We know from experience that one of the greatest obstacles to effective corporate compliance is company programs that are overly-complex, hard to understand and hard to manage. The OIG expects all owners, managers and employees, from owners and Board members to front-line staff, to understand the compliance program and participate in it actively. For that to happen, you have to know how to design, build and implement a compliance program; as well as understand the legal and practical benefits for implementing a program. To do that, AHCA/NCAL has sponsored monthly webinars throughout 2009 and created web-based guidance, specifically for long term care providers at http://www.ahcancal.org/facility_operations/ComplianceProgram/Pages/default.aspx.

TESTIMONY 2

North Dakota Hospital Association

Vision
The North Dakota Hospital Association will take an active leadership role in major Healthcare issues.

Mission
The North Dakota Hospital Association exists to advance the health status of persons served by the membership.

Testimony on HB 1448
House Industry, Business and Labor Committee
February 2, 2011

Good morning Chairman Keiser and Members of the House Industry, Business and Labor Committee.

I am Jerry Jurena, President of the North Dakota Hospital Association. I am here in opposition to HB 1448.

HB 1448 requires the State Auditor to contract on behalf of the state to conduct recovery audits of payments made by state agencies to vendors during the last four fiscal years by agencies with a budget exceeding five hundred thousand dollars regardless of internal or third party audits. HB 1448 seeks recovery of improper overpayments detected, but does not mention under payments to venders found. Section 1. Subsection 5, details improper overpayments; however, does not list any improper underpayments. An audit should be fact finding and not only look for overpayments but also underpayments as does Medicare.

HB 1448 also allows for a re-audit of payments on previously audited payments that were found to be correct or proper.

Currently healthcare facilities are subject to numerous audits; I would like to review a few of these audits: Medicare Recovery Audit Contract (RAC), Medicaid Integrity Audit Program (MIC), Insurance Companies and Workforce safety Insurance (WSI). Medicare RAC was developed out of the Medicare Prescription, Drug, Improvement and Modernization Act of 2003. The Medicaid Integrity Audit Contract (MIC) is currently in place, and there is a proposal to implement a Medicaid RAC program as well. Initially the Medicaid RAC was to be implemented by December 31, 2010; the implementation date was moved to April 2011 and now states must show they are complying with Rules to implement a Medicaid RAC. MIC and Medicaid RAC may be merged into one program in the future.

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The Medicaid RAC program differs from the Medicare RAC program in the following:

Medicaid Appeals are managed at the state level
Medicaid is not bound by limits on the number of claims they can audit
There is no restriction on years of review
Both supply Items and services may be reviewed
Audits are for financial as well as quality of care

Maggie Anderson will be providing information detailing Medicare and Medicaid audits as well as other audit programs that are now in place for healthcare facilities.

I oppose the adoption of HB1448 for healthcare facilities as we are inundated with recovery audits. Adding additional audits would create added expenses to the healthcare facilities and to the state. This process is not needed with all the audits now mandated and in place for healthcare.

Please give HB 1448 a do not pass.

Jerry E. Jurena, President
North Dakota Hospital Association

TESTIMONY 3

HB 1448
Recovery Audits
Testimony – House Industry, Business and Labor

Chairman Keiser and members of the Industry, Business and Labor committee, my name is Jaclyn Bugbee and I am the Director of Development at St. Alexius Medical Center. I am here to testify in opposition to HB 1448 as it is currently written.

HB 1448 provides the state auditor the ability to contract for recovery audits. This bill is very ambiguous and raises a lot of questions, rather then answer the one question it is filed on behalf of – to curve the rise in Medicaid Fraud.

Healthcare service providers in our state are subject to many different types of recovery audits. Appendix A showcases the multitude of audits that can be requested by federal and state agencies. This law does not take into account the Medicaid Integrity Contractor (MIC) audits that were created a few years ago. Without further clarification – can providers be subject to a multitude of audits on the same claim?

1. Line 10 on page one of the bill indicates the audit can be for **vendors.** Are vendors the providers that receive Medicaid payments, or any vendor that receives payment from any state agency?
2. Line 14 on page one notes that any specific improper payments identified by a previous audit is not eligible for identification or recovery. However, line 6 on page two allows for the consultant to reaudit payments that have been previously audited.

This bill doesn't address any appeal process for contracts reviewed in the audit. Federal Medicare RAC audits have five levels of appeals that a provider can go through to appeal the claim. Without an appeal process, how the provider of medical services be allowed some measure of due process? Medical coding and application of codes that drive payment is not an absolute discipline.

Most recovery audits provide the consultant a contingency fee to do recovery audits? If so, there would need to be a fiscal note attached to HB 1448. If a contingency fee is offered – for Medicare RAC audits it is

currently 11% - does the consultant have to reimburse the fee if the claim is appealed successfully? If not, services providers could be subject to many erroneous claims. This can have a negative effect on the entire process.

Will these audits review how claims are coded, and if so – will it reimburse providers if they were undercoded and the agency owes the provider money? Will they reject the difference in the coding, or reject the entire claim?

Medicare RAC audits have a level of transparency. This transparency allows the provider to go onto the RAC website and review issues in audits and understand how to adjust their current practice to ensure their claims will be approved. However, this bill does not take transparency into account.

Lastly, we are concerned with the privacy of the patient. Under HIPAA guidelines, disclosure of information is strictly monitored. On Page 2 of the bill, No. 3 talks about how the agency may not provide access if prohibited by law or contractual obligation. Does this mean that the consultant will not be able to review the entire claim? How can they make the determination of any error without proper review – or even extensive knowledge of the medical record process?

As a healthcare provider, we understand that audits and review of the claims process is necessary. However, we feel that this bill doesn't address the issue at hand. It merely creates more issues and could be a costly endeavor for the state of North Dakota. If the legislature would like to save money and speed up the Medicaid claims process, they should concentrate their efforts on the current MMIS system to ensure that claims are submitted and processed correctly the first time they are received and payments of claims are made in a timely manner. Changes to that system are not scheduled until 2012.

We ask that you do not pass HB 1448 and allow entities in the industry to work with the state and the Department of Human Services to put together a process that makes sense.

Post-Payment Auditors Chart

The editorial staff at **Medical Records Briefing** developed this chart to help you make sense of the multitude of post-payment auditor requests for medical record documentation you may be receiving. Find out who they are, what they need, and how long you have to respond.

	Recovery audit contractor (RAC)	Comprehensive Error Rate Testing (CERT)	Zone program integrity contractor (ZPIC)	Medicare administrative contractor (MAC)	Medicaid integrity contractor (MIC)
Entity being audited	Healthcare providers and suppliers that submit Medicare Part A and B claims	Fiscal intermediaries, MACs, or other carriers	Healthcare providers that submit Medicare claims	Healthcare providers that submit Medicare Part A and B claims	Hospitals, long-term care facilities, pharmacies, physicians, labs, transportation, and other types of providers that submit Medicaid claims
Purpose of audits	To identify underpayments and overpayments and recoup overpayments	To monitor and report the accuracy of Medicare fee-for-service payments	To identify fraud and abuse	To identify fraud, waste, or abuse; locate incorrect payments; and educate providers on correct reporting of services	To identify fraud, waste, or abuse; locate overpayments; and educate providers on integrity issues
Medical record request number limits	Calculated by provider type and/or average number of monthly Medicare claims. Maximum of 200 records per 45 days. This number will increase in 2010 for DRG validation complex reviews.	No limit. However, claims are randomly selected and naturally limited.	No limit.	No limit.	No limit.
Medical record request response time	45 days, plus an additional 10 days mailing time	30 days	Presumably 30 days	30 days	Dependent on state guidelines
Pre-appeal discussion rights	Yes (discussion period)	No	Depending on the type of finding, providers may appeal prior to final decision	Yes (rebuttal period)	Yes (provider has 30-day period to review and comment)
Appeals	Yes	Yes	Yes	Yes	Yes
Auditor payment	Contingency fee.	Set amount based on contract.	Set amount based on contract.	Postpayment activities are included within MACs' operating budget.	Payment is based on a fee-for-service model. The money MICs recover doesn't determine compensation, but MICs may be eligible for bonuses based on how effective and efficient they are, per CMS.

Post-Payment Auditors Chart

	Recovery audit contractor (RAC) *(cont.)*	Comprehensive Error Rate Testing (CERT) *(cont.)*	Zone program integrity contractor (ZPIC) *(cont.)*	Medicare administrative contractor (MAC) *(cont.)*	Medicaid integrity contractor (MIC) *(cont.)*
Desk vs. on-site review	Both. RACs can request an on-site review; however, the provider may deny that request.	Desk.	Both.	Both.	Both.
Look-back period	Three years, but not prior to October 1, 2007.	Up to one year. The look-back period would date to the beginning of the current year.	Not specified.	Within the reopening period (one year without cause and four years with cause).	Dependent on state guidelines.
Web site	*www.cms.hhs.gov/rac*	*www.cms.hhs.gov/cert*	N/A	*www.cms.hhs.gov/MedicareContractingReform/01_Overview.asp#TopOfPage*	*www.cms.hhs.gov/medicaidintegrityprogram*
Additional information	➤ The RAC in each jurisdiction is: – Region A: Diversified Collection Services – Region B: CGI – Region C: Connolly Consulting, Inc. – Region D: HealthDataInsights, Inc. ➤ Provider Resources, Inc., is the RAC validation contractor and will work with CMS and the RACs to approve new issues for RACs to pursue for improper payments, as well as review for accuracy randomly selected claims RACs have already audited	➤ Auditors randomly select a sample of approximately 120,000 claims, request medical records from the providers who submit them, and review the claims and records for compliance with coverage, coding, and billing rules ➤ CMS began calculating a provider compliance error rate in addition to the paid claims error rate in 2003	➤ Replace program safeguard contractors ➤ ZPICs may refer cases of fraud and abuse to CMS, the Office of the Inspector General, the Department of Justice, the FBI, etc. ➤ Investigations are flexible and tailored to each specific circumstance ➤ Details can be found in Chapter 4 of the *Medicare Program Integrity Manual*	➤ MACs are responsible for the receipt, processing, and payment of Medicare fee-for-service claims ➤ There are 15 A/B MAC jurisdictions ➤ Operational integration of Parts A & B will centralize information that will create a platform for the delivery of comprehensive care to Medicare beneficiaries ➤ The transition to MACs was designed to result in more accurate claims payments and greater consistency in payment decisions through a single claims processing interface	➤ There are three types of MICs: review, audit, and educational ➤ Providers may submit questions to *medicaid_integrity_program@cms.hhs.gov* ➤ Provider outreach is not mandatory ➤ The appeal process mirrors the state Medicaid appeal process ➤ The state issues the demand to the provider for any overpayments the MIC finds ➤ MICs will conduct an entrance conference prior to the audit

Source: HCPro, Inc.

testimony 4

Testimony
House Bill 1448 – Department of Human Services
House Industry, Business and Labor Committee
Representative George Keiser, Chairman
February 2, 2011

Chairman Keiser, members of the Industry Business and Labor Committee, I am Maggie Anderson, Director of the Medical Services Division for the Department of Human Services. I am here to provide information regarding House Bill 1448.

In the testimony provided last week, this committee heard that the three largest potential recoveries for a Recovery Audit Contractor (RAC) would be in the areas of (1) Pharmacy Benefit Managers, (2) Medicaid payments, and (3) Accounts Payable. My testimony will provide the committee with a brief overview of various state and federal efforts to provide oversight and recovery of North Dakota Medicaid program payments.

Pharmacy Services

The North Dakota Medicaid Pharmacy Services and the Medicaid Point-of Sale (POS) system are operated by the Department, and there is no Pharmacy Benefit Manager involved in North Dakota Medicaid operations. The North Dakota Medicaid POS has excellent edits that protect patients from drug interactions and overdoses, as well as direct physicians and pharmacists towards more efficient prescribing and dispensing habits. Routine reports are run to determine if duplicate payments are made, and if any are found, the duplicate payment is recovered immediately.

Recovery Audit Contractor (RAC)

According to Section 6411 of the Patient Protection and Affordable Care Act (ACA), each Medicaid agency is mandated to establish a contract with one or more Medicaid RACs for the purpose of indentifying underpayments and overpayments.

The ACA requires that RACs be paid contingency fees for overpayments recouped as well as for underpayments. The contingency payment will be made to the RAC prior to calculating the federal share of the overpayment owed to the Center's for Medicare and Medicaid Services (CMS).

The Department is preparing a Medicaid RAC Request for Proposal which we expect to issue this month. The projected implementation date of the North Dakota Medicaid RAC is August, 2011.

Medicare providers have been audited under Medicare RACs for several years.

Medicaid Integrity Contractor (MIC)

Section 1936 of the Social Security Act requires CMS to contract with Medicaid Integrity Contractors (MIC) to carry out Medicaid Integrity goals. The goals include: reviewing providers to determine whether fraud, waste or abuse has occurred, indentify overpayments, audit provider claims and educate providers and administration about payment integrity and quality of care. A MIC varies in a number of ways from a RAC; one big difference is that they are contracted and paid by CMS. To date, there have been no MIC audits in North Dakota.

Payment Error Rate Measurement (PERM)

The Improper Payments Information Act of 2002 requires federal agencies to annually review programs they oversee that are susceptible to significant erroneous payments, to estimate the amount of improper payments, to report those estimates to Congress, and to submit a report on actions the agency is taking to reduce erroneous expenditures. To implement the requirements of the Improper Payments Information Act, CMS developed the Payment Error Rate Measurement program. Under PERM, reviews are conducted every three years and the efforts focus on three areas: fee-for-service, managed care, and eligibility for both the Medicaid and CHIP programs. The results of these reviews are used to produce national program error rates as well as state-specific program error rates. For states reviewed under PERM in 2009, the overall national Medicaid estimated error rate was 8.98%; and the North Dakota Medicaid estimated error rate was 3.17%.

In Summary, once implemented, the RAC has an ongoing auditing cycle; PERM is conducted every three years; and MIC audits occur based on variance limits detected during the analysis of the data submitted to the CMS contractors. In addition, the Medical Services Division completes quarterly provider audits, based on utilization patterns noted by staff members. It is possible for Medicaid providers to be audited simultaneously under each of the review mechanisms noted in my testimony.

I would be happy to address any questions that you may have.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

CPI – CMCS INFORMATIONAL BULLETIN

DATE: February 1, 2011 **CPI-B 11-03**

FROM: Peter Budetti
Director
Center for Program Integrity (CPI)

Cindy Mann
Director
Center for Medicaid, CHIP and Survey & Certification (CMCS)

SUBJECT: **Clarification of CMS expectations for State implementation of Medicaid Recovery Audit Contractor (RAC) programs**

This informational bulletin is to provide a clarification on the Centers for Medicare & Medicaid Services (CMS) expectations for State implementation of Medicaid RAC programs. Section 6411 of the Affordable Care Act, Expansion of the Recovery Audit Contractor (RAC) Program, required States to establish programs to contract with RACs to audit payments to Medicaid providers by December 31, 2010.

CMS issued a letter to State Medicaid Directors on October 1, 2010, providing preliminary guidance to States on the implementation of their RAC programs. In that letter we indicated States were to submit to CMS a State plan amendment (SPA) through which the State would either attest that it would establish a Medicaid RAC program by December 31, 2010, or indicate that it was seeking to be excepted from this provision. We also stated that we expected States to fully implement their RAC programs by April 1, 2011. In the Notice of Proposed Rulemaking (6034-P, "Medicaid Program; Recovery Audit Contractors," (published on November 10, 2010) we proposed the same date for implementation and solicited comments on that portion of the regulation.

Out of consideration for State operational issues and to ensure States comply with the provisions of the Final Rule, we have determined that States will not be required to implement their RAC programs by the proposed implementation date of April 1, 2011. Instead, when the Final Rule is published, it will indicate the new implementation deadline. We anticipate the final rule will be issued later this year.

We look forward to continuing our work together as we implement this important legislation and will issue more information regarding CMS support to States in the coming months. If you have questions regarding the information presented in this bulletin, please contact Ms. Angela Brice-Smith, Director of the Medicaid Integrity Group (Angela.Brice-Smith@cms.hhs.gov) or at 410-786-4340.

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CMS
CENTERS for MEDICARE & MEDICAID SERVICES

SMDL# 10-021
ACA# 10

October 1, 2010

Re: Recovery Audit Contractors (RACs) for Medicaid

Dear State Medicaid Director:

This letter is part of a series of letters intended to provide preliminary guidance on the implementation of the Affordable Care Act (P. L. 111-148). Specifically, this letter provides initial guidance on section 6411 of the Affordable Care Act, *Expansion of the Recovery Audit Contractor (RAC) Program*, which amends section 1902(a)(42) of the Social Security Act (the Act) requiring States to establish programs to contract with RACs to audit payments to Medicaid providers by December 31, 2010. The Centers for Medicare & Medicaid Services (CMS) expects States to fully implement their RAC programs by April 1, 2011. As required by statute, CMS will be issuing regulations in this area shortly, providing additional guidance.

State Medicaid RACs

Under Section 1902(a)(42)(B)(i) of the Act, States and Territories are required to establish programs to contract with one or more Medicaid RACs for the purpose of identifying underpayments and overpayments and recouping overpayments under the State plan and under any waiver of the State plan with respect to all services for which payment is made to any entity under such plan or waiver. States must establish these programs in a manner consistent with State law, and generally in the same manner as the Secretary contracts with contingency fee contractors for the Medicare RAC program.

States and Territories will need to submit to CMS a State plan amendment (SPA) through which the State will either attest that it will establish a Medicaid RAC program by December 31, 2010, or indicate that it is seeking an exemption from this provision. State programs to contract with Medicaid RACs are not required to be fully operational by December 31, 2010. States should submit Medicaid RAC SPAs to their respective CMS Regional Offices.

Many States already have experience utilizing contingency-fee-based Third Party Liability recovery contractors. CMS will allow States to maintain flexibility in the design of Medicaid RAC program requirements and the number of entities with which the States elect to contract within the parameters of the statutory requirements. There are a number of operational and policy considerations in State Medicaid RAC program design (some of which will be discussed in greater depth in future rulemaking) such as:

a. Qualifications of Medicaid RACs;
b. Required personnel - for example physicians and certified coders;
c. Contract duration;
d. RAC responsibilities;
e. Timeframes for completion of audits/recoveries;
f. Audit look-back periods;
g. Coordination with other contractors and law enforcement;
h. Appeals; and
i. Contingency fee considerations.

Finally, we note that States may not supplant existing State program integrity or audit initiatives or programs with Medicaid RACs. States must maintain those efforts uninterrupted with respect to funding and activity.

Exceptions

Section 1902(a)(42)(B)(i) of the Act specifies that States shall establish programs under which they contract with Medicaid RACs subject to such exceptions or requirements as the Secretary may require for purposes of a particular State. This provision enables CMS to vary the Medicaid RAC program requirements. For example, CMS may exempt a State from the requirement to pay Medicaid RACs on a contingent basis for collecting overpayments when State law expressly prohibits contingency fee contracting. However, some other fee structure could be required under any such exception (e.g., a flat fee arrangement).

States that otherwise wish to request variances with respect to, or an exception from, Medicaid RAC program requirements will need to submit to CMS requests in writing from the State's Medicaid Director to the CMS/ Medicaid Integrity Group. We will evaluate requests from States in a timely manner. CMS anticipates granting complete Medicaid RAC program exceptions rarely and only under the most compelling of circumstances.

As noted above, all States will need to submit SPAs which either attest that they will establish compliant Medicaid RAC programs, or indicate the reason for not doing so. For States that require a State legislative change granting authority to establish a Medicaid RAC program, the SPA can be submitted indicating that the Medicaid RAC program cannot be established until legislative authority is granted.

Contingency Fees and Other Payment Matters

Sections 1902(a)(42)(B)(ii)(I) and (II) of the Act provide that payments to Medicaid RACs are to be made only from amounts "recovered" on a contingent basis for collecting overpayments and in amounts specified by the State for identifying underpayments. CMS will not dictate contingency fee rates, but will establish a maximum contingency rate for which Federal Financial participation (FFP) will be available. This rate will be the highest contingency fee rate that is paid by CMS under the Medicare RAC program.

Currently, the four Medicare RAC contracts have an established period of performance of up to five years, beginning in 2009. The highest contingency fee rate is 12.5 percent. To make States aware of future Medicaid RAC contingency fee cap amounts, we expect to publish in a *Federal Register* notice, no later than December 31, 2013, the highest Medicare RAC contingency fee rate. This rate will apply to FFP availability for any Medicaid RAC contracts with a period of performance beginning on or after July 1, 2014. The established cap would be in place based on the period of performance of the Medicare RAC contracts. A State that determines that it must pay a contingency rate above CMS' ceiling rate (for example, in order to attract any qualified Medicaid RAC applicants) may request a waiver from CMS, or may elect to pay the differential amount between the ceiling and amount paid solely from State funds.

Contingency fee rates for identifying and collecting overpayments should be reasonable and determined by each State, taking into account factors including, but not limited to, the level of effort to be performed by the RAC, the size of the State's Medicaid population, the nature of the State's Medicaid health care delivery system, and the number of Medicaid RACs engaged. A State may pay Medicaid RACs on a contingency fee or flat fee basis for identifying underpayments and the percentage or amount may vary based on factors such as the amount of the identified underpayment. Whichever methodology a State employs, it should be appropriately structured to incentivize the Medicaid RAC to identify underpayments.

A State must refund the Federal Medical Assistance Percentage (FMAP) share of the net amount of overpayment recoveries after deducting the fees paid to Medicaid RACs. In other words, a State must take a Medicaid RAC's fee payments "off the top" before calculating the FMAP share of the overpayment recovery owed CMS. Overpayments are to be reported on the amount remaining after the fees are paid to the Medicaid RAC. This treatment of the fees and expenditures is linked directly to the specific statutory language implementing the Medicaid RAC requirements. It does not apply to any other provisions of Medicaid overpayment recoveries. Section 1902(a)(42)(B)(ii)(IV)(aa) of the Act also provides that amounts spent by a State to carry out the administration of the program are to be reimbursed at the 50 percent administrative claiming rate. CMS will share in States' expenditures through both the contingency fee with respect to payments to the Medicaid RACs and the administrative match for qualified administrative costs associated with the State's implementation and oversight of the Medicaid RAC program.

The total fees paid to a Medicaid RAC include both the amounts associated with (1) identifying and recovering overpayments, and (2) identifying underpayments. Due to the statutory limitations, total fees must not exceed the amounts of overpayments collected. We do not anticipate this will be a problem for States. Our experience with Medicare RAC contractors is that overpayment recoveries exceed underpayment identification by more than a 9:1 ratio. Therefore, a State will not need to maintain a reserve of recovered overpayments to fund RAC costs associated with identifying underpayments. However, the State must maintain an accounting of amounts recovered and paid. The State must also ensure that it does not pay in total Medicaid RAC fees more than the total amount of overpayments collected.

Because of the limitations placed on FFP by Section 1108(g) of the Act, Territories must assess the feasibility of implementing and funding Medicaid RACs in their jurisdiction. CMS will provide technical assistance to the Territories on how to implement the provisions in Sections 1902(a)(42)(B)(ii)(I), (II), and (IV) of the Act in their locality. CMS is encouraging the Territories to review the requirements of these provisions including regulations, when published, and contact the New York or San Francisco Regional Office to work on submitting a SPA or requesting an exception.

Appeals

Section 1902(a)(42)(B)(ii)(III) of the Act requires States to have an adequate process for entities to appeal any adverse decisions made by the Medicaid RACs. Each State has existing administrative appeals processes with respect to audits of Medicaid providers. So long as States are able to accommodate Medicaid RAC appeals within their existing Medicaid provider appeal structure, CMS is not requiring States to adopt a new administrative review infrastructure to conduct Medicaid RAC appeals.

Reporting

States will be required to report to CMS their contingency fee rates, along with other Medicaid RAC contract metrics such as the number of audits conducted, recovery amounts, number of cases referred for potential fraud, contract periods of performance, contractors' names, and other factors such as whether a State has implemented provider or service-specific Medicaid RACs. States will report certain elements of this information via the quarterly Form CMS-64, and other information via separate data reporting forms CMS will require.

Coordination

Section 1902(a)(42)(B)(ii)(IV)(cc) of the Act requires that CMS ensure that States and their Medicaid RACs coordinate their recovery audit efforts with other entities. These entities include contractors or entities performing audits of entities receiving Medicaid payments, as well as with Federal and State law enforcement entities including the U.S. Department of Justice, (including, without limitation, the Federal Bureau of Investigation), the Department of Health and Human Services' Office of Inspector General, State Medicaid Fraud Control Units (MFCUs), and State Surveillance and Utilization Review Units. We will work systematically, both internally and with States, to minimize the likelihood of overlapping audits.

States should ensure that contracts with Medicaid RACs provide that any indication of Medicaid (or other health care) fraud or abuse discerned by the Medicaid RACs will be referred timely either to the State MFCU or directly to an appropriate law enforcement organization. Likewise, States must take affirmative steps to ensure that Medicaid RACs do not duplicate or compromise the efforts of other contractors, entities or agencies that may be undertaking a fraud and abuse investigation. Such coordination should be undertaken in advance of any audit by a Medicaid RAC, and may be accomplished by negotiating a memorandum of understanding or reaching

another agreement between the Medicaid RAC and other Federal and State contractors or entities performing Medicaid audits, as well as the aforementioned law enforcement agencies. CMS expects that States will also provide ongoing information on the nature and direction of their respective Medicaid RAC activities. Moreover, CMS will issue supplemental guidance regarding the interface between Medicaid RACs and CMS' Medicaid Integrity Contractors at a later date.

Section 6411(a)(2)(A) of the Affordable Care Act requires CMS to coordinate the expansion of the RAC program to Medicaid with the States, particularly with respect to States that enter into contracts with Medicaid RACs prior to December 31, 2010. CMS will provide technical assistance and support to States to ensure these programs are compliant with Medicaid RAC program requirements, and will provide continuing guidance through the CMS Medicaid Program Integrity Technical Advisory Group.

Enclosed with this letter is a draft SPA preprint form in which States may attest to the implementation of the Medicaid RAC program, or indicate that the State does not intend to operate a program in accordance with the statutory requirements of Section 6411 of the Affordable Care Act, along with its reason(s) for not doing so. Additionally, the draft preprint requires States to attest that they are in compliance with the provisions of the Medicaid RAC program and, where appropriate, provide additional program details. Currently, CMS is seeking Office of Management and Budget approval to utilize the preprint. Accordingly, this form is recommended for use by States, but not required, until the Paperwork Reduction Act process is completed.

We look forward to our continuing work together as we implement this important legislation. If you have questions regarding the information presented in this letter, please contact Ms. Angela Brice-Smith, Director of the Medicaid Integrity Group, Center for Program Integrity, at Angela.Brice-Smith@cms.hhs.gov or 410-786-4340.

Sincerely,

/s/

Peter Budetti, M.D., J.D.
Deputy Administrator & Director
Center for Program Integrity

/s/

Cindy Mann
Deputy Administrator & Director
Center for Medicaid, CHIP and Survey & Certification

Enclosure
cc:

CMS Regional Administrators

CMS Associate Regional Administrators
Division of Medicaid and Children's Health

State Program Integrity Directors

Richard Fenton
Acting Director
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American Public Human Services Association

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Matt Salo
Director of Health Legislation
National Governor's Association

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Alan Weil, J.D., M.P.P.
Executive Director
National Academy for State Health Policy

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PROPOSED SECTION 4 - GENERAL PROGRAM ADMINISTRATION

4.5 Medicaid Recovery Audit Contractor Program

Citation	
Section 1902(a)(42)(B)(i) of the Social Security Act	_____The State has established a program under which it will contract with one or more recovery audit contractors (RACs) for the purpose of identifying underpayments and overpayments of Medicaid claims under the State plan and under any waiver of the State plan. ____The State is seeking an exception to establishing such program for the following reasons:
Section 1902(a)(42)(B)(ii)(I) of the Act	_____The State/Medicaid agency has contracts of the type(s) listed in section 1902(a)(42)(B)(ii)(I) of the Act. All contracts meet the requirements of the statute. RACs are consistent with the statute. Place a check mark to provide assurance of the following: _____The State will make payments to the RAC(s) only from amounts recovered. _____The State will make payments to the RAC(s) on a contingent basis for collecting overpayments.
Section 1902 (a)(42)(B)(ii)(II)(aa) of the Act	The following payment methodology shall be used to determine State payments to Medicaid RACs for identification and recovery of overpayments (e.g., the percentage of the contingency fee): _____ The State attests that the contingency fee rate paid to the Medicaid RAC will not exceed the highest rate paid to Medicare RACs, as published in the Federal Register. _____ The State attests that the contingency fee rate paid to the Medicaid RAC will exceed the highest rate paid to Medicare RACs, as published in the Federal Register. The State will only submit for FFP up to the amount equivalent to that published rate.

	_____The contingency fee rate paid to the Medicaid RAC that will exceed the highest rate paid to Medicare RACs, as published in the Federal Register. The State will submit a justification for that rate and will submit for FFP for the full amount of the contingency fee.
Section 1902 (a)(42)(B)(ii)(II)(bb). of the Act	_____The following payment methodology shall be used to determine State payments to Medicaid RACs for the identification of underpayments (e.g., amount of flat fee, the percentage of the contingency fee):
Section 1902 (a)(42)(B)(ii)(III) of the Act	_____ The State has an adequate appeal process in place for entities to appeal any adverse determination made by the Medicaid RAC(s).
Section 1902 (a)(42)(B)(ii)(IV)(aa) of the Act	_____ The State assures that the amounts expended by the State to carry out the program will be amounts expended as necessary for the proper and efficient administration of the State plan or a waiver of the plan.
Section 1902(a)(42)(B)(ii)(IV(bb) of the Act	_____ The State assures that the recovered amounts will be subject to a State's quarterly expenditure estimates and funding of the State's share.
Section 1902 (a)(42)(B)(ii)(IV)(cc) Of the Act	_____ Efforts of the Medicaid RAC(s) will be coordinated with other contractors or entities performing audits of entities receiving payments under the State plan or waiver in the State, and/or State and Federal law enforcement entities and the CMS Medicaid Integrity Program.