

Frequently Asked Questions  
Section 6411(a) of the Affordable Care Act  
December 2011

Section 6411(a) of the Affordable Care Act expanded the Recovery Audit Contractor (RAC) program to Medicaid and requires each State Medicaid program to establish a RAC program, absent an exception, to enable the auditing of claims for services furnished by Medicaid providers. These Medicaid RACs must identify overpayments and underpayments. In addition, States and their Medicaid RACs must coordinate their recovery audit efforts with other contractors or entities performing audits of entities receiving Medicaid payments, including State and Federal law enforcement with respect to the Department of Justice (including the Federal Bureau of Investigation (FBI)), the Inspector General of the Department of Health and Human Services, and the State Medicaid Fraud Control Units (MFCU), as well as other Federal and State law enforcement agencies, as appropriate. On September 16, 2011, the Centers for Medicare & Medicaid Services (CMS) published final Federal regulations (Final Rule) implementing this provision. See Final Rule. The effective date of the Final Rule is January 1, 2012. CMS anticipates sharing certain information about each State's Medicaid RAC through its Medicaid RACs-At-A-Glance website. Discussed below are the following: (1) operational guidance to States; and (2) general information regarding the Medicaid RAC program.

### **Medicaid RAC Program – Operational Guidance**

**Q1: When do States need to implement their Medicaid RAC programs? What does CMS mean by “implement”?**

A1: According to the Final Rule, States are required to implement their respective RAC programs by January 1, 2012. Implementation means that CMS expects a State to have a signed contract in place with its selected RAC vendor by January 1, 2012. If a State is unable to have a signed contract in place by January 1, 2012, then the State must request an exception from the implementation date from CMS by submitting a State Plan amendment (SPA) through the normal SPA process.

**Q2: What options do States have if they are unable to implement a Medicaid RAC program by January 1, 2012?**

A2: The deadline for implementing a RAC program according to the Final Rule is January 1, 2012. If a State is unable to implement a RAC program by the implementation date of January 1, 2012, then the State should request an exception to the implementation date by submitting to CMS a revised State Plan amendment (SPA) through the normal SPA process.

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**Q3: What flexibilities are afforded to States in the Final Rule as they design and implement their RAC programs?**

A3: In accordance with the Final Rule, States have considerable flexibility regarding the design, procurement and operation of their respective RAC programs including:

- Establishing the compensation structure for the identification of underpayments
- State appeals process
- State exclusion of claims from Medicaid RAC review
- Bundling of procurements
- Coordination of the collection of overpayments
- Contingency fee rates (States have complete flexibility in the contingency fee rates they pay, exclusive of Federal financial participation (FFP). Absent an exception, however, CMS will provide FFP only for amounts that do not exceed the then-highest contingency fee rate paid to Medicare RACs).

**Q4: Does the Medicaid RAC program include the review of claims from both Medicaid and the Children's Health Insurance Program (CHIP) or Medicaid only?**

A4: Section 6411 of the Affordable Care Act (ACA) expanded the RAC program to Medicaid and Medicare Parts C & D, not CHIP. Accordingly, CHIP is not included within the scope of the Medicaid RAC Final Rule. States, however, are not precluded from otherwise reviewing CHIP claims to identify overpayments and/or underpayments.

**Q5: What should a State do to prepare providers for Medicaid RAC audits? Will providers need to implement new compliance procedures?**

A5: A State should be as informative as possible about the implementation of its Medicaid RAC program. Information furnished to providers should include, at a minimum, the name and contact information of the RAC vendor selected by the State, when the RAC will begin working to identify overpayments and underpayments, and a general description of the scope of its RAC program. We do not expect that providers will have to undertake any major activities to prepare for Medicaid RACs. Providers may need to identify a point of contact, be aware of deadlines, prepare medical records, familiarize themselves with Medicaid coverage guidelines, as well as educate staff.

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**Q6: Are States required to have their Medicaid RACs review managed care claims?**

A6: No. The Final Rule at 42 CFR § 455.506(a)(1) provides that States may exclude Medicaid managed care claims from review by Medicaid RACs. At this time, CMS is only requiring State Medicaid RAC programs to review fee-for-service claims. In the future, CMS will evaluate if further rulemaking is necessary to include Medicaid managed care claims within the scope of Medicaid RAC review.

**Q7: Are States required to give providers advance notice about the audit areas on which the Medicaid RAC might focus similar to when the Medicare RAC program was initially implemented and providers received several communications with indications on specific focus areas for those RACs?**

A7: CMS is not requiring States to publicize the audit areas on which their Medicaid RACs will focus. States have a certain degree of flexibility to design their Medicaid RAC programs to fit their individual needs. However, we believe that States should promote transparency in their RAC programs. Encouraging RACs to give advance notice to providers of audit areas in preparation of a review is an example of how States can facilitate transparency.

**Q8: Does CMS expect a State to prescribe medical record limits in its Medicaid RAC contract?**

A8: The Final Rule at 42 CFR § 455.506(e) provides that a State must set limits on the number and frequency of medical records to be reviewed by its RAC. The State has flexibility to determine such limits. CMS will not prescribe a set number of medical records that may be reviewed by a Medicaid RAC. A State and its RAC vendor could agree, through an audit plan, on the number and frequency of medical records to be reviewed, e.g., limit of 300 medical records per audit for inpatient hospitals.

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**Q9: What is the required look-back period for Medicaid RAC audits?**

A9: The Final Rule at 42 CFR § 455.508(f) specifies that a Medicaid RAC must not review claims that are more than 3 years from the date the claim was filed, unless it receives approval from the State. In order to approve a request from its RAC to review claims that are greater than three years from the date of the claim, a State must first obtain an exception from the three-year look back period from CMS through the SPA process, as provided under 42 CFR § 455.516. Similarly, a State must also seek an exception as provided for under section 455.516, if the State decides to structure its RAC program with a look-back period of less than three years (for example, in the case that the State's MMIS system only retains adjustable claims data for two years). CMS does not object to a procedure pursuant to which the State and its RAC agree on the audit period to be reviewed for each provider.

**Q10: If a Medicaid RAC serves several States and has a Contractor Medical Director who is licensed in some, but not all of those States, do States where the Contractor Medical Director is not licensed need to seek an exception from 42 CFR § 455.508(b)?**

A10: In drafting the Final Rule for the Medicaid RAC program, CMS contemplated that the Contractor Medical Director would be licensed to practice medicine in the State that employs or otherwise contracts with the Medicaid RAC to review its Medicaid claims. If there are multiple States that enter into a single contractual arrangement under which such States hires one Medicaid RAC to serve these States, more than one FTE Contractor Medical Director may not be required to adequately ensure that claims are reviewed properly. Under this type of arrangement, States where the Contractor Medical Director is not licensed to practice medicine, must seek an exception from this requirement pursuant to 42 CFR § 455.516. However, States should be mindful of the volume of claims that could be audited by a RAC that serves multiple States. More than one FTE Contractor Medical Director might be necessary in order to ensure that RAC overpayment determinations are accurate.

Alternatively, in situations where a State has hired a Medicaid RAC that is also independently employed by or otherwise contracted with other States, i.e., distinct **multiple** contractual arrangements, the State must require its RAC to hire a minimum of 1.0 FTE Contractor Medical Director who is licensed to practice medicine in that State, unless the State receives an exception from CMS.

Whether a Medicaid RAC is independently engaged in a contractual arrangement by more than one State has no bearing on the need for each State to require its Medicaid RAC to employ or otherwise contract with 1.0 FTE Contractor Medical Director who is licensed in such State.

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States seeking an exception from this requirement must justify the basis for the exception request using the State plan amendment process.

**Q11: Will Medicaid RACs be required to target and audit all parts of a State's Medicaid program thereby targeting all providers for potential audit, or will States have the option to specify which provider types the RACs will target and audit? May States suggest to the RAC areas upon which to focus?**

A11: Medicaid RACs operate at the direction of the States. States have the discretion to determine what areas of their Medicaid programs to target based on the program integrity landscape in their respective States. States might also consider reports from oversight agencies like the Office of Inspector General (OIG) or Government Accountability Office (GAO) which may identify payment concerns as Medicaid program vulnerabilities. We expect that States and their RACs will work together to develop an audit plan.

**Q12: Is there a uniform standard requiring the Medicaid RACs to establish good cause to reopen a claim similar to the requirement in the Medicare program as found in 42 CFR § 405.986?**

A12: There is no provision in the Medicaid RAC Final Rule that requires the Medicaid RACs to demonstrate good cause for reopening and reviewing a claim that was already paid to the provider. States, therefore, have the flexibility to require their RACs to develop criteria in order to review a paid claim.

**Q13: How will CMS monitor and evaluate Medicaid RAC programs?**

A13: The Final Rule at 42 CFR § 455.502(c) requires States to comply with reporting requirements as specified by CMS. CMS will provide sub-regulatory guidance to States on those requirements at a later date. In addition, CMS intends to monitor and evaluate Medicaid RAC programs by: (1) conducting program integrity reviews, (2) collecting the State Program Integrity Assessment (SPIA); and (3) reviewing the overpayments that are collected by each State in connection with the Medicaid RAC program as reported on the CMS-64 form.

**Q14: What data will a Medicaid RAC use to identify overpayments and underpayments?**

A14: States should provide the Medicaid RACs with the most accurate data available in order to ensure the most accurate audit results. States should carefully consider the manner in which they share data and review the data to identify potential vulnerabilities. This should be incorporated as part of a contract that a State executes with a Medicaid RAC.

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**Q15: How can States identify vulnerabilities in their respective Medicaid programs?**

A15: CMS expects States and their Medicaid RACs to work together in order to identify vulnerabilities within each State Medicaid program. States might consider reviewing reports from oversight agencies that may identify program vulnerabilities. States can share information regarding vulnerabilities identified within their own State on the Resource Information Sharing System or other similar secure network on the internet.

**Q16: What are States required to do if their Medicaid RACs identify program vulnerabilities?**

A16: Although CMS has not set forth any specific requirements that States must follow when program vulnerabilities are identified, CMS encourages States to work with their RACs to identify potential program vulnerabilities or other similar problem areas as well as evaluate identified overpayments to determine if trends are apparent and whether solutions can be developed to address noted vulnerabilities. States can also use RAC findings to identify where provider education is needed in order to help prevent billing errors. CMS anticipates working with States to ensure that any program vulnerabilities that are identified by Medicaid RACs are addressed through policy changes, MMIS edits, or other alternatives available to the States. A key to the overall success of the Medicaid RAC program, as with all other program integrity initiatives, is to assess effectiveness and efficiencies, identify program vulnerabilities, and implement corrective action when necessary.

**Q17: Is a State required to perform quality assurance of the work performed by its Medicaid RAC?**

A17: CMS does not require a State to specify how it will ensure the accuracy of the audit findings of its Medicaid RAC. However, the Final Rule specifies that States must comply with reporting requirements describing the effectiveness of their Medicaid RAC programs as specified by CMS. One measure of performance accuracy, for example, may include the rate at which a RAC's overpayment determinations are reversed on appeal. We will provide sub-regulatory guidance to States on those requirements at a later date. A State should determine how it will validate the accuracy of its Medicaid RAC's overpayment determinations and incorporate this process in the Statement of Work (SOW) that is part of its contract with its Medicaid RAC.

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**Q18: How might States know best practices for implementing their Medicaid RAC program?**

A18: We anticipate that the Medicaid RACs At-A-Glance website, which can be found [here](#) will facilitate knowledge sharing among States on best practices. Additionally, we have previously shared with States the best practices from the Medicare Recovery Audit program. Furthermore, States with Medicaid RAC programs in place also shared their experiences and lessons learned about the development and implementation of a RAC program at the Medicaid Integrity Institute. We also plan to continue providing one-on-one technical assistance to States, hosting all-State calls, webinars, and offering Medicaid Integrity Institute training as appropriate.

**Q19: How will CMS enforce the requirement that States continue all program integrity (PI) activities, as indicated in the Final Rule? How will CMS prevent duplication of efforts in this regard?**

A19: CMS already conducts program integrity reviews in all States in 3-year cycles to ensure that State Medicaid programs are compliant with the State's Medicaid plan and Federal regulations. We intend to make every effort to incorporate and consolidate questions related to PI activities into scheduled PI reviews so as not to overburden States.

### **Procurements/Conflicts of Interest**

**Q20: Will CMS develop requirements for the type of contract States should procure to fulfill the requirements of the Medicaid RAC Final Rule?**

A20: Generally, the Medicaid RAC contracts must be contingency fee based for the identification and collection of overpayments, and States have discretion to determine the fee structure for the identification of underpayments. CMS does not expect to provide States with a list of potential vendors. However, we provided States with guidance and lessons learned from our experience with both the Medicare Recovery Auditors and the CMS Medicaid Integrity Contractors (MIC).

**Q21: What type of activities should be reflected in a State's procurement documentation (e.g., SOW, RFP)?**

A21: The Final Rule at 42 CFR §§ 455.506 and 455.508 reflects the requirements for Medicaid RACs that should be reflected in a State's procurement documentation. Medicaid RACs are required to identify overpayments and underpayments.

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Additional requirements include, but are not limited to, the following: (1) technical capabilities to carry out the activities required by States and their RACs; (2) staffing requirements; (3) certain customer service measures; (4) development of an education and outreach program; (5) referral of suspected cases of fraud and/or abuse to the State in a timely manner; and (6) any other requirements that the State may require.

**Q22: What if the size of a Medicaid program is too small to support the procurement of a RAC contract?**

A22: The statute requires all States to procure a RAC contractor. If a State believes that its unique situation may preclude it from meeting this requirement, the State should seek an exception from CMS. A State must submit a written justification for the exception request to the appropriate CMS Regional Office utilizing the State plan amendment process. CMS will consider a State's basis or rationale for a request for an exception.

**Q23: Is there a conflict of interest for a PERM contractor to also serve as a State's Medicaid RAC?**

A23: There may be a potential conflict of interest if the same entity acts as both Medicaid RAC and a PERM contractor. Because RACs are compensated based upon the amount of overpayments identified, this could impair the ability of the same entity to adequately measure payment error rates. We believe that States should be cognizant of potential organizational conflicts of interest and should take affirmative steps to identify and mitigate any conflicts of interest. CMS will continue to do the same. The following contractors currently serve on behalf of CMS as PERM contractors:

- A + Government Solutions, Inc.
- Livanta LLC
- The Lewin Group
- HealthDataInsights, Inc.

**Q24: Can fiscal agents or MMIS vendors perform the identification and recovery work associated with the Medicaid RAC program while simultaneously serving in the capacity of the respective State's fiscal agent or MMIS vendor?**

A24: CMS believes that there is an inherent conflict of interest if the same entity simultaneously acts as both a Fiscal Agent or MMIS vendor and a Medicaid RAC in the same State. We believe that States should be cognizant of potential organizational conflicts of interest and should take affirmative steps to identify and prevent any conflicts of interest.

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**Q25: Can a State contract with one of the current Medicare Recovery Auditors to serve as its Medicaid RAC?**

A25: Nothing in the statute or the Final Rule prohibits a State from contracting with a current Medicare Recovery Auditor. The following contractors serve on behalf of CMS as Medicare Recovery Auditors:

- Diversified Collection Services
- CGI
- Connolly, Inc.
- HealthDataInsights, Inc.

**Q26: Can a State contract with one of the current MICs to serve as its Medicaid RAC?**

A26: Although nothing in the statute or the Final Rule prohibits a State from attempting to contract with a current MIC, there may be a conflict of interest if the same entity acts as both a MIC and a Medicaid RAC in the same State. We believe that States should be cognizant of potential organizational conflicts of interest and should take affirmative steps to identify and address any conflicts of interest. The following contractors currently serve on behalf of CMS as MICs:

- Thomson Reuters
- IntegriGuard
- AdvanceMed
- Health Integrity
- Island Peer Review Organization
- Booz Allen Hamilton

**Q27: If a State has a third party liability (TPL) contractor that is paid on a contingency basis, can it use that TPL contract to fulfill the Medicaid RAC requirement?**

A27: No. TPL contracts do not meet the requirements of a Medicaid RAC. Because TPL contractors do not perform audits, a contingency fee-based TPL contract will not meet the requirements of a Medicaid RAC. Although a State is not prohibited from using the same **contractor** for both its TPL and Medicaid RAC programs, it is unlikely a State will be able to use the same **contract** to fulfill the requirements of a Medicaid RAC. The State should be cognizant of conflicts of interest with TPL contracts.

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**Q28: What happens if a State does not receive any responses to its RAC RFP?**

A28: States that are unable to get a vendor to bid on a RAC contract in their States can request an exception to the Medicaid RAC program requirements by submitting an exception request to the appropriate CMS Regional Office utilizing the State plan amendment process. States may also wish to consider partnering with other States in order to attract a RAC.

**Q29: If a State has reached an agreement with its RAC to compensate the RAC at a rate that is above the highest contingency fee paid to a Medicare Recovery Auditor, is the excess rate eligible for Federal financial participation?**

A29: States that agree to pay their RAC a contingency fee that is greater than the highest fee paid to a Medicare Recovery Auditor may either use State funds to pay the differential between the agreed upon fee and the highest contingency fee paid to Medicare Recovery Auditors, or request an exception from the maximum fee rate from CMS. Any changes to the contingency fee percentage will be published in a *Federal Register* notice.

**Q30: Will CMS provide a list of potential Medicaid RAC vendors to the States?**

A30: CMS does not plan to provide States with a list of potential vendors. CMS will provide support to States during the solicitation process as requested and appropriate.

### **Medicaid RAC Appeals Process**

**Q31: What responsibilities will States have regarding the administrative appeals process?**

A31: Pursuant to the Final Rule at 42 CFR § 455.512, States are required to provide appeals rights under State law or administrative procedures to Medicaid providers that seek review of an adverse Medicaid RAC determination. Each State has the flexibility to decide the structure of its administrative appeals process. A State may elect to use its existing administrative appeals process, or it may create a new process for RAC-related appeals. If a State creates a new appellate process, it is required to submit the new proposed process to CMS for review. A State may also choose, where permissible under State law, to model its Medicaid RAC administrative appeals process in a manner similar to the Medicare program. Notwithstanding how the appeals process is implemented, in all cases, Medicaid RAC fees must be returned, within a reasonable timeframe as determined by the State, to the extent that the identified overpayments are overturned at any level of appeal as provided in the Final Rule.

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**Q32: What are the Medicaid RACs' responsibilities during the appeals process?**

A32: Generally, it is up to the States to determine the responsibilities of their RACs during the appeals process. States should include these responsibilities in the contracts the States have with their RACs. CMS requires the Medicare Recovery Auditors and CMS's MICs to provide support throughout the administrative or judicial appeals process and strongly suggests that States consider making this a requirement for their Medicaid RACs.

**State Reporting of Improper Payments Identified by Medicaid RACs**

**Q33: Will States be required to return the Federal share of overpayments recovered by the Medicaid RACs?**

A33: Yes. States are required to return the Federal share of any overpayments recovered. This will be reported on the quarterly Form CMS-64 report submission.

**Q34: How should a State report its overpayment recoveries and fees associated with the Medicaid RAC program on the quarterly Form CMS-64?**

A34: A State is required to refund the Federal share of the net amount of overpayment recoveries **after** deducting the contingency fees paid to its RAC, up to the maximum contingency fee percentage allowed absent an exception. In other words, a State should take a RAC's contingency fee "off the top" **before** calculating the Federal share of the overpayment recovery to be returned to CMS. In order to adequately identify recoveries and fees paid, at the correct Federal share, States must report both the recoveries and fees. The recoveries and associated fees would be reported at the same Federal matching assistance percentage (FMAP) rate as paid for the overpayment. Similarly, the fee paid for identifying an underpayment would be reported at the same FMAP rate as the payment of the underpayment amount, or the current FMAP rate if the underpayment is not paid.

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**Medicaid RAC Program – Audit Coordination**

**Q35: How will States and/or CMS ensure coordination and avoid duplication of effort among RACs, MICs, ZPICs, and State agencies' contractors? What actions does a State or its Medicaid RAC need to take to reduce the likelihood that providers will receive duplicative audit requests from different auditing entities?**

A35: A State and any Medicaid RAC under contract with the State must coordinate with other entities performing audits of entities receiving payments under the State plan, including coordinating with Federal and State law enforcement. We are working with States to gain input on how this might be most efficiently accomplished and, once finalized, we will issue additional guidance on this aspect of implementation.

**Q36: When should Medicaid RAC audit activity yield to other agencies and/or entities that perform similar audits of providers and suppliers that receive Medicaid payments?**

A36: CMS is concerned about potential duplicative audits of providers and suppliers as well as compromising the auditing efforts of other contractors, entities or agencies. According to section 1902(a)(42)(B)(ii)(IV)(cc) of the Social Security Act, Medicaid RACs must agree to coordinate their audit activity with other auditing entities including, but not limited to, the following: (1) U.S. Department of Justice; (2) Federal Bureau of Investigation; (3) Office of Inspector General of the U.S. Department of Health and Human Services; (4) State Medicaid Fraud Control Units; and (5) CMS. To the extent that a provider is already being investigated by a Federal or State law enforcement agency, then such agency's audit activity takes precedence over the Medicaid RAC's audit activity. For example, if a provider is already being audited by the Office of Inspector General or a MFCU, then such activity takes precedence over the Medicaid RAC. Similarly, if CMS or the State Medicaid program is already auditing a provider or supplier, then the Medicaid RAC should not proceed with an audit of that same provider or supplier.

**Q37: Will the Medicaid RACs review claims that the Medi-Medi contractor would also be reviewing, or should they exclude these claims from their review? There could be a risk for potential overlap between the Medi-Medi program and the Medicaid RACs if both contractors were reviewing the same claims at the same time.**

A37: There is a possibility that the Medi-Medi contractors and the Medicaid RACs will review the same claim(s). However, these entities review claims for different purposes. The CMS Medi-Medi contractors are tasked with matching Medicare

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and Medicaid data to identify potential fraud, waste and abuse and do not conduct audits, whereas the Medicaid RACs are auditing claims to identify overpayments and underpayments. In order to minimize the burden associated with multiple contractors reviewing the same claim at the same time, we encourage States to minimize the overlap between contractors to the extent possible.

**Q38: What should a State do when its Medicaid RAC identifies potential fraud?**

A38: The Final Rule at 42 CFR § 455.508(h) specifies that States are required to make referrals of suspected fraud and/or abuse as defined in 42 CFR § 455.2 to the MFCU or other appropriate law enforcement agency.

### **Medicaid RAC Program Exceptions**

**Q39: How does a State seek an exception from implementing the Medicaid RAC program or components of the Medicaid RAC program?**

A39: States may seek to be excepted from implementing the entire Medicaid RAC program or any of the requirements of the RAC program. In order to receive an exception, States must submit a written justification for the exception request to the appropriate CMS Regional Office utilizing the State plan amendment process. We anticipate granting complete Medicaid RAC program exceptions rarely and under the most compelling of circumstances.

**Q40: If State law prohibits contracts based on contingency payments, what does CMS recommend or allow as the alternative?**

A40: CMS does not recommend a particular payment methodology or compensation structure as an alternative to contingency payments. CMS believes that States should compensate their RACs consistent with State law. If State law prohibits contingency fee contracts, then the State may seek an exception from the requirement to pay its Medicaid RAC on a contingency fee basis and approval to use a different compensation structure. For example, a State should seek an exception if it is going to pay its RAC a flat fee for the identification of overpayments and underpayments. In order to receive an exception, States must submit a written justification for the exception request to the appropriate CMS Regional Office utilizing the State plan amendment process.

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**Contingency Fees**

**Q41: Will a State be required to set a cap on the contingency fees paid to its Medicaid RAC?**

A41: Generally, the contingency fee a State pays to its Medicaid RACs may not exceed that of the highest fee paid to a Medicare Recovery Auditor, as specified by CMS in the *Federal Register*. A State that wants to pay its RAC in excess of this amount may either pay the differential using State-only funds, or request an exception from CMS, and justify its reasons as to why the Federal portion of the contingency fee should be higher than the current cap paid to Medicare Recovery Auditors.

**Q42: How are contingency payments to Medicaid RACs calculated?**

A42: Contingency fees that are paid to Medicaid RACs must come from the overpayment amounts that are recovered from providers. These overpayments are comprised of both a State and Federal portion. The contingency fee paid to a Medicaid RAC must not exceed the current highest rate paid to a Medicare Recovery Auditor, unless the State receives an exception from CMS. The Federal portion of that contingency fee is based upon the FMAP rate at which the original claim was paid to the provider. Similarly, the Federal share of the remaining overpayment amount that the State must return to CMS should also be based on the FMAP rate of the original claim.

**Q43: Should a State pay its Medicaid RAC the same contingency fee for both overpayments and underpayments?**

A43: It is within the State's discretion to determine what fee will be paid to its RAC for the identification of underpayments. States are not required to use the same fee rate for both overpayments and underpayments. However, 42 CFR § 455.510(c)(2) requires a State to ensure that its Medicaid RAC is adequately incentivized to detect underpayments. CMS may monitor the methodologies and amounts paid by States to Medicaid RACs and may consider future rulemaking depending on the resulting data.

**Q44: Can a State use a tiered structure to make contingency fee payments to its Medicaid RAC?**

A44: A State is permitted to use a tiered structure for contingency fee payments to its Medicaid RAC, as long as the maximum fee percentage does not exceed the highest fee CMS pays to the Medicare Recovery Auditors, absent an exception. FFP will not be paid for amounts paid to Medicaid RACs above the highest fee paid to a Medicare Recovery Auditor unless the State requests and is granted an

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exception to that maximum rate. Any such tiered structure must also ensure that the Medicaid RAC is incentivized to identify underpayments as well as overpayments.

**Q45: Can a State pay a Medicaid RAC for cost avoidance, for example, using a Medicaid RAC to do pre-payment audit of claims?**

**A45:** The intent of the Medicaid RAC program is to audit post-payment claims. The amount recovered is the basis of the compensation paid by a State to its Medicaid RAC. Accordingly, a State's Medicaid RAC program should not be structured to perform activities that are not based on the review of post-payment claims. This includes pre-payment reviews and other similar activities.

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**Medicaid RAC Program – Stakeholder Inquiries & General Information**

**Q1: Will the Medicaid RAC program replace CMS’s MICs? What will be the ongoing role of MICs in light of the addition of the Medicaid RAC program?**

A1: CMS does not intend to replace the MICs with the Medicaid RACs. The CMS National Medicaid Audit Program is complementary to the Medicaid RAC program. CMS will be monitoring State Medicaid RAC efforts and consider how to maximize the goals of the National Medicaid Audit Program in light of these efforts.

In addition, the focus of these two programs differs. For example, the discovery of fraudulent schemes by the National Medicaid Audit Program may not always lead to overpayment recoveries, which provide the source of RAC fees. Moreover, Medicaid RAC programs are poised to address State-specific issues stemming from the individual characteristics of each State’s Medicaid program (e.g., special payment structures under a Medicaid demonstration) and will focus on the needs and vulnerabilities associated with a particular State. In contrast, Federal MICs are poised to address vulnerabilities on a regional and national basis. These regional and national trends would likely go undetected by an individual Medicaid RAC. Accordingly, the National Audit program is complementary to a State Medicaid RAC program.

**Q2: What are the key differences between Medicaid RACs and Payment Error Rate Measurement (PERM) contractors?**

A2: Medicaid RACs are contractors working directly for States for the purpose of identifying underpayments and identifying and recouping overpayments under the State plan and any waivers of the State plan with respect to all services for which payment is made to any entity under such plan or waiver. Through the PERM program, CMS calculates State and national Medicaid and CHIP error rates based on randomly sampled, fee-for-service claims as well as reviews of individual beneficiary-level claims and payments and through eligibility sampling and review of beneficiary records. By design, PERM does not focus on areas suspected or known to be at risk for improper payments, and instead provides an unbiased estimate of the rate of improper payments across the program as a whole.

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**Q3: Providers who operate in a multi-State area have expressed concerns that coordinating with audit requests from individual Medicaid RACs for every State in which they operate could result in a significant administrative burden for such providers. How will the Medicaid RAC Final Rule impact these providers?**

A3: CMS understands the concerns of providers who participate in multiple State Medicaid programs and the potential administrative burden associated with responding to audits from more than one State Medicaid RAC. However, we believe that Medicaid providers who operate in a multi-State area are accustomed to operating in compliance with the rules of each State Medicaid program in which they operate. In the Final Rule, CMS has tried to minimize the impact of the Medicaid RAC program on providers, to the extent possible. For example, CMS established a 3-year maximum look-back period as well as required the State to set limits on the number and frequency of medical records to be reviewed by its RAC, subject to requests for exception from the RAC.

**Q4: When should States anticipate obtaining recoveries of overpayments in connection with their State Medicaid RAC programs?**

A4: States that already have Medicaid RAC programs in place indicated that recoveries may begin anywhere between twelve (12) and eighteen (18) months from the start of the program. Based on our experience with the Medicare Recovery Auditor program, we received recoveries in year one of the program. Importantly, as with the Medicare Recovery Auditor program, we anticipate that recoveries in the Medicaid RAC program will increase in subsequent years as RACs become more familiar with the program and identifying overpayments in Medicaid.

**Q5: How is CMS addressing the concern that State budgetary shortfalls may negatively impact the creation of a Medicaid RAC program?**

A5: Medicaid RACs are a part of an initiative to reduce waste and improper payments and recoup improper payments. We believe that the Medicaid RAC program will lead to significant long-term savings for States. Because the statute requires that the fees paid to a Medicaid RAC must come from amounts recovered and a contingency-fee contracting payment methodology, out-of-pocket expenses are minimized compared with other payment methodologies and the majority of program costs incurred by States will be offset by overpayment recoveries. Nevertheless, States may seek to be excepted from implementing the entire Medicaid RAC program or any of the requirements of the RAC program. In order to receive an exception, States must submit a written justification for the exception request to the appropriate CMS Regional Office utilizing the State plan amendment process. We anticipate granting complete Medicaid RAC program exceptions rarely and under the most compelling of circumstances.

Frequently Asked Questions  
Section 6411(a) of the Affordable Care Act  
December 2011

**Q6: What are some of the major differences between the Medicaid RAC and Medicare Recovery Audit programs that providers should be aware of?**

A6: Medicaid RACs are private contractors working directly for States for the purpose of identifying underpayments and identifying and recouping overpayments. States are required to procure RACs and pay Medicaid RACs on a contingency fee basis with regard to overpayments. States may specify the manner in which Medicaid RACs will be compensated to identify underpayments. Medicare Recovery Auditors are private contractors working directly for CMS. Medicare Recovery Auditors are procured, administered and paid by CMS. The mission of the Medicare Recovery Audit program is to reduce improper payments through the efficient detection and collection of overpayments as well as the identification of underpayments made in Medicare's fee-for-service program. CMS is authorized to pay its Recovery Auditors on a contingency fee basis which is based on the principal amount of the collection or the amount paid back to a provider (underpayments). Currently, there are four Medicare Recovery Auditors operating on a regional basis.

**Q7: Will Medicaid RACs review the same (or similar) issues as their Medicare counterparts?**

A7: States have the discretion to determine what areas of their Medicaid programs to target based on the program integrity landscape in their respective States.

**Q8: Does the Final Rule for the Medicaid RAC program incorporate any of the lessons learned from the Medicare RAC demonstration program?**

A8: Yes. In the development of the Final Rule, CMS began with the premise that as with State Medicaid programs in general, Medicaid RAC programs are State administered and operated. However, we received numerous public comments in response to the proposed rule requesting alignment with the Medicare Recovery Auditor program. Accordingly, in the Final Rule we strived to maintain a balance between State flexibility to structure their respective RAC programs and providers' requests for alignment with the Medicare Recovery Auditor program.