

DEPARTMENT OF HEALTH CARE FINANCE

NOTICE OF SECOND PROPOSED RULEMAKING

The Director of the Department of Health Care Finance (DHCF), pursuant to the authority set forth in An Act to enable the District of Columbia to receive federal financial assistance under Title XIX of the Social Security Act for a medical assistance program, and for other purposes, approved December 27, 1967 (81 Stat. 744; D.C. Official Code §1-307.02 (2012 Repl. & 2014 Supp.)), and section 6(6) of the Department of Health Care Finance Establishment Act of 2007, effective February 27, 2008 (D.C. Law 17-109; D.C. Official Code §7-771.05(6) (2012 Repl.)), hereby gives notice of the intent to adopt an amendment to Chapter 93 (Medicaid Guidelines for Recovery Audit Contractors) of Title 29 (Public Welfare) of the District of Columbia Municipal Regulations (DCMR).

State Medicaid programs are required, under § 6411 of the Patient Protection and Affordable Care Act of 2011 (the Affordable Care Act or ACA), approved March 23, 2010 (Pub. L. No. 111-148; 124 Stat. 119), to establish a Recovery Audit Contractor (RAC) program. Through these programs, states can coordinate with contractors or other entities that perform Medicaid claim audits to better identify and reconcile Medicaid provider overpayments and underpayments. Timely identification of Medicaid provider overpayments and underpayments is an important safeguard against future improper Medicaid payments.

Further, challenges to the RAC program initiative could create delayed recovery revenue for the Medicaid program, lost recovery opportunities for claims that expire during the Medicaid RAC review period, and provider confusion. In turn, those losses and provider confusion could negatively impact the delivery of healthcare services to District Medicaid beneficiaries.

This second proposed rulemaking correlates to an amendment to the District of Columbia State Plan for Medical Assistance (State Plan) which requires approval by the District of Columbia (Council) and the U.S. Department of Health and Human Services, Centers for Medicaid and Medicare Services (CMS). The Council approved the State Plan Amendment (SPA) on June 4, 2012 (PR19-0694). Subsequently, CMS approved the SPA with an effective date of December 1, 2012.

A Notice of Proposed Rulemaking was published on February 8, 2013 (60 DCR 001563). The proposed rulemaking received several comments. Substantive changes have been made that increase the number of days a provider is allowed to submit requested medical records to a Medicaid RAC, clarify the provider notification process when a claim is subject to recoupment based on the Medicaid RAC's determination, and clarify the time limit for filing an appeal. A new subsection 9300.4 was also added to clarify that all audits performed by the Medicaid RAC shall be subject to the billing standards of the District Medicaid program. These changes are necessary for successful implementation of the RAC program initiative.

The Director adopted the proposed rules on October 21, 2015. The Director gives notice of the intent to take final rulemaking action to adopt these proposed rules in not less than thirty (30) days from the date of publication of this notice in the *D.C. Register*.

Chapter 93, Medicaid Guidelines for Recovery Audit Contractors, of Title 29 DCMR is added to read as follows:

93 MEDICAID RECOVERY AUDIT CONTRACTOR PROGRAM

9300 GENERAL PROVISIONS

- 9300.1 In accordance with the requirements set forth in § 1902(a)(42)(B)(i) of the Social Security Act (the Act), (42 U.S.C. § 1396a(a)(42)(B)(i)) and 42 C.F.R. §§ 455.500 *et seq.*, the Department of Health Care Finance (DHCF) shall establish the Medicaid Recovery Audit Contractor (Medicaid RAC) Program.
- 9300.2 The Medicaid RAC Program shall support program integrity efforts by identifying overpayments and underpayments, and fraudulent and abusive claims activity.
- 9300.3 Subject to the requirements set forth in the Procurement Practices Reform Act of 2010, effective April 8, 2011, (D.C. Law 18-371; D.C. Official Code §§ 2-351.01, *et seq.*) (2011 Repl.), DHCF shall contract with one (1) entity that shall be the Medicaid RAC pursuant to 42 CFR §§ 455.500-455.518.
- 9300.4 All audits performed by the Medicaid RAC shall be subject to the billing standards of the District of Columbia (District) Medicaid program.
- 9300.5 The following claims and payments may be excluded from review and audit under the Medicaid RAC Program:
- (a) Claims associated with managed care, waiver, and demonstration programs;
 - (b) Payments made for Indirect Medical Education (IME) and Graduate Medical Education (GME);
 - (c) Claims older than three (3) years from the date of reimbursement;
 - (d) Claims that require reconciliation due to beneficiary liability; and
 - (e) Unpaid claims.
- 9300.6 In accordance with 42 C.F.R. §§ 455.506(c) and 455.508(g), DHCF shall ensure that no claim audited under the Medicaid RAC Program has been or is currently being audited by another entity.
- 9300.7 DHCF shall reserve the right to limit the Medicaid RAC Program audit period by claim type, provider type, or by any other reason where DHCF believes it is in the best interest of the Medicaid program to limit claim review. Notice to the Medicaid RAC of this action shall be in writing and may be communicated through e-mail.

9301 MEDICAL RECORDS REQUESTS

9301.1 Each provider shall make medical records available to the Medicaid RAC upon request, subject to the provisions in this section. Providers may submit medical records in hardcopy or electronic format.

9301.2 Providers shall have thirty (30) business days from the date of the Medicaid RAC request to provide the requested medical records. Failure to submit the requested records within this timeframe, unless an extension has been granted to the provider by the Medicaid RAC, will result in the Medicaid RAC making a determination of improper payment.

9302 GUIDELINES FOR RECOUPING OVERPAYMENTS AND RECONCILING UNDERPAYMENTS

9302.1 A Medicaid provider may be subject to recoupment or reconciliation of claims based on the Medicaid RAC findings.

9302.2 A determination of overpayment or underpayment shall be based on, but not limited to, one or more of the following:

- (a) Whether the service underlying the claim is covered under the District Medicaid program;
- (b) Whether the claim resulting from the service was priced correctly in accordance with billing standards for the District Medicaid program;
- (c) Whether the provider properly coded the claim in accordance with billing standards for the District Medicaid program;
- (d) Whether the claim duplicates a previously paid claim; and/or
- (e) Whether the Medicaid Management Information System (MMIS) failed to apply relevant payment policies.

9302.3 DHCF or the Medicaid RAC shall notify a provider, in accordance with the requirements set forth in Chapter 13 of Title 29 DCMR, when a claim is subject to recoupment based on the Medicaid RAC's determination.

9302.4 Pursuant to Chapter 13 of Title 29 DCMR, a provider may appeal an overpayment determination by the Medicaid RAC to the Office of Administrative Hearings (OAH) within fifteen (15) calendar days of the date the final notice of recoupment was sent to the provider.

9399 DEFINITIONS

For the purposes of this chapter, the following terms shall have the meanings ascribed:

Audit – A systematic process where an entity reviews Medicaid claims, obtains evidence, evaluates findings, and determines compliance with applicable laws, regulations, and policies.

Beneficiary – An individual who is eligible for Medical Assistance (Medicaid) under Titles XIX or XXI of the Social Security Act.

Demonstration – A project approved by CMS and authorized under Section 1115 of the Social Security Act.

Managed Care – The program authorized under section 1915(b) of the Social Security Act in which Medicaid beneficiaries are enrolled into managed care organizations to receive services.

Waiver – A program operated by a state or by the District of Columbia pursuant to a CMS-approved application to waive standard Medicaid provisions to deliver long term care in community-based settings.

Comments on these proposed rules shall be submitted in writing to Claudia Schlosberg, JD, Senior Deputy/State Medicaid Director, Department of Health Care Finance, 441 4th Street, NW, Ninth Floor South, Washington, DC 20001, via email at DHCFPubliccomments@dc.gov, online at www.dcregs.dc.gov, or at (202) 442-8742, within thirty (30) days after the date of publication of this notice in the *D. C. Register*. Additional copies of these proposed rules may be obtained from the above address.