DEPARTMENT OF HEALTH CARE FINANCE

<u>NOTICE OF FINAL RULEMAKING</u>

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 (2014 Repl. & 2015 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 adoption of an amendment to Chapter 93 (Medicaid Recovery Audit Contractor Program) 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.

A Notice of Proposed Rulemaking was published in the *D.C. Register* on October 30, 2015 at 62 DCR 014111. The comment period officially closed on November 30, 2015. Comments were received from the District of Columbia Hospital Association. Following discussion with the Hospital Association, DHCF concluded that no substantive changes were required for this final rulemaking.

The Hospital Association specifically suggested the following in its comments: (1) a further extension to the time period for providers to furnish requested medical records to the RAC; (2) an extension to the time period for providers to appeal overpayment determinations to the Office of Administrative Hearings; and (3) a limitation on the number and type of claims that can be reviewed by the RAC within a given amount of time.

DHCF indicated the following in its responses to the commenter: (1) the time period for providers to furnish requested medical records had already been extended in the second proposed rulemaking based on public comments, and that if providers need more time to furnish the requested records they are able to request an extension from the RAC; (2) the time period for providers to appeal overpayment determinations to the Office of Administrative Hearings is set by the provisions of Chapter 13 of Title 29 DCMR; and (3) as the RAC discusses specific audit requirements with each provider, DHCF does not wish to prescribe limitations on the number or

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type of claims to be furnished to the RAC. Furthermore, DHCF wishes to allay the commenter's concern in this regard by noting that, as described above, providers may request an extension to furnish requested medical records to the RAC if additional time is needed to provide the number or type of records requested.

The Director adopted these rules as final on February 1, 2016, and they shall become effective on the date of publication of this notice in the *D.C. Register*.

Chapter 93, MEDICAID RECOVERY AUDIT CONTRACTOR PROGRAM, of Title 29 DCMR, PUBLIC WELFARE, is amended to read as follows:

    CHAPTER 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.* (2012 Repl.)), DHCF shall contract with one (1) entity that shall be the Medicaid RAC pursuant to 42 C.F.R. §§ 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.

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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.

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