Centers for Medicare & Medicaid Services
Update on Medicaid Integrity Program Open Door Forum
Moderator: Barbara Cebuhar
November 3, 2010
1:00 p.m. CT

Operator: Good afternoon. My name is (Alicia), and I will be your conference facilitator today. At this time, I would like to welcome everyone to the Centers for Medicare & Medicaid Services Update on Medicaid Integrity Program Open Door Forum. All lines have been placed on mute to prevent any background noise.

After the speakers' remarks, there will be a question-and-answer session. If you would like to ask a question during this time, simply press star then the number one on your telephone keypad. If you would like to withdraw your question, please press the pound key. Thank you.

Ms. Barbara Cebuhar, you may begin your conference.

Barbara Cebuhar: Good afternoon, everyone, and welcome to our Open Door Forum. My name is Barbara Cebuhar and I work in the PartnerCHIP Relations Group of the Office of External Affairs here at CMS.

The Centers for Medicare & Medicaid Services is committed to minimizing waste, fraud and abuse in Medicaid which diverts dollars that could otherwise be spent by states to safeguard the health and welfare of Medicaid beneficiaries.

CMS has two broad responsibilities under the Medicaid Integrity Program. The first, to implement and oversee the national Medicaid provider audit program, and the second, to provide effective support and assistance to states and their efforts to combat Medicaid provider fraud and abuse.

Today, we are going to learn more about the Medicaid program integrity activities from the last 12 months as well as to get a summary of ongoing activities from the Medicaid Integrity Program division director.

I'd like to turn the meeting over to Angela Brice-Smith who is the Director of the Medicaid Integrity Group who will give you a perspective of how the national Medicaid audit program is evolving including some recent policy changes that we have implemented.

Our hope is that this Open Door Forum will provide an opportunity to get feedback from you and get a sense of the lessons learned during the initial 18 months of the Medicaid audit program and will offer an opportunity to discuss areas for improvement.

If there are questions that come up on this call that you're unable to ask or if we ran out of time, please feel free to use the following email address to reach us, and its medicaid_integrity_group@cms.hhs.gov.

Angela, I'm turning it over to you now.

Angela Brice-Smith: Thank you, Barbara. Welcome. My name is Angela Brice-Smith. I'm the Director of the Medicaid Integrity Group. I appreciate Barbara mentioning and highlighting some of the activities that we planned to really spend some time with you on, over the past few months that I've been on board at least. And we want to inform you of the recent policy changes that we've also put into effect so that the providers can be aware of them as well.

In April of this year, Secretary Sebelius established the Center for Program Integrity within CMS. When she did that, she basically tapped the new leader of that group, Peter Budetti, J.D., M.D. to lead that group, and her intent was to bring both sides of the house, both sides of the various federal healthcare programs together, that is Medicare and Medicaid and CHIP (typically on the Medicaid side).

We refer to Medicaid primarily for our Medicaid integrity efforts but I think you will see oftentimes in any regulations going forward that CHIP may be

included in proposed rulemaking so that we are consistent across all programs.

CPI, Center for Program Integrity's goal has been to ensure correct payments are made to legitimate providers for appropriate and reasonable services to eligible beneficiaries. Our activities and practice focus on two main areas – one is preventing and reducing improper payments, and two, preventing fraud, waste and abuse.

Secondly, I'd like to highlight two recent policy changes regarding the audit program and that information is published on the CMS Web site. When I say CMS Web site, I'm referring to cms.gov, so www.cms.gov, and you would go to – once that screen comes up, you would scroll down to the Medicaid which will be on the left column, click on that and then Medicaid section will come up and in the right column at the very top will be the Medicaid Integrity Program.

And if you double-click on that, you will go to What Is New section and you can actually download the bulletin that we recently released about those two areas which are Reference to Look-Back Period for Audits and the Documentation Request.

In terms of the look-back period, what the bulletin describes is that we want to establish a consistent audit look-back period of five years. The five-year period again, from the start of the audit to the date the engagement letter is sent to the provider.

Secondly, we've extended the amount of time allowed to providers to produce the records. Previously, it was 10 business days to produce records and we have extended that period to 30 business days with an option to an extension if that is necessary.

With that said, let me talk a little bit about the infrastructure of the Medicaid Integrity Group so that you'll have some sense of the features that we'll be speaking shortly.

Basically, in MIG, in the Medicaid Integrity Group, there are basically four divisions. The first speaker, the director is Barbara Rufo, but her Deputy will be speaking today, Crystal High, and they had led the area of Division of Medicaid Integrity Contracting. So they handle the procurement activities and the oversight activity for the review MICs, the audit MICs and the education MICs, and you'll hear more about that shortly.

Then you will hear from Mark Anderson who's our Acting Director for the Division of Fraud Research and Detection, and he'll describe for you how we perform our analytics and develop algorithms to actually target our audits in the Medicaid program.

Then you will hear from our Director of Division of Field Operations and he is Robb Miller, and about 50 percent of my staff is out in the field located in roughly five regional offices.

And you'll hear about the activities that they perform in terms of what I refer to as boots on the ground, in terms of assistance to the states, in terms of also overseeing and sorting the Medicaid Integrity Institute and oversight activities in terms of monitoring through state program integrity reviews.

And then the fourth speaker will be Monica Harris. She's the Director of the Division of Auditing and Accountability. That is a new division. Basically much of the staff of that was moved from the MIG front office.

But their main area of responsibility is finalizing those final audit reports that go to the state and then she's actively involved in a lot of Executive Order reporting, a lot of the executive order around in improper payments, metrics and accountability issues around tracking our activities and reporting our activities around the Affordable Care Act.

With that said, I think we can go ahead and turn it over to – I'll have it first go to Crystal High to talk about Division of Medicaid Integrity Contracting and then we'll open it up for Qs&As at the very end of the session just so you can sort of experience the full content of all the activities that are going on in the Medicaid Integrity Group. Thank you. Crystal.

Crystal High: Thank you, Angela. As Angela indicated, I'm Crystal High. I'm the Deputy Director of the Division of Medicaid Integrity Contracting. The division is charged with the contract management and oversight of the Medicaid Integrity Contractors referred to as the MIC as well as other support contracts.

The Medicaid Integrity Group has three types of MICs. They are the Review of Provider, Audit and Education MICs. The Review of Provider performs data analysis. They are to develop algorithm and perform data trend analysis.

The Audit MIC is charged with conducting audit to identify inappropriate payments. And the Education MIC develops educational materials and performs education outreach to providers and other stakeholders.

The review of provider and audit IDIQ contract identifies five jurisdictions. They are the New York jurisdiction which is comprised of Regions I and II, Atlanta, comprised of Regions III and IV, Chicago, V and VII, Dallas, VI and VIII and San Francisco is comprised of Regions IX and X.

Task orders have been awarded for all five jurisdictions to conduct data analysis and audits of inappropriate payments. The contractors responsible for conducting these activities are as follows.

In the New York jurisdiction, we have Thomson Reuters as the Review of Provider MIC. Island Peer Review Organization (IPRO) is the Audit MIC.

In Atlanta, Thomson Reuters is the Review of Provider MIC and Health Integrity is the Audit MIC. In Atlanta jurisdiction, there are still a few audits being conducted by Booz Allen Hamilton but that workload is very minimal.

In Chicago jurisdiction, the Review of Provider MIC is Advanced Med and the Audit MIC is Health Integrity.

In Dallas, we have Advanced Med as the Review of Provider MIC and Health Management Systems (HMS) is the Audit MIC.

San Francisco, Advanced Med is the Review of Provider MIC and HMS is the Audit MIC.

CMS also awarded two task orders to support our educational activities. The educational tasks are national task orders and are not based on particular jurisdictions as the review and audit MICs are.

Strategic Health Solutions has been awarded two task orders and they are currently working on a gap analysis to identify gaps within Medicaid Education Program for providers and beneficiaries related to fraud, waste and abuse. The second task order is to develop a Web-based and traditional-type provider training regarding Medicaid payment integrity and the quality of care. CMS anticipates awarding additional educational activities for the fiscal year but the anticipated award dates have not been determined.

Mark Anderson is the Director of the Division of Fraud Research and Detection and he will elaborate on the review of provider activities. Robb Miller is the Director of Division of Field Operations and he will elaborate on audit activities.

At this time, I'll turn it over to Mark Anderson and he will give more information on review of provider as well as other data activity. Mark?

Mark Anderson: Thanks, Crystal.

The Division of Fraud Research and Detection's responsibilities focus around our need to support the analytical leg of the Medicaid Integrity Program. We perform research and provide statistical and analytical review of Medicaid claims data.

We are responsible for the MIG, Medicaid Integrity Group's data engine which is our national repository of Medicaid claims. Our responsibilities include loading all the data into the data engine, making sure all the data is secure and supporting any type of analytics against that data.

Our major activity is focused on the development of algorithms, models and metrics with an effort to identify historic, current and emerging trends and

claims activity in support of MIG's mission which is fraud, waste and abuse detection.

We use a data-driven approach effort meaning we are using the data that we have on Medicaid claims and taking that data and trying to find out something about that data that is an indication of an issue that needs to be addressed.

Our efforts in DFRD support the process from the initiation of a concept about an algorithm through its final implementation which obviously include things like review and approval of the concept, the initial analysis from both a clinical and technical nature, the development of markups and models to test and determine whether analytics can actually identify the problem we are trying to investigate, performing sample runs, validating and verifying the correctness of the algorithm and its results and finally a release to production for use out in the field.

We work very closely with the review of provider MIC, the Medicaid Integrity Contractors who are also responsible for analytical work. We support them in several ways by giving them assignments and tasks on the types of algorithms to be developed, giving them models to work from, scheduling, giving them direction on what to do in priority order and analytical support on the development of their new algorithms as well as the modification of algorithms that we give them and finally, quality assurance of their products. Every month, we get their results and review them for accuracy before they are released to the auditors for work.

During the last year, the Division of Fraud Research and Detection along with the review MICs have developed 328 state-specific algorithms. These implementations – these algorithm implementations are in support of actually 69 state-independent concepts within four broad areas of focus, those areas being pharmacy, inpatient, professional services and long-term care.

Our algorithms and efforts come in different analytical areas. The first is basically a rule-based algorithm where we apply logic to calculate a potential overpayment. The second is a metric where we derive metrics and values for comparison of utilization and trends. Finally, models where we look at a

number of indicators and produce a composite ranking based upon weighted combination of – the combination of those indicators.

Another effort that we are supporting is the education Medicaid Integrity Contractor that Crystal spoke of. We are in the process of developing an education Web site to house all MIG-related educational information, links to training, and links to other sites of import.

The Web site will also house at some point sanitized results of analysis to show utilization and prescribing trends that can be viewed. The plan is that the Web site will be open to all states and the provider community and that hopefully will be used as the provider education vehicle we hope it to be.

Over the last year, we have placed much more emphasis on working directly with states as a partner to improve both our analytical efforts and our audit processes. We think that we've had good results in those areas.

I would like to turn the microphone over to Robb Miller who is the Director of the Division of Field Operations. Thank you.

Robb Miller: Thanks, Mark. As mark said, my name is Robb Miller. I'm the Director of the Division of Field Operations. As Angela indicated, we are out in the field. We provide variety of services to the Medicaid Integrity Group, the Medicaid Integrity Program.

As I think Barbara indicated during the introduction, there's two broad mandates under the Medicaid Integrity Program, to develop and manage this national audit program which I suspect most of your questions will be about but it's also to provide support and assistance to the states to help them do a better job combating fraud and abuse, and I'll talk a little bit some of the things with you in that respect as well.

As the Division of Field Operations, we kind of have the primary responsibility for some of the early stages of the provider audit leads that come out of the Division of Fraud Research and Detection.

We work closely with the states, the Department of Justice, the Office of Inspector General, the Medicaid Fraud Control Units and the respective states and the Medicare contractors to first make sure that we're not going to duplicate any service or any audits that may be actually be going on or jeopardize any investigations that maybe going on. So we clear all of our audit leads with those parties as the front end of any kind of audit process.

We also provide subject matter expertise within the Division of Field Operations. We have a number of experienced healthcare and financial and Medicaid auditors who help do quality assurance on the work of the audit MICs themselves.

Angela asked me to finish talking about the audit resolution process. You know, when we give the audit leads back to the contractor, the contractor initiates and can audit, there's a notification letter to the provider and Angela talked about the changes.

We have a longer period now for the production of records which is, in fact, longer than what the Medicare RAC policy is. So, that's been one thing that a lot of folks could ask about and so I think that should be something that folks can appreciate, so to speak. Going forward, we now have a uniform look-back period for our audit periods to start with.

We've also given direction to our contractors to tailor the questions in the provider intake questionnaire more tightly to the provider type and the issues that are being looked at.

Once the contractor produces a draft report, it comes back to the Medicaid Integrity Group where we do quality assurance on it. The state Medicaid agency has the opportunity to review it to make sure that we have – the contractors have not misinterpreted any of the issues. I'm sure you can imagine, even though Medicaid is a national program, there are 50 variations of it across the country and we have to be very careful to make sure we're not overlooking some state-specific issue.

The provider has an opportunity after that to review the draft report for 30 days and offering and mitigating information any medical records that may have been located in the interim and just generally, react to the audit.

The state has the second opportunity to review that draft audit report after the provider has reviewed it and then it becomes what we call a final audit report which goes to the state and then the state has the obligation to adjudicate that with the provider using whatever due process rights exists in that individual state, and we support that adjudication through the use of our contractors and all the documentations that goes along with it. At the end of the day, we want this to be as fair to providers as possible to provide – like I've said, to provide that kind of same appeal as you get in the states herein.

We also provide a great deal of technical assistance to states to support the general efforts and to support audit as well. Both Mark and Crystal talked a little bit about our education contractor efforts. We're providing – beginning to provide a lot of information out there. Our education contractors presented at conferences.

My division has itself done 14 presentations in fiscal year '10 to provider associations in various conferences where providers were present. We've done a lot of outreach in that respect.

We've also provided training since February 2008. We've trained 1,900 state employees at our Medicaid Integrity Institute and a variety of program integrity discipline including auditing and data mining, data analysis and other aspects of program integrity to help them doing more professional job as well.

And we also provided, as Angela used the term, boots on the ground. We were – have worked closely with a few states to do actual field projects where we are working in vulnerable areas and trying to make sure that the services being claimed are actually being provided.

And one last thing I wanted to mention was, Angela also talked about, our What's New section on the Medicaid Integrity Program Web site. Let me remind you of that, cms.hhs.gov. Then you can actually shortcut that by just doing /medicaidintegrityprogram.

We have a What's New section, and the newest thing out there is a link to the Statements of Work for our Medicaid Integrity Contractors so that's something that folks would ask about as well.

And I think with that, I'd like to turn it over to our Director of the Division of Audits and Accountability, Monica Harris.

Monica Harris: Thanks, Robb.

I am the Director of MIG's Division of Audits and Accountability. And as Angela mentioned, this division is responsible for a pretty varied portfolio of areas in the Medicaid Integrity Group.

In terms of the national audit program, staff in that division lead the audit resolution process that Robb described. They are receiving those draft audit reports and incorporate comments from the state.

And at that point in the process, the provider comments would have already been considered by the Medicaid Integrity Contractor. They may or may not have been incorporated at that point.

The division also has the lead for policy development of a few of the Affordable Care Act provisions. One of those that you've likely heard about is the requirement for state Medicaid programs to establish a Recovery Audit Contractor program, or RAC program.

States are required to establish their Medicaid RAC program by the end of this year and CMS has put out guidance that our expectation is the states will implement those programs no later than April 1, 2011.

You might also be familiar with the RAC programs that are run by the Medicare program. Medicaid RAC programs will be similar to the Medicare program with the exception that the Medicaid RAC program will be procured and administered by the states.

RACs are contractors that audit payments that are made the healthcare providers and identify Medicaid payments that may have been underpaid or overpaid.

States will pay those Medicaid RACs on a contingency fee basis for identification and recovery of any overpayments. However, states do have the flexibility to determine the fee paid to Medicaid RACs to identify underpayment.

One thing that we stress in our guidance is that whatever fee structure is developed, it must appropriately incentivize the identification of underpayments as well as overpayments.

Another element about the RAC programs that we've stressed is that states must have an adequate appeals process for providers to appeal any adverse determinations. States have the flexibility to utilize their current appeal process as long as the providers are ensured due process.

Also, Medicaid RACs must coordinate their efforts with other auditing entities including state and federal law enforcement agencies. This is similar to the process that Robb described in our national audit program where we check in with other entities to ensure that we're not inappropriately stepping in where other audits are taking place.

We're also working internally and with states to work to minimize the likelihood of overlapping audits and overburdening providers. And we've done some extensive work with states in terms of education and assistance for them to get their programs up and running.

Another area that the Division of Audits and Accountability is focusing on is CMS' implementation of Executive Order 13520 on reducing improper payments. You may have heard that the President signed the Executive Order last November. The goal of the order is to reign in improper payments while making sure that those who are eligible for government assistance continue to have access to those important programs.

As you might imagine, Medicare and CHIP has been identified as high-priority programs so the executive order required agencies that administer those high-priority programs to establish annual or more frequent measurements of reduction of improper payments.

Where this might actually impact you, the provider, is through our work with State Medicaid programs to develop the supplemental metrics. As Mark discussed, we've shifted to some degree how we work with states on a more collaborative level in our approach.

So to give you an example of how this might intersect with you, the provider, recently, we launched the first national supplemental measurement project in October. The focus of this cluster of states is pharmacy based and it's focusing on over prescribing.

The intervention that's being put in place is provider education that's tailored to mitigate the identified vulnerabilities in each of the states.

We have about 12 States participating in the project. How this will work is we're conducting right now the baseline measurements for the group of states and then the participating states decide on just how they want to measure themselves in terms of the success of the project.

The intervention in this case is provider education which will be in place for about six months, and at that point, we'll do a second measurement to take a look to see and evaluate the project and how successful it was.

After that, the intention is to publish the project results so that we can determine if this intervention was successful. We can share this with other states and they might choose to adopt it.

If it wasn't successful, we can share those lessons learned. This will be published on paymentaccuracy.gov which is the Web site that was established by the Administration for all of the results from the Executive Order.

And if states express more interest in this project and they develop common themes, we'll work with them as well to launch additional clusters both targeting the national focus areas that Mark mentioned and state-specific areas.

I'm going to turn it back over to Angela to start our questions and answers.

Angela Brice-Smith: (Alicia) or Barbara, can you open up the phone lines for Qs and As now?

Operator: At this time, I would like to remind everyone, in order to ask a question, you may press star then the number one on your telephone keypad. If you wish to withdraw your question, please press the pound key.

Our first question comes from the line of (Sheryl Forster) from Washington. Your line is open.

(Sheryl Forster): Hi. I appreciate the work that it sounds like you've done regarding the questionnaire that was sent by the audit MICs but my question is has there been any work on the claims data?

We received our audit requests and the identifiers listed are inadequate for us to locate the patients. And so my question is – and the answer we got from our contractor was, that's all the information they have. Is there any work being done on the data and the accuracy of the data from CMS' standpoint?

Barbara Cebuhar: Hi, (Sheryl). I'll have Mark Anderson talk – speak to that.

Mark Anderson: Yes. Thank you for your question. The answer is yes. We have identified that there is a need for some additional data particularly in this specific area. We'll be working with the state closely to have the states supply that additional information so that when we go out to the providers, things like the RX number are supplied, and we can identify both the beneficiary and whatever needs we have for that provider information to be supplied.

(Sheryl Forster): As a follow-up, was there work done with the contractors so that when a provider brings this to their attention that they actually respond and – because we did respond immediately and indicated we couldn't identify the

patient or pediatric group, we didn't have social security numbers even for some of the patients even though we don't typically gather that.

But the response that we received was very – there was no offer or any kind of indication that the contractor felt that they need to do anything more. We were given a list of patients and that was it.

So is there work being done with the contractors so that they can actually or feel like they have some responsibility in helping us when we indicator that some of the information is inadequate?

Crystal High: This is Crystal. Yes, we have been speaking with our contractors on this issue as Mark was stating though. For the most part, some of our contractors, when they get out there, may not have had the information that they need and then we may have not worked with the state at that point.

But what our contractors can do is come back to us, let us know their problems and then we can have Mark's division or Robb's division to actually talk to the state to get us the missing information that we need. So the things that we're just saying, we'll go back to our contractors and remind them of that.

Barbara Cebuhar: Next question.

Operator: Our next question comes from the line of (David Smith) from Pennsylvania. Your line is open.

(David Smith): Thank you for giving me an opportunity to clear up the somewhat nebulous area. I'm looking for a little further clarification. Now, it was fortunately mentioned that you're going to make every effort not to do duplicate audits that is audits have already been done on a particular hospital admission or whatever.

And the other regards, your timely appeal process. Now, any event that you are requesting a medical record and we have documentation that it's been reviewed by someone else, can w provide that and prevent going through having the copies of medical record all over again?

And with regard to the timely appeals, currently, we have – well, I don't know – we're not a real big hospital but we have about 35 or 40 cases pending hearings in just with the local medical assistance program. Do you have a timeframe that a hearing should take place within a certain period for example?

Robb Miller: Well, let me address your second question first. The time period in which any appeals take place is set forth in your own state Medicaid rules and regulations. Each state has its own administrative code, regulatory scheme, whatever it's called in that state and those timeframes are those timeframes.

In terms of your first question about – I'm sorry, this is Robb Miller by the way. In terms of your first question, I think what I heard you say, David was we've been asked for a medical record as part of the earlier audits. Can we just give you – can we, the provider, give you CMS the name of the entity that has that medical record? Was that what you were asking?

(David Smith): More or less, whether or not it's something that has been reviewed by an external agency previous to this or in some cases, it's had physician review that we've mailed the chart to our local Department of Public Welfare and they've accepted it as an appropriate admission and then you're requesting it again as part of your audit. Is that something that we can just show you that it's been reviewed by an external agency?

Robb Miller: I don't think I can give you a hard and fast answer on that but I would think, generally speaking, we were going to look at that medical record because we may be looking at issues that are nuanced beyond whatever kind of review may have already taken place.

You know, our algorithm may have gotten to multiple issues and, you know, as an example, you know, providers have said, "Well, you know, this admission, you know, had prior approvals so well, it shouldn't be questioned." But after the claim was sent in, there may still be some reason to question whether they can offer services and providers.

So I would say that generally, we would probably be expecting you to provide us that medical record. I think it's good though that you tell us all these

mitigating factors, to tell the contractors all these mitigating factors so that they cal close that in and take that into account.

(David Smith): OK. I was also wishing, were you planning on paying for medical record copies?

Robb Miller: No. Actually, we wouldn't reimburse for medical record cost.

(David Smith): Because you mentioned you more like the RAC now.

Robb Miller: Well, in some ways, but not all. I know the RAC pays for the cost of medical records and I suspect some states may as well although I think most states probably don't. You know, being able to substantiate the service as part of the program then…

(David Smith): Thank you for your time.

Robb Miller: Thank you.

Barbara Cebuhar: OK. Next question please.

Operator: Our next question comes from the line of (Sarah Shaffer) from North Carolina. Your line is open.

(Sarah Shaffer): Hi. I was just – you mentioned that there was no Statement of Work and I didn't get the address for that. If you could just state what that was again?

(Robb Miller): Sure. Anything to do with the Medicaid Integrity Program can be found at this Web site, www.cms.gov/medicaidintegrityprogram, all one word run together.

(Sarah Shaffer): OK. And then when I click on the What's New, the Statement of Work isn't there. Is it pinned somewhere else?

(Robb Miller): When you click on What's New, there should be a link to set this up. If not, I'll check after this call. I looked at it earlier today and that link should be there but I can double-check that after the meeting.

(Sarah Shaffer): OK. And is there any consideration being given to providers being able to give you one mailing address for all the audit letters to be sent to? Before,

we have been told they would be mailed to the address that was on the claim and that's a little worrisome with the timelines and we, getting the records back to you in a timely fashion.

(Robb Miller): I think that's – you know, I certainly understand your concern there, a big hospital could have mail go to a lot of different places and there's a clock ticking when a notification letter goes out.

I would suggest that you – if you have that specific point of contact that you notify the audit project manager for your jurisdiction, that information, I believed, you know – who the contractors are, I believed, it's on our Web site but we could certainly, you know, provide that to anybody that was looking for it.

(Sarah Shaffer): OK. Thank you.

(Robb Miller): notify them of that.

(Sarah Shaffer): Thank you.

Barbara Cebuhar: Next question. Thank you, (Alicia).

Operator: Our next question comes from the line of (Michael Cook) from Washington, D.C. Your line is open.

(Michael Cook): Thank you. Two questions – the first involves settlement. If the state is doing the appeal process, once it settled a matter, are they able to do that without facing disallowance, without facing a disallowance for that part of the claim that they don't – that they may settle on?

And secondly, does the state has flexibility to pay the provider, for example, if the settlements were taking an inpatient claim and agreeing to pay that was alleged to be observation and agreeing to pay the observation, the amount that was paid under observation that the state has the ability to do that as well.

Angela Brice-Smith: (Mike), this is Angela Brice-Smith and let me take a snap at that. The audits we perform are geared towards, let us say, recovering the federal share back

from the states where we have identified improper payments or payments that shouldn't have been made.

So from our perspective at the federal government, we simply want the federal share back. If the state chooses to pursue a settlement with the provider, that's up to them, so we were not in a fear with that but that's just sort of the nature of the engagement that we have in terms of the audit.

(Michael Cook): Yes. But if the provider, for example, to win the appeal, he would ask for the state share back then, would you?

Angela Brice-Smith: We typically ask for the federal share back based on the final audit that we have performed. So that is really where our head is in terms of the recovery of both dollars that are explicit in that final report.

(Michael Cook): So if an independent judge concludes that you were wrong, the state still has to pay you back?

Angela Brice-Smith: I think you're taking it down a path of further appeal when that probably needs further counsel to – it sounds that we have a specific issue going on and I'm certainly open to hearing more about that. But can we go to your second question?

(Michael Cook): Sure. Again, if the state chooses – if for example if the state chooses to pay the provider – what it would have paid if the provider had build in the manner that the state – that the federal audit or the auditor concludes they should have paid, will the state face a disallowance of the federal share for that example that would be if you have an inpatient stay the allegation from the MIP auditors that it should have been – that it really should have been handled this as an observation payment?

And the state – does the state have the flexibility to say to settle with the provider for repayment of the difference between the inpatient observation payment amounts and avoid the federal recovery of the entire amount? Everyone in this…

Angela Brice-Smith: I would describe it as in lieu of – I would describe it as – we have found in situations similar to this that typically, the state does an adjustment or they net out the difference, if you will, whatever that billing amount is for inpatient versus observation, and that has been acceptable.

(Michael Cook): Great, thank you.

Barbara Cebuhar: Next question.

Operator: Our next question comes from the line of (Kesha Paterson) from Georgia. Your line is open.

(Kesha Paterson): Hi, good afternoon. My first question is – actually, I have two. My first question is, I know that the providers are given 30 days with this new mandate to respond to the audit MIC. My question is how long does the audit MICs have to respond to the provider?

Currently, we sent our request, the requested medical records to our audit MIC and it's been over six months since we've got a response. Our contact to our individual auditor, he said there is a data problem and our request is still pending and is that within the Statement of Work their review period versus ours?

Crystal High: The Audit MICs are responsible for reviewing it in a timely manner. Where the difficulty comes in is when we have a back-and-forth between the states reviewing the provider's review so we can't give them an exact timeframe because we don't know how that back-and-forth is going to be and if the extensions are being requested or not, but what I would advise you to do, if you're not getting information in by all means send that request to us through our mailbox and we can look into that in further detail.

(Kesha Paterson): OK. My other question was when the data algorithm or how you figured out the analytical, you know, selection of the accounts, was the concept of Medicaid being primary versus secondary ever included in that data analysis because the majority of the claims that were selected for our audit were all Medicaid secondary and they were low-dollar claims?

Mark Anderson: Thanks for the question. This is Mark Anderson. Generally, if we are looking at any Medicaid payments, Medicaid is normally the payer of last resort and that's considered as part of our algorithm.

But if the data that we're looking at are the claims submitted by the provider to the state for payment and those are the claims that were paid, even though they may be low-dollar amount, ultimately if they added up to a sum of money, they are targeted for investigation.

(Kesha Paterson): So are you able to review the Medicare payment as well?

Mark Anderson: Normally, we do not review the Medicare payment as well but that – I'm unclear that that was the issue because the Medicaid claim that we're reviewing was paid.

And now, we see situations where the Medicaid – or Medicaid made a payment that it should not because Medicare had already made the payment and, let's say, paid inappropriately and we should try to get that money back. I'm just perhaps a little confused about the situation…

(Kesha Paterson): Were the differences is because Medicare is paying as primary and Medicaid is paying as secondary? Medicaid is not paying the full amount. Medicaid is only paying for the co-insurance and those are the claims that are being selected.

Mark Anderson: OK. I understand that but if the co-insurance payment was proper then…

(Kesha Paterson): Yes.

Mark Anderson: …that's not an improper payment so that's what you recover.

(Kesha Paterson): Yes.

Mark Anderson: So if there are situations where we're going out and identifying a co-payment for example as an improper payment then my guess is that would be inherent to the algorithm itself. It should have taken into consideration that this is a co-payment as opposed to an actual service...

(Kesha Paterson): And I do believed that's what occurred in – with our – I mean maybe that's why we haven't received a response in six months because in my analysis, all of the Medicaid payments were just co-insurance and deductibles. There was no duplicate payment.

Mark Anderson: Yes. I understand and I'd be happy to look into that specific situation to determine whether the co-payment was the proper payment or an improper payment. Obviously, if it's a proper payment then there's no recovery. If the co-payment was improper payment though then there would be a recovery. So we would have to investigate that specific situation to see what occurred and obviously, you've done some analysis already so we would like to share your results and compare that to what we found.

(Kesha Paterson): OK.

Barbara Cebuhar: Next question please.

Operator: Our next question comes from the line of (Lisa Young) from North Carolina. Your line is open.

(Lisa Young): Yes. I wanted to know if there is a limit on the number of records that I can request at one time, and also, will they accept a CD with the downloaded images of the record or does it have to be a paper record?

Robb Miller: Hi. This is Robb Miller. And, you know, there's no official limit on the number of records. I know that there are in the Medicare RAC program but that's not the case here and we will accept electronic versions of the medical records.

(Lisa Young): OK. Thank you.

Operator: Our next question comes from the line of (Dana Williams) from Arkansas. Your line is open.

(Dana Williams): Hi. I actually have three questions, and one, on the CD, we tried to submit our records on CD the first time and I've called to see if there was any particular formatting or if a metadata file is required. And the person who answered the phone couldn't help me. So there might need to be some additional instruction about submitting records on CD.

And I also wondered if you were going to have a provider portal and when information will be provided on that as well as if you'll be using extrapolations. That's all.

Barbara Cebuhar: OK. For the first one…

Robb Miller: Well, if there's – this is Robb Miller. If there's a communication issue on formatting these medical records, we'll be happy to work with the Medicaid Integrity Contractor for Arkansas.

If you would be so kind as to sending the particulars to our corporate email address, let me give that to you again. It's Medicaid_integrity_program@cms.hhs.gov. I think we might have said it earlier but it's Medicaid_integrity_program@cms.hhs.gov. If you'll send us the particulars, please, we'll work with our contractor and try to work out those formatting issues.

The provider portal, I'm not sure exactly where we're on.

Angela Brice-Smith: What did you have in mind, (Dana), before I speak to your specific question?

(Dana Williams): You know, we have issues with getting – well, I represent six hospitals and so, you know, it's hard to get all the letters to come to the same place and that's something that the other callers have just get.

So if you had a portal where you can enter to provider numbers and passwords, where you could see if letters were in the mail, what day they were mailed, what was the number of records requested, you know, that could kind of help you plan ahead, the letters come in next week, it's five records versus the letters come in next week and it's 150 records.

You know, you could also say the few records we received and accepted, if the review was – you know, has started, that it's in progress, that it's completed, what day your results letter was mailed out. You know, just something to really help us all manage the process and communicate well back and forth.

Angela Brice-Smith: (Dana), I think that's really a great, great idea. In fact, I like that way you're going in terms of the customer service speak to that. At this point in time, I'd be honest with you. I think we're in the early stages of our contractual relationships with many of our contractors and we can see what we can do in terms of the future to kind of refine things here so I really like that question.

The third issue you raised, and I'll tackle that one as well, is, are we planning to use extrapolation. At this point in time, I am not interested and we are not planning to use extrapolation in large part because I want to see us in a better place in terms of the robustness of our data, more comprehensive data and the refinement of our data around many of the data elements that many of you are experiencing because of our audit activities in terms of challenges that are before us in terms of all of the content that it would be – things that would be nicer and easier for all of us to do our work better.

But at this time, I would say it's something we're looking at but we have not at this point plan to pull the trigger on using extrapolation at this time. So when that happens, I assure you there will probably be another communication effort to let the provider community know, there will be some kind of information bulletin or something posted on our Web site so that you have some idea of the refinements that we are planning to make in the audit program.

(Dana Williams): Great. And also on this Medicaid Web site that you gave us, on the RAC Web site, you can subscribe there and if there is something new posted, it will send you an email. Will you have a function similar to that?

Angela Brice-Smith: Actually, on our Web site, we're trying to actually get something similar to that because if you probably to tell, we don't have a listserv dedicated to program integrity for Medicare or Medicaid.

However, there is a way that, as I understand that, if there are changes to certain Web sites, the person such as yourself, could request to be notified. We're doing our best to try to make sure that Medicaid integrity is a selection item for that vehicle on the CMS site so I'm hopeful that maybe by the end of the year, or maybe I should say, beginning of next year, that will b an option

for the provider community to at least be able to select of the site if they want to know if there's been any new information on that site.

(Dana Williams): That's great, and I hope you guys do that. One thing that happens with that is that it will send you an email that says that it's been updated but then when you click on it, it doesn't really show you what's new.

And it's not – wasn't too bad at first because you can kind of see what wasn't on there previously, but now that there's so much information out there, you really kind of have to dig around to find what's new. And so if you offer that, if you could please direct us to what information is new so that it would be a little more efficient.

Angela Brice-Smith: Thank you.

(Dana Williams): Thanks.

Angela Brice-Smith: (Alicia), next question.

Operator: Our next question comes from the line of (Linda Metrel) from the District of Columbia. Your line is open.

(Linda Metrel): Thank you. I have two questions. Will there be any special considerations for pediatric records and that sometimes the identification cannot be obtained through social security numbers because often, that's obtained with parent information?

And the second question relates to the MIC contractors. The expertise requirements of the contractors whether they would be physicians or coding experts with credentialing?

Crystal High: This is Crystal. In regards to your second question about the MIC's credentials, within the statement of work, there are requirements wherein they have licensed practitioners, the specialties for specific areas so they are required to go have like personnel for specialty areas. So that is not a problem if you are experiencing that. We would definitely like to know that.

(Linda Metrel): What – can you also stand upon the coding workforce if they are credentials as well when they look at those kinds of things?

Mark Anderson: They are the coding experts and know policy and coding responsibilities of each individual states that they work.

(Linda Metrel): Did you say yes?

Mark Anderson: Yes, I'm sorry, if I didn't speak loudly enough. The answer is yes, they are required to have coding experts that are knowledgeable in both the policy and coding practices with any specific state.

(Linda Metrel): Thank you. Any follow-up on the special consideration for pediatric records when requesting them?

Mark Anderson: This is Mark Anderson. I don't know how we would be able to identify the parent of a child claim because there's no parent information as part of that claim. The only thing we would have is whatever identification number comes in as part of the claim and that is the social security number as well as the Medicaid ID.

And I don't – and until we start to capture parent's name as part of what is submitted to us in that claim, I don't know how we could solve that issue.

(Linda Metrel): OK. Maybe you can further think about that because we had an experience with the request on about a year and a half ago and quite often, the social security number is the parent's social security number that we take out upon registration so often there are instances they don't have them or parents are protective of their child's social security number so that is not demonstrated in then registration process and it took an extra, you know, two to three weeks to identify.

We have to go back and forth with the contractor and restart the time clock. So as you roll through this, I'd appreciate some consideration for how pediatric cases would be handled for record requests because it wouldn't be very successful for these organizations that handles children if it's not thought about a little bit more. Thank you.

Mark Anderson: Thank you.

Barbara Cebuhar: Next question please.

Operator: Our next question comes from the line of (Camilla Grayson) from Georgia. Your line is open.

(Camilla Grayson): Hello. My impression from the Medicare kinds of audits that have occurred and presumably similar once that occurred during the pilot programs, it looks like that your companies are not really focusing in on real fraud and abuse. It appears to be more along the lines of small administrative errors such as the physician not signing every single page of the medical record or that it was typed signature, et cetera.

I guess what I – my question is two-fold. One, will you actually be trying to focusing on real possibilities of fraud and abuse or will it continue to be these administrative errors that I think are very unfair on the part of the auditors' do?

And secondly, earlier, you mentioned, your emphasis on education. A few years back, CMS allowed when audits were done that the first time that this was reported in that particular field of error with the physician that they would simply cancel them and there was no money collected which seems a very reasonable thing to do if you're reminding someone to sign every page of the medical record. Will you be allowing an educational period for those initial contacts or is that a totally money collection, money refund effort? Thank you.

Angela Brice-Smith: Thanks, (Camilla). Let me sort of tackle some of the nature of your question and make the distinction that the MIC audits we're performing are really geared toward what Congress wants us to do, which is to basically perform reviews and identify overpayments where they exist.

So our focus, to be frank with you, is not about signatures, it's not about that. It's really about whether there was a fiscal element in terms of whether that would have been a service we would have paid for, whether that's a service that we may have paid for in a duplicative way or medical necessity, that sort

of things. So we really don't get into whether a physician's signature was there. That's not sort of the sole essence of our audits that we perform.

In terms of education, our hope there is I am familiar with this sort of progressive corrective action approach on the Medicare side and we're hoping that we can take a tailored approach but it may be a broader tailored approach to certain segments of the industry where those educational tips can be helpful.

For example, if we are to define that maybe as a general practice, we find certain kinds of payment errors in hospitals or children's hospitals or long-term care facilities or whatever that segment piece is, what we want to be able to do is provide educational tips to them either through some global way to address that problem or prevalent findings that we have discovered.

So we wanted to be as truthful to as many people or as many provider types as possible and hopefully those providers will be able to do their own self-assessments and see that reflected there as well.

Now, in terms of – I think the – another element, I was sort of thinking through your first question on signatures and the nature of that, I do know and I am aware that the partners or the contractors that perform those improper payment calculation for, whether it's Medicare or Medicaid, one of the major findings that they have expressed and I have identified is that many of those errors, there are documentation issues, there are signature issues, there are lack of documentation issues and that's sort of a known fact but I think it's probably in many of their reports that's publicly available and even on paymentaccuracy.gov. I think you can even find that kind of information. But for the most part, that's not the nature of the Medicaid audits that we are performing. Thank you.

Barbara Cebuhar: Next question, (Alicia).

Operator: Our next question comes from the line of Ada Gain from North Carolina. Your line is open.

(Ada Gain): Hey, (Alicia). Thanks, everybody. My question was asked and answered. Thank you.

Operator: Our next question comes from the line of (Barbara Green) from Wyoming. Your line is open.

(Barbara Green): Hi. I'm curious. In different places of presentation, you've talked about MIC audits and then you talked about Medicaid RACs. My understanding is they're basically the same thing. Is that a correct assumption?

Angela Brice-Smith: It is not. This is Angela Brice-Smith. The MIC audits are different and distinct. We wanted to share with you the facts that there will be another type of auditor coming on board probably very soon in many states that are state-level. They are Medicaid RACs which have a great deal of parity or the intent is congressionally that they have a great deal of parity with the Medicare RAC program that's already in place.

Angela Brice-Smith: And if I can add to that for just a second.

(Barbara Green): OK, and…

Angela Brice-Smith: Also, two other differences are is that RACs – state-run RACs will identify underpayments as part of their charge to do that under the Affordable Care Act, and also that the RAC will be required to recover those overpayments.

(Barbara Green): OK. So as follow-up to that, when you were talking about being in the CMS region, I'm actually in Wyoming, not Wisconsin, how do I know what region we're in and will both the RAC and – the Medicaid RAC and the MIC audits come from those two organizations for both?

Angela Brice-Smith: So in terms of your region, for CMS purposes, you're in Region VIII, I believe, the regional office that comes out of Colorado.

(Barbara Green): OK.

Angela Brice-Smith: That means – so your own State of Wyoming will establish their very own RAC programs.

(Barbara Green): OK. So the ones that you've listed were New York, Atlanta, Chicago and Dallas.

Crystal High: That's correct. This is Crystal. Those are the jurisdictions that we have MICs and our jurisdictions are comprised of the various regions. So you're actually under the Dallas jurisdiction.

(Barbara Green): OK, OK.

Robb Miller: Each jurisdiction has two CMS regions and for our own purposes, we consider Denver and Dallas to be Dallas. That's a…

(Barbara Green): OK.

Robb Miller: That's how we…

(Barbara Green): OK. I just want to make sure on that.

And then so anything we get from MIC and anything we get from Medicaid RAC will come from those two organizations that are listed…

Monica Harris: Let me just clarify you one thing. So in RAC, we were just presenting that to you because it was part of the Affordable Care Act. We do want to be very clear that those will be state-administered programs. So any information about Wyoming's recovery, audits, contracting programs, it will come to you from the State of Wyoming.

(Barbara Green): OK.

Monica Harris: What Crystal High was alluding to in terms of the region has to do with the jurisdictions and how it's structured for the Medicaid Integrity Contractors here.

(Barbara Green): OK. That was the clarification I needed. Thank you.

Monica Harris: Yes.

Operator: Our next question comes from the line of (Patsy Timmons) from Texas. Your line is open.

(Patsy Timmons): Thank you. Will the Medicaid RACs main focus be Medicare patients who happen to have Medicaid or is Medicaid RAC all inclusive of all Medicaid patients such as moms and babies?

Monica Harris: So the guidance that we put out so far under the state Medicaid director's letter and as Angela alluded to, we will be putting a regulation on this as required by the Affordable Care Act itself.

The RACs – state RACs will be required to have the ability to audit the entire Medicaid program, however, we have not defined for states what that focus have to be, but any RAC that's established, we are taking it as an acceptation from the state that that RAC that they contract with will have the ability to audit the entire Medicaid program in their states.

(Patsy Timmons): Thank you.

Angela Brice-Smith: This is Angela, and I think that, you know, this was a good example of the challenge for all of us in being clear about the type of contractors that are auditing all of us and you as well.

On the Medicare side, you're going to see a world of Medicare administrative contractors that do activity in terms of audit. You're going to see PSCs or Program Safeguard Contractors, and in some jurisdictions, you're going to see ZPICs or Zone Program Integrity Contractors that are performing reviews around whether it is medically necessary, whether there is overpayment, or whether there are underpayments in the situation of Medicare RACs.

So Medicare RACs are contingency fee-based. They are looking at overpayments and underpayments. So that's sort of the Medicare side.

Also, on the Medicaid side, we've described MICs, Medicaid Integrity Contractors, and what we tried to sort of give you a hint of the future is there's going to be Medicaid RACs but that's going to be administered through the states.

In addition to that, they're the elements of law enforcement whether that'd be at the state level or the federal level in terms of audit activity. So like I say,

we have a lot of different potential contractor types, law enforcement entity, government body that are performing contracts or audits on behalf of the government, on behalf of their various entities. So I think it's a really good question.

In addition to that, just to add a little bit more flavor to this suit we have is that we have contractors that perform the calculations to try to determine what is the improper payment rate in the Medicare program, what is the improper payment in the Medicaid program and the various other federal programs that have to do those calculations.

So this is really, really important and I think if it's not already on our Web site there will be Frequently Asked Questions section that will be posted related to this very important point that, you know, I want to impress upon that there are a lot of different contractors out there. Make sure you know who is auditing and for what reason. Thank you.

Barbara Cebuhar: Next question.

Operator: Our next question comes from the line of (Andy Smith) from Alabama. Your line is open.

(Andy Smith): Hi. Thanks for taking my call. My question is very simple. I just want to verify, and I might have missed this because I stepped out, but I wanted to verify the timeframe to respond to a record request. Is that 30 calendar days or 30 business days?

Angela Brice-Smith: It's 30 business days.

(Andy Smith): OK. Thank you.

Barbara Cebuhar: Next question.

Operator: Our next question comes from (Philonias Brown) from Pennsylvania. Your line is open.

(Philonias Brown): Thank you. Good afternoon, everyone. I'm definitely hearing a lot of things. I am at a predominantly pediatric institute and the same issue like the first

caller when she said that there wasn't enough information. Another caller had mentioned that too.

You know, that's a pretty valid and good suggestion regarding identification of the patients because we don't really use social as searchable field because of the difficulty that we have with obtaining them and then, you know, some of the patients that are born here may not have a social.

So like for one audit that we had and we're working with a contractor, we explained to them – basically, the information that they gave to us, it was just a date of birth and a social, not even a name.

So when we submit the claims to you, you know, it has account numbers on there, it has date of birth, the names, you name it, but when we went back to them and told them that, you know, we can't identify the patients. They said they would take it back to the government and get back to us.

Four months later, they come back and they say, "Oh, well, you know, the government told us though this is enough information to identify the patient and by the way, you have 10 days to give us the required information. You will not have an extension."

It wasn't until, you know, we've got our legal team involved that they began to, you know, play nice and give us some more information. So one of my questions is, what should we do and, you know, instance like that where the contractor is just, you know, unwilling to budge. They're not really, you know, giving us additional information.

Even though we know, you know, we submitted that to you. It's on the claims, like how can we go about – you know, what's the remedy to that? You know, should we just email the email address that you've provided earlier or like how should we handle that?

Mark Anderson: Hi. This is Mark Anderson. I'll start to answer the question, and I think hopefully you've heard the answer before. These situations are occurring much more than we would hope. And we are working with the state to make

sure that we get the additional data that's needed to identify the specific medical record that we are asking of you.

The problem with these data that we are working from is that sometimes it doesn't contain all of the identification information that we want. Yes, you submitted in your claim but unfortunately not all that information has made it to the federal government's database as defined. We're working on getting that additional data but we haven't gotten it in all situations.

So, we are working with the states to identify these specific areas particularly those that are harder to track down the provider. We're going to try to work with the states to get that information upfront before the auditor comes to you with a request for records, all of you.

Now, as far as what to do in situations where the auditor has perhaps not been as agreeable or supportive, let me ask Crystal to comment on that if she's online.

Crystal High: Thanks, Mark.

(Philonias Brown): OK.

Crystal High: As Mark indicated, those were the challenges that we were having early on but we don't foresee those types of problems happening in the future. If you do want to call somebody on these, please send to our mailbox and certainly, we will go back to all of our audit MICs and let them know that if they had such challenges, they should bring it to our attention so we can reach out to the states and try to get the information upfront.

(Philonias Brown): OK. And then the next question I had is, this is already answered before as far as the providers and, you know, as to having 30 days to submit the information to you and then there's really not a timeframe to get the information, you know, like back to us so, you know, for instance, right now, we have an audit that we submitted within a 3-day timeframe. It's been eight months and we still haven't even gotten like the preliminary findings back.

What about like retractions and offsets? So when we get our final letter saying that, you know, and let's say we agreed to the findings and, you know, we'll send that into the government and then, you know, the government send us a letter saying, "You know, we received your information, you agreed to the final findings, you know, here's the amount of money that we're retracting."

There is no date on there, you know, as far as like when are we going to retract it. There's nothing there that says what we're going to offset. So basically, what we have to do is just keep going back and monitor and see if, you know, money has been taken from there, if, you know, money has been offset at another place, like are you working on some sort of timeframe for that too for, you know, any retractions or offsets?

Robb Miller: Well, as you've heard earlier, we do have – there is a lot of back-and-forth so sometimes, it's hard to predict exactly how long an audit might take to resolve. But once it is resolved, the state adjudicates it. And if the state has a process as the state I used to work for where a provider that we're still in good standing but had a debt that you all agreed to, to the states. We allow that to be offset against future claims which, you know, minimize the impact of the recovery on the provider.

How that plays out is again up to each state, so that wouldn't come into play until a final audit report is actually given to the state and the state begins its normal adjudication period or process.

(Philonias Brown): OK. Thank you.

Barbara Cebuhar: (Alicia), we have time for two more questions. Thank you.

Operator: Absolutely. Our next question comes from the line of (Erika Lyndon) from Iowa. Your line is open.

(Erika Lyndon): Thank you. In December, we had a request for 200 records which we submitted in January. We hadn't heard anything back until early October and we received a phone call and then a follow-up letter indicating that the audit had been discontinued by CMS due to changes in review criteria.

And, of course, we sent our records in. We spent a lot of time and energy gathering those and three FedEx boxes were shipped off to the contractor for review. Is that an unusual circumstance or is that going to happen regularly where we get mail feedback on what was the cost of the change in review criteria? It was just very frustrating for us because we were actually hopeful to get some clarification from the contractor about how these claims should be handled?

Angela Brice-Smith: This is Angela Brice-Smith. You're raising a good question and issue that I was not aware of. I'm a little bit disturbed about it. On the other hand, I'm sort of like I'm trying to think of a few scenarios in which we may have chosen not to continue to pursue the particular issue that we pull the records for.

For example, sometimes, at the 11th hour, we may discover that there may be a waiver that has been approved and we were not aware of it maybe at the time when we initiated the audit or another situation where maybe that the findings were less than some of the thresholds of that in terms of continuing to pursue the audit in terms of resources and activity like that.

So both are a couple of examples in which I could see that situation occurring. I'm just not familiar with whether I made any of those decisions involving Iowa audits. So pardon me.

And then certainly I recognized that we may need to put in place a message that after so many months that the provider can be assured of whatever decision has been made by CMS in terms of continuing to pursue or not pursue a particular audit. So I will take that as a suggestion that we'll work on. Thank you.

(Erika Lyndon): Thanks.

Operator: Our final question comes from the lines of (Lorrie Gray) from New Jersey. Your line is open.

(Lorrie Gray): Hi. Good afternoon. Thanks very much. I appreciate this.

Most of my questions were answered but I do have one question. What jurisdiction is New Jersey and please, and what was the name of the audit contract manager? I'm just concerned with the point of contact for the notification letters.

Hello?

Angela Brice-Smith: We're just checking the record.

(Lorrie Gray): Thank you. Then let me just clarify too, and I appreciate the explanation regarding the MICs and the RACs because I was a little confused about that. So are you them going to ensure that we don't receive duplicate request that we've received for the RAC or may we receive a request, the same request from the MIC and the RAC? I just – I understand the difference between the two entities. I'm just not clear on whether or not what the coordination is of the request.

Crystal High: You asked about the jurisdiction for New Jersey. That's actually under the New York jurisdiction and IPRO is the audit MIC and Thomson Reuters is the review of provider Medicaid Integrity Contracting.

(Lorrie Gray): And I'm sorry, it was Thomson…

Crystal High: Reuters – R-E-U-T-E-R-S.

(Lorrie Gray): OK. And in order to contact them, I guess we have to notify them to – for the point of contact for the notification letters, how do I obtain the information to do that? What is their information? That's why (inaudible) contact, right?

Robb Miller: Well, this Robb Miller. When you get an actual audit notice, there is a point of contact at that notification but that doesn't really do you any good if you're just trying to learn more or if you're trying to anticipate as one of the earlier callers did.

And so we will look at putting the contact information of project directors out there and make publicly available (inaudible) the right people as the actual contract.

(Lorrie Gray): Thank you. I appreciate that. And then about the coordination between the MICs and the RACs, how does that work again?

Monica Harris: Hi. I guess I can address that for you. So it's required by the Affordable Care Act that states will coordinate with all entities conducting audits in their states. Again, these are state-administered recovery audit contracting programs.

The state will have to tell CMS that they will indeed coordinate those efforts of their RACs with other auditing entities in the state. So when they put in their state plan amendments, they will let us know that. We are working with states and states are going to be working on their own to ensure that that coordination happens so that the provider community isn't overburdened with audits of the same claims.

OK, great, so both entities. It's actually the accountability and the expectations of both entities are responsible for that. OK, that helps. So hopefully, that will minimize duplicate efforts.

(Lorrie Gray): OK, great. Thank you very much.

Barbara Cebuhar: (Alicia), thank you very much and to everyone for their calls and their questions. We are very grateful for the insights that you've provided.

I just want to make sure I repeat the email address. I'm sorry, I made a mistake earlier, but it's Medicaid_integrity_program@cms.hhs.gov.

I also wanted folks to know that there is an audio recording and a transcript of this Special Open Door Forum which will be posted to the Special ODF Web site and I'm going to go ahead give that to you now.

So you can find it, it will be available starting November 17th and it will be available for 30 days. So it's http://www.cms.hhs.gov/opendoorforums – plural– /05_odf_specialodf.asp. So if people are interested in listening to this later, you'll have access to that.

So I think we're fine now, (Alicia). I do appreciate everyone's time.

Angela Brice-Smith: Can you tell me how many callers were on the line at the end?

Barbara Cebuhar: We're going to go into a special session.

Operator: This concludes today's conference call. You may now disconnect.

END