



## Arizona Hospital and Healthcare Association

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***Submitted electronically***

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Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Room 445-G, Hubert H. Humphrey Building  
200 Independence Avenue, SW  
Washington, DC 20201

***Re: Medicaid Program; Recovery Audit Contractors; File Code CMS-6034-P (42 CFR, Part 455)***

Dear Dr. Berwick:

On behalf of our member hospitals, health systems and other healthcare organizations, the Arizona Hospital and Healthcare Association (AzHHA) appreciates the opportunity to respond to the Center for Medicare & Medicaid Services' (CMS') proposed rule implementing provisions in the *Patient Protection and Affordable Care Act* (ACA) related to the Medicaid Recovery Audit Contractor (RAC) program.

All of our hospitals strive for payment accuracy and work with the Arizona Health Care Cost Containment System Administration (AHCCCS) and its contractors to ensure the financial integrity of the program. Our provider network assists our Medicaid agency, AHCCCS, to identify inappropriate payments by participating in the Medicaid Integrity Program (MIP) and other similar Medicaid audit programs. These programs have the same charge as the Medicaid RAC program and have proven effective in identifying and recouping improper eligibility or payments. While we appreciate your mandate to implement yet another Medicaid audit program, we are concerned that the Medicaid RAC program will result in duplicative audits and will add yet another layer of disruptive and costly administrative burden for both the agency and the provider community.

AHCCCS is a national model for Medicaid managed care programs, with a seasoned history that spans more than 25 years. AHCCCS currently operates under an 1115 Waiver, and has well established mechanisms for detecting improper payments. Contracted health plans are prepaid a monthly rate for each member, manage the care for members, and accept the financial risk for member health care costs that exceed the amount received. The appropriate management controls in a prepaid managed care environment include detecting underutilization of services by the health plan and its provider networks, not looking for overutilization or excessive payments to providers.

AHCCCS serves approximately 1.3 million —members, more than 88 percent of whom are enrolled in prepaid health plans. Because the proposed Medicaid RAC program is intended to detect improper payments in a fee-for-service reimbursement structure, the program would only “fit” or apply to approximately 12 percent of existing AHCCCS business, and would add a complicated and burdensome administrative process into a system that already has highly effective systems in place for encounter validation and program integrity. The Payment Error Rate Measurement (PERM) FY 2008 Final Report issued October 9, 2009 reported that the national Medicaid FFS estimated payment error rate for fiscal year 2008 was 2.62 percent. Notably, the FY 2008 Medicaid Managed Care estimated payment error rate was 0.10 percent, statistically zero. Requiring the RAC program for Medicaid managed care programs like Arizona is not only unnecessary and an unwise use of manpower and financial resources, it is also an inappropriate method for monitoring program integrity, quality, and cost-effectiveness. Simply put, a Medicaid RAC program for Arizona just doesn’t make good business sense.

**For this reason, we urge you to use the authority provided in section 6411 of ACA to exempt Arizona (and other states with existing managed care programs or Medicaid audit programs) from the requirement to establish a Medicaid RAC program.**

For state programs that will be required to implement a Medicaid RAC program, we would like to identify problems that, if left unaddressed in the Medicaid Recovery Audit Contractor (RAC) rule, will result in fundamental flaws in the design and operation of each state RAC program. We understand your desire to allow states flexibility in designing their RAC programs, but without some restrictions placed in federal rule, RACs will engage the same overzealous and aggressive payment denial patterns experienced when the RAC program was first introduced to Medicare. We urge you to revise the Medicaid RAC rule to incorporate each of the provisions below.

### **Medical Necessity Reviews**

**Problem:** Contingency fee-based RAC payment and lack of appropriate medical training among RAC staff led to aggressive and inappropriate medical necessity denials during the Medicare RAC demonstration program. Hospitals that disagree with RAC medical necessity denials are required to appeal each denial through a costly and complex process. Preparation of these appeals is a time-consuming undertaking that often involves outside legal counsel and, on average, 18-24 months per appeal to complete.

CMS commissioned one validation study of RAC medical necessity reviews to assess the accuracy of RAC findings and found a **40 percent error rate** – a woefully high rate for a government auditor. This finding affirms concerns that some auditors lack the training in Medicare guidelines needed to accurately audit the broad array of provider settings and

related Medicare policies. Medicaid RAC review of medical necessity is prone to similar shortcomings.

Solution: CMS should revise its rule to exclude medical necessity reviews from the purview of the Medicaid RAC program. Medical necessity is too subjective for RACs that have limited clinical expertise or staff. If medical necessity reviews are allowed in the program, it is critical that the CMS issue key oversight and payment provisions in the rule to mitigate incentives for aggressive and/or inaccurate medical necessity denials. These include the following provisions:

- The rule should establish a systematic process for reviewing and approving, in advance, the types of claims that will be subject to medical necessity review by the Medicaid RAC. This process should include:
  - A requirement that the RAC submit to the state Medicaid agency for review and approval a rationale for each medical necessity review. Such requests should include data demonstrating that a pattern of errors exists, which, if warranted, will serve as the primary basis for state approval. This may involve the Medicaid RAC conducting a sample medical necessity audit to support the data identifying the pattern of errors to be targeted through medical necessity audits.
  - A requirement that any medical necessity review approved in advance by the state Medicaid agency be posted on the RAC's website prior to commencing with the audits.
- Final validation of medical necessity review denials should be signed off by a physician, rather than other RAC auditors such as nurses or therapists. RACs should ensure access to an appropriate array of specialist physicians for this purpose to cover the broad clinical range of Medicaid-covered services. CMS and/or the state Medicaid agency should share with providers the training materials used for auditors conducting medical necessity review. CMS should also establish a method to regularly validate the accuracy of Medicaid RAC medical necessity findings. Such a "medical necessity accuracy score" should be used as the basis for determining whether to 1) continue to use the services of the RAC; 2) design and implement remedial training for unacceptable scores, or 3) terminate the services of the RAC if the accuracy score is not adequately maintained at an acceptable level.

### **Duplication of Existing Effort**

Problem: The expansion of RACs to Medicaid could result in duplicative and costly audits for hospitals already subject to audits associated with the Medicaid Integrity Program (MIP) or other Medicaid audit programs. In addition, there is concern that

RACs may attempt to audit claims that already are under review by another entity (Medicare or Medicaid contractors or law enforcement). The other entity already may have denied payment on the claim.

Solution: We appreciate your acknowledgement in the preamble of the proposed rule that overlapping or multiple provider audits may result from the expansion of the RAC program to Medicaid and welcome your stated desire to minimize the likelihood of overlapping audits. As you state, coordination of Medicaid audits may present a challenge because of the number of other agencies or entities that may be conducting audits. The only way to truly avoid the overburdening of Medicaid providers is for CMS to issue exceptions to the Medicaid RAC program to Arizona and other states that already have or are currently implementing a MIP or similar program.

If CMS requires a state to implement a RAC program, the final rule should require each state to fulfill its statutory obligation to coordinate RAC efforts with other audit programs by prohibiting Medicaid RACs from conducting audits on claims that are under review by a MIP contractor or other entity and excluding from RAC review any claim in which payment has already been denied. All Medicaid auditors and RACs should be required to use the RAC Data Warehouse to determine which claims are currently under review or have resulted in a recoupment.

### **Medical Record Requests**

Problem: During the Medicare RAC demonstration, RACs were requesting hundreds of medical records at a time, causing significant administrative burden for providers and inhibiting hospitals' ability to respond to RAC requests in a timely manner. RACs also did not accept imaged medical records, requiring hospitals to mail hundreds of pages of medical records.

Solution: The proposed rule should establish a medical record request limit policy similar to that of the Medicare RAC program. RACs also should be required to accept medical records electronically and pay the copying and mailing costs of medical records that must be mailed.

### **Transparency and Oversight**

#### **Audit Issues**

Problem: During the Medicare RAC demonstration, many providers experienced inappropriate and arbitrary RAC denials. RACs did not inform providers of the types of issues they were auditing and did not provide a rationale for claim denials. RACs audited claims using the wrong payment codes. RACs also were auditing claims from several years ago. This led to provider appeals, **64 percent** of which were decided in the favor of

the provider (CMS Update to the RAC Demonstration Report, June 2010). The lack of transparency caused significant provider confusion, led to slow provider response to RAC requests and resulted in hospital, RAC and CMS resources wasted in the appeals process.

**Solution:** The final rule should establish the types of improper payments that are included and excluded from the Medicaid RAC program. RACs should be required to obtain approval from their state's Medicaid agency to audit new issues and to post approved audit issues on their websites prior to conducting the audit. Additionally, RACs must be required to provide a case-specific rationale for each denial determination. RACs also must be required to use the appropriate codes when conducting audits (*i.e.*, use ICD-10 codes once they are implemented) and ensure that they are not penalizing hospitals for any payment errors made by Medicaid managed care entities. Lastly, CMS must limit the number of years a RAC can audit retrospectively. The look-back period should be limited to a 12-month window to limit the opportunity for RACs to incorrectly apply new payment rules to old claims. If Medicaid RACs are granted a look-back period longer than one year, then providers should be allowed to re-bill claims in the same look-back window.

### **RAC Correspondence**

**Problem:** Medicare RACs have sent correspondence – including medical record requests, review results letters and letters demanding recoupments – to the wrong address, wrong contact and/or wrong hospital. This impacts the hospital's ability to respond to the RAC's requests in a timely manner, sometimes causing hospitals to miss prescribed response timeframes. We have had several instances in Arizona in which demand letters were not received by our member hospitals in a timely manner; some were never received before the recoupment actually occurred. Fifty percent of AzHHA members reporting data to the RACTrac for the third quarter of 2010 reported an increase in administrative costs related to RAC requests, and 25 percent of those members also reported that they had employed additional staff or other resources to respond to the RAC program.

**Solution:** The final rule should require RACs to ensure they have the correct address and point of contact before issuing correspondence to hospitals, including letters requesting medical records and/or demanding recoupments. Each RAC should be required to develop a web-based mechanism to allow providers to customize their address and point of contact. In cases in which a RAC sends correspondence to the incorrect address or point of contact, providers should be given an extended timeframe to respond to the RAC request. Also, to prevent confusion, RACs should be required to send only one review results letter per claim.

## **RAC Customer Service/Website**

Problem: During the Medicare RAC demonstration program, hospitals were not able to obtain answers to questions they had regarding the RAC process. This inhibited hospitals' ability to respond appropriately and timely to RAC requests.

Solution: The final rule should require each RAC to provide customer service to providers, including a designated telephone number that providers can call to obtain answers to questions. RACs must be required to respond to hospital questions in a timely manner. RACs also should be required to use their websites to provide as much information as possible about the RAC process. This will enhance hospitals' ability to respond to RAC requests quickly and accurately.

## **RAC Oversight & Accountability**

Problem: During the Medicare RAC demonstration program, CMS provided little oversight of the RACs. As a result, RACs engaged in overzealous denials, resulting in patterns of erroneous decisions.

Solution: Although we are strongly urging CMS to grant Arizona and states with existing Medicaid audit programs an exemption from the RAC program, if CMS does not grant this exemption, we believe that it is imperative for CMS each state Medicaid agency to establish close must engage in close oversight of the RAC program. The Medicaid agency should be required to appoint at least one staff person to be the RAC project officer responsible for this oversight. The project officer should have regular discussions with the RAC to ensure it is following all of the program requirements.

We appreciate that the proposed rule requires states to report to CMS certain elements describing the effectiveness of their Medicaid RAC program. The preamble identifies specific elements of the report, including program metrics (*i.e.*, number of audits conducted, recover amounts, etc.). This list should be included in the final rule and should be expanded to include data specific to audit outcomes, accuracy of RAC determinations, appeals activity and appeals outcomes. The report also should share the contract terms to which RACs will be held, including the RAC's contingency fee rate. The reports should be made available to the public.

## **Timeframes**

Problem: During the Medicare RAC demonstration, RACs had an indefinite period of time to complete their review of a claim and were not required to inform the provider of

the results of the review. This creates accounting problems for hospitals as they are unable to reconcile claims that are indefinitely under review by the RAC.

Solution: The final rule should be revised to specify timeframes for RAC determinations as well as timeframes for notification of those determinations in order to provide some structure and predictability for the RAC program. There should be penalties for RACs that fail to conduct key functions in a timely manner.

### **Appropriate RAC Expertise**

Problem: During the Medicare RAC demonstration program, some RAC employees reviewing claims did not have experience with Medicare coding practices. They also lacked the clinical expertise needed to understand decisions made by physicians and others who take care of patients in hospitals and other settings.

Solution: We appreciate that the proposed Medicaid RAC rule requires RACs to employ trained medical professionals to review claims. However, we urge you to revise the final rule to specifically require that each RAC have a medical director and at least 1.0 FTE physicians per 400,000 Medicaid discharges. Medical professionals should conduct reviews, provide clinical guidance to other personnel conducting reviews and be available to respond to provider inquiries on denied claims. Such physicians should be licensed and collectively have a broad array of medical training and clinical experience. Each RAC auditor should be comprehensively trained on Medicaid payment and coverage policy related to all target areas approved by the state, billing and re-billing protocols, and the Medicaid appeals process. RAC auditor should demonstrate proficiency **prior to** conducting audits. Training materials should be shared with providers.

### **Discussion Period**

Problem: Sometimes a hospital has additional information that substantiates a denied claim and is unable to share this information with the RAC before the appeals process begins. As a result, both the hospital and the RAC waste time and resources in the appeals process where the denial is eventually overturned.

Solution: In designing the permanent Medicare RAC program, CMS realized that it is in the best interest of the RACs and the providers to discuss the denial before it is appealed in order to avoid the costly and administratively burdensome appeals process wherever possible. Thus, CMS implemented a “discussion period,” for RACs and hospitals to share information to confirm the accuracy of the RAC’s findings. During this period, providers can ensure that the RAC has all the information it needs to make an accurate determination. We support the inclusion of a discussion period for a Medicaid RAC

program, as it will save hospitals and RACs the time and expense of long, unnecessary appeals when information is readily available to assist in determination.

## **Appeals**

**Problem:** While we appreciate that the proposed rule requires an appeals process for the Medicaid RAC program, we are concerned that the rule allows states to use their current Medicaid appeals process or to develop a new appeals process for the RAC program. This will require health care systems with hospitals in more than one state to expend resources to navigate different and distinct appeals processes in all 50 states.

Another concern is that the rule fails to prevent RACs from recouping funds associated with denials under appeal and also fails to require RACs to return their contingency fee if a denial is overturned at any stage of the appeals process. This policy would not require RACs to exercise diligence in their review process—RACs could just zealously and inappropriately deny claims, keeping the contingency fee regardless of the quality of their own work. Finally the proposed rule does not require the Medicaid RAC to provide any data on the number of claims appealed and the number of denials overturned during the appeals process. This data is important in ensuring RACs do not engage in overzealous and inappropriate denials. A report issued several years after the conclusion of the Medicare RAC demonstration program revealed that **64 percent** of the appealed claims during the demonstration were decided in the provider's favor (CMS Update to the RAC Demonstration Report, June 2010). This data can and must be captured on a timely basis and should be used to hold RACs accountable for inappropriate denials. RACs have a financial incentive to deny claims. There must be appropriate controls in place to prevent inappropriate claim denials by RACs, who ironically are charged with a program integrity function.

**Solution:** The final rule should establish one appeals process for the Medicaid RAC program and require each state to use the prescribed process. In addition, RACs must not be able to recoup funds until the appeals process is exhausted and must not receive their contingency fee in cases where the denial is overturned. Finally, information on appeal turnover rates should be shared with the public and penalties should be assessed on RAC contractors with a high reversal rate. RACs with an overturn rate of 25 percent or greater per year should be subject to a monetary penalty. Widespread patterns of erroneous RAC decisions should be reversed automatically without formal appeals.

## **Provider Education**

**Problem:** During the RAC demonstration program, providers did not have access to basic information on RAC program operations, including how audits were conducted, what errors were being targeted and how the appeals process worked.

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Solution: We appreciate that CMS has announced plans to conduct widespread provider education on the Medicaid RAC program and offer our support in reaching out to the hospital community. In order to ensure RACs engage in provider education in each state, the final rule should require the RAC to share information with hospitals regarding the details of their program operations and appeals processes. Education should include information on types of claims approved for RAC review, how the audits will be conducted, where providers can access information on status and outcome of audits and how the RAC will communicate requests and findings to the provider. Additionally, the Medicaid RAC appeals process should be identified and explained.

### **Preventing Improper Payments**

Problem: Despite the fact that educating providers promptly on how to correct billing errors reduces the risk of improper payments, providers have received limited education on the improper payment vulnerabilities identified by the RACs during the demonstration project. While hospitals are implementing changes to reduce billing mistakes, information from CMS on RAC-identified problem areas would significantly enhance our efforts to improve our billing systems. In addition, providers continue to be penalized for problems identified in the CMS payment system that have yet to be fixed.

Solution: CMS should collect information on improper payments identified by the RACs and use this information to educate providers and improve the payment system. The final rule should require RACs to provide education to hospitals and other providers on Medicaid criteria for high-error claims and process improvements to prevent errors commonly identified by RACs. The final rule should require state Medicaid agencies to implement fixes to payment system problems identified by the RACs. A portion of the funds recouped by the Medicaid RAC program should be devoted to provider education and payment system improvements to prevent payment errors.

Thank you again for the opportunity to comment on the proposed rule. If you have any questions or would like further information regarding our comments, please call me at (602) 445-4300.

Sincerely,



Laurie Liles  
President and Chief Executive Officer