



**American Hospital
Association**

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December 20, 2010

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 more than 5,000 member hospitals, health systems and other health care organizations, and our 40,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to respond to the Centers 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.

RAC PROGRAM EXEMPTIONS

Hospitals strive for payment accuracy and are committed to working with their state Medicaid program and its contractors to ensure the validity of Medicaid payments. In fact, providers in many states already work with their Medicaid agencies to identify inappropriate payments by participating in the Medicaid Integrity Program (MIP) or similar Medicaid audit programs. These programs have the same charge as the Medicaid RAC program and have proven effective in identifying and recouping improper provider 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. **For this reason, we urge CMS to use the authority provided in Section 6411 of the ACA to exempt states with MIPs or other Medicaid audit programs from the requirement to establish a Medicaid RAC program.**



In addition, we request that CMS use its exemption authority in states that operate a Medicaid managed care program. In these states, providers already are subject to audits by private managed care organizations (MCOs) with a strong financial incentive to prevent improper payments to providers. Managed care Medicaid programs have some of the lowest monthly per member costs in the nation and requiring them to implement a RAC program will only result in increased costs and administrative burden for the MCO, providers and the state Medicaid agency.

Lastly, some states and/or individual providers may participate in pilot programs and demonstrations associated with payment system reform. In some cases, the RAC program may conflict with program or demonstration requirements, thus providing justification for participating states and/or hospitals to be exempted from the Medicaid RAC program. **In these circumstances, we encourage CMS to issue exemptions to avoid creating a disincentive for states and hospitals to engage in meaningful efforts to reform our health care payment system.**

RAC PROGRAM REQUIREMENTS

In states where CMS requires implementation of a Medicaid RAC program, we urge CMS to revise the rule to ensure that states do not repeat the mistakes made during the Medicare RAC demonstration program. While we appreciate CMS' desire to allow states flexibility in designing their Medicaid RAC programs, we are concerned that, without some restrictions placed in federal rule, RACs will engage in the same overzealous and aggressive payment denial patterns seen when RACs were first introduced to Medicare. Inappropriate provider payment recoupments, excessive medical record requests and a general lack of accountability and transparency in the Medicare RAC demonstration program created significant administrative burden and confusion for hospitals and hampered the overall efficiency of the program. The fundamental flaws in the design and operation of the Medicare RAC demonstration program 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).

To address the problems in the Medicare RAC demonstration program, CMS worked with the hospital community to develop solutions that have proven effective in increasing the transparency and accountability in the permanent program; these solutions were incorporated in the Medicare RAC Statement of Work (SOW). **We are disappointed that the proposed rule does not incorporate these solutions into the Medicaid RAC program.** While we understand that there are differences between the Medicare and Medicaid programs, many Medicare RAC policies, such as a new audit issue review process and medical record request limits, are absolutely applicable to the Medicaid RAC program. CMS' press release announcing the proposed Medicaid RAC rule states, "We are using many of the lessons that we learned from the Medicare RAC program in the development and implementation of the Medicaid RACs..." We appreciate this statement and urge that the final rule adopt the policies that have worked in the Medicare RAC program.

Below please find specific areas of concern that CMS must address in the final rule.

Medical necessity review (MNR). CMS should revise its rule to exclude MNR from the purview of the Medicaid RAC program. 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 are required to appeal each inappropriate denial through a costly and complex process that on average costs \$2,000 and take 18-24 months to complete.

If MNRs are allowed in the program, it is critical that CMS issue key oversight provisions in the rule to mitigate incentives for aggressive and/or inaccurate medical necessity denials. Before engaging in MNR, the RACs must demonstrate to the state Medicaid agency that a pattern of error exists. MNR should only be conducted by physicians with the appropriate training on Medicaid-covered services, and CMS should establish a method to regularly validate the accuracy of Medicaid RAC medical necessity findings. CMS and/or the state Medicaid agency should share with providers the training materials used for auditors conducting medical necessity review. **Finally, if the RAC determines that a Medicaid claim was not medically necessary at the billed level but was appropriate for a lower claim/payment amount, the provider should be eligible to re-bill for the lower claim/payment amount.**

Duplication of audits. As CMS acknowledges in the preamble of the proposed rule, overlapping or multiple provider audits may result from the expansion of the RAC program to Medicaid. If CMS requires a state to implement a Medicaid RAC program on top of an already existing audit program, we urge CMS to revise the final rule to specifically prohibit Medicaid RACs from conducting audits on claims that are under review by a MIP contractor or other entity. Also, the rule should exclude from RAC review any claim in which payment already has been denied. Like the Medicare RAC program, all Medicaid auditors and RACs should be required to use a RAC data warehouse to identify any claims that are being reviewed by the RAC or other Medicaid audit program.

Medical record requests. During the Medicare RAC demonstration, RACs requested 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. The final 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.

RAC restrictions and transparency. 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. Furthermore, RACs audited claims using the wrong payment codes and audit 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.

To avoid repeating the mistakes of the demonstration program, the Medicaid RAC rule should be revised in the following ways:

- **Audit Process:**
 - Establish the types of improper payments that are included and excluded from the Medicaid RAC program. Supplemental payments such as disproportionate share hospital and other special hospital payments should be excluded from the purview of the RACs.
 - Establish a 12-month look-back period to limit the opportunity for RACs to incorrectly apply new payment rules to old claims.
 - Require RACs to obtain approval from their state's Medicaid agency to audit new payment issues.
 - Require RACs to provide a case-specific rationale for each denial determination.
 - Specify timeframes for RAC determinations, as well as timeframes for notification of those determinations.
 - 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. Allow an extended timeframe to respond to the RAC request when correspondence is sent to the wrong address.

- **RAC Customer Service:**
 - Require RACs to maintain websites where they post approved audit issues and information on audits currently being performed, provide a portal for hospitals to submit their contact information and post customer service contact information.
 - Require RACs to provide a telephone number that providers can call to obtain answers to questions. RACs must be required to respond to hospital questions in a timely manner.

Oversight of RACs. CMS and each state Medicaid agency 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. Additionally, if a hospital is not able to resolve a problem directly with its RAC, the project officer should make himself available to assist the hospital in resolving the problem.

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, recovery 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 should be made available to the public and should share the contract terms to which RACs will be held, including the RAC's contingency fee rate.

Appropriate RAC medical expertise. 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 rule to specifically require that each RAC have a medical director and at least 1.0 FTE physicians per 400,000 Medicaid discharges. These medical professionals should conduct reviews, provide clinical guidance to other personnel 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; and each RAC auditor should demonstrate proficiency prior to conducting audits. Training materials should be shared with providers.

Discussion period. 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 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. The discussion period has significantly reduced the number of inappropriate denials in the Medicare RAC program and has saved both hospitals and RACs the time and expense of going through the appeals process. The Medicaid RAC program should likewise require a discussion period. State Medicaid agencies should participate in the discussion period when issues are raised regarding RAC interpretation of the state plan and other Medicaid payment policies.

Appeals. We appreciate that the proposed rule requires an appeals process for the Medicaid RAC program and we urge CMS to require each state to prescribe a robust appeals process that provides multiple levels of appeal.

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. CMS' silence on these important issues in the proposed rule will result in overzealous and inappropriate denials on the part of the Medicaid RACs. 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, 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. These data can and must be captured on a timely basis and should be used to hold RACs accountable for inappropriate denials. Information on appeal turnover rates should be shared with the public.

Provider education on RAC process. We appreciate that CMS has announced plans to conduct widespread provider education on the Medicaid RAC program and we offer our support in reaching out to the hospital community. In order to ensure that RACs engage in provider education in each state, the final rule should require the RAC to share information with hospitals regarding program operations and appeals processes prior to any reviews. 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.

In many states, the Medicare RACs have worked with the state hospital associations to conduct provider education on the RAC program. This collaboration should continue for the Medicaid RAC program. Prior to commencing audits, RACs should be required to submit a provider outreach plan to the state Medicaid agency and to work with the state hospital association to educate providers on the RAC process.

Underpayments. Although the ACA requires Medicaid RACs to identify overpayments *and* underpayments, the law provides a strong financial incentive for RACs to focus on overpayments. While the states are required to pay RACs a contingency fee for recovered overpayments, they are allowed to determine the fee paid to a Medicaid RAC for identifying underpayments. Therefore, RACs will receive a percentage of each overpayment they recover—a payment that increases as the size of the recoupment increases—but may only receive a small, flat fee payment for identification of underpayments. During the Medicare RAC demonstration program, 96 percent of RAC-identified improper payments were overpayments and the focus on overpayments has continued in the permanent Medicare RAC program.

CMS should require state Medicaid agencies to carefully monitor the volume of underpayment audits conducted by the RACs. CMS also should require states to increase their underpayment fee when RACs are not applying a balanced approach to identifying underpayments and overpayments. Annual RAC reports should include information on the general methods used to identify Medicaid underpayments, and the steps taken to ensure a balance between underpayment and overpayment review.

EFFORTS TO AVOID IMPROPER PAYMENTS

CMS' press release indicates that the agency will engage in a "far-reaching education effort for health care providers and State managers." We applaud this effort. **We urge CMS not to limit educational efforts to the RAC process. After all, preventing improper payments before they are made is the ultimate goal of the RAC program. The rule should be revised to require CMS, state Medicaid agencies and RACs to use program findings to educate providers and implement payment system fixes to avoid billing mistakes before they are made.** We offer our support in reaching out to the hospital community to provide education and share best practices to reduce incidences of improper payments in the Medicaid program.

Donald Berwick, M.D., M.P.P.

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IMPACT OF RAC PROGRAM ON PROVIDERS

Finally, we respectfully disagree with the assertion in the preamble to the proposed rule that most providers will experience limited financial impact from the Medicaid RAC program. Hospitals expend significant resources responding to RAC requests, and many hospitals have hired additional staff to meet the demands of the Medicare RAC program. In fact, the AHA's most recent RACTrac survey revealed that 72 percent of nearly 1,700 responding hospitals indicated that the RAC program has impacted their organization, and 51 percent reported increased administrative costs. These costs will be exacerbated if the Medicaid RAC rule is not revised to incorporate policies necessary to avoid aggressive and overzealous RAC denials.

CONCLUSION

We appreciate your consideration of these recommendations, which we believe are essential to ensuring that the Medicaid RAC program is administered effectively and transparently. We urge you to revise the rule to incorporate the above suggested improvements. To ensure RAC compliance, we request that you include penalties in the final rule for RACs that fail to meet prescribed program requirements.

If you have questions about our comments, please contact me or Elizabeth Baskett, associate director, at (202) 626-2294 or ebaskett@aha.org.

Sincerely,



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