State Medicaid Recovery Audit Contractor (RAC) Program

Section 6411 of the Patient Protection and Affordable Care Act 2010 (ACA) requires — by December 31, 2010 — each state Medicaid program to contract with one or more Recovery Audit Contractors to identify underpayments and overpayments to providers and to recoup overpayments from providers. Each state is required to coordinate RAC efforts with other contractors or entities performing audits of Medicaid providers. Although the Centers for Medicare & Medicaid Services will issue regulations to provide a framework for the Medicaid RAC program, as well as a letter to state Medicaid directors providing guidance on the implementation of the program, CMS has indicated that individual Medicaid agencies will have some discretion in determining the structure and requirements of their RAC programs. CMS has advised that associations speak directly with Medicaid agency officials to recommend program requirements that will make the Medicaid RAC program effective and efficient for the state and for providers.

The Medicare RAC demonstration project was plagued with many problems that led to inappropriate provider payment recoupments, excessive medical records requests and a general lack of accountability and transparency in the program. These problems created significant administrative burdens and confusion for providers, caused frustration among the provider community and hampered the overall efficiency of the program. In response to problems associated with the RAC demonstration project, CMS worked with the provider community to develop solutions to the problems identified during the demonstration and implemented numerous program improvements to the permanent RAC program, which are beneficial for both the RACs and providers.

We encourage you to adopt the policies implemented in the permanent Medicare RAC program to ensure that the Medicaid RAC program is administered effectively and transparently.

This letter provides comment on several issues of concern, including:

- Lack of provider education to understand RAC process and avoid payment errors;
- Unbalanced RAC focus on overpayment;
- Medical necessity reviews;
- Duplication of existing audits already conducted by the Medicaid Integrity Program;
- Excessive and unmanageable medical record requests;
- Lack of transparency and oversight in the RAC program;
- Insufficient RAC medical expertise;
- RACs conducting audits for unlimited periods of times; and
- Disincentive for RACs to avoid appeals.

**PROVIDER EDUCATION**

**RAC Program**

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.
Solution: MO HealthNet, before the program begins, should share information with providers regarding program operations, patterns of errors and appeals processes. Education to address commonly identified errors should include information on RAC audit protocols, appeals outcomes for such errors, relevant Medicaid criteria and notification on the types of claims, diagnoses and errors to be targeted for review. Additionally, the Medicaid RAC appeals process should be identified and explained.

In many states, the Medicare RACs have worked with associations to conduct provider education on the RAC program. Each of our associations is happy to assist in conducting provider education on the Medicaid RAC program. In addition, RACs should be required to post on their website issues which have been approved for review, a requirement that was imposed in the permanent RAC program.

Preventing Improper Payments

Problem: Although educating providers promptly on how to correct billing errors reduces the risk of improper payments, providers have yet to receive any education on the majority of the improper payment vulnerabilities identified by the RACs during the demonstration project.

Solution: MO HealthNet should collect information on improper payments identified by the RAC and use this information to educate providers and improve the payment system to avoid improper payments in the first place. RACs should provide education on Medicaid criteria for high-error claims and process improvements to prevent errors commonly identified by RACs. A portion of the funds recouped by the Medicaid RAC program should be dedicated and applied to provider education and payment system improvements to prevent payment errors.

Medicare RAC Policy: The Statement of Work requires RACs to assist CMS in the development of a Medicare Improper Payment Prevention Plan, which includes a listing of all RAC vulnerabilities identified that CMS can address through provider education or system edits (SOW, pg. 26).

UNDERPAYMENTS

Problem: Despite the statutory requirement that RACs conduct reviews for overpayments and underpayments, RACs primarily conducted overpayment reviews during the demonstration.

Solution: MO HealthNet should require the RACs to conduct both overpayment and underpayment reviews, and the same contingency fees should be provided to RACs for identifying overpayments and underpayments. MO HealthNet annual RAC reports should include information on the general methods used to identify Medicare underpayments, and the steps taken to ensure a balance between underpayments and overpayments.

Medicare RAC Policy: The Medicare RAC SOW requires RACs to review claims to identify underpayments and applies the same contingency fee for overpayments and underpayments (SOW, pgs. 27 and 42).

MEDICAL NECESSITY REVIEWS

Problem: During the Medicare RAC demonstration program, medical necessity reviews by RACs
were the source of two primary concerns for providers: first, that the method by which Medicare pays RACs — a contingency fee payment for each identified payment error — incentivizes aggressive denials by RACs; and second, that in many cases RAC auditors conducting retroactive review of Medicare claims lacked the appropriate training and qualified personnel to accurately determine whether the prior care to beneficiaries was clinically reasonable and necessary. The issue of whether individual auditors possess adequate knowledge of the Medicare coverage guidelines remains a concern, as does the practice of providing financial bonuses to individual auditors to identify denials. As a result, providers disagreeing with RAC medical necessity denials were required to appeal each denial through a costly and complex process. Preparation of an appeal is a time-consuming undertaking that often involves outside legal counsel and, on average, 18-24 months to complete, per appeal.

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 affirmed concerns that some auditors lack the training in Medicare guidelines needed to accurately audit the broad array of provider settings and related Medicare policies.

Solution: It is critical that the Medicaid RAC in Missouri be subject to key oversight and payment provisions by the MO HealthNet to mitigate incentives for aggressive and/or inaccurate medical necessity denials. These include the following provisions:

- RACs should be paid an equal amount for identified overpayments and underpayments;
- RACs should not be reimbursed or should be required to refund payments for denials that are overturned on appeal at any level;
- The MO HealthNet 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 MO HealthNet 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 MO HealthNet is posted on the RAC’s website prior to commencing an audit.
- Final validation of medical necessity review denials should be signed off by a professional licensed by the same board as the providing the services, rather than other RAC auditors possessing different licensing credentials (such as nurses for physicians). RACs should ensure access to an appropriate array of licensed, specialist providers for this purpose to cover the broad clinical range of Medicaid-covered services.
- The MO HealthNet should share with providers the training materials used for auditors conducting medical necessity review.
- The MO HealthNet should 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 continue to use the services of the RAC;
• to design and implement remedial training if such accuracy scores are unacceptably low; or
• to terminate the services of the RAC if the accuracy score is not adequately maintained at an acceptable level.

• 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 EXISTING EFFORTS

Problem: The expansion of RACs to Medicaid could result in duplicative and costly audits for providers already subject to audits associated with the Medicaid Integrity Program. 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 may have already denied payment on the claim or found appropriate.

Solution: Section 6411(a)(1)(iv)(cc) of the ACA requires each state to coordinate RAC efforts with other contractors or entities performing audits of Medicaid providers. MO HealthNet can fulfill this statutory obligation by prohibiting the Medicaid RAC from conducting audits on providers or claims that are currently under review by a MIP contractor or other entity and excluding from RAC review any claim in which payment has already been denied or found appropriate. MIP contractors and RACs should be required to use the RAC Data Warehouse to determine which claims are currently under review or have resulted in an alleged overpayment. The ACA requires states to establish similar databases.

Medicare RAC Policy: The Medicare RAC SOW (Attachment A) requires RACs to use the RAC Data Warehouse to determine if another entity already has the provider/claim under review and prevents the RAC from reviewing a claim currently under review by another entity. The SOW also excludes from review any claim in which payment has already been denied (SOW, pg. 9).

MEDICAL RECORD REQUESTS

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

Solution: MO HealthNet should establish a policy on limiting treatment or care record requests 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. Steps were taken in the Medicare RAC permanent program to minimize provider burden by limiting the number of requests that could be made.
**Medicare RAC Policy:** The Medicare RAC SOW indicates that CMS will institute an appropriate treatment and care record request limit before a contract is awarded (SOW, pg. 11). CMS issued a medical record request limit per hospital (Attachment B), which sets the limits at 1 percent of all claims submitted for the previous calendar year, divided into eight periods (45 days). RACs may not make more than one medical record request per 45-day period. RACs are required to pay for copying of medical records and must accept imaged medical records on CD/DVD (SOW, pg. 12). MO HealthNet should impose similar requirements.

**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 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 on appeal (source: 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 provider, RAC and CMS resources wasted in the appeals process.

**Solution:** MO HealthNet 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 the 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. Lastly, MO HealthNet 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. **It is also important that the MO HealthNet publicly share the contract terms to which RACs will be held, including the RAC’s contingency fee rate.**

**Medicare RAC Policy:** The Medicare RAC SOW specifies the types of improper payments that are included and excluded from the program. The RAC must obtain approval from CMS to audit new issues and to post CMS-approved issues on its website prior to conducting the audit. Additionally, a RAC must provide a case-specific rationale for each denial determination. The SOW also limits the look-back period to three years (SOW, pgs. 6, 14-17, 20-21). We oppose the three-year look-back period for reviews and urge MO HealthNet to limit reviews to one year. The look-back period for RAC reviews should be limited to a 12-month window instead of the current three years, which leads to RAC confusion and error as RACs incorrectly apply new payment rules to old claims. If RACs are granted a longer look-back period, then providers should be allowed to re-bill claims in the same look-back window.

**RAC Correspondence**

**Problem:** RACs have sent correspondence — including medical record requests, review results letters and letters demanding recoupments — to the wrong address, wrong contact and/or wrong provider. This impacts the provider’s ability to respond to the RAC’s requests in a timely manner, sometimes causing providers to miss prescribed response timeframes. In some circumstances, Medicare RAC coordinators have had to grant exceptions to the timeframes on a case-by-case basis. Additionally, RACs have sent multiple review results letters pertaining to a single claim — some of which indicate
conflicting outcomes — causing significant confusion for the provider.

**Solution:** MO HealthNet should require RACs to ensure they have the correct address and point of contact before issuing correspondence to providers, 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.

In many states, the Medicare RACs worked with provider associations to ensure they have the appropriate contact information for each provider. Each of our associations is happy to assist the Medicaid RAC in collecting this information.

**Medicare RAC Policy:** The Medicare RAC SOW requires RACs to develop a web-based mechanism to allow providers to customize their address and point of contact. RACs are encouraged to work with the state associations to collect this information. The SOW also requires RACs to send only one review results letter per claim (SOW, pgs. 12, 21). CMS RAC project officers have the authority to grant extensions to providers unable to meet RAC timeframes due to RAC correspondence sent to the incorrect provider address or contact.

**RAC Customer Service/Website**

**Problem:** During the Medicare RAC demonstration program, providers were not able to obtain answers to questions they had regarding the RAC process. This inhibited providers’ ability to respond appropriately to RAC requests. Often providers had information that, had it been shared before the denial was issued, would likely have prevented the denial in the first place. These denials were often overturned in the appeals process when providers were able to use the information they had to substantiate the claim. It is in the best interest of the RAC and the provider to discuss the denial before it is issued in order to avoid the costly and administratively burdensome appeals process wherever possible.

**Solution:** MO HealthNet 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 provider 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 providers’ ability to respond to RAC requests quickly and accurately. MO HealthNet also must allow the RAC and the provider to engage in a “discussion period” during which providers can speak directly with RAC staff considering the denials. During this period, providers can ensure the RAC has all the information it needs to make an accurate determination. This discussion period has significantly reduced the number of inappropriate denials in the Medicare RAC program.

**Medicare RAC Policy:** The Medicare RAC SOW requires the RAC to have a customer service telephone number (SOW, pg. 37). CMS also requires RACs to have a “discussion period,” which offers an opportunity for the RAC to reverse an inappropriate denial prior to entering the formal appeal process. Additionally, the SOW requires each RAC to operate a website that provides information providers find useful in responding to RAC requests. The website must include a copy
of the standard medical record request, review results and demand letters the provider may receive. 
Each RAC’s website is required to report the status of a claim currently under the review by the 
RAC (SOW, pg. 26).

**RAC Oversight**

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

**Solution:** MO HealthNet should engage in close oversight of the RAC program. The agency should 
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 provider is not able to resolve a problem directly with the 
RAC, the project officer should be available to assist the provider in resolving the problem. RACs 
should issue regular reports to the agency and to the public including data specific to audit and 
medical necessity review volume, outcomes, appeals activity and appeals outcomes. An independent 
report on RAC performance should be issued to CMS, the governor, state legislature and the public 
twice per year.

**Medicare RAC Policy:** The Medicare SOW requires RACs to participate in monthly conference 
calls with CMS to discuss program issues, discuss findings and process improvements (SOW, pg. 4). 
CMS appointed a RAC project officer for each of the four Medicare RAC regions. These project 
officers meet with the RACs on a regular basis to ensure they are meeting program requirements and 
assist providers in resolving concerns. RACs also are required to submit monthly financial reports to 
CMS that detail overpayments and underpayments collected, number of medical records requested 
and number of reviews that did and did not meet the 60-day timeframe requirement (SOW, pg. 5). 
RAC validation contractors provide annual accuracy scores for each RAC.

**APPROPRIATE RAC EXPERTISE**

**Problem:** During the Medicare RAC demonstration program, 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. This was proven true even in cases where the RAC employed a chief medical officer.

**Solution:** MO HealthNet should adopt the same staffing requirements prescribed in the Medicare 
RAC program to ensure RAC staff has the appropriate medical expertise to conduct audits and make 
payment determinations. Such physicians should be licensed and collectively have a broad array of 
medical training and clinical experience. When other primary care professionals are being audited, 
the RAC should have an appropriate number of reviewing professionals trained and licensed in the 
same profession as those being audited. 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.

**Medicare RAC Policy:** Whenever performing complex coverage or coding reviews, the Medicare 
RAC SOW requires RACs to ensure that coverage/medical necessity determinations are made by 
RN s or therapists and that coding determinations are made by certified coders (SOW, pg. 19). RACs
also must employ a minimum of 1.0 FTE contractor medical director with relevant work and educational experience (SOW, pg. 25).

**TIMEFRAMES**

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

**Solution:** MO HealthNet should implement timeframes for RAC 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.

**Medicare RAC Policy:** The Medicare RAC SOW requires RACs to complete complex reviews within 60 days of receipt of the medical record documentation (SOW, pg. 19). RACs also must send a review results letter detailing the RAC’s findings to the provider within 60 days (SOW, pg. 23).

**APPEALS**

**Problem:** During the Medicare RAC demonstration program, RACs were able to recoup funds even when the provider was appealing the denial. Additionally, CMS and the RAC did not provide any data on the number of claims appealed and the number of denials overturned during the appeals process. It was revealed later in a CMS report that 64 percent of the appealed claims during the demonstration were decided in the provider’s favor (source: CMS Update to the RAC Demonstration Report, June 2010).

**Solution:** It is very important to have an effective appeals process to allow providers to challenge inappropriate RAC denials. We believe that the provisions of section 208.156, RSMo. would apply to the results of any RAC audit finding a disallowance.

To prevent overzealous and inappropriate RAC denials, MO HealthNet must not allow the RAC to recoup provider payments until all appeals have been exhausted, and RACs must not be able to receive their contingency fee in cases where the denial is overturned on appeal. Information on appeal turnover rates also 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.

**Medicare RAC Policy:** The Medicare RAC SOW prohibits a RAC from recouping funds until the first two appeal stages are exhausted; RACs do not receive their contingency fees when a denial is overturned (SOW, pg. 37).