

January 10, 2011

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

Re: Proposed Rule concerning Medicaid Program; Recovery Audit Contractors [CMS–6034–P] RIN 0938–AQ19

Dear Dr. Berwick:

The undersigned organizations appreciate the opportunity to provide our comments regarding the Centers for Medicare and Medicaid Services' (CMS) *Proposed Rule concerning Medicaid Program; Recovery Audit Contractors [CMS–6034–P] RIN 0938–AQ19*.

We continue to have concerns about the perverse incentive structure and burdensome nature of the Medicare Recovery Audit Contractor (RAC) program, and firmly believe that the best way to reduce improper coding is through education and outreach. In regard to the Medicaid RAC program, while we support CMS's efforts to identify improper or fraudulent activity in the Medicaid program, we are concerned that the proposed rule does not provide sufficient guidance to States in establishing and implementing their Medicaid RAC programs. We urge CMS to review the improvements already instituted in the Medicare RAC program, and to require that similar safeguards are put in place for the Medicaid RAC program. **We ask CMS to be mindful of the multitude of new challenges facing physicians as a result of health system reform, in addition to the implementation of health information technology and the transition to ICD-10-CM and ICD-10-PCS codes, and request that CMS set forth streamlined and straightforward requirements for the Medicaid RAC program to ensure efficient and high quality care delivery.** We offer below our detailed comments on the proposed rule.

#### Learning from the Medicare RAC program

CMS proposes to allow States broad discretion in determining their own Medicaid RAC program requirements. CMS notes in the proposed rule: "We will apply the lessons learned from the Medicare RAC Demonstration, as well as from the current program in providing States technical support and assistance in their efforts to implement their programs." We believe that a more assertive approach is required, both by statute and by reason.

Congress contemplated the value of the Medicare RAC program as a precursor to the Medicaid RAC program. Section 6411 of the Affordable Care Act (ACA) provides that States shall

establish Medicaid RAC programs “consistent with State law and in the same manner as the Secretary enters into contracts with recovery audit contractors under Section 1893(h),” the statute that establishes the Medicare RAC program. We disagree with CMS’s stated interpretation of the aforementioned provision, namely, that “some of the provisions of the Medicare RAC program, generally, should serve as a model for the proposed Medicaid RAC program.” To the contrary, we believe that the statutory language clearly states that the Medicaid RACs should be established *in the same manner* as CMS currently contracts with Medicare RACs, and with the *same* program requirements.

Further, the proposed implementation date of the Medicaid RAC program, April 1, 2011, is swiftly approaching, and States would be well served by CMS’s direction on the front end of their program development. Provider input regarding weaknesses in the Medicare RAC Demonstration project served as a basis to improve the permanent Medicare RAC program. It would be unproductive not to institute these same “lessons learned” at the outset of the Medicaid RAC program, rather than waiting until States begin to encounter these same pitfalls as they administer the program.

Lastly, parallel Medicare RAC and Medicaid RAC standards are consistent with CMS’s aim of harmonization of the anti-fraud activities of the Medicare and Medicaid programs under the Center for Program Integrity (CPI). It is our understanding that CPI is focused on several aims, moving from: “pay and chase” to prevention and detection; stand alone program integrity programs to coordinated and integrated programs; “one size fits all” to risk based approaches; and, inward-focused communication to transparency and accountability. Improvements to the Medicare RAC program following the demonstration have begun to move that program from where program integrity *was* (pay and chase, inward-focused communication, etc.) to where program integrity *is going* (prevention and detection, transparency and accountability, etc.). If States are compelled to design novel Medicaid RAC programs, those programs may more closely mirror the program integrity efforts that CPI is now moving away from because they have already been found to be ineffective.

**We urge CMS to heed the statutory language and issue Medicaid RAC program requirements that are consistent with the Medicare RAC program requirements, thereby empowering States to avoid problems already encountered and addressed in the Medicare RAC program.**

#### Improvements to the Medicare RAC Program

We appreciate CMS’s past efforts to incorporate some of the specific recommendations made by physicians to improve the Medicare RAC program. As providers with first-hand experience with Medicare RAC audits, physicians have been a primary source of useful feedback on that program. In the following sections, we briefly examine the key CMS adjustments made to the

Medicare RAC program as a result of physician feedback, and urge CMS to establish corollary requirements for the Medicaid RAC program.

#### *Look Back Period*

After receiving input from the physician community, CMS shortened the time frame that a Medicare RAC can go back and review claims from four years to three. However, the proposed rule does not require that Medicaid RAC contractors are constrained by any look back time period, leaving the door open for Medicaid RACs to conceivably request documentation for claims ten years old or more.

Physicians are excessively burdened by RAC audits; RACs typically require physicians to collect and send myriad documents including physician orders and progress notes, diagnostic test results, history, operative reports, and certificates of medical necessity, even when the requested documentation is housed in a multitude of different locations or facilities. The administrative and logistic burden of complying with such onerous requests would be unduly amplified by an unlimited look back period. **We urge CMS to limit the look back period to no more than three years, at the most, and to preclude Medicaid RACs from reviewing claims from the past twelve months.**

#### *Medical Record Request Limit*

The Medicare RAC Demonstration provided an optional medical record limit set by each individual RAC. Under the expanded program, CMS set medical record limits, and Medicare RACs may now request up to 10 medical records per single practitioner within a 45 day period. Without medical record request limits, physicians are unjustly burdened by unlimited “fishing expeditions” for medical records that may be erroneous. Since the charge of the RACs should be to conduct targeted audits in good faith for claims that are likely to be erroneous, medical record request limits are appropriate and equitable. We continue to believe that the medical record limit per solo practitioner should be reduced to no more than three medical records within a 45 day period. **At a minimum, we ask that CMS impose at least the medical record limit established for Medicare RAC record requests on the Medicaid RACs.**

#### *Physician Medical Directors*

We commend CMS for acknowledging the benefit of a physician presence on Medicare RAC staffs, and for changing the Medicare RAC program to require each RAC to have a *physician* medical director. While CMS rightly notes this improvement in the proposed rule, it does not mandate that the States similarly require a physician medical director on Medicaid RAC staffs. Rather, the proposed rule merely requires “employment of trained medical professionals to review Medicaid claims.”

As CMS points out, physician medical directors “oversee the medical record review process; assist nurses, therapists, and certified coders upon request; manage quality assurance procedures; and maintain relationships with provider associations.” According to the Medicare RAC Statement of Work, a Medicare RAC physician medical director must be a “board certified doctor of medicine or doctor who is currently licensed.” Physician medical directors serve as a unique resource of specialized and technical information, and are vital to RACs’ understanding of diverse medical claims. We continue to believe that RAC programs would benefit from an additional requirement that a physician who is board certified in the same specialty as the physician undergoing audit review the claim prior to any request for repayment. **We strongly urge CMS to clearly issue a requirement for physician medical directors on Medicaid RAC staffs.**

#### *Good Cause*

As CMS notes in the proposed rule, during the demonstration, Medicare RACs were inconsistent in documenting their “good cause” for reviewing a claim. CMS now requires that Medicare RACs document their good cause for reviewing the claim when claims are reopened more than 12 months from date of the initial determination. RACs must document good cause in the demand letter and in all case files. This requirement facilitates communication between providers and RACs. **We request that CMS similarly require Medicaid RACs to document good cause for claim review.**

#### *RAC Websites*

Under the demonstration, Medicare RACs were not required to maintain a website. In the expanded program, each Medicare RAC is required to maintain a Web presence, where they must post new issues approved for RAC review and identified vulnerabilities (discussed below), and a service whereby physicians can look up the status of their audits. This has amplified CMS’s efforts to improve transparency and accountability, and to prevent improper payments before they occur. **RAC websites have been a key tool in facilitating productive communication between physicians and Medicare RACs, and Medicaid RACs should be required to maintain a Web presence, including posting timely information on newly approved issues.**

#### *Vulnerabilities*

One of the shortcomings of the Medicare RAC Demonstration was a lack of education and outreach to providers concerning which billing methodologies were audit-prone. Following the demonstration, CMS has made an effort to communicate with the provider community regarding how to avoid Medicare RAC audits by identifying audit-prone errors and claims, or “vulnerabilities.” While we continue to believe that greater communication and education is necessary, we support CMS’s effort to publish information on identified vulnerabilities to educate providers on how to avoid problems in the future. **Correspondingly, we ask that CMS**

**require outreach and education on Medicaid RAC identified vulnerabilities, including website posting.**

*Validation Contractors*

We commend CMS for retaining an independent validation contractor to review Medicare RAC-identified vulnerabilities and claims review methodology and issue annual accuracy scores. We request that a similar validation process be put in place for the Medicaid RAC program. We note that the proposed rule requires States to report to CMS on certain elements describing the effectiveness of their Medicaid RAC program. We think that, similarly, Medicaid RAC accuracy and methodology should be under CMS review. **CMS should require a validation contractor to independently examine Medicaid RAC vulnerability and claim determinations, and to issue annual accuracy scores.**

*Contingency Fees: Recoupment upon Appeal and Public Notice*

During the Medicare RAC Demonstration, RACs only had to pay back a contingency fee on a disputed overpayment if they lost at the *first* level of appeal. This created a perverse incentive for RACs to unjustly pursue legitimate claims, betting on the fact that the overpayment determination would not be overturned on the first level of review, and the RAC would keep the fee, regardless of later adjudication in the provider's favor. With physician input, CMS identified this weakness and now requires that Medicare RACs repay the contingency fee if a disputed overpayment is adjudicated in favor of a provider at *any* level of appeal. Further, CMS now requires that the payment rate a RAC receives for locating improper payment be made public. **We request that these two Medicare RAC program requirements, return of payment upon successful provider appeal at any level, and public access to payment rates, be required in the Medicaid RAC program.**

*Certified Coders*

Certified coders were not mandatory in the Medicare RAC Demonstration. The permanent program, however, does require that each RAC must have certified coders to make coding determinations. Certified coders bring requisite expertise to the RACs' coding determination process, and aid RACs in avoiding improper coding interpretation. **Certified coders should be required in the Medicaid RAC program.**

*Demand Letters*

After the demonstration, CMS developed standardized base letters for each RAC to use when issuing demands. While RACs may continue to amplify or adjust these letters, each demand letter is subject to CMS approval. We believe that a streamlined demand letter format is absolutely necessary; with the myriad of auditing contractors and agencies operating at the state level, some degree of uniformity is required. Medicaid RAC demand letters should include, at a

minimum, patient identifier information, the date of the service in question, and the amount of alleged overpayment. Further, all demand letters should carry the state / Medicaid logo to ensure physicians understand that the letters come from a trusted source. **CMS should require that standardized base letters be used for Medicaid RAC demands.**

### Appeals

CMS proposes to allow States broad discretion in determining their appeal processes for Medicaid RAC appeals. The rule allows for States to use existing administrative appeals processes already in place in each State, or to allow States to establish Medicaid RAC-specific appeals processes. Although it is unclear, it appears that States would be required to submit their proposed appeals processes to CMS for review. We agree that Medicaid RAC program appeals should be approved by CMS, and further suggest that CMS outline specific requirements for Medicaid appeals. As CMS notes in the proposed rule, appeal adjudication structure and timeframes have an impact on payment methodologies. More concerning, lengthy and divergent appeals processes can be burdensome and costly for physicians, effectively discouraging equitable adjudication of RAC determinations. **We urge CMS to set forth clear appeals processes requirements, using past lessons learned in the Medicare RAC program, to aid States in administering Medicaid RAC appeals.**

### Federal Matching of Contingency Fees

CMS states in the proposed rule that it will not provide federal financial participation (FFP) for any contingency fee amount that exceeds the highest contingency fee rate paid to a Medicare RAC *unless* a State requests an exception and provides an acceptable justification. We oppose any exception to the FFP limit. We have long maintained that the contingency fee structure is inappropriate for any RAC program, as it perversely incentivizes RACs to engage in bounty hunting, which leads to increased expenses and administrative burdens for providers. Further, we submit that allowing States to obtain exceptions from the maximum FFP is not only needless, but would also further exacerbate the predatory nature of RAC audits. **We believe that the Medicare RAC maximum contingency fee rates already employed by CMS are ample to achieve the aims of the Medicaid RAC program, and ask that CMS revise the proposed rule to limit the FFP to the maximum Medicare RAC contingency fee.**

### Coordination

We commend CMS for its recognition of the need for coordination among the multiple anti-fraud and audit programs active in the States. Congress also envisioned this dynamic, and included specific statutory language in the ACA requiring that Medicaid RAC contactors coordinate recovery audit efforts with the myriad of other state and federal entities conducting audits. The

proposed rule admits that “coordination may be a challenge because of the number of other agencies or entities that may be conducting audits,” and reminds States of their obligation to ensure that audits are not duplicative or counter-productive. **We urge CMS to institute specific requirements to aid States in protecting physicians from duplicative audits.**

Additionally, we believe that education and outreach are imperative to the success of coordination efforts in the Medicaid RAC program. We have long advocated for increased physician education on billing errors, as errors are the cause of the vast majority of overpayments. Further, we believe that more education regarding data mining criteria and programs should be available to physicians. In 2007, CMS produced a guide for physicians to identify the various audit contractors operating in their State and region. We request that CMS simplify, update, and re-publish that document. We believe that a focus on educating physicians as to 1) why overpayment occurs; 2) which entities are charged with auditing for overpayments; and, 3) who physicians should contact regarding quality or duplication issues, would be productive. **We ask that CMS focus on education and outreach to the physician community regarding Medicaid RACs and coordination efforts.**

#### Fraud Referrals

As discussed in the previous section, Congress envisioned Medicare RAC and law enforcement interaction in the ACA, and included explicit language to require coordination of recovery audit efforts. The proposed rule goes beyond the statutory language by requiring Medicaid RACs to make immediate referrals to law enforcement whenever they have “reasonable grounds” to believe that fraud or criminal activity has occurred. While we fully support law enforcement’s efforts to identify truly fraudulent activity, we do not think that the determination of what may constitute “reasonable grounds” for referral is within the purview of Medicaid RACs, or that RACs should be absolutely required to make such referrals. RACs already have the ability to refer any matter to law enforcement they deem necessary. However, mandatory immediate referral is a step too far. **We urge CMS to remove the immediate referral for suspicion of fraud requirement from the proposed rule.**

#### Underpayments

The ACA allows States to pay RACs “in such amounts as the State may specify for determining underpayments.” We are encouraged that Congress acknowledged that contingency fees are not the only fee arrangement that is conceivable, or, we would argue, desirable, in the context of RAC payment. However, we are concerned that the flexibility that CMS proposes to give States in determining underpayment fee *structure*, as opposed to fee *amount*, will further compound the lackluster efforts of RACs to identify underpayments. We have been longtime advocates of allowing physicians, or, at the very least, medical societies, to report underpayment issues to RACs, because underpayments recoveries are so infrequent. CMS notes in the proposed rule:

“Our experience with Medicare RAC contractors is that overpayment recoveries exceed underpayment identification by more than a 9:1 ratio.” As the goal of the RAC programs is to identify improper payments, both overpayments and underpayments, we believe that continuity is required to provide RACs with parallel incentives to undergo underpayment reviews. **We strongly urge CMS to set forth Medicaid RAC underpayment fee structure requirements.**

#### Access to Data

We understand that efforts are currently underway to harmonize data collection and provide a method for prevention of duplicative audits. We commend CMS for their efforts to prevent an overburdening of providers with multiple audits of the same claim in the Medicare RAC program. We also believe that these efforts by CMS squarely address the ACA’s requirement of coordination in the Medicaid RAC program, and data on Medicaid and Medicare RAC claims review should be included in data collection efforts. **We strongly urge CMS to require Medicaid RACs to run checks for duplicity prior to initiating audits.**

#### New Issue Approval

In the Medicare RAC program, RACs must request approval through the CMS New Issue Approval (NIA) process to begin a new type of review, and if approved, post the issue on its website. The proposed rule is silent on a corresponding requirement in the Medicaid RAC program. Many States may not have the capacity to independently review and approve each new issue, and will likely turn to CMS for detailed guidance on what types of issues merit approval and will be eligible for the federal match. While we disagree with many of CMS’s past decisions to allow audits on certain new issues, CMS already has a working NIA process, and could harmonize Medicare RAC issue approval with Medicaid RAC issue approval by requiring Medicaid RACs to submit directly to CMS for approval. **We urge CMS to require streamlined new issue approval processes for the Medicaid RAC program, and urge CMS to consider requiring Medicaid RACs to submit to CMS’s current approval process for Medicare RAC issues.**

#### Electronic Submission of Documentation

We understand that CMS is developing an electronic submission of medical documentation, or “esMD,” system to allow providers to respond to RAC audits electronically. We commend this effort; physicians often have to commit extra time and personnel to RAC audit responses, which can result in less patient care. While the Web service CMS proposes to facilitate esMD, the National Health Information Network (NIHN) Direct, it is still under development, we generally support the agencies’ efforts to provide a mechanism for electronic submission of RAC requested documentation, as long as physician participation is voluntary. We caution, though,



that CMS's proposal to require providers to contract with a "gateway provider" to provide access to NIH Direct may result in low utilization; many small physician practices do not have the resources required to hire an outside company to facilitate their communication with a CMS Web network. **We generally support CMS's recognition of the utility of optional electronic documentation submission in response to RAC audits, and ask that CMS extend that effort to Medicaid RAC document submission.**

### Conclusion

The undersigned organizations appreciate the opportunity to provide our views on the proposed Medicaid RAC rule. We support CMS's efforts to identify improper or fraudulent activity, but caution that physicians have been unjustly and negatively affected by untested and uninformed program implementation. While we commend CMS for the prior changes made to the Medicare RAC program, we urge CMS to be mindful of Congress' intent and employ the lessons learned in the Medicare RAC program by establishing harmonious requirements for the Medicaid RAC program. As CMS implements this and other ACA provisions, we look forward to a productive working relationship whereby the views of the physician community may positively inform CMS's work. Should you have any questions on this letter, please contact Cybil Roehrenbeck, Washington Counsel, American Medical Association, at [cybil.roehrenbeck@ama-assn.org](mailto:cybil.roehrenbeck@ama-assn.org).

Sincerely,

American Medical Association  
Medical Association of the State of Alabama  
Alaska State Medical Association  
Arizona Medical Association  
Arkansas Medical Society  
California Medical Association  
Colorado Medical Society  
Connecticut State Medical Society  
Medical Society of Delaware  
Medical Society of the District of Columbia  
Florida Medical Association Inc  
Medical Association of Georgia  
Hawaii Medical Association  
Idaho Medical Association  
Illinois State Medical Society  
Indiana State Medical Association  
Iowa Medical Society  
Kansas Medical Society

Kentucky Medical Association  
Louisiana State Medical Society  
Maine Medical Association  
MedChi, The Maryland State Medical Society  
Massachusetts Medical Society  
Michigan State Medical Society  
Minnesota Medical Association  
Mississippi State Medical Association  
Missouri State Medical Association  
Montana Medical Association  
Nebraska Medical Association  
Nevada State Medical Association  
New Hampshire Medical Society  
Medical Society of New Jersey  
New Mexico Medical Society  
Medical Society of the State of New York  
North Carolina Medical Society  
North Dakota Medical Association  
Ohio State Medical Association  
Oklahoma State Medical Association  
Oregon Medical Association  
Pennsylvania Medical Society  
Rhode Island Medical Society  
South Carolina Medical Association  
South Dakota State Medical Association  
Tennessee Medical Association  
Texas Medical Association  
Utah Medical Association  
Vermont Medical Society  
Medical Society of Virginia  
Washington State Medical Association  
West Virginia State Medical Association  
Wisconsin Medical Society  
Wyoming Medical Society  
AAHCP  
American Academy of Dermatology  
American Academy of Family Physicians  
American Academy of Hospice and Palliative Medicine  
American Academy of Neurology  
American Academy of Pediatrics  
American Academy of Physical Medicine & Rehabilitation  
American Association of Clinical Endocrinologists  
American Association of Clinical Urologists

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American Association of Neuromuscular & Electrodiagnostic Medicine

American College of Emergency Physicians

American College of Osteopathic Surgeons

American College of Phlebology

American College of Physicians

American College of Radiology

American College of Surgeons

American Congress of Obstetricians and Gynecologists

American Gastroenterological Association

American Psychiatric Association

American Osteopathic Academy of Orthopedics

American Society for Gastrointestinal Endoscopy

American Society of Anesthesiologists

American Society of Hematology

American Society of Neuroradiology

College of American Pathologists

Medical Group Management Association

Renal Physicians Association

Society of Hospital Medicine

Society of Nuclear Medicine