COLORADO DEPARTMENT OF HEALTH CARE POLICY & FINANCING

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Bill Ritter, Jr., Governor • Joan Henneberry, Executive Director

January 10, 2011

Angela Brice-Smith, Director
Medicaid Program Integrity Group
Centers for Medicare & Medicaid Services
Department of Health and Human Services,
Attention: CMS-2325-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: CMS-6034- P Medicaid Program; Recovery Audit Contractors. Proposed Rule

Dear Ms. Brice-Smith:

I am writing to you on behalf of Colorado's single state Medicaid agency, the Department of Health Care Policy and Financing to provide comment related to proposed rule CMS-6034-P *Medicaid Program, Recovery Audit Contractors* under section 6411 of the Affordable Care Act of 2010.

Colorado shares the federal interests in ensuring the integrity of the Medicaid Program and wishes to respond to the *Federal Register* notice request for specific comment on the Medicaid Recovery Audit Contractor (RAC) program contingency fee percentage limit and the implementation deadline, in addition to the proposed regulatory provisions.

Contingency fee limit. Colorado believes that there is insufficient basis to link a State's Medicaid RAC program contingency fee rate to the Medicare RAC maximum. This link to the Medicare contingency rate maximum is not specifically mandated in the provisions of the Affordable Care Act, and is therefore subject to the Secretary's discretion. As acknowledged by CMS, the Medicare RAC program "is still a relatively new program" (*Federal Register* Vol. 75 No. 217 page 69040), while the Medicaid RAC program is not yet implemented. Colorado appreciates CMS' likely concern that the federal share of any recovered overpayments not be unduly reduced by an unreasonable State-approved contingency fee percentage. However, keeping Medicaid RAC program fees tied to Medicare may have unintended consequences. Some Medicaid program expenditures do not correspond well to the magnitude of Medicare RAC regions so a State Medicaid RAC contractor may lack sufficient claims audit volume to achieve the same efficiencies of scale. Additionally, State procurement cycles may not align well with the stated Medicare RAC procurement cycle, and States may experience challenges in being sufficiently nimble to revise competitively selected contingency fee rates with only a 6-month time period between notification of a new percentage limit and expected

implementation of that limit. Further, should the Medicare contingency fee rate maximum decrease, it is not clear that States could successfully renegotiate the Medicaid RAC program limit without a corresponding decreased scope of work under the State's Medicaid RAC contract. Finally, State Medicaid RAC contractors will have reasonable expectations that the scope of work, and corresponding anticipated incurred expenses for which they are bidding, will be covered by the contingency fee percentage they offer. Developing a competitive selection process that includes a federally mandated potential reduction in the contingency fee percentage will likely inhibit development of robust and more costly audit recovery activities as the Medicaid RAC contractors will need to ensure their business costs can be supported by the anticipated payments. If CMS is committed to maintaining some alignment with the Medicare RAC rate maximum, Colorado strongly recommends that CMS be flexible and allow sufficient time for States to come into compliance in keeping with state-specific procurement cycles. In the event of a reduced Medicare RAC maximum, Colorado requests that future State RAC contracts competitively procured at a higher percentage rate be "grandfathered" in at those higher rates with a State commitment to transition to the lower percentage limit with the next procurement cycle.

Proposed April 1, 2011 implementation date. Colorado respectfully suggests that rushing the Medicaid RAC program implementation date is ill-advised. Comments on the proposed regulations were not due until January 10, 2011 and State Plan Amendments were due December 31, 2010. It is easy to contemplate the circumstance where the available time period from a State's approved SPA and final federal regulation to the proposed implementation date is less than 90 days. Having even a 90-day cycle to conduct a competitive procurement that is in accord with published final Federal regulation and State approval (via a SPA) is unreasonable.

In order, Colorado has the following specific comments on the proposed regulations:

§455.502 (b) Establishment of program. Please confirm that the provisions of paragraph (b) will permit Colorado to continue current statutorily authorized practices where providers send any identified recovery amounts directly to the State for deposit and clarify whether such State-specific practices must be articulated in the State Plan Amendment.

§455.504 Definitions. *Medicaid RAC Program.* Please clarify whether the RAC program contractor activities contemplated under "recoup overpayments" may include legal defense of an appealed overpayment determination.

§455.506 (a) Activities to be conducted by Medicaid RACs. Please clarify the intended scope of review anticipated and clarify whether States have the flexibility to target reviews to specific focus areas based upon perceived risk of over or under payment, or efficacy. Please also clarify whether the contingency fee percentage may vary according to a specific focus area of review, should that focus review approach be determined allowable. Additionally, Colorado asks CMS to add clarifying language to confirm that consistent with the provisions of 42 CFR Subpart F that the single State Medicaid Agency (SMA) and not the RAC contractor is the final arbiter of whether an over or under

payment has been "discovered." Colorado is specifically concerned that absent such explicit link to the provisions of 42 CFR Subpart F, States may be vulnerable to Federal share refund expectations when a RAC contractor's methods for identifying overpayments are flawed.

§455.506 (b) Activities to be conducted by Medicaid RACs. Colorado wishes to note that best practices on auditing for overpayment recovery conflict with having the contractor both identify an overpayment amount and receive the refunded monies. Please confirm that paragraph (b) allows States, in keeping with their specific State statutory requirements, to receive any identified overpayments directly rather than delegate actual collection of the overpayments to the Medicaid RAC program contractor and clarify whether such State-specific practices must be articulated in the State Plan Amendment. Further, Colorado recommends that CMS consider revising this paragraph to comport with best practice.

§455.508 (b) Eligibility requirements for Medicaid RACs. Please clarify how States and Medicaid RAC program contractors will be notified of efforts initiated by the OIG or criminal investigations in order to facilitate coordination of efforts. Colorado is concerned that routine RAC contractor activities such as record requests may alert providers and subsequently jeopardize investigations.

§455.508 (c) Eligibility requirements for Medicaid RACs. Colorado's state law requires certain timeframes and options must be available to providers under any audit; please confirm that States may continue to enforce such requirements and clarify whether such State-specific requirements must be articulated in the State Plan Amendment.

§455.510 (a) Payments to RACs. Colorado notes that the background information accompanying the proposed regulation indicates that payments to the RAC contractor are to be made based upon actual overpayments recovered, while the States' obligation for Federal share refund of overpayments must continue in accord with the requirements of §433.312 and are based upon amount identified, without regard to actual recovery. Colorado strongly recommends that CMS revise its proposed methodology for RAC payment to permit State flexibility, allowing States the option to claim contingency fees for the RAC in a manner consistent with current administrative FFP claiming protocols for existing TPL and non-TPL overpayment recovery contracts. Colorado believes requiring States to run an accounting process for RAC contingency fees that may differ from existing non-RAC overpayment recovery contingency fee claiming processes is administratively burdensome and invites opportunity for error.

§455.510 (b)(3) Payments to RACs. Colorado strongly recommends that CMS reconsider its current proposal to set the contingency fee percentage limit at the highest Medicare RAC rate. Currently there are four regional Medicare RACs that likely result in some efficiency of operation due to size. It is not clear that similar operational efficiencies can be expected for State Medicaid RAC program contractors, particularly for States with relatively lower Medicaid expenditure levels. Colorado suggests letting the competitive procurement process define the contingency fee percentage limit for Medicaid, as was done for the Medicare RAC program at its inception. Setting the fee percentage at a pre-determined limit runs the risk of incenting less costly, and perhaps less rigorous, RAC contractor practices. At minimum, in the event of a reduced Medicare RAC maximum Colorado requests that State contingency-based recovery contracts competitively procured at a higher percentage rate be "grandfathered" in at those higher rates with a State commitment to transition to the lower percentage limit with the next procurement cycle.

§455.510 (c) Payments to RACs. Please clarify expectations around a fee paid for identification of underpayments when State law lacks authority to pay fees for such action. Colorado strongly recommends that CMS consider including alternatives that achieve the goal to incent identification of underpayments.

§455.512 Medicaid RAC provider appeals. Please clarify whether the State may contractually obligate the RAC to defend its findings in the administrative appeal and clarify whether such State-specific requirements must be articulated in the State Plan Amendment.

§455.516 Exceptions from Medicaid RAC programs. Please clarify the manner in which such request should be communicated to CMS and the anticipated timeframe for CMS response.

Thank you for the opportunity to provide comment and ask for clarification. Should you have any questions, I can be reached at Barbara.prehmus@state.co.us or via telephone at (303) 866-2991.

Sincerely,

Barbara B. Prehmus, M.P.H.
Federal Policy & Rules Officer

Cc: Ms. Joan Henneberry, Executive Director
Ms. Lorez Meinhold, Director of Health Reform Implementation & Senior Health Policy Analyst, Colorado Governor Bill Ritter, Jr.
Ms. Monica Harris, Division of Audits and Accountability, Medicaid Program Integrity Group
Ms. Cynthia Mann, Center for Medicaid, CHIP, Survey & Certification