COLORADO
Department of Health Care Policy & Financing

1570 Grant Street
Denver, CO 80203

March 9, 2023

Megan Axelrod, Director
Regulatory Policy and Federal Affairs
Colorado Hospital Association
7335 E. Orchard Rd.
Greenwood Village, CO 80111

RE: Colorado Hospital Association (CHA) Document "Medicaid Recovery Audit Contractor (RAC) Issue Summary"

Dear Megan:

Thank you for providing information and the above-referenced document that has been shared with members of the Joint Budget Committee. The Department of Health Care Policy and Financing (the Department) remains committed to working with the hospitals and stakeholders, like CHA, in addressing the concerns of the provider community while also upholding our program integrity and compliance requirements.

The Department is disheartened that the CHA continues to have concerns with the RAC program and has prepared information in the enclosure that clarifies information on the RAC program and the intent of the Department's FTE request in HCPF R-11. In summary, the Department is:

- reiterating the request for FTE for the Fraud, Waste and Abuse program is not solely for the RAC Program, but it is to meet the growing needs of the Department's internal and external program integrity work;
- clarifying that a portion of the Department's request for FTE is not related to post-payment hospital claims reviews, but instead to address the increasing number of complaints from our Clients who are being illegally billed by providers, which include hospital facilities; and
- clarifying misinformation of its RAC Program, and also providing additional information about the federal government's interest in the Colorado RAC Program and its plans to change the federal landscape of all Medicaid RAC programs nationwide.

As always, the Department values the hospitals' and CHA's partnership and hope to continue a collaborative dialogue.

Sincerely,

Bart Armstrong

Digitally signed by Bart Armstrong
DN: cn=Bart Armstrong, o=Colorado Department of Health Care Policy & Financing, ou=Fraud, Waste and Abuse Division, email=bart.armstrong@state.co.us, c=US
Date: 2023.03.09 12:38:12 -07'00'

Bart Armstrong, Director
Fraud, Waste and Abuse Division
Medicaid Operations Office

Enclosure

cc: Sen. Rachel Zenzinger, Chair, Joint Budget Committee
Rep. Shannon Bird, Vice Chair, Joint Budget Committee
Rep. Rod Bockenfeld, Member, Joint Budget Committee
Sen. Jeff Bridges, Member, Joint Budget Committee
Sen. Barbara Kirkmeyer, Member, Joint Budget Committee
Rep. Emily Sirota, Member, Joint Budget Committee

The Department has prepared a point-by-point response to each statement and concern given by CHA in its document "Medicaid Recovery Audit Contractor (RAC) Issue Summary":

Regarding HCPF Budget Request R-11:

CHA Comment:

"Through HCPF R-11, the Department is seeking to expand RAC audit activity. **CHA does not believe the current program is working as intended, and the entire program should be reviewed to ensure transparency, accountability, and efficiency."**

Department Response:

CHA's statement makes an assumption that is incorrect. CHA's position places the Department at a disadvantage in its efforts to ensure overall program integrity through provider audits, fraud investigations, and preventing the illegal billing of our members. The FTE's requested in HCPF R-11 will be an addition to the Department's Fraud, Waste, and Abuse (FWA) Division and will be tasked with performing all of the duties and requirements of the FWA Division. This is not an exclusively RAC-centered position.

As the Department have mentioned in our December briefing, while the FWA Division has reviewed 104,000 claims of all provider types in the last fiscal year, that figure presents only about .28% of all claims paid by the Department to providers in that same year. There is a clear disparity in the amount of claims Department staff can review for fraud, waste, and abuse which makes it evident that the Department needs to do more to ensure Medicaid funds are paid appropriately and correctly to all of Medicaid providers, including hospitals.

In terms of the Recovery Audit Contract FTE, to put the staffing deficit in context, in March of 2021 the staffing for the whole Colorado RAC Program was 1.0 fully dedicated FTE and increased to 3.0 FTE later that year to handle the effectiveness of the RAC Program and the additional dollars being spent on healthcare services. Comparatively, in states with similar effectiveness of the RAC Program, the staffing averages 20-30 FTE.

However, as more dollars are spent on healthcare in Colorado, the Department will be limited to reviewing fewer and fewer claims proportionally if staffing levels remain the same, making the 0.28% of claims reviewed decrease exponentially. This potentially increases fraud, waste, and abuse throughout the state and will increase the already high costs of healthcare in our state.

Regarding SB 13-137:

CHA Comment:

"CHA's assessment is that the RAC audit program is failing to abide by these principles. In addition to several streams of ongoing litigation acknowledged in the accompanying narrative to HCPF R-11, which appear to admit flaws in the RAC audit program."

Department Response:

The Department disagrees that the RAC audit program is failing to abide by the principles cited. To begin, CHA has quoted from a legislative document in their request which does not apply to the RAC Program. Instead, the authority cited is a requirement for predictive analytics and reviews that are irrelevant to the RAC program. The RAC program is specifically a post-payment claims review program.

Link to CHA citated legislative document: https://leg.colorado.gov/sites/default/files/images/olls/2013a_sl_285.pdf

Nevertheless, CHA's statement is also just not accurate. In fact, the RAC Program, based on its effectiveness, quality, and outcomes has resulted in national recognition, collaboration and coordination of audits across regions and states. For example, the Government Accountability Office (GAO) has reached out to give a report to Congress on the effectiveness of the Colorado RAC Program. The Department has also been working with the Colorado Medicaid Fraud Control Unit, the Federal Bureau of Investigation, the National Association of Medicaid Fraud Control Units, the US Attorney's Office, the US Department of Health and Human Services, and the US Office of Inspector General to utilize the Colorado RAC audits to substantiate Federal cases and further develop identification of fraud, waste and abuse through the Program. Additionally, the Department has been working with other states to help them to build effective RAC programs for their states, as well as collaborating nationally to identify trends and create standard processes for the RAC Program as a whole.

It is also inaccurate to state that the existence of litigation constitutes an admission of flaws in the RAC Program. To date, no court has issued any findings that the RAC Program is flawed.

Regarding RAC Audit Claims Limits and Tiers:

CHA Comment:

"Over the past several years, providers have identified significant transparency, accountability, and efficiency failures that have led to considerable administrative burden, unwarranted recoupments, and considerable litigation activity – all of which increases health care costs and jeopardizes provider participation in the Medicaid program."

Department Response:

Communications have been given to Providers as well as CHA regarding the Department's commitment to ongoing stakeholder engagement and communications. The Department has committed to:

- Updating processes to help streamline Provider access to audit reports.
- Increasing transparency through publicly posted audit outcomes.
- Working to operationalize rebilling options, when warranted.

The Department will be holding an upcoming webinar in May to further communicate RAC Appeal changes and to take stakeholder feedback into consideration from all parties while updating any processes.

To address the audit activity, while the Department recognizes that audits are never popular among the provider groups subject to those audits, they serve an important function to preserve the integrity of the Medicaid program. The fact remains that the RAC audits, with which CHA has taken issue, are required by federal law. And when the Department identifies overpayments, it has a legal responsibility to report the findings and recover those overpayments. All recoveries are then put right back into the Department's Personal Services Line, which funds medical treatments for our Clients. When the federal portion of a recovery is paid back, the federal government uses those funds to pay for the RAC Program, which in turn, makes it a $0.00 program for the state.

It is true that audit activity has increased through the RAC program; however, this is only to maintain the Department's review rate consistent with previous years and in light of the increases in Colorado Medicaid client enrollments, rate increases, and the number of claims being billed.

The growth in audit activity, Medicaid populations and healthcare costs are not unique to Colorado. In a recent report to Congress, CMS made the following statements:

"This 5-year period is projected to be one of continued growth in Medicaid enrollment and rapid growth in federal and state investment. Over FYs 2019–2023, Medicaid enrollment is projected to increase by 6 percent, while total Medicaid expenditures are projected to grow to $777 billion in FY 2023, an increase of nearly 25 percent. Over $98 billion of this projected $153.7 billion increase would be paid from the federal Treasury. **Because the federal government will pay at least 90 percent of the cost of the expansion of Medicaid coverage to newly eligible, low-income adults during this time period, program integrity challenges for participating state Medicaid programs and CMS will remain at the forefront of program administration and oversight.**

…

Medicaid is a federal-state partnership, and that partnership is central to the program's success. CMS provides states with guidance to use in meeting statutory and regulatory requirements, technical assistance including tools and data, federal matching funds for their expenditures, and other resources. States fund their share of the program, and, within federal and state guidelines, operate their individual programs through activities including setting rates, paying claims, enrolling providers and beneficiaries, contracting with private plans, improving service quality, and claiming expenditures. **State Medicaid programs and CMS share responsibility for ensuring that state and federal dollars are used to deliver health care services consistent with efficiency, economy, and quality to eligible individuals and are not misused for fraud, waste, or abuse."**

Link: https://www.cms.gov/files/document/comprehensive-medicaid-integrity-plan-fys-2019-2023.pdf

CHA Comment:

"Federal law sets the requirements for Medicaid RAC audits (42 CFR § 455.508(f)) specifies that states cannot extend the lookback period beyond three years unless they receive express approval from CMS. For unclear reasons, Colorado is one of only six states that requested an extended lookback period, and one of only two states that a) has the most aggressive 7-year lookback and b) did so without providing any justification. The other four states' lookback periods relate to pre- existing record retention laws in their state.

Colorado obtained an unwarranted exception to federal regulation to look back further than three years."

Department Response:

The Department disputes that an exception to the three-year look back was "unwarranted." To begin, the Department submitted and received approval from CMS, through a State Plan Amendment (SPA), to extend the look-back period to seven years. The CMS-approved SPA for the Colorado RAC Program is available on Medicaid.gov, which outlines the authorities for claims limits and look back periods.

Link: https://www.medicaid.gov/sites/default/files/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/CO/CO-16-0003.pdf

Providers are required, regardless of the reason, to retain medical records for 7 years as part of state law, and for some claims (i.e. x-rays), Providers must retain all medical records and documentation for 10 years.

Specific to the RAC SPA, in making its request for a 7-year look back period, the Department was attempting to align with CMS's own standard of reviewing claims as far back as 10 years. Indeed, there have been instances where CMS has directed the Department to recover from providers on claims that go beyond a 3-year lookback period. Given the intent of the RAC to

reduce improper Medicaid payments through the efficient detection and collection of overpayments–and CMS's approval of the extended look back, the Department sought the ability to audit back 7 years rather than 3.

CHA Comment:

"Reduce the length of the lookback period to three years and limit the number of records the RAC contractor may request

- Federal law provides for a limited lookback of three years (compared to seven years for HCPF RAC audits) and limits the frequency and number of records that may be requested from providers."

Department Response:

The Department follows all regulatory rules of the RAC program including claims and limits on any RAC Audits. The 7-year look back is one CMS requirement through Medicare, but this is also a recommendation from the Colorado Medical Board. The RAC currently audits 7 years post-payment, but the Department's FWA Division does not audit claims within the timely filing period (1 year after the date of service). Our reason for not auditing within the Timely Filing Period is because there is another vendor, Utilization Management, responsible for reviewing claims within that period of time. This means that the RAC program is effectively only auditing 6 years of claims at any given time.

However, the Department is mindful to be fair and balanced and takes a tiered approach to the amount of claims it requests records for to substantiate inpatient services provided. These tiers are based on the size, staffing, and reimbursement rates to inpatient facilities.

In an effort to continuously improve our own processes, the Department is updating the tiers to be more effective given the increase in costs, claims and enrollments in Health First Colorado. This will be publicly available once the process and communication are completed.

Regarding RAC Contingency Fees:

CHA Comment:

"Place a limit on the RAC Audit contractor's "bounty-hunting" contingency payments

- RAC audit fees are paid out on a contingency fee basis, which means the more aggressive HMS is against providers, the higher their recoveries and subsequent commission and creates a perverse incentive for the contractor to pursue aggressive, unfounded audits. For reference, the federal maximum contingency rate is 12.5% for all services except for durable medical equipment."

Department Response:

The RAC Program is a federal program. Federal law states that the Department must pay the Contractor in a contingency fee-based agreement. Sections 1902(a)(42)(B)(ii)(I) and (II) of the Social Security Act provide that payments to Medicaid RACs are to be made only from amounts "recovered" on a contingent basis for collecting overpayments. Thus, the contingency fee arrangement CHA compares to "bounty-hunting" is, in fact, a federal requirement. And, as an important point of context, hospitals also have a similar financial incentive when submitting claims for reimbursement to receive the maximum amount for the services provided.

Per CMS:

"Contingency fee rates for identifying and collecting overpayments should be reasonable and determined by each State, taking into account factors including, but not limited to, the level of effort to be performed by the RAC, the size of the State's Medicaid population, the nature of the State's Medicaid health care delivery system, and the number of Medicaid RACs engaged. "

Link: https://www.medicaid.gov/federal-policy-guidance/downloads/smd10021.pdf

The State Plan Amendment (CO-16-0003) was approved by the CMS for the Colorado Recovery Audit Contract, and is available on Medicaid.gov, which outlines the contingency based payments the Department is allowed to apply to the Colorado RAC Program.

Link: https://www.medicaid.gov/sites/default/files/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/CO/CO-16-0003.pdf

Regarding RAC Appeals:

CHA Recommendation:

"Allow appeal decisions made by the Office of Administrative Courts to have precedential value.

- Currently, appeals must be pursued on each incident, and decisions of OAC do not have precedential value that extends to other appeals. This significantly increases burdens on providers and increases health care costs.

Department Response:

Appeals of overpayment determinations to the Office of Administrative Courts (OAC) are de novo proceedings where neither the Department nor the provider are bound by previous positions, conducts, or statements. 10 C.C.R. 2505-10, Section 8.050.6.E. All proceedings by OAC are governed by the State Administrative Procedure Act, which limits OAC's jurisdiction, in this instance, to that which is derived from statute. C.R.S. 24-4-105(2); 10 C.C.R. 2505-10,

sec. 8.050.7.A. The precedential value of administrative appeals is also governed by constitutional due process concerns that protect both providers and agencies like HCPF

Although certainly not binding, it may be persuasive to note that the OAC, in a recent 2020 case, seemed to disagree with similar arguments to those raised by CHA attacking the validity of the RAC audits.

The Administrative Law Judge in that case stated:

"In its Reply, the Hospital suggests that it faces an all or nothing proposition in terms of compensation. It fears that if the inpatient treatment is denied as not medically necessary, it would receive no compensation at all for its care. The ALJ does not view this case that way. To continue the metaphor, the facts may show that Cadillac care was not indicated. But that does not mean that the Hospital should not receive compensation at the Chevrolet level. The ALJ understands in general that billing manuals have less expensive codes for most procedures. In order to avoid an all or nothing result, the Hospital may want to present evidence of what it should receive in the event the ALJ determines that outpatient care was sufficient.

Certainly, though, the ALJ understands that it is the Hospital's position that its inpatient treatment was correct. The ALJ views the Hospital's Motion and Reply as demonstrating a fundamental misconception about the nature of this case. This case does not turn on the precise language of the State Department rules. As stated, the concept is simple: was Medicaid billed for more expensive care than was needed? This is a factual dispute and one unsuited to a motion for summary judgment."

Regarding CMS RAC Program Exemptions:

CHA Comment:

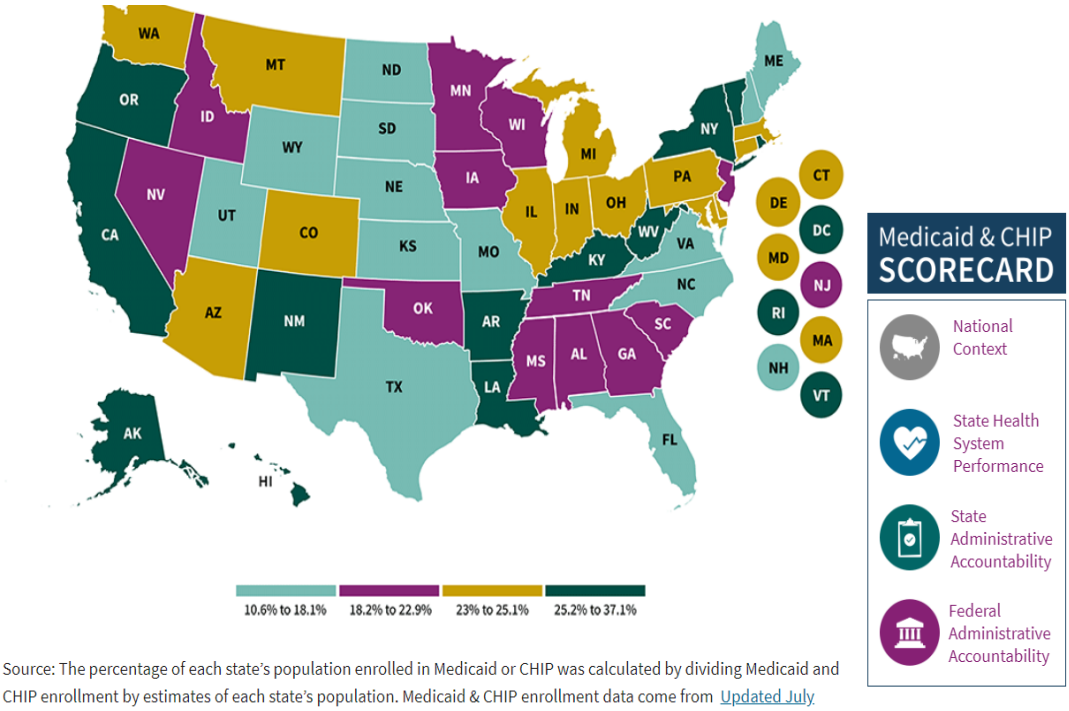
"Of the 28 states with exemptions to the RAC audit process entirely, 13 (AK, ID KS, KY, LA, ME, MA, MD, MO, NJ, WA, WI, WY) indicated that their current program integrity work is more than enough to replace the RAC audit."

Department Response:

States with exemptions do so according to the rules and authorities that apply in their state, which vary greatly from the rules and authorities that apply in Colorado. For example, some states utilize 100% managed care programs, and the RAC would be unable to audit claims that are under audit or validation from another entity like a managed care organization. There are also significant differences in the populations, enrollment numbers, and the regulations that apply to the Medicaid Programs for those states.

The RAC final rules contain clarifications on the Recovery Audit Program for state Medicaid agencies which can be reviewed at: https://www.govinfo.gov/content/pkg/FR-2011-09-16/pdf/2011-23695.pdf

One illustration of how each state's Medicaid program differs from the others is shown by the following scorecard published by CMS that utilizes data from Kaiser Family Foundation to show the differences in the percentage of each state's population enrolled in Medicaid and/or CHIP:



Source: The percentage of each state's population enrolled in Medicaid or CHIP was calculated by dividing Medicaid and CHIP enrollment by estimates of each state's population. Medicaid & CHIP enrollment data come from Updated July 2020 Applications, Eligibility, and Enrollment Data. Estimates of each state's population come from U.S. Census Bureau. Estimates of the Total Resident Population and Resident Population for the Nation, States, Counties, and Puerto Rico (Vintage 2020 population estimate).

Link: https://www.medicaid.gov/state-overviews/scorecard/how-states-deliver-care-medicaid/index.html

The program integrity policies in states like Colorado with 23% - 25.1% enrollment should not and cannot be compared to states with significantly lower or higher enrollment statistics, or to states with other significant differences in their Medicaid programs.

Moreover, the states cited by the CHA may not be exempt from the federal RAC requirements for much longer. The GAO is currently compiling a report to Congress detailing the successes of the Medicaid RAC programs across the nation and has reached out to the Department to document the RAC program's efforts in Colorado. GAO officials have stated that CMS is considering raising the standards for granting RAC program exemptions and waivers to state agencies, including possibly revoking program exemptions currently in place.

Regarding Audit Effectiveness and Authority:

CHA Comment:

"CHA believes Medicaid payment reviews and audits have value to ensure the state's resources are safeguarded from fraud, but also that these reviews and audits should be warranted, effective, and efficient."

Department Response:

The Department agrees it is committed to safeguarding the state's resources and that these audits should be warranted, effective and efficient. In the last SFY, the Department audited 0.28% of all claims that were paid out by the Department. Because of increases in Medicaid program costs, client enrollment, and the number of claims submissions to the Colorado interChange, the Department has a responsibility to review what it can. However, just as the Department has a responsibility to audit and ensure the integrity of the program, so do providers.

Hospitals and providers are required to bill claims appropriately according to all applicable state and federal billing requirements. Providers and state Medicaid agencies are required to follow the coding standards outlined in the HIPAA Administrative Standardization Act set forth in 45 CFR Part 162. This Part also requires the provider to have correct coding and to maintain education and documentation on coding requirements. As made clear in the Medicaid Provider Participation Agreement signed by each of the hospitals represented by CHA, providers must take responsibility for billing claims correctly.

Link: https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-C/part-162

Regarding CHA Recommendations:

CHA Comment:

"Conduct an independent review of recent audits to ensure compliance with coding practice standards and Colorado law.

- For one series of audits CHA has been engaged in to-date regarding "same-day, same service" audits for specialty providers providing care to hospital inpatients, HCPF has been unable to articulate the coding logic behind the audit, which appears to conflict with standard coding practice.
- For another series of audits regarding hospital "observation" visits, HCPF's audit appears to conflict with the state's own rules regarding the definition of observation status and the qualification of auditors to conduct state-based audits."

Department Response:

As a general matter, all RAC projects are thoroughly vetted, researched, and approved prior to implementation. This vetting involves policy and program staff as well as doctors and nurses utilized by HMS. All RAC audits are based on publicly available regulatory guidance, such as the medical coding and other federally required rules outlined in the Affordable Care Act and the HIPAA Administrative Standardization Act. RAC audits need to be tailored to our state. However, providers can find the "Approved RAC Topics" located on CMS.gov. CMS is the authority for National Correct Coding Initiatives and has transparent billing instructions for providers as well as state Medicaid agency resources.

As to the "same-day, same service" audit to which CHA is referring, it is based on Medicaid National Correct Coding Initiatives (NCCI) rules and on American Medical Association (AMA) Medical Coding rules. During discussions of this audit, CHA has fundamentally misunderstood the differences between the Medicare and Medicaid Programs and the authority which requires certain coding standards. The Department's position is that the "same day, same service" audit does not conflict with standard coding practice, and was conducted in accordance with AMA CPT guidelines, as required by Federal Rule.

As to the "observation visits" audit with which CHA also takes issue, this is outlined in the section below under the recommendation from CHA to allow payment for services rendered.

CHA Comment:

"Prohibit "nonpayment" for legitimate care provided and ensure reimbursements are sufficient to enable access to care.

- Currently, when RAC audits identify that a service could have been provided in a lower cost setting, they recoup the entire cost of the service, rather than the difference between high- and low-cost."

Department Response:

The Department is currently working on updating processes for the RAC Audit entitled "Level of Care, Inpatient Audits" in which an inpatient admission was found to be not appropriate because a lower level of care, such as outpatient, would have been the appropriate setting for that patient. Although complex, the Department has been engaging with several hospitals and hospital systems about these concerns, and as a result, the Department is currently implementing a new process that will enable Providers to rebill the audited claims at the more appropriate setting and level of care. The permanent operational process is still in development, but a temporary solution is currently in effect, enabling providers to rebill as of the date of this response. Accordingly, CHA's representation about "recoup[ing] the entire cost of service" is now outdated.

Implementing the new process for rebilling claims is a complex process and will likely require:

- Stakeholder engagement from the provider community
- Provider education about the new processes through the development of standard operating procedures, policy memos, and provider bulletins.
- Statutory and regulatory analysis to ensure compliance with state and federal requirements
- Rulemaking and/or State Plan Amendments, as necessary
- Operational programming utilizing the Medicaid Claims Processing system, which may require CMS approval of claims processing updates
- Coordination with the Department's Fraud, Waste and Abuse Division to ensure it is documenting rebilling for services appropriately and following state and federal audit requirements.
- Coordination with the RAC to ensure successful claims rebilling.

CHA Comment:

"Improve engagement with providers, transparency, and accountability.

- CHA recommends HCPF create a provider advisory group for RAC audits in order to provide some accountability for the Department's decision-making. The legislature may wish to consider whether such a group has oversight authority for RAC audits or the opportunity to escalate complaints to another oversight entity.
- CHA recommends HCPF routinely publish summary information regarding audits, findings, appeals, overturned decisions, and efficacy…

Take an "education first" continuous improvement approach to engaging providers and provide clear and transparent coding guidance when errors are identified.

- When HCPF identifies billing errors, they must publish and promote the "correct" coding construction to encourage compliant billing practice among providers."

Department Response:

Regarding engagement, transparency, and accountability, the Department has engaged with stakeholders, including specifically with CHA, over the past several years regarding the RAC program. And, as outlined above, the Department has further stakeholder engagement opportunities planned to enhance transparency and communication regarding upcoming changes and improvements.

By way of example, the Department is currently working on a publicly available reporting mechanism for RAC audits. The reports would include data on the current audits being conducted, the cost impacts to the state, the basis and rationale for the audits, the cents on the dollar for quality/cost (based on findings and reimbursements information), and additional regulatory documentation as needed. These reports will be publicly available on the Health

First Colorado RAC website, the HMS Colorado RAC website, as well as any other platform to ensure transparency with providers, as well as taxpayers.

While the Department is certainly not opposed to exploring whether a need exists for a more robust communications team for the RAC program in Colorado, as envisioned by CHA, it is simply not possible with the Department's current staffing resources. Based on the efforts already underway by the Department and in order to meet the communication and engagement needs articulated by CHA, HCPF would require at least additional 2.0 FTE outside of any current budget request to constantly meet the requirements. The Department simply cannot do more, without more resources.

Finally, the Department respectfully declines CHA's invitation to create a provider advisory group with oversight authority for RAC audits. The RAC program is already subject to robust oversight by CMS and by the state and federal authority that requires these audits. Further, providers are given ample opportunity to seek both informal reconsideration and formal appeals when they disagree with the outcome of a RAC audit. Last, it would be a conflict of interest for the providers who are subject to RAC audits to then also govern the way those audits are to be conducted.

Regarding Department Efforts to Collaborate While Maintaining Compliance in State and Federal Fraud Investigations:

CHA Comment:

"CHA has been actively engaged for the past six months on at least two ongoing audits that we believe conflict with either Colorado law or industry-standard coding procedures."

Department Response:

Within the past 6 months, the Department has worked tirelessly with the Colorado Medical Society and CHA to provide education, vet regulatory guidance, and collaborate with the Department's policy staff while listening to and addressing the Colorado Medical Society and CHA's correct coding concerns. Although the Colorado Medical Society and CHA continue to disagree with the Department's position, the Department's position remains that the audits are supported by both Colorado law and industry-standard coding procedures. Furthermore, as CHA is aware, the Centers for Medicare and Medicaid Services (the CMS) recently responded to a request for guidance from the Colorado Medical Society by expressing agreement with the Department's position.

CHA Comment:

"CHA has had an ongoing dialogue with HCPF staff regarding audit policies and procedures. Importantly, our dialogue is independent from ongoing litigation involving hospital-based

providers, HCPF, and the Attorney General's Office, and focuses on general policies and procedures for RAC audits, as opposed to any particular dispute between a provider and the RAC auditor. CHA would be happy to provide additional material or correspondence upon request."

Department Response:

As discussed above, the Department is committed to an active and robust stakeholder engagement process with all stakeholders, including CHA. As future stakeholder opportunities arise, the Department invites CHA to participate and provide feedback. However, the Department disputes that CHA's dialogue can be entirely independent from the ongoing litigation involving both hospital-based providers and CHA itself. It is the Department's position that effective stakeholder engagement necessarily requires stakeholders to act in good faith and in cooperation with the Department, not as an adverse party to ongoing litigation. As such, the Department encourages CHA to engage with the Department as a valued stakeholder.

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