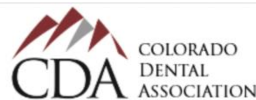

Our coalition strongly believes that Medicaid payment reviews and audits have value to ensure the state's resources are safeguarded from fraud, but also that these reviews and audits should be warranted, effective, and efficient as well as consistent with clear, transparent billing standards. We appreciate the Department of Health Care Policy and Financing (department)'s commitment to quarterly provider meetings and feedback opportunities. **We write to request an update on reforms that have been previously committed to and responses to questions and requests raised during the first quarterly provider meeting in May 2023 to be provided during the August 2023 meeting.** We believe there are shared areas for collaboration that improve patients' access to care, support the financial health of providers, and protect the integrity of the Medicaid program.

Provider update since the May meeting: Unfortunately, providers continue to experience issues with communication, subjective interpretations, timing, the volume of audits, and significant claw backs when claims could easily be rebilled.

We appreciate the department's commitment to institute a process to rebill claims where there were small errors in billing or medical necessity considerations. This is a top priority issue as those claw backs apply to appropriately rendered services that should be paid at the correct amount.

Other top priorities for collaboration include:

- Working with providers to identify new screening tools that are not based on flawed InterQual criteria
- Establishing a clear, transparent, and reasonable process for volume limit changes
- Requiring the contractor to follow timelines and to identify concerns for contested claims using descriptor and code to ensure providers are able to learn from billing errors

Status of Reforms:
During the May meeting, HCPF committed to six website updates and a new training with the contractor – to our knowledge, these items have not been added or scheduled at this time:

1. Website summaries of trends and audit findings **(not on the website)**
2. Recently completed audit details **(not on the website)**
3. Overpayment and underpayment reports **(not on the website)**
4. Error rates **(not on the website)**
5. Score cards **(not on the website)**
6. The RAC contract and HCPF information on oversight of deliverables **(not on the website)**
7. Trainings with the contractor on common billing errors identified by audit findings **(no trainings scheduled)**

Additionally, in a March 2023 letter, HCPF committed to seven distinct steps that they are taking to improve the program (detailed below). We support the steps detailed below and request an update on

the timeline and process for these changes. At this time, we are only familiar with three of seven areas where any action has been taken.

1. Updating processes to help streamline provider access to audit reports (p. 5) **(pending action)**
2. Increasing transparency through publicly posted audit outcomes (p. 5) **(pending action)**
3. Working to operationalize rebilling options, when warranted (p. 5) **(initial action taken)**
4. Updating the record request tiers to be more effective (p. 7) **(pending action)**
5. Developing a new process that will enable providers to rebill the audited claim at the more appropriate setting and level of care (p. 12-13) **(initial action taken)**
    - Opportunities for stakeholder engagement from the provider community
    - Provider education about planned reforms
    - Statutory and regulatory analysis to ensure compliance with state and federal requirements
    - Rulemaking and/or a new State Plan Amendment
    - Operational programming
    - Coordination with HCPF's Fraud, Waste, and Abuse Division
    - Coordination with the RAC to ensure successful claims rebilling
6. Releasing a new publicly available reporting mechanism for the RAC audits. Including: 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, and additional regulatory documentation (p. 13) **(pending action)**
7. Developing an active and robust stakeholder process (p. 15) **(initial action taken)**

Priority Areas Identified During the May Provider Meeting: During the May provider meeting, providers expressed significant interest and consensus regarding the reforms below. We request an update on areas to partner on in making improvements to the Program.

Topic	Background	Request
Process Reforms		
Volume of record requests	We are hearing concerns that HMS has been requesting medical records above the limit established by HCPF pursuant to CFR Section 455.506. It is impossible for providers to keep up with the current limits to fairly retain payments rendered.	Establish a process in rule where the department must work with stakeholders to fairly define the volume of record requests and transparently communicate updates prior to formal changes.
Issues with missed contractor deadlines	The department is currently required to respond within 45 days or to provide notice of its inability to respond; however, providers have experienced frequent issues with slow response times from both the department and its contractor that fall outside of the statutory window.	Establish clear, transparent protocols to hold the contractor accountable for meeting program expectation timelines or risk forfeiting the right to the alleged overpayment.

Process for rebilling claims	We greatly appreciate the commitment to a new process to rebill claims.	Release a clear timeline and roadmap for implementation of this critical tool.
Audit Criteria Reforms		
Concerns with InterQual	InterQual is a flawed guideline for inpatient claims as it has many diagnoses that can never be met for inpatient services. During the May meeting, providers expressed clear concern with inappropriate overreliance on InterQual criteria.	Establish stakeholder process to evaluate fair, relevant criteria options.
Issues with coding logic	Providers continue to experience issues where the reasoning behind recoupment differs from the provider manual guidance or federal billing standards.	Establish a stakeholder process to discuss and institute a fair and effective review process. Establish a clear, efficient process to challenge and resolve audits undertaken by the contractor that differ from HCPF provider manual guidelines.
Education Reforms		
Clarity surrounding audits	Providers spend a significant amount of time and resources complying with the exact request criteria when requesting reconsideration from the auditor. Unfortunately, the department and its auditor do not provide a response that is specific to each overpayment, rather they respond to claims as a batch. This makes it impossible for providers to understand which claims were reconsidered and which were overturned or omitted from reconsideration.	Specify in its decision on informal reconsideration the specific determination on each alleged overpayment. This will ensure providers have clarity surrounding billing practices.

Appendix: Providers continue to experience significant issues with specific audits that violate coding practices and threaten access to care.

Example 1: Specialty Audit Billing

Since November, the Colorado Hospital Association (CHA), the Colorado Medical Society (CMS), and HCPF have been discussing a component of an audit specifically related to billing practices for initial

codes. The most recent department response continues to omit any justification from HCPF's provider billing manual or sound guidance from the American Medical Association (AMA) current procedural terminology (CPT) that contradicts the basic billing principle that admitting providers and consultants are able to and encouraged to code the first time they saw the patient under the initial visit (99221, 99222, 99223) for any given hospital stay. Providers have not received any response since March 31. In that time, providers impacted by the audit have expended a significant resources on legal expenses and the Medicaid program lacks clear billing guidance. Additional information can be found here.

Example 2: Durable Medical Equipment

Durable medical equipment (DME) providers received an audit in early May related to a supposed violation of Medicare National Correct Coding Initiative (NCCI) edits that were deactivated through appropriate regulatory channels in Colorado. While they received an extension to the audit response, they still are awaiting a response to their questions about the audit itself violating HCPF provider guidance. Additional information can be found here.

Example 3: Medicare Administration

DME suppliers have also received audits for "medication administration" on claims that do not have any medication on them. The audits ask for items such as a Medication Administration Record (MAR), documentation of any product wastage, and documentation of National Drug Code strength, which are all irrelevant metrics for DME. This audit wastes time and resources.

Example 4: Timing of Changes

A small critical access hospital was audited retroactively for compliance with changes that did not take effect until Jan. 1. While the hospital received a six-month stay for this audit, they have not received any clarification surrounding the root of the issue, the correct coding guidance both now and previously, and certainty surrounding the audit.

Example 5: Aggressive Audit Activity

One hospital system reports that it have had over 7,800 accounts targeted since Jan. 1, all through complex automated audits. There is significant administrative burden associated with this volume and the system is constantly chasing account reconciliation with the department.

Example 6: Previously Approved Claims

Providers also indicate that they will get thousands of requests to verify and protect payment for claims that were directly approved by Medicaid through prior authorization.

Example 7: Differences Between Federal Government

Hospitals report that they see 178 percent more Medicaid audit activity than Medicare, despite seeing similar numbers of patients and Medicare and Medicaid.