Aug. 6, 2024

Members of the Joint Legislative Audit Committee
Colorado General Assembly
200 East Colfax Avenue
Denver, CO 80203

RE: Office of State Auditor's Evaluation of Colorado's Medicaid Recovery Audit Contractor program, Department of Health Care Policy & Financing Performance Evaluation, May 2024, 2356P

Dear Senators and Representatives:

On behalf of Colorado Hospital Association, Colorado Medical Society, Colorado Rural Health Center, Colorado Association for Medical Equipment Services, Eastern Plains Health Consortium, and Western Healthcare Alliance, which are primary partners to the state in delivering health care services to the 1.7 million Coloradans insured through Health First Colorado, Colorado's Medicaid program, we write to you today to **thank your committee for your engagement with the Medicaid Recovery Audit Contractor (RAC) program and to request continued oversight.**

We greatly appreciate the Committee's attention to the State Auditor's May 2024 report. This report provided extensive background that affirmed the significant, ongoing difficulties providers continue to experience with this program. The audit clearly identified that:

- Colorado has one of the most aggressive RAC programs in the country;
- There are significant program operations and oversight issues, including potential misuse of the General Fund; and,
- There is a lack of clinical expertise or alignment with Health First Colorado billing rules.

The Colorado Department of Health Care Policy & Financing (HCPF) has substantial work to do to address the seven findings and corresponding recommendations resulting from the audit. And, perhaps even more concerning, the audit identified several structural flaws that cannot be addressed through operational adjustments or changes to the vendor contract but would require more material redesign of the RAC program. We are **deeply troubled by the serious nature of the findings of the audit**, **however, not surprised,** given our experiences with the RAC program, particularly in recent years. We write this letter in the spirit of constructive partnership and in the interest of making Colorado's Medicaid program stronger, more efficient, and more effective in serving the 30 percent of Coloradans who rely upon it.

The contractor working with HCPF gets an 18 percent reward for any claim they label as an overpayment. This creates a strong incentive for them to find as many overpayments as possible, which puts pressure on health care providers. Providers then have to spend time and resources disputing these claims, even if their billing was correct. Additionally, the contractor does not provide clarity about why they mark claims as overpayments. This makes it hard for providers to understand and fix any potential billing issues.

While we appreciate HCPF's agreement with most of the findings, we are concerned that most of HCPF's proposed commitments of action in response to the report will be insufficient to meaningfully address the recommendations. In general, HCPF seems to be largely focused on doing "more of the same" without dedicating meaningful or appropriate new resources or bringing new approaches to bear. Based on their responses and action commitments, we are not convinced that HCPF is taking seriously the material nature of program reform that will be required to make Colorado's RAC successful in reducing overpayments and improving provider billing accuracy. For a detailed and specific response to each of HCPF's commitments on the findings and recommendations of the audit, please see attached table.

As you review our specific comments, we encourage you to keep in mind that Colorado is one of just 18 states with an active Medicaid RAC program (see Auditor's Report page 5) and that Colorado's RAC program features several provisions that are more aggressive than federal provisions require (see Auditor's Report page 6), specifically including:

- Under federal policy, the RAC *must not review claims that are older than three years* from the date of the claim, unless an exception is granted. Colorado has an approved *exception allowing the RAC to review claims up to seven years old* from the date the claim was paid.

- Under federal law, the contingency fee paid to a RAC vendor may not exceed the maximum set by the Centers for Medicare and Medicaid Services, which for most claims is *a 12.5 percent% maximum*. Colorado has an *approved exception to pay a contingency fee of up to 18 percent.*

- Under federal law, states must determine a rate to pay a RAC vendor to identify underpayments to providers, in order to adequately incentivize the detection of underpayments. Colorado has an approved exemption from this requirement, and *the contract does not pay the vendor for identifying underpayment*.

- Under federal law, states must hire a minimum of 1.0 FTE Contractor Medical Director who is a Doctor of Medicine or Doctor of Osteopathy in good standing with the relevant state licensing authorities and has relevant work and educational experience. Colorado sought and received an exemption from this requirement, and its RAC contractor provides a 0.1 FTE medical director, who is not licensed in Colorado.

We believe that if HCPF insists on implementing a **uniquely aggressive RAC program**, it must then be **uniquely effective in structuring contract incentives** and **uniquely diligent in providing thorough and detailed program oversight**. According to the Auditor's report, neither is the case.

Additionally, the audit did not identify an additional major problem with the RAC program: when the contractor decides that care should have been provided at a lower level, they can demand the entire

claim amount back. This means that even if a doctor decided years ago that hospital care was necessary, the contractor can later argue that it wasn't needed and recoup the payment. The contractor can contest thousands of claims at once, making it hard for providers to dispute them and often forcing them to accept settlements or provide complete recoupments. Although HCPF promised to address this by introducing a rebilling process, they are restarting audits without committing to implement this solution effectively.

As you know, this is a critical time for Colorado's health care system and the millions of Coloradans who rely on it, particularly Medicaid clients. In this post-COVID context, health care providers and consumers alike are struggling with medical inflation and the increasing cost of delivering and accessing care. Additionally, there have been well-documented challenges with Medicaid redeterminations in Colorado as the Public Health Emergency wind-down has happened. (See Colorado News Connection story May 9, 2024, Denver Post article June 4, 2024 and USA Today article July 8, 2024.) Given this context, it is particularly alarming that HCPF appears to be doubling down on audit practices that further stress health care providers by creating undue administrative burden and driving up costs, rather than taking a partnership approach.

We would be happy to answer any questions you have in response to this letter and our attached table and / or discuss options we see for more material reforms to the RAC program. We look forward to continuing constructive collaboration with Governor Polis' administration and members of the General Assembly in service to our shared goal of supporting a strong and successful Medicaid program.

Respectfully,

Colorado Hospital Association

Colorado Association for Medical Equipment Services

Colorado Medical Society

Eastern Plains Healthcare Consortium

Colorado Rural Health Center

Western Healthcare Alliance

Provider Response to State Auditor's Office Evaluation of Colorado's Medicaid Recovery Audit Contractor program
May 2024, 2356P

Audit Recommendation 1: The Department of Health Care Policy & Financing (HCPF) should improve the controls that it has in place to ensure that Recovery Audit Contractor (RAC) audit scenarios are complete and accurate and to identify any problems in the scenario design before the audits are conducted. This should include implementing additional policies and procedures that:

A. Define the HCPF divisions that should be included in the review and approval of audit scenarios and identify the roles and responsibilities of each division.
B. Identify the information each division needs to fulfill its responsibilities and establish processes for distributing the information to the divisions.
C. Establish how HCPF will hold its RAC accountable for thorough development of audit scenarios that includes ensuring the policies, rules, and other standards to be used in the audit are complete and accurate.

HCPF Response (summarized): The Department agreed with all elements of the recommendation. Specifically, they commit to (a) better engaging HCPF's Executive Leadership Team (ELT) and other appropriate division staff in review and approvals, (b) better engaging and communicating with stakeholders and (c) reviewing national standards, laws and guidelines to enhance current processes.

Provider Response: HCPF's response is insufficient. It is vague and makes no specific commitment of ***how*** it will better engage the ELT or other divisions, ***how*** it will improve engagement and communications with stakeholders or ***which*** national standards, laws and guidelines it will review and consider. As stakeholders of the RAC program, we don't know what changes we can reasonably expect to see and, without further detail, we don't have a way to reasonably hold our partners at HCPF accountable to the implementation. We recommend that HCPF take clear, transparent action to detail the process behind how each audit is approved in its quarterly reporting and be sure to engage specific divisions in the follow-up education practices.

Audit Recommendation 2: The Department of Health Care Policy & Financing should amend the Recovery Audit Contractor (RAC) contract to eliminate the provision to pay the RAC for the amounts identified as overpayments during RAC audits but not recovered from providers to bring the contract into compliance with federal regulations and State statute.

HCPF Response: The Department agreed with this recommendation. The Attorney General's Office and HCPF are reviewing all state and federal laws and are working with HMS to amend the contract accordingly.

Provider Response: We appreciate this commitment and look forward to seeing the revised contract with HMS by the August 2024 deadline HCPF committed to in the report. We agree that this is an important administrative step. However, we feel this is insufficient as it does not address the amount that has been previously paid to HMS in violation of federal regulations. HMS should repay those funds to the Colorado general fund.

Audit Recommendation 3: The Department of Health Care Policy & Financing should promote appropriate and consistent use of contract transmittals by implementing written policies and procedures that:

A. Specify the purpose of transmittals, including the scope of guidance or direction that is appropriate for a transmittal.
B. Identify the kinds of direction, guidance, or changes to contract provisions that cannot be provided through transmittals, such as changes that require a contract amendment.
C. Require transmittals to be updated or reissued if they reference an expired contract but the information they contain is still relevant.

HCPF Response (summarized): The Department agreed with all elements of the recommendation.

Provider Response: We find HCPF's response to this recommendation sufficient and have no further comment.

Audit Recommendation 4: The Department of Health Care Policy & Financing (HCPF) should strengthen its monitoring processes for ensuring that its Recovery Audit Contractor (RAC) staff, who are reviewing claims, have the qualifications and experience required by the RAC contract. This should include either requiring its RAC to provide routine staffing updates, including licensing and certification documentation, as part of its monthly reports to the Department and implementing a process for consistently tracking this information or revising the RAC contract to reflect that HCPF will rely on the RAC's accreditation by the Utilization Review Accreditation Commission (URAC) and to require the RAC to provide evidence of ongoing accreditation.

HCPF Response (summarized): The Department agreed with this recommendation. However, HCPF stated it will continue to rely upon URAC accreditation, update its contract to require URAC accreditation, maintain a tracking mechanism that ensures the credentials of the contractually defined Key Personnel and ensures consistent achievement of URAC accreditation of its RAC vendor.

Provider Response: We find HCPF's response to be insufficient and unlikely to result in better practices. HCPF commits to better documenting its current practice through a vendor contract change and establishment of an internal tracking mechanism. It is not actually changing practice to ensure HMS is providing qualified and experienced staff, as the audit recommends. This is a major concern for us because, as the audit report states (page 35):

"Consequences of unqualified or inexperienced staff performing RAC procedures may result in:

- *Unidentified overpayments resulting in excessive Medicaid costs for both the federal and state governments.*
- *Inaccurate findings, which could cause providers to repay funds they do not actually owe or to contest the findings through Informal Reconsideration or appeals processes, which could result in additional costs to the providers, as well as HMS and HCPF.*
- *Systemic billing errors may not be identified and would then not be addressed through policy or guidance changes, or provider education, to prevent the errors from recurring in the future.*

In addition, if RAC claim reviewers are not qualified, it can erode confidence and trust in the RAC program on the part of both providers and CMS."

Instead, we'd like to see HCPF change its approach and strengthen its monitoring as recommended by requiring its RAC to provide routine staffing updates, including licensing and certification documentation,

as part of its monthly reports to the Department and implementing a process for consistently tracking this information. Furthermore, it is critically important that HCPF provide true clinical oversight over this program as previously promised to stakeholders in March 2024. Without clinical oversight, providers will continue to waste time and resources debating clinical decisions with non-clinicians.

Audit Recommendation 5: The Department of Health Care Policy & Financing should strengthen its oversight and enforcement of the Recovery Audit Contractor (RAC) contract provisions related to conflicts of interest by:

A. Obtaining disclosures from both HMS and Gainwell Technologies that comply with contract conflict of interest provisions, and documenting its thorough assessment of the disclosures along with its determination that no conflict exists.

B. Clarifying policies and practices to align with contract provisions requiring contractors to notify the Department of any purchases, mergers, or other changes in legal or financial relationships during the contract period that could create an actual conflict of interest or create the appearance of a conflict.

C. Distributing a communication to the provider community about the purchase of HMS by Gainwell Acquisition Corporation that includes information about how an actual conflict of interest is being prevented.

D. Working with HMS to ensure it communicates with providers under HMS branding with respect to its RAC function in Colorado.

HCPF Response (summarized): HCPF disagreed with recommendation element A and agreed with elements B, C and D. For the elements with which they agreed, HCPF committed to updating contracting policies and procedures, clarifying and better communicating with stakeholders about roles and responsibilities for Gainwell and HMS.

Provider Response: While we appreciate that HCPF says there is no conflict of interest, that does not address the reality that Gainwell could make a billing error that HMS then identifies and makes 18 percent profit on. This feels like a true and dangerous conflict of interest for providers and General Fund stability. We would recommend additional safeguards to ensure that when Gainwell makes the billing error, HMS (and through that Gainwell) cannot profit off of it.

Audit Recommendation 6: The Department of Health Care Policy & Financing (HCPF) should revise its guidance on Recovery Audit Contractor (RAC) audit limits to clearly define the intent of the established limits on the number of claims selected for audit from a provider. This guidance should define what constitutes a provider for purposes of determining the RAC claims limit and clearly describe how the claims limits are calculated in instances where a provider has multiple locations. Further, HCPF should consider providing a training for providers that explains how claims limits are applied for health care systems with multiple practices.

HCPF Response (summarized): The Department agreed with this recommendation. HCPF committed to doing a better job documenting and posting its guidance but also made point of stating: *"As the Department receives clarifications on which physician groups are owned by which hospitals, we can enhance the clarity of claim audit volume by hospital. Because of the massive acquisition of physician practices and other health care providers by hospitals, hospitals will have a far higher claim audit volume*

than other providers." The Department made no commitment regarding the suggestion to consider providing training specific to how claims limits are applied for health care systems with multiple practices.

CHA Comment: These claim limits are unrealistic and burdensome. As noted above, the contractor has an incentive to identify as many "overpayments" as possible and bury providers in paperwork. If providers are unable to meaningfully participate in the formal appeals process, then they forego claims they were rightfully paid. Limits need to be measured and appropriate to ensure that both HCPF and providers can participate in a robust conversation.

Audit Recommendation 7: The Department of Health Care Policy & Financing (HCPF) should enhance provider support, outreach, and education in the Recovery Audit Contractor (RAC) program by:

A. Establishing a means for HCPF to monitor the RAC's compliance with the 48-hour response requirement, such as through requiring the routine reporting of how the RAC is meeting this requirement.

B. Enforcing the contractual requirement that the RAC conduct informal conferences or phone calls with providers or provider associations to discuss the RAC program, processes, and findings.

C. Enforcing the contractual requirement for the RAC to prepare provider education plans after each audit that identify and address the common errors and issues found through the audit and describe the content and materials the RAC will use to educate providers to prevent such errors in the future.

D. Enforcing the contractual requirement for the RAC to include updates on its outreach and education activities in its monthly reports to HCPF.

E. Implementing written policies, procedures, and/or guidance, that establish a process for HCPF to log provider communications, provide direction on how HCPF staff should respond to communications in a manner that is timely and relevant, and institute routine analysis of provider communications to inform decisions on program improvements.

HCPF Response (summarized): The Department agreed to all elements of the recommendation. Specifically, they commit to (a) holding HMS accountable for responding to providers in a timely way, (b) better tracking and reporting on informal communications, (c) establishing processes to identify common errors in order to improve communications and trainings, (d) improving communications regarding training and education activities and (e) developing a tracking system to support more timely communications.

Provider Comments: HCPF's response is insufficient. It is vague and provides very little detail about *how* it will make these changes and what specifically providers can expect to see different in the future. Without further detail, we don't have a way to reasonably hold our partners at HCPF accountable to the implementation deadlines that it set.

We are disappointed that HCPF does not commit to dedicating any new resources to provider communications, engagement, or training, and that there are no new strategies or approaches identified as part of itsresponses. We have little confidence that HCPF's commitments will result in better experience for Medicaid providers. Further, we think it is critical to point out that the RAC program is intended to "reduce Medicaid overpayments *and improve provider billing*" (emphasis added). We believe that this finding and HCPF's insufficient response to it are evidence of the Department's lack of focus on and prioritization of the "improve provider billing" part of the RAC program. We find this

disheartening and frustrating, although not surprising given our experience with the RAC program, particularly in the past few years. We believe this program, and all elements of Medicaid, should be approached in a partnership manner and would appreciate HCPF putting equal emphasis and attention on provider support and education to ensure accurate billing overall, as it does to reducing and recovering Medicaid overpayments.